Occupational health insurance policy “Outpatient Care”

Ambuflex Plus

Concluded with: *name of policyholder
Policy Number: 0000* 784

This occupational health insurance policy consists of the attached terms and conditions and any annexes and is concluded between:

**name of policyholder*
**address of policyholder* (street/number)
**address of policyholder* (town)
company number: *

hereinafter referred to as “the policyholder”

*acting in its own name and on behalf of the associated companies listed further below, for anything relating to the execution of this occupational health insurance policy “Outpatient Care”, signature, on behalf of the associated companies, of all annexes modifying the terms of this contract, included:

*

and

Justitia NV
Plantin en Moretuslei 301
2140 ANTWERP
company number: BE0404 479 211

company authorised (Royal Decree of 04.07.1979 – Belgian Official Gazette of 14.07.1979) to exercise the “Sickness and Invalidity” branch under code number 878.

hereinafter referred to as "the insurer".

This policy is administered by:

Vanbreda Risk & Benefits NV
Plantin en Moretuslei 297
2140 ANTWERP
company number: BE0404 055 676

hereinafter referred to as “administrator”.

1. The insured

The insured is the person who satisfies the affiliation requirements, who is affiliated under this contract and who is at risk.

In addition:

- the principal insured is the person who is occupationally connected to the policyholder at the time of affiliation.
- the co-insured, a member of the family of the principal insured.

2. Duration of the occupational health insurance policy

This policy is concluded for the duration of *****1 year and starts on */*/*. It is tacitly renewed on the annual renewal date for the duration of one year, except in the case of cancellation by registered letter by one of the parties to the other, at least 3 months before the end of the insurance year. This term starts on the day following the day on which the registered letter is registered with the post office. The insurance starts and ends at 00:00.

In the event of a fundamental change in the social security legislation, the law on hospitals or any other legislation that may have an impact on this policy, the company may change the terms and conditions of the insurance. This will be discussed beforehand with the policyholder. The policyholder may, if desired, cancel the policy within three months of the notification of the change.

3. Definitions

3.1. Accident

Any damage to the state of health caused by a sudden event occurring outside the organism, occurring independently of the will of the insured and the cause and symptoms of which are medically objectifiable and which, as such, permit diagnosis and require therapy.

3.2. Hospitalisation

A medically necessary stay in an institution that is legally recognised as a hospital and for which accommodation costs in the context of “Hospitalisation” or “One-day clinic” (whether or not surgical) are charged.

3.3. Illness

Any damage to the state of health that is not caused by an accident and the cause and symptoms of which are medically objectifiable and which, as such, permit diagnosis and require therapy.

3.4. Insurance year

The period of 12 months from the start date of this plan to the date of the first following annual expiration date and, thereafter, each new period of one year that follows.

3.5. Medication

Any product that is sold exclusively in pharmacies and:

- either registered as medication in Belgium;
- or for which the European Medicines Agency (EMA) has authorised to be placed on the market.

3.6. Statutory compensation

Any compensation that is provided under the Belgian laws that apply to salaried workers. The Belgian laws applicable to salaried workers in the event of illness or an accident are understood to include the relevant legislation:

- the legislation regarding the mandatory health and disability insurance;
- occupational accidents;
- occupational illnesses.

3.7. Outpatient care

Medical care provided without hospitalisation

Costs charged on the hospitalisation (or one day clinic) invoice not refunded by an hospitalisation insurance can be borne according to the reimbursement conditions of this agreement, Ambuflex Plus.

3.8. Waiting period

A one-off period beginning on the date of affiliation of the insured during which no reimbursement is provided by the insurer.

4. Commencement and end of affiliation

4.1. The affiliation of the principal insured and the co-insured

All members of staff employed by the policyholder who belong to **named staff category* may optionally join this plan provided they are affiliated to and benefit from the Belgian social security. These are called the **principal insured**.

The family members of the principal insured may also optionally join on the condition that all the family members join. They are referred to as the **co-insured**. For the co-insureds also applies they should affiliate to and benefit from the Belgian social security.

The term family members refers to:

- *;
- *;
- *.

The affiliation of both the principal insured and the co-insured does not involve any medical formalities or waiting periods. The choice regarding affiliation may be made annually. The principal insured is responsible for providing the correct affiliation details of the insured.

4.2. Choice of insurance cover

Ambuflex Plus offers 2 insurance covers:

- basic “Outpatient Care” cover;
- “Optical & Dental” extension.

The principal insured can make a choice from the following scenarios of affiliation:

- **only the principal insured signs up:**
  - for either *only* the basic “Outpatient Care” cover;
  - or for *both* the basic “Outpatient Care” cover and the “Optical & Dental” extension.
- **as well the main insured as all family members who fulfil the affiliation conditions sign up:**
  - for either *only* to the basic “Outpatient Care” cover;
  - or for *both* the basic cover “Outpatient Care” as well as to the extension “Optical & Dental”.

It is not possible to take out only the “‘Optical & Dental” cover.

4.3. End of the affiliation

The affiliation of the principal insured and the co-insured is terminated on the next annual renewal date following the day on which:

- the employment contract between the principal insured and the policyholder ends or is broken, *including in the case of unemployment with company supplement (SWT) and in any case at the latest on receipt of the statutory pension;
- the principal insured no longer belongs to the **named staff category*;
- the co-insured are no longer considered as being insured;
- the principal insured voluntarily stops the affiliation.

5. Covers

5.1 Basic “Outpatient Care” cover

Ambuflex Plus provides for a reimbursement in the limited list of medical expenses summarised below. The following costs for outpatient care are covered:

- the costs of **doctors' fees** for services included in the nomenclature of medical services provided by the compulsory insurance for medical care and benefits, on the condition that the insured also actually receives a statutory compensation for the service in question. All costs related to dental treatment and dental care are excluded. This exclusion also includes the costs for stomatology, periodontology, endodontic dentistry and orthodontics.

- the costs of **medical and paramedical services** included in the nomenclature of medical services provided by the compulsory insurance for medical care and benefits, on the condition that the insured also actually receives a statutory compensation for the service in question. The following is the limited list:

  - medical imaging;
  - medical lab tests;
  - nursing care;
  - physiotherapy
  - physical therapy;
  - occupational therapy;
  - speech therapy.

- costs of **registered medication.**

All the costs referred to above are 100% reimbursed. In the case of **doctors' fees and the medical and paramedical services**, this is done after deduction of the actual statutory compensation.

The **registered medication is reimbursed** subject to the annual ceilings. The **annual ceiling depends on the size of the family**, as set out below. A family member can be the partner or a child.

- max. EUR 145.00: the principal insured (employee) alone;
- max. EUR 290.00: the principal insured and one co-insured (family member);
- max. EUR 435.00: the principal insured and a maximum of three co-insured (family members);
- max. EUR 580.00: the principal insured and at least four co-insured (family members).

In addition, a **global annual ceiling applies to the total of all insured costs under this cover**. This is the total maximum reimbursement per year and per family, as set out below. The annual ceiling is:

- max. EUR 290.00: the principal insured (employee) alone;
- max. EUR 580.00: the principal insured and one co-insured (family member);
- max. EUR 870.00: the principal insured and a maximum of three co-insured (family members);
- max. EUR 1,160.00: the principal insured and at least four co-insured (family members).

For the determination of the annual ceiling per family, the family situation on * *fill in the due date* is considered. At that time, the ceiling is set for the new insurance year that is beginning. The annual ceiling can then be adjusted on each annual due date based on the family situation at that time and according to the arrangements mentioned above.

5.2 "Optical & Dental" extension

5.2.1 Optical

a) Eye glass lenses and contact lenses

The costs for corrective eye glass lenses and corrective contact lenses are insured.

These costs are reimbursed up to 60% of the amount that is charged to the insured after the deduction of any statutory compensation. This means that, if the insured receives any statutory compensation, said amount will be deducted from the amount paid. The repayment percentage of 60% is applied to that balance. If the insured does not receive any statutory compensation (*), the compensation under this plan will be equal to 60% of the amount the insured paid. In addition, an annual ceiling applies per insured person as set out in article 5.2.3.

b) Spectacle frames

Ambuflex Plus provides for a reimbursement of the costs for spectacle frames.

These costs are reimbursed up to 60% of the amount that is charged to the insured after the deduction of any statutory compensation. This means that, if the insured receives any statutory compensation, said amount will be deducted from the amount paid. The repayment percentage of 60% is applied to that balance. If the insured does not receive any statutory compensation (*), the compensation under this plan will be equal to 60% of the amount the insured paid. In addition, the reimbursement equals maximum EUR 100.00 per insurance year and an annual ceiling applies per insured person as set out in article 5.2.3.

(*) If the insured does not receive any statutory compensation for any reason he/ she is responsible such as for example if the insured did not pay the legal contribution for affiliation to the legal health insurance (health insurance fund), a theoretical legal intervention is taken into account. This theoretical legal

intervention for a particular service or cost is equal to the amount an employee is entitled to according to the Belgian social legislation if the insured meets the conditions of intervention or reimbursement.

5.2.2 Dental

For the full "Dental" cover applies that the costs of aesthetic dental care and treatment are never covered. Are nevertheless insured, the costs for:

a) Dental care

The following are covered: the costs of **consultations, dental care and dental treatment by a dentist** for services that are included in the nomenclature of medical services of the compulsory insurance for medical care and benefits.

These costs are reimbursed up to 80% of the amount that is charged to the insured after the deduction of any statutory compensation. This means that, if the insured receives any statutory compensation, said amount will be deducted from the amount paid. The repayment percentage of 80% is applied to that balance. If the insured does not receive any statutory compensation, the compensation under this plan will be equal to 80% of the amount the insured paid. In addition, an annual ceiling applies per insured person as set out in article 5.2.3.

b) Orthodontics

The costs for **orthodontics** for insured persons up to and including 25 years of age for services that are included in the nomenclature of medical services of the compulsory insurance for medical care and benefits are covered.

These costs are reimbursed up to 80% of the amount that is charged to the insured after the deduction of any statutory compensation. This means that, if the insured receives any statutory compensation, said amount will be deducted from the amount paid. The repayment percentage of 80% is applied to that balance. If the insured does not receive any statutory compensation, the compensation under this plan will be equal to 80% of the amount the insured paid. In addition, an annual ceiling applies per insured person as set out in article 5.2.3.

c) Dental prostheses

This plan provides for a reimbursement of the costs of **removable and fixed dental prostheses**, such as implants, false teeth, crowns and bridges. These costs are reimbursed up to 60% of the amount that is charged to the insured and within the annual ceiling foreseen for these costs (see 5.2.3). There is a maximum of one reimbursement every three years for the same tooth.

In addition, for the **removable dental prosthesis**, these costs must be included in the nomenclature of medical services of the compulsory insurance for medical care and benefits. If the insured receives any statutory compensation, said amount will be deducted from the amount paid. The repayment percentage of 60% is applied to that balance. If the insured does not receive any statutory compensation, the compensation under this plan will be equal to 60% of the amount the insured paid. In addition, an annual ceiling applies per insured person as set out in article 5.2.3.

The costs for repairing both removable dental prostheses and fixed dental prostheses are not reimbursable.

(*) If the insured does not receive any statutory compensation for any reason he/ she is responsible for such as for example if the insured did not pay the legal contribution for affiliation to the legal health insurance (health insurance fund), a theoretical legal intervention is taken into account. This theoretical legal

intervention for a particular service or cost is equal to the amount an employee is entitled to according to the Belgian social legislation if the insured meets the conditions of intervention or reimbursement.

5.2.3 Annual ceiling "Optical & Dental" extension

The **annual ceiling per insured person** for the full "Optical & Dental" extension, that is eye glass lenses, contact lenses, spectacle frames, dental care, orthodontics and dental prostheses combined, is equal to:

- the first year of affiliation: EUR 500.00
- the second year of affiliation: EUR 1.000.00
- from the third year of affiliation onwards: EUR 1.500.00

These annual ceilings mentioned above apply only if the years of affiliation are continuous, with no interruptions between any years of affiliation. Any re-affiliation after an interruption will be regarded as a new affiliation, with the annual ceiling restarting at the level for the first year of affiliation. From then on, the annual ceiling for a further uninterrupted affiliation will rise according to the schedule set out above.

6. Territorial scope

The cover described above applies only for costs incurred in Belgium.

7. Exclusions

No reimbursements are provided for the following costs:

- cosmetic care and treatment;
- the costs that are not included in the nomenclature of the medical services of the compulsory insurance for medical care and benefits, unless otherwise stated;
- costs incurred before the date of affiliation of the insured.

8. Premium

8.1 Basic "Outpatient Care" cover

The **annual net premium *per family*, insurance tax excluded,** is:

- global annual ceiling of EUR 290.00: EUR 299.05
- global annual ceiling of EUR 580.00: EUR 598.10
- global annual ceiling of EUR 870.00: EUR 897.16
- global annual ceiling of EUR 1,160.00: EUR 1,197.54

This net premium is increased by the legally determined insurance tax that applies at the time of the conclusion of this contract, which is 9.25%. In the event of any changes in these charges and taxes, the premiums will automatically be adjusted.

The **annual gross premium *per family***, including the insurance tax of 9.25%, is:

- global annual ceiling of EUR 290.00: EUR 326.71
- global annual ceiling of EUR 580.00: EUR 653.42
- global annual ceiling of EUR 870.00: EUR 980.15
- global annual ceiling of EUR 1,160.00: EUR 1,308.31

8.2 "Optical & Dental" extension

The **yearly net premium *per insured,*** insurance tax excluded, is 227,01 EUR.

This net premium is increased by the legally determined insurance tax that applies at the time of the conclusion of this contract, which is 9.25%. In the event of any changes in these charges and taxes, the premiums will automatically be adjusted.

The **annual gross premium *per family***, including the insurance tax of 9.25%, is 248,01 EUR.

8.3 Acquisition and administration costs basic "Outpatient" cover and "Optical & Dental" extension

The acquisition costs (see 1) included in the net or commercial premium at the time of entering into this insurance policy are estimated at 5.37%. The administration costs (see 1) included in the net or commercial premium at the time of entering into this insurance policy are estimated at 3.21%.

	estimate of the acquisition costs in the commercial premium (1)	estimate of the administration costs in the commercial premium (1)
Basic "Outpatient" cover		
global annual ceiling of EUR 290.00	EUR 16.06	EUR 9.60
global annual ceiling of EUR 580.00	EUR 32.12	EUR 19.20
global annual ceiling of EUR 870.00	EUR 48.18	EUR 28.80
global annual ceiling of EUR 1,160.00	EUR 64.31	EUR 38.44
"Optical & Dental" extension		
per insured	EUR 12.19	EUR 7.29

(1) Information about the costs and charges in implementing the Royal Decree of 2 May 2017, Belgian Official Gazette of 11 May 2017.

Warning

"Please note that, if you are going to compare different insurance contracts, you should compare not only the estimated costs and charges of the contracts with each other but also take into account other elements, such as the scope of the cover, the amount of any excess or the exclusion clauses.

The estimates given above offer a better picture of the part of the premium that is used for the cover of the risk that the insurance contract covers. The balance of the premium, after deduction of taxes and contributions, as well as of the acquisition and administration costs, is made up of the part of the premium that is used for the contractually defined services and of the costs other than those mentioned above (including the aggregated and mutually shared costs of claims and the management thereof).

These estimates are calculated on the basis of the accounting data of the previous financial year of the insurance company, as approved by its general meeting."

These estimates are recalculated each year on the basis of the previous financial year. The relevant information will always be included in the policy schedule for the current year. In the calculation of the premiums with taxes and the estimates of the costs on the schedules, a slight difference can occur due to the rounding-off rules that are applied.

8.4 Payment of the premium

This gross premium is due for both the principal insured and the co-insured * *at a frequency to be determined in consultation with the policyholder*. The principal insured pays the gross premium for him or herself and the family members (co-insured). These gross premiums are collected by the policyholder from the principal insured.

The policyholder is obliged to pay, together with the premiums, all existing or future taxes and parafiscal charges. The policyholder is notified of the premium amount to be paid by a premium statement from the insurer or its authorised representative.

In the event of non-payment no later than fifteen days from the day following the delivery by post of a registered letter reminding the policyholder of the premium's due date and the consequences of non-payment within the specified term, the cover is immediately suspended upon expiry of the aforementioned term for all costs incurred from the date of suspension.
The cover will be reinstated only after full payment of all overdue premiums. The insurer reserves the right to cancel the contract during the aforementioned period of suspension. In that case, the cancellation becomes effective after the expiry of the 15-day term from the first day of the suspension or the notice of default in which the suspension is announced.

8.5 Indexation of premium and ceilings

8.5.1 "Outpatient care" basic cover

The basis for the indexation of all annual ceilings and annual premiums is the indexation of the overall annual ceiling on the cover for the main policyholder only, referred to below as the base ceiling. At the start of this plan, the reference year for indexation is *2023.

The base ceiling is indexed upwards each year on 1/1 (N) based on the health index for the month of May. The increase is defined using the health index for the month of May of the year N-1, divided by the health index for the month of May in the reference year. The indexation percentage arrived at in this way is then applied to the base ceiling. If the result of this calculation is equal to or more than a new tenth following the base ceiling, then the indexed base ceiling is rounded down and set to the equivalent of the highest tenth reached. The ratio between the indexed base ceiling arrived at in this way and the base ceiling provides the effective indexation percentage for all annual ceilings (global ceilings and ceilings for medication) and for the net premiums. The indexed amounts are applied from the renewal date, */* and the reference year for indexation is adjusted for the following year to N. If the result of the calculation described above is less than a new tenth above the base ceiling, then the indexation is not applied and the reference year is maintained for the following year.

8.5.2 "Optical & Dental" extension

The **net premiums** are indexed upwards each year on 1/1 (N) based on the health index for the month of May The increase is defined using the health index for the month of May of the year N-1, divided by the health index for the month of May of the year N-2. The indexed premiums are applied from the renewal date, */*.

The **annual ceilings and the ceiling for frames** are not indexed.

9. Administrator

For the management of this occupational health insurance policy, certain tasks are entrusted by the insurer to the administrator.

A framework agreement regulates the tasks that the administrator performs for the account of the insurer.

In the event of termination of the framework agreement, it will remain in force until the end of the current insured period of this occupational health insurance policy. All claims that occur during that period will continue to be dealt with by the administrator.

In the event of termination of the occupational health insurance policy, the framework agreement will remain in force until the end of the insured period provided for under this occupational health insurance policy. All claims that occur during this period will continue to be dealt with by the administrator.

10. Disputes

The parties shall try to settle any dispute regarding this agreement first in an amicable manner.
Should this not be possible, the dispute will fall under the exclusive jurisdiction of the courts of the Antwerp District, Antwerp Division.

11. Final provisions

11.1 Individual continuation and pre-financing

This contract is an occupational policy to which the law on health insurance policies applies.

11.2 Terms of payment

The insured will receive the reimbursement calculated on the basis of this policy within 10 working days of the delivery of the necessary substantiating documents to the administrator. The insurer shall under no circumstances be liable for late interest.

11.3 Calculation of reimbursement

The following is deducted from the amount of the insured costs: any reimbursement arising under any other insurance policy for the same purpose or from any similar scheme, fund, organism or institution, including the supplementary insurance policy of the health insurance fund. In addition, the reimbursement of the insured costs is calculated on the basis of the conditions set out in Article 5.

11.4 Declaration of costs

When declaring medical expenses, the insured and the policyholder shall use the various digital applications offered by the administrator.

For purchases in the pharmacy, the insured preferably uses AssurPharma. If that is not possible, these costs must be submitted using a BVAC certificate

11.5 Data transfer

All exchanges of data between the policyholder and the administrator are based on an annual interface. By an exchange of data is meant:

- surname, first name, gender, date of birth and address of the insured persons;
- e-mail address of the principal insured;
- date of affiliation;
- for the co-insured: relationship to the principal insured;
- date of the end of the affiliation.

11.6 Lapse of the cover

The cover shall expire if the policyholder or the insured submits false certificates or makes false declarations, or facts that would have influenced the insurer's decision were deliberately withheld.

11.7 Information when processing personal data

In the context of the cooperation between the parties, the policyholder provides the insurer with personal data, which the insurer processes as Data Controller in accordance with the applicable privacy legislation as the Data Controller.

1. The insurer has appointed a Data Protection Officer. This officer can be reached at dpo@justitianv.be or Justitia NV, attn. Data Protection Officer, Plantin en Moretuslei 301, 2140 Antwerp, Belgium.

2. The insurer processes this personal data to meet its legal obligations (hereinafter 'LO') (such as, among others, in the framework of the AssurMiFID, anti-money laundering, and the anti-terrorism legislation), in the context of the performance of the Contract (hereinafter 'CT'), if the processing is necessary in the framework of legal claims (hereinafter 'LC') and for the representation of its legitimate interests (hereinafter 'LI'). In certain cases, the Data Subject will have to grant consent for the processing.

3. The insurer shall process this personal data for the following purposes:

    - client management (LO and/or CT and/or LI);
    - handling of requests and claims (CT);
    - management of health insurance (CT);
    - management of disagreements and disputes (CT and/or LC);
    - technical-commercial enquiries (CT and/or LC)
    - public relations (LI);
    - combating fraud and breaches by clients (LI);
    - security (LI);
    - protection of society, own sector or organisation (LO and/or LI).

4. The insurer reserves the right to outsource the administration of this contract and/or of the claims to Vanbreda Risk & Benefits. The insurer will enter into a framework agreement with the latter for that purpose.

5. In the context of the cooperation, the insurer may pass on this personal data to the administrator Vanbreda Risk & Benefits, experts, medical examiners and health insurance funds. This personal data may also be processed by suppliers or subcontractors of the insurer which act as Processors. If the insurer is required to do so by law, this personal data may be forwarded to government authorities.

6. Unless it is necessary for the performance of the contract, the personal data is not processed or forwarded to countries outside the European Union.

7. This personal data shall ultimately be destroyed after the expiry of the liability period for potential complaints.

8. Every Data Subject is entitled to ask the insurer for access to as well as rectification, erasure or restriction of the personal data processed in respect of said subject. They may object to the processing and are entitled to data portability.

9. When the processing is based on consent, the Data Subject is entitled to revoke this consent. Such withdrawal shall not prejudice the lawfulness of the processing based on the consent prior to the withdrawal thereof.

10. Every Data subject is entitled to submit a complaint to the Data Protection Authority.

11. The personal data requested by the insurer is necessary for the proper performance of the cooperation. If this personal data is not provided, the insurer may refuse to cooperate any further or may not be able to (fully) implement it in accordance with standard practice.

12. The personal data may be used for automated decision-making. If this is the case, the insurer shall inform the Data Subject about it.

More information about Justitia's privacy policy can be found at www.justitia.be/en/privacy-statement/.

11.8 Substitution or subrogation

The insurer, which is obliged to pay or has made a payment, enters into the rights and claims that the insured may have towards liable third parties. The insured may therefore not waive, in whole or in part, any recourse against third parties.

The substantiating document submitted shall become the property of the insurer.

11.9 Choice of domicile

The domicile of the policyholder and that of the insurer are ipso jure their respective registered offices and that of the insured the last domicile known to the policyholder.

11.10 TRIP

Justitia plc takes part in the « Terrorism Reinsurance and Insurance Pool » (TRIP). Therefore, this occupational health insurance policy covers damage caused by an act of terrorism as defined and regulated by the law of 1 April 2007 (BS 15 May 2007), within the framework, limits and time limits of this law.

11.11 Applicable legislation

Belgian legislation applies to this contract, which is more specifically regulated by the Insurance Act of 4 April 2014 and by the various implementing decrees.

Its mandatory provisions result in the cancellation, replacement or supplement of the conditions of this contract that would conflict with it.

Done in Antwerp, on */*/201* in * originals, each party acknowledging receipt of one original.

the policyholder	the insurer
*	Justitia NV
*name and position of signatory	Kris Heyman
	Director