Corporate-sponored Hospitalisation Insurance

Insurance Product Information Document

AG

Belgian insurance company licenced under code 0079

The purpose of this product information document is to summarise the main covers and exclusions featured in this insurance policy. It has not been individually tailored to meet your specific needs, and the information contained herein is not intended to be exhaustive. The exact scope of coverage and maximum caps will be specified in the General and Special Terms and Conditions of the policy. For additional details about the selected insurance product as well as your obligations, please review the pre-contractual and contractual information provided in the policy documentation.

What kind of insurance is this?

Corporate-sponsored hospitalisation insurance is a supplementary policy on top of statutory compensation payable by the Sickness Fund, that refunds the cost of medically necessary healthcare treatment and services during an inpatient stay as well as during a pre-defined pre-admission and post-discharge period. The costs of critical illness-related treatment will be covered year-round, even if no hospital stay is required. This policy may be taken out by any employer established in Belgium (headquarters or branch office) for the benefit of staff members/directors that work for this establishment. Under certain conditions, members of the employee's/director's family are also eligible for coverage.

What exactly is covered?

The corporate-sponsored hospitalisation insurance refunds the cost of medically necessary inpatient stays (illness, accident, childbirth, etc.) not covered by the Sickness Fund.

- ✔ **Hospitalisation**: Refunds will be provided for medical expenses (supplemental doctors' fees and room surcharges, prescription medication, transportation, rooming-in (room and board for one of the parents throughout their insured child's hospital stay), medical equipment and palliative care) during a hospital stay.
- ✔ **Pre-admission and post-discharge**: Refunds will be provided for the cost of medical care directly related to a hospital stay starting from one month prior to admission and up to three months post-discharge.
- ✔ **Critical illnesses**: Medical expenses to treat any of the 30 critical illnesses listed in the policy will be covered year-round, even if no hospital stay in required. In addition, there is no deductible to pay.
- ✔ **Coverage and assistance while travelling abroad**: Refunds for emergency medical care in a foreign country plus additional services such as search and rescue efforts, repatriation, etc.
- ✔ **Options**:
  - ✓ **Medi-Assistance**: AG will settle the bill with the hospital directly. In addition, the insured will be entitled to additional services during and after a hospital stay such as childminding, help with household chores, etc.
  - ✓ **Delta**: With this coverage, the insured's pre-admission and post-discharge periods will be doubled from one to two months and from three to six months, respectively.

What isn't covered?

- ✘ Expenses incurred for services such as:
  - ✗ Cosmetic procedures and treatments.
  - ✗ Spa treatments such as thermal baths, thalassotherapy, and diet/wellness/detox treatments.
  - ✗ Contraceptive treatments.
  - ✗ Preventive check-ups, with the exception of preventive colonoscopies with a stay in a double- or multiple-occupancy room.
- ✘ Medical expenses that are the result of "gross negligence" (e.g. culpable and reckless conduct or the consumption or abuse of alcohol or narcotics) as well as treatment for illnesses or accidents caused by acts of war or that are the consequence of active participation in a riot
- ✘ Prosthetics, orthopaedic devices, medical equipment and medical aids that are ineligible for statutory compensation, unless your policy includes coverage for these types of expenses (subject to a maximum reimbursement cap)
- ✘ For late enrolments: any pre-existing condition or pregnancy in the year immediately following the enrolment date will be excluded from coverage.

Are there any restrictions?

- ! For home births, a flat reimbursement rate will apply.
- ! For mental disorders, coverage for hospital stays will be capped at a maximum of two years, whether consecutive or intermittent.
- ! An annual deductible may apply.
- ! If your policy includes coverage for prosthetics, orthopaedic devices, medical equipment and medical aids that are ineligible for statutory compensation: a combined maximum reimbursement cap per year and per insured will apply.
- ! For medication ineligible for statutory compensation, there may be a general reimbursement rate per year and per insured in the 'Pre-admission and post-discharge' and 'Critical illnesses' covers.
- ! For medically-assisted reproduction (IVF, IVM and ICSI), a maximum of six treatment cycles will be eligible for a refund. A reimbursement cap will apply per insured and per policy year.

Where am I covered?

Coverage will be provided worldwide as long as:

✓ the insured's primary residence is in Belgium and s/he resides there for more than nine months of the year
✓ s/he is eligible for compensation payable by the Belgian social security system

For hospital stays in a foreign country, coverage will be provided as long as:

✓ the hospital admission is the result of emergency, unplanned circumstances, or has been pre-approved by the Sickness Fund

If one of these conditions is not met, the insurance proceeds will be capped at EUR 75 times the number of inpatient days and at 50% of the pre-admission/post-discharge expenses.

What are my obligations?

- The employer must provide AG with all the necessary applicant-related information as soon as they meet the eligibility requirements stipulated in the insurance policy.
- In accordance with the acceptance policy for healthcare risk defined by AG, medical formalities may apply. This is the case for late enrolments, i.e. when individuals who did not apply for coverage in the three months following the date they became eligible then request enrolment at a later date.
- It is the employer's responsibility to provide AG with the names of the plan participants and the date their enrolment was terminated. In this case, you are required to inform your staff member about the option to take out continuation healthcare coverage on an individual basis.
- In the event of a claim, the insured must notify AG as soon as possible, in paper or in digital format. AG must also be notified before or during the inpatient stay if the insured would like to activate third-party payer services.
- Coverage for the following treatments will be only be provided subject to prior approval by the medical advisor: breast reconstructive surgery, treatment of jaw-related conditions, bariatric surgery, eyelid corrective surgery and abdominal reconstructive surgery.

How and when to pay?

- On each due date, the employer will pay AG the premiums for all plan participants, plus charges and taxes. Payment will be made based on a statement issued by AG.
- The premiums payable for each plan participant will be due from the first day of the month of their enrolment until the last day of the month when the enrolment is terminated.

When does my coverage start and end?

Coverage will be provided for a period of one year, effective as of the inception date. At the end of each policy year, the coverage will be tacitly renewed on a year-to-year basis.

For the staff member, enrolment will be terminated on the day s/he ceases to work for the employer following the termination or suspension of his/her employment contract (for example, due to dismissal, a career break, a sabbatical), participation in an unemployment scheme with company supplement, retirement, or on the contract maturity date at the latest.

How can I cancel the policy?

Both the employer and AG may cancel the policy by giving at least three months' notice prior to the end of the policy year. Any such cancellation must be made by bailiff's writ, by registered letter or by delivery of a cancellation letter against acknowledgement of receipt.

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