Corporate-sponsored outpatient care insurance

Insurance Product Information Document

AG Insurance

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 outpatient care 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 (doctors' appointments, medication, eyewear, etc.) unrelated to an inpatient stay. 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?

Outpatient care insurance provides (partial) coverage for medical treatment and services unrelated to an inpatient stay. Refunds may be claimed for:

- ✔ **Outpatient medical care***, such as doctors' appointments, house calls, medical-technical services and minor surgery. This also includes nurse-administered treatment, kinesitherapy and physiotherapy. Radiology, medical imaging and laboratory analysis are also eligible for coverage.
- ✔ **Pharmaceutical products, orthopaedic devices and eyewear****, including:
  - ✓ Licenced medication and bandages sold in pharmacies.
  - ✓ Eyeglass frames and eyeglasses, contact lenses and hearing aids.
  - ✓ Orthopaedic devices, artificial limbs and splints.
- ✔ **Dental care and dental prosthetics** (crowns, bridges and implants) and **orthodontic treatment** and devices such as braces**.
- ✔ **Paramedical treatment (if stipulated in the policy terms and conditions).** Refunds may be claimed for:
  - ✓ Consultations with a psychologist, nutritionist, podiatrist or speech pathologist.
  - ✓ Consultations with an osteopath, chiropractor, homeopath or acupuncturist.
  - ✓ Homeopathic remedies.

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.
  - ✗ Medically-assisted reproductive treatments.
  - ✗ Preventive check-ups and consultations for newborns.
- ✘ Assistance services, childminding and maintenance for plan participants.
- ✘ Medical expenses that are the result of "gross negligence" (e.g. culpable and reckless conduct or the consumption and abuse of alcohol or narcotics) as well as treatment for illnesses or accidents caused by acts or war or that are the consequence of active participation in a riot.

Are there any restrictions?

- ! There is a limit on refunds for eyeglass frames per policy year.
- ! The maximum reimbursement rate for paramedical treatment is 50%.
- ! The policy may include an annual deductible.
- ! A maximum cap may apply, depending on the terms of the policy.

* insofar as the treatment is administered or prescribed by a licenced physician and included on the INAMI/RIZIV list of services

** insofar as the treatment is prescribed by a licenced physician or dentist

Where am I covered?

Coverage will be provided worldwide and can be claimed as long as the following three conditions are met:

- ✓ In the 12 months preceding the claim, the insured cannot have been residing abroad for more than three consecutive months.
- ✓ The treatment and services must be eligible for statutory compensation. This requirement does not apply to medication.
- ✓ For expenses incurred in a non-member country of the European Union, coverage will be provided if it can be demonstrated that the purpose of the stay in the country was not solely to obtain treatment or medication.

What are my obligations?

- The employer must provide AG Insurance with all the necessary applicant-related information as soon as they meet the eligibility requirements stipulated in the insurance policy.
- Any time an enrolment is terminated, the employer must provide AG Insurance with the necessary information about the insured in question. The employer is also required to inform the insured about the option to take out continuation healthcare coverage on an individual basis.
- In the event of a claim, the insured must notify AG Insurance as soon as possible. This may be in paper or in digital format.

How and when to pay?

- On each due date, the employer will pay AG Insurance the premiums for all plan participants, plus charges and taxes. Payment will be made based on a statement issued by AG Insurance.
- 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.
- If the premium is paid by the staff member, the notice of premium due will be sent to him/her directly.

When does my coverage start and end?

Unless otherwise stipulated in the policy, coverage will be provided for a period of one year, effective as of the inception date. At the end of the 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 as well as AG Insurance 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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