Policyholder: VUB
Policy number: 07/2793.01 – 07//2793.03

Notes to the hospitalisation plan

This version is valid as of 1/10/2016.

This group insurance policy, which is concluded by VUB on behalf of its members of staff with the insurance company AXA Belgium, through the agency of Vanbreda Risk & Benefits, commences on 01.04.2003.

Who benefits from this policy?

The principal insured

Following categories are considered principal insured:

- all members of staff with an employment contract;
- members of the board of directors.

The principal insured are automatically affiliated.

The co-insured

Following categories are considered co-insured:

- the principal insured mentioned above who are (early) retired as from 01.04.2003 onward;
- the family members of the principal and co-insured mentioned above i.e.:
  - the spouse or official co-habiting partner when the affiliation takes place before the age of 65 years;
  - the unmarried children who are entitled to claim child allowance;
  - the unmarried disabled children who live with the principal and co-insured mentioned above and are entitled of a handicap allowance.

The co-insured can affiliate voluntarily.

In case of (early)retirement, the employee can remain affiliated to this insurance policy as a co-insured provided that the continuation has been confirmed within 3 months following the (early) retirement.

Cover may be continued for the affiliated co-insured at decease of the beneficiary. For this purpose a written application should be send to the insurer within two months following the date of decease.

Cover will be ended at marriage or marital co-habitation of the widow, widower or the surviving partner.

Are there medical formalities?

There are no medical formalities to perform at affiliation.

Are there waiting periods?

The principal insured

There are no waiting periods.

The co-insured

There are no waiting periods for a timely application.

A membership is considered timely if the membership application is made within 3 months following the date of the right of membership or within 3 months after the termination date of a similar group policy with compulsory affiliation or within 3 months after the first termination date of a similar group policy with voluntary application or individual policy.

A membership is considered late when the application is not done within 3 months after the end date mentioned in the previous paragraph. A general waiting period of 3 months will then be taken into consideration.

Are pre-existing conditions reimbursed?

The principal insured

Pre-existing conditions are reimbursed.

The co-insured

Pre-existing conditions are reimbursed in case of a timely application.

For members who made a late application, pre-existing conditions are not covered. However, costs will be reimbursed if the pre-existing condition is established only after 3 years of membership.

What is individual continuation?

If you lose the right to affiliation to this occupational health insurance agreement, you are given the possibility, together with the family members who are affiliated to this insurance policy, to continue the insurance on an individual basis. This continuation can be effected without medical formalities or waiting periods if a number of conditions are fulfilled.

1. Entry conditions

To continue the insurance on an individual basis without waiting periods and without medical formalities, the main insured party must have been continuously affiliated to one or more successive 'hospitalisation – medical costs' insurance contracts concluded with an insurance company for at least two years prior to the date of the loss of your affiliation. You can only continue on an individual basis provided that you were affiliated for at least two years prior to the date of the loss of affiliation.

Moreover, any pre-existing disorders which were already insured at the time of affiliation to the occupational health insurance agreement remain insured in the individual contract.

2. Periods

Main insured party
Within thirty days of the loss of the benefit of this insurance, your employer will inform you in writing or electronically of the possibility of individual continuation.

You have a period of thirty days to inform the administrator of your intention to continue the insurance fully or partially on an individual basis. This period is extended by thirty days provided that you inform the administrator of this in writing or electronically.

These periods begin to run as of the day when the employer informs you in writing or electronically of the loss of the benefit of the occupational health insurance agreement and the possibility of individual continuation. This period expires in any case one hundred and five days after the day of the loss of the benefit of the occupational health insurance agreement.

Additional insured parties
For the additional insured party, the same periods apply as those set out above for the main insured party. A different period only applies if the additional insured party loses the benefit of the occupational health insurance agreement for a reason other than the loss of the benefit of the occupational health insurance agreement by the main insured party. In that case, the additional insured party has a period of one hundred and five days to inform the administrator in writing or electronically of their intention to exercise the right of individual continuation. This period begins to run as of the day when the additional insured party loses the benefit of the occupational health insurance agreement (e.g. the day of divorce).

3. Rate conditions

The conditions of the individual contract are those of the individual contracts in force at the insurance company at the time of the individual continuation. The cover offered is at least similar to the cover provided by the occupational health insurance agreement.

The rate conditions are equal to those in force at the time of the loss of the benefit of the occupational health insurance agreement.

The individual contract begins at the time of the loss of the benefit of the occupational health insurance agreement. The individual contract cannot in principle be terminated by the insurer.

What is prefinancing?

The premiums of individual insurance policies are usually slightly more expensive than the premiums of an occupational health insurance agreement. The law on health insurance therefore makes provision for a pre-financing system.

You can pay an additional premium on an individual basis whereby the premium in the event of individual continuation is equal to the premium of the age at which you began the pre-financing. This is done through a separate contract, known as a pre-financing policy.

More information is available on the website: www.wachtpolis.be.

What does the policy cover?

This Group Health Care insurance consists of 3 chapters:

I. Hospitalisation and pre-post costs
II. Serious illnesses
III. Outpatient care

I. Hospitalisation and pre-post costs

Cover:

1) The insurers will refund the expenses incurred during the hospitalisation of the insured for medically necessary treatment and caused by an illness, an accident, pregnancy or childbirth.

With statutory intervention:
- costs of accommodation including surcharges for private or semi-private accommodation;
- the doctor's fees and fee supplements;
- the costs for paramedical care;
- the costs for pharmaceutical products, bandages, medical equipment and other medical supplies ;
- the costs for surgery and anaesthesia;
- the costs for the use of the operating room and labour room;
- the costs for dental care, dental prostheses and therapeutic prostheses including orthopeadic devices placed during the hospitalisation and in direct connection with the hospitalisation. It is specifically determined that prostheses for cosmetic purposes only will not be reimbursed;
- the medical costs for the newborn during the hospitalisation of the mother consequent to a covered childbirth, including the medical costs for the isolation of stem cells;
- the costs death examination;
- thet costs of IVF treatment (In Vitro Fertilisation).

Regardless whether there is statutory intervention or not:
- the costs of viscerosynthesis- and endoprosthesis material;
- the material used during surgery that cannot be recycled;
- the medicines defined in category 'D';
- medical expenses for homeopathy, chiropraxis, osteopathy and acupuncture;
- the costs for:
  - specialised urgent transportation to the hospital;
  - specialised transportation during the hospitalisation, required due to medical reasons;
  - the medical urgency team (MUG);
- the accommodation expenses of the organ or tissue donor at the moment of donation are refunded up to 1.239,47 EUR per insured and per insurance year;
- the amounts charged for acommodation for rooming-in (one of the parents staying in the room of the insured, hospitalised child up to 15 years of age) will be refunded up to a maximum of 24,79 EUR per night, per insured and per insurance year;
- the mortuary costs provided that they are charged on the hospital invoice;
- the costs of childbirth at home;
- the costs of maternity care for childbirth at the hospital or at home will be reimbursed up to a maximum of twelve calender days.

2) This additional cover provides for the reimbursement of the costs of medically-necessary outpatient care linked directly to the hospitalisation, in the period of 2 months before and 6 months after the insured hospitalisation.

With statutory intervention:
- the costs of medical care provided by a doctor after a consultation or doctor's visit;
- the costs of paramedical care and drugs prescribed by a doctor;
- the costs for medical equipment prescribed by a doctor;
- the costs for medical prostheses in direct connection with the insured hospitalisation.

Regardless whether there is statutory intervention or not:
- the medicines defined in category 'D';
- medical expenses for homeopathy, chiropraxis, osteopathy and acupuncture;
- the costs for bandages and medical equipment with the exclusion of any type of product that is also available in stores where non-medical products can be bought.

Extension of the refunds in section I:

When there is statutory intervention the reimbursement is limited to 1 time the statutory intervention.

In case of hospitalisation at UZ Brussel, the reimbursement of doctor's fees supplements will be refunded up to maximum 1,75 times the statutory intervention.

In case there is no statutory intervention, refunding is limited up to 1.860,00 EUR per insured and per insurance year. There is also a complementary limitation up to a maximum of 50% for the intervention of medical expenses for homeopathy, chiropraxis, osteopathy and acupuncture.

Excess in section I:

In case of hospitalisation at UZ Brussel and in the Dental Clinic VUB, no excess will be applied.

The excess amounts up to 75,00 EUR per insured and per insurance year in case of hospitalisation in any other hospital.

II. Serious illnesses

The outpatient health care costs incurred outside the hospital for the following diseases are covered:

Cancer, leucemia, tuberculosis, multiple sclerosis, amyotrophic lateral scleroses, Parkinson's disease, diphtheria, poliomyelitis, cerebrospinal meningitis, smallpox, typhoid and paratyphoid fever, encephalitis, anthrax, tetanus, cholera, Hodgkin's disease, AIDS, viral hepatitis, scarlet fever, diabetes, kidney disease requiring dialysis treatment, Crohn's disease, mucoviscidosis, Alzheimer's disease, progressive muscle dystrophy, malaria, Creuzfeldt-Jakob's disease, Pompe's disease, Chronic Fatique Syndrome.

With statutory intervention:

- the costs for special treatments, analyses and research inherent to the disease;
- the costs for medical benefits, honorary fees and honorary supplements;
- the costs for paramedical benefits;
- the costs for renting various medical equipment;
- the drugs.

Will also be compensated regardless whether there is statutory intervention, on condition that the patient care is given in UZ Brussel, the Dental Clinic VUB, the own medical service, Sjerp, Kinetiek and provided that the costs are charged on the invoice of one of these institutions:

- the non-refundable or in category 'D' defined drugs;
- medical expenses for homeopathy, chiropraxis, osteopathy and acupuncture;
- pharmaceutical products, bandages, medical equipment and other medical aids, with the exclusion of any type of product that can also be bought in a non-medical store.

Other benefits than mentioned above without statutory intervention will not be refunded.

Extension of the refunds in section II:

For outpatient care linked to the mentioned serious illnesses for which there is statutory intervention, reimbursement is limited up to a maximum of 1 time the statutory intervention.

The reimbursement of the costs without statutory intervention is limited. See chapter III for the conditions of reimbursement. Anyhow, a reimbursement is only provided on condition that the patient care has been given in UZ Brussel, the Dental Clinic VUB, the own medical service, Sjerp and Kinetiek. The medical expenses have to be charged on the invoice of one of these institutions.

Excess in section II:

No excess.

III. Outpatient care

The costs for outpatient medical care are reimbursed to a maximum of 1 time the statutory intervention (providing there is statutory intervention) and limited up to a maximum of 250,00 EUR per insured and per insurance year on condition that:

- the outpatient medical care is received in one of the following institutions: UZ Brussel, Sjerp, the own medical service, the Dental Clinic VUB and Kinetiek;
- the outpatient medical costs are charged on the invoice of one of the following institutions: UZ Brussel, Sjerp, the proper medical service, the dental clinic VUB and Kinetiek.

Which expenses are not refunded?

Expenses that are the result of:

- cosmetic care and rejuvenation treatments;
- drunkenness, alcohol intoxication, doping, non-therapeutic use of narcotics or drugs;
- sterilisation and contraceptive treatments;
- artificial insemination or thermal cures;
- an act of war, except if the insured played no active part in them or if the insured acted out of legal self defense;
- payed sports;
- a deliberate act by the insured, a crime or felony, a reckless act, a bet or challenge;
- the harm caused by radioactive substances;
- attempted suicide;
- costs of a private nature (drinks, telephone,...).

What is the Medi-Link third-party payer system?

In the event of insured hospitalisation, the Medi-Link third-party payer system pays your hospitalisation invoice directly to the hospital. You do not have to pay an advance to the hospital and afterwards you only pay *the excess and the costs that are not covered by this insurance.

Each insured party receives a personal Medi-Link card by post containing all useful data about Medi-Link.

For the method and general terms and conditions, please see the explanatory brochure and the letter that you received with your Medi-Link card. For more information you can also visit our website *www.medi-link.be.* This website always includes the most recent list of hospitals at which you can use our Medi-Link service.

How much are the premiums?

The premiums for the principal insured are borne by the employer.

The premiums for the co-insured are borne by the employee and deducted by the employer from the employee's pay.

The premiums are to be paid at the end of each month.

The monthly premium, including charge (RIZIV) and tax, is equal to:

- for a child aged under 21	:	5,52	EUR
- for a principal insured aged under 65	:	11,07	EUR
- for a co-insured aged under 65	:	11,07	EUR
- for an adult aged between 65 and 69	:	33,16	EUR
- for an adult aged 70 and more	:	44,22	EUR

The premiums after retirement or early retirement are collected through direct debit order on a yearly basis.

The premiums of the widows, widowers and orphans are collected through direct debit order on a yearly basis.

How are claims settled?

In the event of **hospitalisation** you should notify as soon as possible. In case of a scheduled hospitalisation, we advise you to contact us *in advance*. This can be done in one of the following ways:

- by calling: 03 217 69 57;
- by e-mail: VRB-HCCO@vanbreda.be;
- in writing using the 'Claim form'.

In the event of a **serious illness**, when the serious illness is ascertained/diagnosed you should notify as soon as possible using the 'Claim form'. Do not forget to attach a certificate confirming the diagnosis from your attending physician.

The ‘Claim form’ is available from the administrator at the following address:

Vanbreda Risk & Benefits
Health Care Claims
Post box 38
2140 ANTWERP

Telephone: 03 217 69 57
E-mail: VRB-HCCO@vanbreda.be

Should you have any questions about the affiliation and reimbursement conditions, please contact the above telephone number or e-mail address.

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