INFORMATION BROCHURE

HOSPITAL ADMISSION MEDICAL INSURANCE

Edition: April 2015 (2)

1 The information contained in this document is supplied by way of information only and has no contractual value.
This brochure provides a summary explanation of your hospital admission – serious illnesses healthcare cover by way of a number of concrete items. To find out more about the exact coverage, please do not hesitate to contact the Medi-Assistance service on 078/15.57.40 (F) or 078/15.57.50 (NL).

<table>
<thead>
<tr>
<th>CONTENTS</th>
</tr>
</thead>
</table>
| 1 Insurer  
Who is providing the coverage? |
| 2 Who is covered?  
2.1 Employees  
2.2 What about family members?  
2.3 What is the price of the optional memberships? |
| 3 What coverage is provided or which costs will be reimbursed to you?  
3.1 Expenses incurred during a hospital stay  
3.2 Expenses incurred before and after a hospital stay  
3.3 Special cases  
3.4 Which expenses are not reimbursed?  
3.5 How is the amount of the reimbursement calculated?  
3.6 What about compensation in case of serious illness? |
| 4 When does the healthcare coverage expire? |
| 5 Medi-Assistance: "I have my hospital admission covered!"  
5.1 What to do if you are admitted to hospital?  
5.2 What should you do with the hospital bill?  
5.3 The formalities in the event of admission to a non-regulated hospital  
5.4 What are the correct procedures to follow when submitting a claim?  
5.5 Which bills and expense receipts should be sent to Inter Partner Assistance?  
5.6 How are your expenses reimbursed? |
1. Insurer

The healthcare coverage is provided by:

INTER PARTNER ASSISTANCE (IPA) – member of the AXA Group
Avenue Louise, 166 – bte 1
1050 BRUSSELS

INTER PARTNER ASSISTANCE (IPA) CONTACT PERSONS:

For general queries regarding hospital admission coverage and the complete preparation of a hospital admission, please call 078/15.57.40 (F) or 078/15.57.50 (NL). You can also contact Medi-Assistance’s secretariat by sending an e-mail to: secretariats.mediassistanceBNL@axa-assistance.com. The number stated on the Medi-Assistance cards issued before Winterthur joined the AXA Group, i.e. 02/510.83.93, is still valid.

For queries regarding reimbursements and certain administrative aspects (e.g. for copies of the Medi-Assistance card), please contact either of the following staff:
- Mrs Nathalie GEMMEKE on 02/550.48.70, nathalie.gemmeke@axa-assistance.com
- Mrs Samira NADIR on 02/550.48.73, samira.nadir@axa-assistance.com

2. Who is covered?

2.1 Employees

A. Membership is automatic for staff members who fulfil the following conditions:
- all members of the administrative, technical, management and specialised staff (PATGS) employed by ULB and employees having taken early retirement who come under the consolidated framework (budgetary sections 1, 2 and 3), appointed at least under a part-time open-ended contract;
- all members of the teaching and scientific staff (PES), appointed on a definitive or temporary basis, who come under the consolidated framework and holders of at least a part-time contract;
- the members of the Belgian National Research Foundation (F.N.R.S.) appointed under at least a part-time open-ended contract;
- all the employees in the research section appointed under at least a part-time open-ended contract or appointed under at least a half-time fixed-term contract and that have been in their position for at least two whole consecutive years;
- persons who are awarded a grant subject to Social Security payments and that have been in their position for at least two whole consecutive years.

B. Membership of this contract is optional for:
- members of the PATGS and of the PES appointed under a contract that is less than part-time;
- members of the PATGS and of the PES that do not come under the consolidated framework, appointed under a fixed-term contract and that have been in their position for under two whole consecutive years;
- the holders of a scientific mandate of a fixed or open-ended duration working less than part-time at the Belgian National Research Fund as well as persons benefitting from a grant subject to Social Security payments and that have been in their position for under two whole consecutive years;
- all future pensioners can request the continuity of the contract, as well as for their spouse or
common law partners;
- the spouse, common law partners;
- dependent children under the age of 21 and those still in education between the age of 21 and 25.

Please note:
- For all persons for whom membership is voluntary, the membership application may only be made within the two months following the start of the first contract, of the first mandate or of the first grant awarded to the person making them eligible for membership. Once this two-month deadline after the entry into function has expired, the membership application will no longer be possible (even if another mandate, another grant or another contract takes over from the previous one).
- Membership will take effect at the earliest the month during which the application for cover is received by the University’s Payroll Department at the CP 104.
- Consequently, voluntary membership is possible exclusively within the two months following a change to the family situation (marriage, birth, cohabitation) and after the submission of an official certificate issued by the local town hall (Maison Communale) (copy of a marriage certificate, birth certificate or household composition certificate in the event of cohabitation).
- **Note:** common-law partners are considered in the same way as married members. (Common–law partner is understood to mean a person, designated by name, who cohabits with the main member and who had no family ties with the latter. In the event of claim, proof of cohabitation may be requested by the Company). This means that there is no change in family situation when common-law partners marry or make a statement of legal cohabitation. By change in family situation, we mean a change of common-law partner, legal cohabitant or spouse. **It is only within the two months following this change and on the basis of a household composition certificate issued by the municipal authorities that it is possible to sign up the new spouse or common-law partner for membership.**
- Tutors, Scientific assistants, beneficiaries of a grant not subject to Social Security and Clinical researchers are not entitled to the insurance.
- People taking a career break remain affiliated.
- Any member who voluntarily gives up this insurance for any reason can will no longer be entitled to request re-join the scheme thereafter, with the exception of special situations such as, for example, the end of the activity due to loss of employment with an employer that had also signed a contract of the same type (for the partner). Such re-affiliation will only be possible through a membership certificate issued by the previous insurer and provided that there is no interruption between the covers.

2.2 What about family members?

As a staff member, you have the possibility of signing up members of your family on an optional basis. All family members must be signed up at the same time as the employee, i.e. within two months of taking up their post.

Please note:
If you want to sign up one member of your family at the time you take up your post, you are under obligation to sign up all other members of your family. In other words, membership is on a full family basis. An exception is made for common law partners who are covered for hospital admission through their employer.

What is meant by “family member”?
- Your legal spouse (husband or wife) or common law partner.
- Your children living under the same roof as long as they are entitled to family or disability
benefits. This refers to the children of the employee and/or their legal spouse/common law partner living as part of the family. Children who are studying or living in student accommodation are considered on a par with children living under the same roof. Employees can also sign up children who, further to a divorce, no longer live under the same roof as the employee and to whom they pay child support. However, any children of the legal spouse/common law partner who no longer live under the same roof as part of the employee’s family can no longer be covered by the hospital admission insurance.

2.3 What is the price of the optional memberships (as at 1 April 2015)?

<table>
<thead>
<tr>
<th>Membership Type</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional member and spouse &lt; 60 years</td>
<td>€ 16.67</td>
</tr>
<tr>
<td>Child &lt; 21 years</td>
<td>€ 8.48</td>
</tr>
<tr>
<td>Child &gt; 21 years</td>
<td>€ 16.67</td>
</tr>
<tr>
<td>Optional member and spouse between 60 and 65 years</td>
<td>€ 18.27</td>
</tr>
<tr>
<td>Optional member and spouse &gt; 65 years</td>
<td>€ 58.67</td>
</tr>
</tbody>
</table>

These premiums are monthly and are understood to be inclusive of taxes and INAMI (Belgian national institute for sickness and disability insurance) contribution. They are subject to an annual adjustment according to the “health” index.

It is for the employee to immediately inform the ULB of any changes to the family situation to avoid the ULB from paying premiums for persons who no longer meet the criteria set out in the present document. Therefore, any change to the composition of the household, to the civil status and the completion of studies for children between the ages of 18 and 25 shall be notified in writing to the University's Payroll Department at CP 104. It is important also to notify of a change of address or bank account.

Please note:
In the event of the death of the staff member or in the event of separation, the spouse and/or the children automatically lose their status as optional members. They may contact the Company to pursue the contract on an individual basis. For further details, please see point 4.

When does the coverage expire?

3. What coverage is provided and which expenses will be reimbursed to you?

The coverage provides for reimbursement of up to 300% of the sickness and disability insurance pay-out of the medical expenses incurred BEFORE, DURING and AFTER a hospital stay due to ILLNESS, ACCIDENT, PREGNANCY or CHILDBIRTH.

If case of pay-out for a person residing in a different Member State of the European Union, the Company's pay-out for all covers shall be limited to three times the amount of the pay-out under Belgian law if reimbursements is paid by the Mutual Health Benefit society in the country of origin. Failing such reimbursement by the latter, the Company shall reimburse 50 % of the sum paid out by the statutory Sickness and Disability Insurance in Belgium for the same type of ailment.

The pay-out of the insurance only covers the part of the costs incurred in excess of that which is payable by the Mutual health insurance scheme and what is reimbursed by any other free or compulsory insurance. We draw your attention to the fact that when there is no pay-out by the statutory Sickness and Disability Insurance in Belgium (INAMI), the Insurance Company shall also refuse cover. In other words, the IPA insurance is only paid out to supplement that of the INAMI when
it has also contributed to the cost. We advise you therefore to find out beforehand whether the procedures that you have to undergo are subject to INAMI approval or codification.

No qualifying period applies to the pay-out of costs. Newborns are members from the day of their birth, without qualifying period, as long as a membership application has been received within two months following their date of birth. For illnesses, accidents and pregnancies before the effective date of the insurance for the staff member and their family, the cover shall be granted from membership. Similarly, the costs incurred by outpatient treatments relating to serious illnesses already suffered on this date are covered.

It should be stressed that members have a free choice of hospital room, doctor, surgeon, etc.

3.1. Expenses incurred during a hospital stay

The following expenses shall be reimbursed:

- Your stay in hospital, even for one day (one-day clinic);
- Medical care and examinations;
- Fees and medical care and attendance provided by doctors, surgeons, anaesthetists, physiotherapists, etc.;
- Surgery and anaesthesia expenses;
- Nursing;
- Medical aids;
- Medicines and all manner of preparations;
- Pharmaceutical products (e.g. surgical stockings, bandages, etc.)
- Medical analyses and medical imaging;
- Medical prostheses (see item 3.3. below);
- Orthopaedic devices (such as corsets, etc.);
- Ambulance transport (see item 3.3. below);
- Cot death test in infants;
- Rooming-in (one parent staying with a sick child under the age of 18 on the condition that the presence at the child’s bedside is considered to be necessary by the attending physician and up to €25 per day);
- Costs relating to the stay of an organ donor as necessary for the treatment of the insured, up to € 2,500;
- Hospital admission costs relating to a nervous disease that does not appear in the list under item 3.6 (730 days at most);
- Medically necessary implants with the exclusion of aesthetic treatments and up to 50% of the invoiced amount up to a maximum of €2,500 per annum and per member;
- Etc.

**Please note:**

An annual excess of € 500 per insured applies if you opt for a private room. This excess is € 225 if you opt for a twin-bedded room or in case of a one-day clinic admission.

In the event of a hospital stay in a twin-bedded room at Erasme, the annual excess is € 100.

3.2. Expenses incurred before and after a hospital stay

These expenses are reimbursed insofar as they have been incurred during a two-month time period before, and a four-month time period after the hospital admission and insofar as they are directly associated with the reason for the hospital admission.

The following shall be reimbursed:

- Medicines and all manner of preparations;
• Pre and post hospital admission health care provided by the GP;
• Medical analyses and medical imaging;
• Medical prostheses;
• Orthopaedic devices (such as arch supports, etc.);
• Nursing or physiotherapist fees;
• Etc.

Please note:
Medicines, medical aids and all medical care and attendance are to be prescribed by a doctor at all times.

3.3. Special cases

• **Prostheses, orthopaedic devices and eyeglasses**
  The reimbursement of eyeglasses, prostheses and orthopaedic devices may be obtained subject to the following cumulative conditions:
  • they have been prescribed by a doctor or ophthalmologist;
  • during hospital admission or within a two month period before and four-month period after admission to hospital;
  • and are directly associated with the reason for the hospital admission or with the serious illnesses listed under item 3.6.

• **Transport expenses**
  Ambulance transport expenses upon admission shall be reimbursed as long as they are justified by the required urgency and health of the patient concerned.

• **Admission to a recognised convalescence home and admission for rehabilitation**.
  The reimbursement shall apply insofar as the stay or the rehabilitation takes place during a four-month time period following admission to hospital and if it is medically necessary (a medical report will be requested). The official amounts determined and published every year by Royal Decree shall be taken into consideration. You are also advised to get in touch with Inter Partner Assistance in advance to know whether it is a recognised convalescence home.

• **One-day clinic or one-day admission**
  All expenses are reimbursed insofar as they relate to a one-day admission for medical care recognised by the INAMI (National Institute for Sickness and Disability Insurance) and the procedures come under the application:
  • of either a maxi fee when they are performed in a hospital service:
  • or of an A, B, C or D fee when they are performed in a One-Day clinic.
  Consult Inter Partner Assistance in advance. Here again, the expenses incurred during a two-month time period before and a four-month time period after the one-day hospital admission shall be reimbursed.

3.4. What expenses are not reimbursed?

Some expenses are NOT reimbursed. Generally speaking, these are:

• Expenses that are NOT MEDICALLY NECESSARY.
  *Examples: purely aesthetic treatments, telephone expenses, etc.*
• Expenses relating to a stay in an establishment NOT RECOGNISED as a hospital.
  *Examples: stations offering various kinds of thermal cures, thalassotherapy, nursing homes, medical-pedagogical institutes, etc.*
• Expenses related to experimental treatments and medicines or that are not scientifically
proven.

- Expenses that result from circumstances caused DELIBERATELY. *Examples: drunkenness, drug use, attempted suicide, deliberate participation in brawls, etc.*
- Expenses that are related to dental treatment in any way.
- Expenses incurred by acts of war, riots and civil disturbances.
- Sterilisation, treatment to aid conception and contraceptive treatment, artificial insemination.
- Expenses incurred by alternative medicine (homeopathy, acupuncture, chiropractic and osteopathy).
- Expenses to cover assistance to persons in the event of admission to hospital abroad.

### 3.5. How is the amount of the reimbursement calculated?

The expenses listed under 3.1 to 3.3 are reimbursed:

- After deduction of the pay-out of the mutual health insurance scheme or any other insurance institution.
- After deduction of a € 500, € 225 or € 100 excess per insured employee/per insurance year/per insured family member and per annum. This excess only applies once if you are admitted to hospital a second time within the year following the date of the beginning of the first hospital admission. *Example: an insured is admitted to hospital from 20 June 2015 to 10 July 2015. The insurance year will therefore be set as follows: 20 June 2015 to 19 June 2016; period during which the excess will only be deducted once.*

### 3.6. What is the coverage for serious illness?

The coverage provides for supplementary pay-out for the reimbursement of the out-patient care expenses relating to the treatment of the serious illnesses as listed below:

- Cancer
- Anthrax
- Cholera
- Diabetes
- Kidney dialysis
- Diphtheria
- Muscular dystrophy
- Encephalitis
- Epilepsy
- Typhoid fever and paratyphoid fever
- Viral hepatitis
- Leukaemia
- Alzheimer’s disease
- Creutzfeldt-Jakob disease
- Crohn disease
- Hodgkin's disease
- Parkinson’s Disease
- Pompe’s disease
- Malaria
- Cerebrospinal meningitis
- Cystic fibrosis
- Muscular dystrophy
- Poliomyelitis
- Multiple sclerosis
- Amyotrophic lateral sclerosis
- AIDS
- Scarlet fever
- Tetanus
- Tuberculosis
- Typhus
- Smallpox

The pay-out is completely separate from the reimbursement of the expenses incurred during, before or after a hospital admission. I.e. a hospital admission is not required and the pay-out shall continue to apply provided the required medical care and attendance is directly associated with the serious illness. Furthermore, the excess does not apply.
In the event of hospital admission, items 3.1 through 3.4 shall apply.

If you are claiming expenses in connection with a serious illness, please do not forget to specify at all times that these expenses relate to one of the serious illnesses as listed above. Failure to do so will see Inter Partner Assistance process your claim as a regular application for pay-out and only the expenses for a two-month time period before and four-month time period following admission will be reimbursed if you have been admitted into hospital.

4. When does the coverage expire?

If the membership conditions are no longer met for the employee (end of contract or mandate), the insurance coverage shall cease to be available for them and the members of their family.

It should be noted that for admissions to hospital underway at the time the coverage ceases, the Company shall pay the fees due for this hospitalisation and for the post-hospital costs related to it for a maximum duration of 180 days as from such time as the risk cover ceases.

The employee is also free to continue coverage on an individual basis in total or in part with Inter Partner Assistance, subject to compliance with certain conditions, without medical formalities or qualifying period as long as they have been insured for at least three consecutive years. The same applies to any members of your family. In the event of the death of the main member, the widows/widowers and orphans already members at the time of death must contact the Company to continue the contract on an individual basis.

Any request to continue cover must be submitted no later than two months after the end of membership of the collective contract.

Any contract taken out on an individual basis would enter effect on the date of the cessation of the collective insurance cover. This is a life annuity contract, which means that the insurance company can no longer in principle cancel your policy, unless in the event of non-payment of premiums. The price conditions applied are those in force at the time of signing up to this contract.

For all information or membership relating to continuation on an individual basis, you can send a letter to Inter Partner Assistance – TPA Production – avenue Louise 166/boîte 1 – 1050 Brussels and/or consult the web site www.hospi4ever.com using the following codes: User ID: 5109200 - Digit: 16

5. Medi-Assistance: "I have my hospital admission completely covered."

Each member receives a Medi-Assistance card. The card is made out in your name and is therefore strictly personal. We advise you to always keep it on you. Furthermore, on the back, you can mark the telephone number of the person(s) to be contacted in the event of an emergency. To obtain a copy in the event of loss, please contact the following staff at Inter Partner Assistance:

- Mrs Nathalie GEMMEKE on 02/550.48.70, nathalie.gemmeke@axa-assistance.com
- Mrs Nathalie PURNELLE on 02/550.48.73, nathalie.purnelle@ip-assistance.com

5.1 What to do if you are admitted to hospital?

- When you know that you will be admitted to hospital, phone the Medi-Assistance service. You will obtain information about how Inter Partner Assistance will cover the hospitalisation expenses as
well as the expenses incurred before (pre) and after (post) your admission to hospital, in accordance with the specific guarantees provided for in the contract. During that telephone call, you can ask any questions you may have regarding the portion to be paid by Inter Partner Assistance of the invoice you will be sent by the hospital (third party payment system). At the end of the call, Inter Partner Assistance will send you a written confirmation of the telephone conversation: the hospipass. The confirmation is accompanied by information that will be useful for your admission to hospital. Inter Partner Assistance also sends a copy of the confirmation to the hospital concerned. This allows the hospital, if it so wishes, to prepare and facilitate the admission of the insured and to enter them into the “third party payer” channel. You can then proceed to the hospital having with all administrative formalities already sorted out.

You can also submit your hospital admission statement online at the Medi-Assistance site at the following address: www.medi-assistance.be

• If the hospital admission is not planned but takes place urgently, you can still use the Medi-Assistance service. It can be done by the hospital administration or by the family at the time of admission to hospital. The confirmation is then sent to the hospital directly.

5.2 What should you do with the hospital bill?

The hospipass that you will receive from the service centre guarantees you the “third party payment” system. This means that the hospital will send the bill directly to Inter Partner Assistance. Inter Partner Assistance will pay the bill directly to the hospital. This makes your life much easier.

Payment of the sums that are not reimbursed (excess, limits, various costs, etc.) will be claimed from the insured later on by letter, or these sums will be netted with the pre and post-admission expenses for outpatient care.

5.3 The formalities in the event of admission to a non-registered hospital.

You telephone the Medi-Assistance service, which will confirm to you that the hospital in question is not registered. You will then ask it to send you a “healthcare pay-out application”.

You complete this document:

- the front of the healthcare pay-out application ⇒ To be completed by the patient or their representative.
- the back of the healthcare pay-out application (= medical certificate) ⇒ to be completed by the attending physician.

Pay your medical expenses always directly to your healthcare providers and submit them first of all to your mutual health insurance scheme for reimbursement. Then send (within the year) the legal evidence of the expenses incurred, preferably grouped together.

5.4 What are the correct procedures to follow when submitting a claim?

The CLAIM FORM must be sent in as soon as possible (no later than 30 days after hospital admission and a few days earlier if possible) duly completed by the medical care provider. The claim form must not necessarily be signed by the attending physician but can also be signed by your GP. All ORIGINAL BILLS and EXPENSE RECEIPTS are to be sent in as quickly as possible (no later than one year as from such time as the care was dispensed).
Note:
Please make sure you keep the duplicates at all times and make photocopies of any documents sent in.

5.5 Which bills and expense receipts must be sent in to Inter Partner Assistance?

- If the bills or expense receipts are not to be handed in to the mutual health insurance scheme: always provide us with the ORIGINAL.
  
  **Example:** hospital bill

- If the expense receipts are to be handed in to the mutual health insurance scheme: please provide us with a photocopy (the original statement of expenses delivered by the mutual health insurance scheme will also do).
  
  **Example:** doctor’s fees

  - For an expense receipt or certificate to be reimbursed to valid effect, the following DETAILS are to be specified by the CARE PROVIDER HIMSELF:
    o Patient’s name and first name.
    o The date on which the medical care was provided.
    o Nature of the medical care provided (INAMI code number or description).
    o The amount received for each medical service.
  
  - With regard to MEDICINES and PHARMACEUTICAL EXPENSES, please provide us with the following documents:
    o A copy of the medical prescription or pharmaceutical preparation issued by the physician.
    o A duly signed and dated receipt from the pharmacist. This is the standard form intended for the insurer, specifying:
      ▪ The patient’s name.
      ▪ The price actually paid.
      ▪ The name of each pharmaceutical product.
      ▪ Date of delivery.

- With regard to consultations of PHYSIOTHERAPISTS, a copy of the medical prescription is to be sent in together with a copy of the certificate of the treatment provided.

- All receipts are to be duly SIGNED by and carry the STAMP of, the person who issued the receipt in question.

- Please send all expense receipts to:
  Mrs Nathalie GEMMEKE
  nathalie.gemmeke@axa-assistance.com
  Inter Partner Assistance - Health Care
  Avenue Louise, 166 – bte 1, 1050 Brussels
  Tel.: 02/550.48.73 Fax: 02/545.79.47

5.6 How are your expenses reimbursed?

Reimbursements are paid after Inter Partner Assistance has received the original and final hospital bill. Then, the reimbursement is paid as and when expense receipts are submitted. However, a provisional hospital bill is not sufficient to be reimbursed.

Please note that reimbursements are paid directly into the bank account number held in the ULB’s database, i.e. the bank account number where the pay, pension or grant of the agent is paid.