Policyholder: VLAAMSE BALIES
Policy numbers: CVR14301 – CVR14302 – CVR14309

Notes to the hospitalisation insurance

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

WHAT ADVANTAGES DOES THIS INSURANCE OFFER?

In the event of hospitalisation or serious illness, this insurance contributes to the medical costs that you still have to pay after the intervention of the health insurance fund. The costs related to your hospitalisation incurred in the period of 1 month before and 3 months after the hospitalisation are also eligible for intervention.

You decide in which hospital or clinic and by which recognised doctor you are treated.

WHO CAN BENEFIT FROM THIS INSURANCE?

You can benefit from this insurance as **main insured party**:
- If you are registered to one of the participating bars;
- when you enter into service as member of staff at one of the participating bars.

By **family members (additional insured parties),** we understand:

- the spouse;
- the officially cohabiting partner of the main insured party without family links;
- the unmarried children, younger than 25 years of age and eligible for family allowance.

If you decide to affiliate your family members, all your family members should become affiliated. This rule does not apply to family members who already have a similar insurance policy. They should, however, submit a certificate attesting to this.

You should inform the administrator of all changes in the composition of your family. You are responsible for providing the correct data.

If you **retire or take early retirement**, you can remain affiliated to this insurance policy. This applies both for you as the main insured party and for your family members (additional insured parties) who were affiliated to this insurance policy at the time of your (early) retirement. You should request this continuation of your affiliation in writing from the administrator.

In the event of the **death** of the main insured party, the family members who were already affiliated to this insurance policy can remain affiliated. The widow, widower or orphan can request this continuation in writing from the administrator.

The coverage stops when:
- the surviving spouse or the officially cohabiting partner without family links gets remarried;
- an orphan no longer fulfils the definition of a child.

HOW AND WHEN CAN YOU AND YOUR FAMILY MEMBERS BECOME AFFILIATED?

Main insured parties

You can, as the main insured party, affiliate on the day you register to one of the bars or you enter into service at the “orde”

Additional insured parties (family members)

Your family members can become affiliated to this insurance as of the first day of the month that follows or coincide with the day of entitlement to affiliation and at the earliest on the day that you, as the main insured party, become affiliated.

The day of entitlement to affiliation is:
- for the spouse: the day of the wedding;
- for the cohabiting partner: the day of the official start of the cohabitation. Beginning date of the official cohabitation must be proven with a certificate of cohabitation, given by the local authority;
- for a child: the day of birth.

If the request for affiliation is made within two months of the day of entitlement to affiliation, then the family member becomes affiliated on time and we refer to **affiliation on time**. If the request is made later, then the family member becomes affiliated belatedly and this is considered a **belated affiliation**.

ARE THERE ANY MEDICAL FORMALITIES? WAITING PERIODS? ARE PRE-EXISTING DISORDERS INSURED?

Main insured parties & additional insured parties (family members) – Affiliation on time

If you and your family members become affiliated on time, there are no medical formalities and no waiting periods.

For family members who become affiliated on time, any pre-existing disorders are insured.

Main insured parties & additional insured parties (family members) - Belated affiliation

If you or your family members become affiliated belatedly, medical formalities do have to be fulfilled. This means that a medical questionnaire has to be complete. In this case, the applicant insured parties are also responsible for the costs of any additional examinations. The insurer can accept the affiliation, exclude certain disorders, refuse the affiliation or request an additional premium.

If any medical exclusions are stipulated, the applicant insured party receives a letter about this. The affiliation is definitive when you sign this letter and return it to the insurer.

If the insurer refuses the affiliation, the applicant insured party also receives written notification of this.

In the event of a belated affiliation, a general waiting period of 10 months applies. A waiting period is a period of time that begins as of the date of affiliation of the insured party. The insurer does not reimburse the costs incurred during this period.

In the event of a belated affiliation, the insurer never reimburses the costs for any pre-existing disorder(s).

WHEN DOES THIS INSURANCE END?

Main insured party

For the main insured party the affiliation ends:
- when you leave one of the participating bars or when the contract of employment with the bar ends or is terminated (after a contract of 6 years with this insurance or in case of (early) retirement the contract can be continued);
- in case of non-payment of the premium;
- upon death;
- in case of a stay abroad of longer than 3 months as a seconded employee, an employee working abroad or a similar status involving a stay abroad;
- upon the end of the occupational health insurance agreement;
- in case of the voluntarily termination of the contract on the annual renewal date. Except when the termination of the contract is due to a similar insurance contract. The voluntary termination of the contract must be notified in writing at least 1 month before the renewal date. Taking out a later insurance contract is not possible unless the termination was due to a similar insurance contract.

Additional insured parties (family members)

For family members the affiliation ends:
- when they terminate the affiliation voluntarily on the annual renewal date, except when the termination of the contract is due to a similar insurance contract. The voluntary termination of the contract must be notified in writing at least 1 month before the renewal date. Taking out a later insurance contract is not possible unless the termination was due to a similar insurance contract;
- when the main insured party leaves one of the participating bars or when the contract of employment between the principal policy holder and the bar ends or is terminated (if the principal policy holder has had this contract for 6 years with this insurance or in case of (early) retirement the contract can be continued);
- in case of non-payment of the premium;
- if they lose the status of additional insured party. The coverage stops as of the day on which they no longer fulfil the definition of additional insured party (e.g. the day of divorce);
- in case of a stay abroad of longer than 3 months as a seconded employee, employee working abroad or a similar status involving a stay abroad;
- in the event of death.

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 PRE-FINANCING?

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.

WHICH COSTS ARE REIMBURSED?
HOW MUCH IS THE INTERVENTION?

Main 'hospitalisation' cover

The insurer reimburses the medical costs that you have incurred during the hospitalisation for a **medically necessary treatment** and caused by an illness, an accident, a pregnancy or a childbirth. These costs must be directly related to the cause of the corresponding hospitalisation.

By hospitalisation we understand the medically necessary stay in a recognised hospital or clinic for which fees are charged for the stay. Admission to a day clinic is insured insofar as a legal flat rate is charged (maxi-flat rate, mini-flat rate, flat rate day clinic 1 to 7 or flat rate chronic pain 1 to 3).

The insurance contributes to the following costs:

- the costs for **stay**, **fees** of the **doctor or paramedic**, **examinations, treatment** and **medication**;
- the costs incurred by the use of **medical techniques and equipment**;
- the costs of **palliative care.** Palliative care refers to the treatment provided in a hospital which is given over to people in a terminal phase. This treatment is geared to the physical needs of the patient and contributes to safeguarding a certain quality of life;
- the costs of the **mortuary**. The insurer reimburses these costs provided they are charged on the hospitalisation invoice;
- the additional costs after any intervention by the health insurance for **medically justified transport** by ambulance or medical helicopter, where a medical certificate is showing that the state of health of the insured requires an urgent hospitalisation;
- the costs charged for **rooming-in**. By rooming-in we understand the stay of one of the parents with an insured, hospitalised child, on condition that the presence of the parent is considered as medically necessary by the doctor in attendance;
- the costs of **plastic surgery** in the event of **reconstructive surgery**;
- the costs of **sudden infant death** test;
- the costs of a stay in hospital by an **organ or tissue donor**;
- the costs of **home birth and childbirth at a policlinic**;
- the costs of **maternity assistance** in the event of **home birth** or **childbirth at a polyclinic**. These are reimbursed for a maximum of 12 calendar days. Maternity assistance is understood to mean the costs invoiced by a recognised maternity clinic for the care provided by a competent maternity assistant;
- the costs of **IVF treatment** (In Vitro Fertilisation), provided that the legal, mandatory health insurance intervenes in the costs of the treatment in question. The maximum amount is 500,00 EUR per cycle;

the costs of **prostheses**, **orthopaedic appliances** and **spectacles** prescribed by an ophthalmologist. The mandatory insurance for medical care and allowances must intervene for these costs.

The costs for the treatment of a psychiatric or mental condition, and for all types of depression, the reimbursement of the costs described above is limited to a maximum period of two years, which may or may not be continuous.

Related 'pre- and post-hospitalisation' cover

This additional cover provides for the reimbursement of the **costs of medically necessary outpatient care** provided during a period of **1 month before and 3 months after** the covered hospitalisation or prescribed by a doctor. These medical costs must be directly related to the cause of the corresponding hospitalisation and included in the nomenclature of medical services of the mandatory health and disability insurance.

This insurance intervenes for the following medical costs:

- the **fees** of the doctor or paramedic;
- **examinations** and **treatments**;
- **medication** prescribed by a doctor and purchased at a pharmacy;
- the costs of **prostheses, orthopaedic appliances and spectacles** prescribed by an ophthalmologist, insofar as the mandatory insurance for medical care and allowances intervenes.

All costs must of course be incurred further to insured hospitalisation.

The insurer does not reimburse the costs for **transport and the cost of the rental and the purchase of medical appliances** during this pre- and post-hospitalisation period.

The **maximum reimbursable amount** for the hospitalisation and pre- and post-hospitalisation cover is without restriction

Costs for outpatient care in the event of 'serious illnesses'

In the event of one of the following disorders:

AIDS, amyotrophic lateral sclerosis, brucellosis, cholera, diabetes, diphtheria, encephalitis, meningitis, cancer, leukaemia, malaria, anthrax, mucoviscidosis, multiple sclerosis, kidney complaint requiring dialysis, paratyphoid fever, variola, poliomyelitis, progressive muscular dystrophy, tetanus, tuberculosis, typhoid fever, viral hepatitis, typhus, Alzheimer's disease, Creutzfeldt-Jakob's disease, Crohn's disease, Hodgkin's disease, Parkinson's disease or Pompe's disease

the insurer reimburses the costs of the outpatient care actually incurred for the treatment. This means all medical costs for services that are prescribed or provided by a doctor and which are included in the nomenclature of medical services of the mandatory health and disability insurance.
This insurance intervenes for the following medical costs:

- the **fees** of the doctor or paramedic;
- **examinations** and **treatments**;
- **medication** prescribed by a doctor and purchased at a pharmacy;
- the costs of **prostheses, orthopaedic appliances and spectacles** prescribed by an ophthalmologist, insofar as the mandatory insurance for medical care and allowances intervenes;
- the **rental of medical appliances**.

These costs must of course be incurred further to an insured serious illness.

No contribution is made towards the costs of **transport and the purchase of medical appliances**.

The **maximum reimbursable amount** for the cover for outpatient care in the event of "serious illnesses" is without restriction.

Important: If you are admitted to hospital further to an insured serious illness, then the reimbursement conditions of the 'hospitalisation' cover apply for the costs incurred during this period of hospitalisation.

WHICH COSTS ARE NOT REIMBURSED?

Non-covered risks are those of serious misconduct. These risks are:

- the result of an intentional act of suicide attempt of the insured, or a notoriously reckless action, except to rescue people or goods;
- the result of the voluntary involvement of the insured in a felony or criminal offense;
- the direct of indirect consequence of alcoholism, toxicomania, or the abusive use of medication;
- a situation when the insured party is in a state of inebriation or alcohol inebriation, or under the influence of narcotics, hallucinogenic or other drug, unless the insured party can prove that there is no causal relationship between the circumstances and the illness or the accident.

In accordance with the description of the above-mentioned guarantees the plan does not provide for the reimbursement of the costs which, amongst others, arise from it:

- cosmetic care or treatments, or care with a cosmetic purpose with or without functional disorders, except with a prior permission of the medical commissioner;
- cures, for example: thermalism, thalassotherpay, diet cures;
- assistance, attendance and maintenance of the insured;
- contraceptive treatments (like sterilization);
- sterility treatments (the costs for IVF treatment above 500,00 EUR per cycle), contraceptive treatments, termination of pregnancy, artificial insemination;
- check-ups, preventive screening or consultations for infants;
- illnesses or accidents caused by an act of war or by civil war;
- illnesses or an accident caused by uprisings or civil unrest or political, ideological or social inspired collective actions of violence. The cover is granted if the insured party can prove that:
  - or, he didn't participate actively;
  - or, he did it in case of self-defense;
  - or, he acted with a view to save people or goods.

HOW IS THE INTERVENTION CALCULATED?

This insurance always intervenes after the intervention of the legislation on social security, occupational illnesses, industrial accidents and accidents on the way to and from work, as well as contracts already taken out for the same purpose.

If you do not receive or are not entitled to the legal intervention for any reason, then a theoretical intervention is taken into account for the calculation of the insurance payments guaranteed. This theoretical intervention is equal to the legal intervention as stipulated by Belgian social legislation applicable for employees in the event of illness or accident. This means that the legal intervention is deducted, even if you are not entitled to the legal intervention for any reason.

You are not taxed on the insurance payments that you receive and therefore do not have to pay social charges on the benefit received.

IS THERE AN EXCESS OR DEDUCTIBLE?

The **excess or deductible amounts to 125,00 EUR** per insured party and per insurance year. An insurance year is the period that begins on the general renewal date of the insurance policy and ends twelve months later.

The excess is only applied once in the following situations:
- for various insured parties from the same family involved in the same accident;
- for the costs of the childbirth for mother and child, provided that the entire family is insured;
- for an uninterrupted hospitalisation spanning two insurance years.

There is no excess or deductible for outpatient costs relating to the cover for “serious illnesses”.

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.

WHAT ABOUT COSTS INCURRED ABROAD?

The costs in case of an admission are reimbursed (without limitations) when the following 3 conditions are met:
- the admission must be urgent and unforeseen or the mutual health insurance fund must have given its approval beforehand;
- there must be a refund under the statutory health insurance scheme;
- during the 12 months preceding the loss, the insured must not have spent more than 3 months abroad.

If any of the above mentioned conditions is not met:
- the refund will be limited to 75,00 EUR multiplied by the number of days of hospitalization for the hospitalization costs;
- 50% for the pre- and post-hospitalisation costs.

The costs in relation to a serious illness are not refunded.

WHAT IS ASSI-LINK+?

This assistance insurance supplements your existing hospitalisation insurance. The additional insurance covers assistance in case of medical problems abroad, as well as hospitalisation in the country in which you are domiciled (Belgium, The Netherlands, France, Germany and the Grand Duchy of Luxembourg).

Assistance abroad:

- first aid;
- assistance to family members;
- extension of the stay abroad;
- transportation;
- coverage in case of death abroad;
- reimbursement of hospitalisation expenses incurred abroad without deduction of exemptions.

Assistance in the country in which you are domiciled (Belgium, The Netherlands, France, Germany or the Grand Duchy of Luxembourg):

- coverage "During hospitalisation", for example, domestic help, child care and transportation;
- coverage "After hospitalisation", for example, domestic help, babysitting, postnatal care by a midwife, supply of medication and transport;
- coverage for "Additional Assistance", for example, psychological assistance, contact details of homecare institutions and pharmacy and doctor on call.

Specific repayment terms apply to each coverage mentioned above.

If you wish to avail of Assi-Link+, please call **+32 2 773 62 26**.

HOW MUCH ARE THE PREMIUMS?

The quarterly premium, for the hospitalisation insurance, is equal to:

- 25,71 EUR for a child younger than 25 years
- 51,35 EUR for an adult younger than 65 years
- 179,65 EUR for an adult from 65 years

The quarterly premium, for Assi-Link+, is equal to:

- 3,45 EUR for a child younger than 25 years
- 3,45 EUR for an adult younger than 65 years
- 3,45 EUR for an adult from 65 years

The premium is payable quarterly in advance and collected by the by the administrator via direct debit.

WHAT IS THE CLAIM SETTLEMENT PROCEDURE?

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 55 11;
- by e-mail: OrdeVlaamseBalies@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 34
2140 ANTWERP

Telephone: 03 217 55 11
E-mail: OrdeVlaamseBalies@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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