General Terms and Conditions Dentalia Up

as from 1 January 2024

General Terms and Conditions Dentalia Plus of the Health insurance company MLOZ Insurance
voted by the Board of Directors on 31 May and 20 September 2023 and the Extraordinary General Meeting
on 21 June and 18 October 2023

"MLOZ Insurance" is the health insurance company of the Independent Health Insurance Funds (Helan Onafhankelijk ziekenfonds - Partenamut - Freie Krankenkasse). Approved under code OCM 750/01 for branches 2 and 18 by the Control Office of health insurance funds and national associations.
Head office: route de Lennik 788A, 1070 Brussels - Belgium (RPM Brussels)
www.mloz.be - Enterprise number: 422.189.629. - 01/01/2024

Dentalia Up

1. DEFINITIONS

1.1. Insurer: "MLOZ Insurance" HEALTH INSURANCE COMPANY, insurance company approved by the Control Office of health insurance funds and national associations, by decision of 24 June 2013 to offer health insurances under branch 2 of appendix 1 of the royal decree of 22 February 1991 on general regulation of the supervision of insurance companies, as well as to cover, on a complementary basis, risks belonging to the assistance such as stipulated under branch 18 of appendix 1 of the above-mentioned royal decree, under code no OCM 750/01.

1.2. Policy holder: the person who subscribes the insurance for himself and/or for insured persons and who has to pay the premiums.

1.3. Insured: By insured we mean the person who bears the risk of the insured event occurring and who is the beneficiary of the insurance policy.

1.4. Sections : the sections of MLOZ Insurance are the intermediaries which offer the insurance products: 509: Partenamut (www.partenamut.be) - 515: Freie Krankenkasse (www.freie.be) - 526: Helan Onafhankelijk ziekenfonds (www.helan.be), all members of the National Association of independent health insurance funds.

1.5. Medical dispensations: the term refers to the list of the dispensations of the nomenclature.

1.6 Waiting period: period during which the insurer does not have to provide benefits and beginning at the starting date of the policy.

1.7. Accident: unexpected event, independent of the will of the insured person, involving a corporal injury of which (one of) the cause(s) is external to the organism. This accident must have involved traumatic injuries for which the treatment is of such a nature that it is covered by these dispositions.

1.8. Year of affiliation: a period of twelve months after the affiliation anniversary date. The first year of affiliation starts on the starting date of the affiliation.

1.9. Preventive behaviour: the fact of having a dispensation for reimbursed dental care during the civil year that precedes any new payment request.

1.10. Dental Care:

- all the dispensations mentioned, either in the Royal Decree of 1 June 1934 laying down rules for the practice of dentistry, or in the Royal Decree of 9 November 1951 completing the Royal Decree of 1 June 1934 lying down rules for the practice of dentistry,
- administrated by one of the care providers listed in article 4, §1 of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of health dispensations regarding the compulsory insurance for health care and sickness benefits.

1.11. Preventive dental care: as defined by the compulsory insurance for health care, the following dispensations by a general dentist, dental practitioner, stomatologist or maxillofacial surgeon (limited list of providers): the examinations of the mouth and teeth, the Dutch Periodontal Screening Index (DPSI), the scaling (including related polishing), the prophylactic cleanings, the sealing of fissures and cavities, and the consultations. Orthodontic and periodontal dispensations, regardless of the qualification of the provider, are excluded as preventive dental care as referred to in this article.

1.12. Curative dental care :
By curative dental care we mean :

1) dental extraction

2) conservative dental care: removal of tooth decay or replacement of an old filling with one that replaces the original volume of the treated tooth and restores its function;

3) endodontics: a speciality of dentistry whose aim is to treat or retreat the endodontium (pulp chamber and dental canals). The aim is to seal the entire root canal network (or root canal treatment);

4) minor oral surgery as provided for in 1.12, excluding the following devices, which are considered as removable dental prostheses:

- hard synthetic resin devices used for pain treatment and treatment of dysfunction of the maxillo-mandibular system and interposed between the dental arches;
- repositioning systems used during maxillofacial surgery, especially those attested under code 317295-317306.

5) the following diagnostic dental care:

- intraoral, extraoral and panoramic X-rays;
- dental conebeams (CBCT), provided they are medically necessary.

Curative dental care as referred to in this point does not include diagnostic dental care carried out as part of orthodontic treatment, dental prostheses and implants or periodontology.

1.13. Minor oral surgery: the dispensations of article 14, I) of the appendix to the R.D. of 14 September 1984 establishing the nomenclature of health dispensations in the context of the compulsory insurance for Health Care and Sickness Benefits, of which the codes are followed by the sign "+".

1.14. Periodontology: a speciality of dentistry whose aim is to treat the periodontium (the tissues supporting the teeth, i.e. the gums and alveolar bone) to ensure the periodontal health necessary for the longevity of teeth and/or implants. This includes consultations, diagnostic dental care, periodontal maintenance and periodontal surgery.

1.15. Dental prostheses and dental implants: all dispensations inherent in the placement of a dental implant or fixed or removable dental prosthesis, meeting the requirements stipulated in the applicable regulations, including EU Regulation 2017/745. They are defined as follows:

1) Dental implant: a machined part, inserted into the maxillary or mandibular bone into which it will osseointegrate. It will anchor or retain a fixed and/or removable dental prosthesis. A dental implant includes diagnostic dental care, pre-implant modelling, design and production of surgical guides, supply and placement of the implant, and all the materials, services and technology used for its installation.

2) Dental prosthesis: the final placement of a removable or fixed dental prosthesis. This includes all preparatory and modelling work, diagnostic dental care, moulds, supply of moulds, anchoring or retention of the dental prosthesis, and all necessary alterations.

- removable dental prosthesis: any removable device designed to replace one or more missing teeth. Removable dental prostheses can be complete or partial, consisting of a resin base or metal frame to support artificial teeth.

Removable dental prostheses include:

- synthetic resin devices used for pain treatment and treatment of dysfunction of the maxillo-mandibular system and interposed between the dental arches
- prostheses for which code 317295-317306 is attested, in view of their design and manufacturing techniques

- fixed dental prosthesis: any prosthetic element designed either to reinforce a decayed tooth, or to replace one or more missing teeth. Fixed dental prostheses can be made of metal, ceramic or ceramic-coated

metal, and can be supported by a natural tooth or an implant.

1.16. Orthodontic treatment: speciality of dentistry whose aim is to alleviate orthodontic problems (anomalies in dental position and relationships) and orthopedic problems (anomalies in the bony bases resulting in a shift of the maxilla and/or mandible). Orthodontic treatment includes all preparatory work, consultations, diagnostic dental care, moulds, supply and placement of custom-made, activatable appliance(s), as well as monitoring and retention procedures.

1.17. Modelling: any digital or laboratory work used to simulate the process or result of a treatment.

1.18. Excessive or discriminatory fees: excessive fees are qualified as such by comparing the fees charged by a dentist to an insured with:

- the convention rate (in effect at the time of the dispensation) for reimbursable dispensations; or
- the sector reference rate for non-reimbursable dispensations

or

- the rate set out in the appendix to the Royal Decree of 1 October 2013 establishing the conditions for compensation for dental prostheses required as a result of injuries sustained in a work accident, updated annually on 1 January.

Discriminatory fees refer to the fact that the fees charged by a dentist vary depending on whether or not his or her patient has subscribed to a dental care insurance and/or on the insurer with whom this insurance has been subscribed.

2. ADMISSION

2.1. To join and remain a member of the cover Dentalia Plus, the policy holder has to be affiliated to the compulsory insurance as well as to the complementary services under one of the three sections mentioned above. However, there are some statutory exceptions (cf those sections: Partenamut, Freie Krankenkasse, and Helan Onafhankelijk ziekenfonds). The policy holder has to affiliate his/her dependants within the meaning of the regulation on the compulsory insurance for health care and sickness benefits, except when the partner, the cohabiting partner, or the children are already covered by a similar insurance of the "actual costs" type. The cancellation or deregistration of an insured person implicitly leads to that of all the people whose affiliation is compulsory.
The age limit to join the insurance is 64 years included, except in case of transfer within the compulsory insurance for persons who were previously members of a similar "dental care insurance" of another Belgian health insurance fund and who have paid their premiums for this insurance.
2.2. Impact on your affiliation to MLOZ Insurance if the contributions to the complementary services of your health insurance fund are not paid It is important that all contributions for the complementary services of your health insurance fund are always paid.
If your payment is not in order, this can have serious consequences for your affiliation to MLOZ Insurance and for the covers of the insurances you contracted.
2.2.1. Consequences for the affiliation to MLOZ Insurance
You can only join MLOZ Insurance if you have not lost your rights to the complementary services of your health insurance fund due to non-payment of contributions for these services for a period of 24 consecutive months.
2.2.2. Consequences for maintaining your affiliation to MLOZ Insurance
If you are already affiliated to MLOZ Insurance, it is legally obliged to terminate your affiliation, and therefore all your covers, if you are sanctioned by the loss of your rights to the complementary services of your health insurance fund because you have not paid for these services during 24 consecutive months. This automatic exclusion is independent of whether you have always paid the contributions for the insurances of MLOZ Insurance. You will then be able to reaffiliate with MLOZ Insurance only if you resume regular payment of your contributions for the supplementary services provided by your health insurance fund. The period during which you must pay contributions without being able to claim dispensations under the supplementary services depends on whether you are or were in a situation worthy of consideration (e.g. (but not exhaustive) integration allowance, collective debt settlement, personal bankruptcy, etc.). Any interruption of 6 months in the payment of these contributions during the period referred to in the previous sentence will result in a new exclusion from MLOZ Insurance.

3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion of the insurance policy

All new affiliation requests must be submitted through the forms provided by MLOZ Insurance or via the website of the section to which the policy holder is linked.
The insurance policy is composed by the acceptance letter and the general terms and conditions with additional clauses.
The insurance policy starts the first day of the month following the month during which MLOZ Insurance received the duly completed "New affiliation request or request to change a product" (internal date or scanning as proof), if MLOZ Insurance receives the first premium for each insured person at last on the last day of the third month following the joining date.
The membership of a newborn or an adopted child under 3 years of age, not exempted from waiting period, starts the first day of the month following the birth or adoption, under the condition that MLOZ Insurance receives the membership application before the end of the third month following the birth or adoption and that MLOZ Insurance receives the first premium at last the last day of the third month following the joining date.
The spontaneous payment of a premium without being requested to do so is not worth membership. If the above-mentioned 3-month term is not respected, this premium will be reimbursed and a new membership procedure will have to be started.
The decision of acceptance is communicated by letter to the candidate policy holder. The letter will detail the amount and the payment date of the first premium, the date of acceptance of the membership and the starting date of the membership, the duration of the waiting period, the annuity duration of the membership and the insurance product provided.

3.2. Ending of the insurance policy

The insurance policy is a life policy. However, it ends in case of:

- cancellation by the policy holder, according to the terms stipulated in the law of 4 April 2014, with a prior notice of at least one month starting the first day of the month following the sending of the registered letter or the qualified registered electronic letter (via digiconnect.be), or the delivery of the writ or the cancellation letter against deposit receipt, addressed either directly to MLOZ Insurance or to one of the sections mentioned above.
- fraud or attempt to fraud.
  - the insurance guarantee is refused or reduced proportionally to the loss suffered by MLOZ Insurance; and
  - the policy is terminated.
- voluntary caused injury to the interests of MLOZ Insurance and notably in case of intentional omission or inaccuracy in the statements at the time of joining or introducing reimbursement requests or if the policy holder refuses to conform to these terms, the insurance policy is null and void. It may also be decided to cancel the insured's affiliation. In both cases, premiums due up to the time when the insurer became aware of the omission or intentional inaccuracy of inaccurate data, revert to MLOZ Insurance.
- cancellation by the insurer in case of non-payment of the premiums.
- expulsion of the complementary health insurance services.
- transfer to a health insurance fund that does not belong to the Independent health insurance funds (legal cancellation).
- death.
- nullity.

4. BEGINNING, EXCLUSIONS AND ENDING OF THE GUARANTEE

4.1. Beginning of the insurance guarantee

The insurance guarantee begins at the starting date of the insurance policy stipulated in the acceptance letter if the waiting periods have been accomplished.

4.1.1. General rule: 6-month waiting period

To benefit from the interventions of Dentalia Plus, a 6-month waiting period starting at the joining date has to be accomplished. The waiting period is extended to 12 months for the reimbursement of prostheses, implants and orthodontic dispensations.
Dentalia Plus does not intervene for a dental care dispensation made during the waiting period.

4.1.2. Specific rules:

- Waiting period exemption for the newborn or the adopted child
  If one of the parents joined Dentalia Plus before the birth or adoption, the newborn is covered as from its birth and the adopted child under three years of age as from the date of its adoption, against delivery of a copy of the birth or adoption certificate before the end of the third month following its birth or adoption and provided that the first premium is received at last on the last day of the sixth month following the joining date. The first premium will only be due by the first day of the month following the birth or adoption.
  This is only applicable if the entitled person of the child in compulsory insurance has achieved his waiting period.
- Suspension in case of detention
  In case of detention and on demand of the policy holder, the statutory rights and obligations may be suspended. These rights and obligations start again the first day of the month following the request of the policy holder to end this period of suspension and on condition that the request is made within 90 days after the end of the reason of suspension and that he pays his premium within 15 days after payment request of MLOZ Insurance.

- Waiting period exemption for similar dental care insurances
  The new insured persons proving with documents that they were covered for more than 12 months and until the date of joining Dentalia Plus by a similar dental care insurance will be exempted from the 6-month and 12-month waiting periods.

  For the affiliation to Dentalia Up, by similar dental care insurance, we mean a 'compensatory' insurance where reimbursements are made on the basis of expenses actually billed to the insured person per dispensation, as opposed to an insurance that pays a lump sum, and which (cumulative conditions):
  - offers a financial intervention for dispensations of dental care, of at least 50 % of the expenses charged to the insured persons with an annual maximum of at least € 500. In order to determine if that maximum is reached in another entity, the highest intervention maximum in that other entity's service in force at the time of affiliation to the present service must be taken into account; and
  - is not limited to an intervention for dispensations covered by the compulsory insurance for health care and benefits; and
  - covers the following guarantees: preventive care, curative care, periodontology, orthodontics, dental prostheses and dental im plants.

4.2. End of the guarantee

The insurance guarantee ends with the insurance policy.

5. RIGHT TO BENEFITS

MLOZ Insurance and the policy holder collaborate in order to determine the right to benefits which is established on basis of the provided information. The policy holder allows the insurer to ask the needed information and commits himself to collaborate to the right execution of the information and investigation measures which result from the examination of the right to benefits. The insurer refrains from any measure which, regarding to the examination of the right to benefits, is inappropriate, irrelevant or abusive.
If the policy holder can pretend to the compensation of damage, the insurer is subrogated to the rights of the policy holder in the extent of his benefits.
The conventions concluded by the policy holder with third parties regarding rights that exist according to the insurance policy or that start in execution of the insurance policy are only opposable to the insurer as from the date on which he approved them.

6. OBLIGATIONS OF THE POLICY HOLDER

The policy holder has to:
- make statements and communications by letter or electronic communication to the head office of the insurer or its sections.
- inform the insurer as soon as possible of the date on which the prior conditions for maintaining the policy are no longer met;
- inform the insurer as soon as possible of any convention covering a similar or identical risk, either totally or partially;
- provide the insurer or its sections with every requested information.

If the policy holder fails to comply with the obligations of the insurance policy or those arising with the execution of the policy, and if after a peril, this breach causes an injury, the insurer can reduce his benefits for the relevant amount.

7. PREMIUMS

Monthly amounts in € on 01/01/2024, including all taxes, depending on the age

An increase of the premium of respectively 35, 50 or 70% is calculated on the current rates for the policy holders who are respectively between 40 and 44 years, 45 and 59 years or 60 years and over at the joining date to MLOZ Insurance.

Affiliated to the product Dentalia Up			
under 40 years old*		between 40 and 44 years old*	
from 0 to 3 years	Free	from 39** to 44 years	15.93
from 4 to 6 years	3.91	from 45 to 49 years	22,42
from 7 to 19 years	7.59	from 50 to 64 years	22,42
from 20 to 34 years	8.67	65 years and over	23.96
from 35 to 44 years	11.80		
from 45 to 49 years	16.61		
from 50 to 64 years	16.61		
65 years and over	17.75		

between 45 and 59 years old*		60 years old and over*	
44 years**	17.70	from 59** to 64 years	28.24
from 45 to 49 years	24.92	65 years and over	30.18
65 years and over	26.63		

* On the starting date of the membership
** Age on 1 January of the membership year

8. TERMS OF PAYMENT OF THE PREMIUM

The policy holder has to pay his premium on due date, following the agreed periodicity (quarter, semester, year).
The premium can be asked and must be paid in advance. It is sent to the last known address of the policy holder.
Is considered as in advance, any premium received before the first day of the first month of the quarter, semester or year, or, in case of monthly direct debit, within the first 10 days of the month, quarter, semester or year.
The policy holder who did not pay his premium before the first day of the quarter, receives a formal notification by registered letter or qualified electronic registered mail, demanding payment of the premium within 15 days as from the day after the delivery of the registered letter at the post office or of the qualified electronic registered mail. This formal notification informs him of the suspension of the guarantee in case of non-payment within the stated term. It starts a 45-day term at the end of which the membership will be cancelled automatically. The policy holder who did not pay his premium at the end of a quarter will automatically be charged for a fixed allowance of 15 € as reminder costs.
The disaffiliated policy holder will only be able to affiliate again if he pays all overdue premiums. He will also have to complete a new waiting period to pretend to the benefits again.

9. SEGMENTATION OF DENTAL INSURANCE

At the moment of affiliation to an insurance policy, the insurance companies apply segmentation criteria that influence the access to the insurance product, the determination of the premiums and the scope of the guarantee.

Underneath, you will find an overview of all the criteria that MLOZ Insurance uses for its dental insurance.

The following criteria are taken into consideration for Dentalia Up:

9.1. At the beginning of the policy:

9.1.1. The age of the insured person because, according to statistic data, the probabilities of treatment increase with age. Therefore, this parameter is taken into account for the fixation of premium amount and access to the product.
a) Access could be limited for certain products: the age limit for Dentalia Plus is 64 years included.
This age limit does not apply to insured parties who were in order with their contributions to a similar insurance with another HIC or to policy holders who wish to change their Dentalia Plus insurance coverage to Dentalia Up.
b) Affiliation after a certain age may lead to supplementary premiums. In case of transfer from Dentalia Plus to Dentalia Up no additional premium will be applied.
9.1.2. The state of health, particularly the presence of a pre-existing disease, as this may increase the risk of treatment, as well as the amount of medical expenses. It may also justify the exclusion of certain medical expenses related to a pre-existing condition.
9.1.3. The previous existence of a similar insurance impacts:
a) Access: the age limit (cf point 9.1.1 a) does not apply to insured parties who were in order with their contributions to a similar insurance with another HIC, or to policy holders who wish to change their Dentalia Plus insurance coverage to Dentalia Up.
b) Waiting period: the waiting period can be reduced or even cancelled for persons who were insured by a similar insurance until the date of affiliation to MLOZ Insurance. In that case, the waiting period will be reduced by the duration of that insurance.
MLOZ Insurance does not make a distinction based on the nature of the insurance (insurance with a health insurance fund or private insurer (individual or collective)) the insured person was covered by before joining MLOZ Insurance.
9.1.4. Nature of the treatment: the waiting period is extended to 12 months in the context of the Dentalia Up cover for reimbursement of dental prostheses, dental implants and orthodontics.

9.2. During the policy:

9.2.1. Age of the insured person because, according to statistic data, the

probabilities of treatment increase with age. This criterion might influence the amount of the expenses. Therefore, the contribution amount increases with the age of the insured.

9.2.2. The previous existence of similar insurance with another insurance company has an impact on the Dentalia Up maximums: the number of years of affiliation to this similar insurance at the time of joining Dentalia Up is taken into account in the following way to determine the Dentalia Up maximums:

· if affiliated to similar insurance for less than 2 years: the date of affiliation in similar insurance is not taken into account. The date used to determine the start date of the maximums is the date of affiliation to Dentalia Up.

· if affiliation for two years or more to this similar insurance: the date used to determine the start date of the maximums is the date of affiliation to Dentalia Up minus two years.

9.2.3. The reimbursements already granted under Dentalia Plus have an impact on Dentalia Up maximums.

The following measures will apply to Dentalia Plus policy holders in case of transfer to Dentalia Up:

· reimbursements for preventive and curative care within the current Dentalia Plus maximum will be deducted from the Dentalia Up 'Preventive and curative care' maximum

· orthodontic treatment reimbursements within the current Dentalia Plus maximum will be deducted from the Dentalia Up 'Orthodontic treatment' maximum

· reimbursements granted for prostheses, implants and periodontology within the current Dentalia Plus maximum will be charged to the Dentalia Up 'Prostheses, implants and periodontology' biennial maximum

9.2.4. The seniority in Dentalia Plus has an impact on Dentalia Up maximums.

If the insured was covered by Dentalia Plus up to the date of affiliation to Dentalia Up, the date of affiliation to Dentalia Plus is taken into account to determine the start date of the Dentalia Up maximums.

10. ADJUSTMENT OF THE PREMIUM, THE BENEFITS AND THE GENERAL TERMS AND CONDITIONS

The premium, the pricing conditions and the conditions for the coverage of the benefits are defined by taking into account the parameters that are included in the technical plan the insurer compiles on the basis of actuarial criteria and insurance techniques.

Without prejudice to the statutory options for adjusting the premiums and regardless of their adjustment to the index on consumer prices or the medical index linked to the "dental care" guarantee, the contributions may not be increased.

For the application of the index, a comparison will be made between the index rate of April of the current year and the index rate of April of the previous year.

This index rate variation is expressed in percentage and can be applied to the premium and to the benefits in force before indexation.

MLOZ Insurance may decide annually not to apply the indexation possibilities for premiums based on these indices, or to apply them only partially.

Nevertheless, the premiums will be increased in function of the different taxes applicable on that matter.

Premiums and coverage can be modified in accordance with article 504 of the Law of 13 March 2016.

11. REIMBURSEMENTS OF DENTALIA UP

11.1. Dispensations

MLOZ Insurance offers an intervention for preventive dental care, curative dental care, periodontology, dental prostheses and implants and orthodontic treatment as defined in point 1, provided that the dispensations are provided by one of the care providers listed in article 4, §1 of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of health dispensations in the compulsory insurance for health care and sickness benefits. There is no reimbursement for advances or deposits as long as the medical act has not been performed.

11.2. Territoriality

Dispensations are covered as long as they are provided in the metropolitan territories of the following neighbouring countries: France, the Netherlands, Germany and the Grand Duchy of Luxembourg, by care providers approved by the competent authorities of the country concerned.

11.3. Interventions for dispensations abroad

11.3.1. Preventive dental care

As part of Dentalia Up coverage, MLOZ Insurance reimburses preventive dental care provided the date of treatment is equal to or later than the date of affiliation to Dentalia Up. For preventive dental care reimbursed under the compulsory insurance for health care, the intervention amounts to 100 % of the amount charged to the insured. Supplements included in the amount charged to the insured will however be limited to 200 % of the convention rate. For preventive dental care that can be reimbursed by the compulsory insurance for health care, but are not reimbursed, the intervention will be limited to twice the convention rate, without prejudice to the application of point 15. For preventive and medically necessary care not reimbursed by compulsory insurance for health care, the intervention will be limited to twice the sector reference rate. If a reference rate is not available, the MLOZ Insurance Medical Advisor may request justification of the amounts incurred and limit the reimbursement to the dispensations legitimately performed and invoiced, and up to the amount invoiced by a normally reasonable and prudent dentist. Legitimately invoiced dispensations do not include: dispensations already included in the nomenclature code of a main procedure.

11.3.2. Curative dental care:

as part of Dentalia Up coverage, the intervention by MLOZ Insurance for curative dental care reimbursed by the compulsory insurance for health care: amounts to 50 % of the amount charged to the insured person, or 80 % if this person shows a preventive behaviour. Supplements included in the amount charged to the insured will be limited to 200 % of the convention rate. For curative dental care that can be reimbursed by the compulsory insurance for health care, but is not reimbursed, the intervention will be limited to 50 %, or 80% if the insured shows a preventive behaviour, of twice the convention rate, without prejudice to the application of point 15. For curative and medically necessary care not reimbursed by compulsory insurance for health care, the intervention will be limited to 50 %, or 80 % if the insured shows preventive behaviour, of twice the sector reference rate. If a reference rate is not available, the MLOZ Insurance Medical Advisor may request justification of the amounts incurred and limit the reimbursement to the dispensations legitimately performed and invoiced, and up to the amount invoiced by a normally reasonable and prudent dentist. Legitimately invoiced dispensations do not include: dispensations already included in the nomenclature code of a main procedure.

Exceptions :

- During the first year of membership, the rate of reimbursement of curativecare is fixed to 80% of the amount charged to the insured person.

- The rate of reimbursement of the curative care for insured persons of 6 years and less is fixed to 80% of the amount charged.

11.3.3. Dental protheses, dental implants and periodontology

As part of Dentalia Up coverage, the intervention by MLOZ Insurance for dental prostheses, implants and periodontology amounts to 50 % of the amount charged to the insured person, or 80 % if this person shows a preventive behaviour.

11.3.4 Orthodontic treatment

As part of Dentalia Up coverage, the intervention by MLOZ Insurance for orthodontic treatment: amounts to 60 % of the amount charged to the insured person.

11.3.5. 'Accidents' warranty

MLOZ Insurance provides specific terms for the dental treatment costs listed in point 11.1 following an accident, provided that the following cumulative conditions are met:

· it is an accident in private life, at school or during supervised practice (unpaid sport, youth movement); this does not apply to traffic accidents involving a motor vehicle subject to compulsory motor vehicle liability insurance*;

** In accordance with the law of November 21, 1989 on compulsory motor vehicle liability insurance*

· the accident occurred after the date of affiliation to Dentalia Up

· the accident resulted in traumatic injuries for which the treatment is of such a nature that it is covered by these dispositions

· the costs are medically necessary to restore the teeth to their pre-accident condition

· the treatment is incurred during the coverage period specified in the accident treatment plan granted. This coverage period is limited to two years from the date of the accident.

To benefit from the advantages of this 'Accidents' warranty, the insured must submit the following documents in addition to the harmonized document 'Dispensations of dental care - justificatory document for treatment(s)':

· the 'Accident declaration' form, to be submitted to MLOZ Insurance within 30 days of the accident; and

· the 'Accident Treatment Plan' form for the attention of the MLOZ Insurance Medical Advisor, together with X-ray and photographic evidence of the injuries sustained as a result of the accident

11.3.6. Warranty 'Illnesses whose pathology or treatment have an impact on oral health'

The diseases concerned are included in the following restrictive list:

· cancer

MLOZ Insurance has specific terms and conditions for each illness:

CANCER

There is an intervention for the dental treatment costs listed in point 11.1 following cancer, provided that the following cumulative conditions are met:

· cancer is diagnosed after the date of affiliation to Dentalia Up

· dental care is related to the cancer diagnosed and covered by these dispositions

· the costs are medically necessary

· the treatment is incurred during the coverage period specified in the treatment plan granted

· the cancer treatment plan must be introduced no later than one year after the end of the oncologic treatment

To benefit from the advantages of this warranty, the insured must submit the following documents to the Medical Advisor of MLOZ Insurance in addition to the harmonized document 'Dispensations of dental care - justificatory document for treatment(s)'.

· the cancer warranty application, accompanied by a doctor's certificate stating the insured's cancer diagnosis, confirmed by biological or anatomopathological examinations, medical imaging or any other medical examination usually approved in the medical world. Based on this information, the Medical Advisor of MLOZ Insurance will accept or refuse to grant the warranty, starting at the earliest on the day of the diagnosis; and

· the form 'Cancer Treatment Plan' together with radiological and photographic iconography

12. INTERVENTION LIMITATIONS

12.1. Annual maximum

12.1.1. Preventive and curative dental care

Intervention is limited, for all preventive and curative dental care dispensations combined, to €350 in the first year of affiliation, €650 in the second year of affiliation and €1.250 in the third and subsequent years of affiliation. The balance of the intervention maximum cannot be transferred and added to the next maximum.

12.1.2. Dental protheses, dental implants and periodontology

Intervention is limited to a two-year maximum for dental prostheses, dental implants and periodontology. The maximum starts on the anniversary of the affiliation preceding the dispensation date of the first dental prosthesis care, dental implant or periodontal treatment over a two-year period. This maximum, applicable for two years of affiliation, is determined on the basis of the number of years of affiliation completed at the start date of the biennial maximum

- first year of affiliation: waiting period; €350 in case of waiting period exemption;

- second year of affiliation: €650;

- third year of affiliation: €1.050;

- fourth to ninth year of affiliation: €1.400 ;

- tenth year of affiliation and more OR affiliated before the age of 5: €2.200.

The amount is determined at the start of the biennial maximum. If a seniority threshold is reached during the biennial period, the maximum amount is not updated. The balance of the intervention maximum cannot be transferred and added to the next maximum.

12.1.3. Orthodontic treatment

The intervention is limited to a maximum for orthodontic treatment. This maximum depends on the number of years of affiliation to Dentalia Up at the time of the attestation of the lump sum for orthodontic appliances at the beginning of the treatment:

- first year of affiliation: waiting period; €350 in case of waiting period exemption;

- second year of affiliation: €650;

- third year of affiliation: €1.050;

- fourth to ninth year of affiliation: €1.800;

- tenth year of affiliation and more OR affiliated before the age of 5: €2.200.

If a seniority threshold is reached during the treatment, the maximum amount determined at the beginning of the treatment is not updated. The maximum amount is recalculated on the basis of seniority in the product at the date of attestation of the lump sum for appliances at the start of 'regular' treatment. Reimbursements already made during 'first-line' treatment are taken into account when calculating the amount consumed.

Reimbursements already made during a preceding affiliation to Dentalia Up are taken into account when calculating the amount consumed.

12.1.4. Accidents warranty

Expenses will be reimbursed at 100 % of the amount charged to the insured person for dental treatment resulting from the accident, up to a maximum of €4.000 per accident, regardless of the year of affiliation to Dentalia Up. This is an additional coverage in case of an accident. If the total cost of accident-related treatment under the Accident treatment plan exceeds the 'Accident' maximum, the excess costs will be reimbursed in accordance with the respective conditions applicable to the concerned care (preventive care, curative care, prostheses, dental implants, periodontics, orthodontics).

12.1.5. Warranty 'Illnesses whose pathology or treatment have an impact on oral health'

Expenses will be reimbursed at 100 % of the amount charged to the insured person for dental treatment resulting from an illness, including the treatment, from the limited list below, up to a maximum of €4.000 for all illnesses covered by this warranty, of which the insured could be a victim during his/her lifetime, regardless of the date of affiliation to Dentalia Up. This maximum of €4.000 can only be used once per insured person. Reimbursements already made during a preceding affiliation to Dentalia Up are taken into account when calculating the amount consumed. This is additional coverage in case of illness: if the total cost of illness-related treatment under the treatment plan exceeds the maximum of €4.000, the excess costs will be reimbursed in accordance with the respective conditions applicable to the concerned care (preventive care, curative care, prostheses, dental implants, periodontics, orthodontics).

12.2. Specific conditions applicable in the case of affiliation to similar dental care insurance

For preventive and curative dental care, dental prostheses and implants, periodontology and orthodontic treatment as listed inpoints 12.1.1, 12.1.2 and 12.1.3, Dentalia Up's maximums are calculated according to the following rules: When the insured was covered by a similar dental insurance policy subscribed with another insurance company, up to the date of affiliation to Dentalia Up, the number of years of affiliation to this similar insurance at the time of affiliation to Dentalia Up is taken into account as follows to determine the Dentalia Up maximums:

· if affiliated to similar insurance for less than 2 years: the date of affiliation in similar insurance is not taken into account. The date used to determine the start date of the maximums is the date of affiliation to Dentalia Up.

if affiliated for two years or more to this similar insurance: the date used to determine the start date of the maximums is the date of affiliation to Dentalia Up minus two years.

12.3. Specific intervention rules

As part of Dentalia Up coverage, MLOZ Insurance intervenes taking into account the following dispositions:

· the health insurance company intervenes for dental conebeams (CBCT) provided that all the administrative conditions for the use of the conebeam set out in article 6, §17bis of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of dispensations in terms of compulsory insurance for health care and sickness benefits, are met, and in particular that the care provider holds a conebeam authorization issued by the AFCN, and that both the device and the care provider are registered with the NIHDI Health Care Department. Dental conebeams will be reimbursed insofar as they are medically necessary and in accordance with the terms and conditions applicable to the treatment to which they relate. Intervention for dental conebeams is limited to once every 2 years of affiliation.

From the moment the regulation comes into force, MLOZ Insurance reserves the right to intervene only after prior submission and acceptance of a treatment plan and quotation for dental prostheses and implants, periodontal dispensations and orthodontic treatment.

· in case of manifestly excessive or discriminatory amounts, MLOZ Insurance may limit the amount of its intervention by limiting the amount to be taken into consideration, up to the lowest amount listed in the reference documents below:

- the appendix to the Royal Decree of 1 October 2013 establishing the conditions for compensation for prostheses required as a result of injuries sustained in a work accident, updated annually on 1 January; or
- the convention rate for reimbursable dispensations; or
- the sector reference rate for non-reimbursable dispensations

or

- the rate commonly applied by the provider to patients who do not have dental insurance

· the intervention hard synthetic resin devices mentioned in point 1.14.2)

is limited to once every 5 years of affiliation
Under no circumstances can the adjustment of these devices can lead to a separate intervention.
· the renewal periods for prostheses are 7 years for removable prostheses and 15 years for fixed prostheses
· under no circumstances may dental care modelling lead to an intervention separate from the treatment to which it relates
· costs related to the same dental prosthetic work, as defined in point 1.14, may under no circumstances be spread over several dates with the aim of obtaining a greater benefit or intervention than that contractually provided for, and may only be taken into account globally on the date of final placement.
MLOZ Insurance reserves the right to check the therapeutic relevance of multiple treatments on the same implant or prosthetic site, and if necessary to limit its intervention.
· MLOZ Insurance reserves the right to make its intervention conditional on obtaining a copy of the advising practitioner's agreement or the appendix required to obtain reimbursement from the compulsory insurance for orthodontic treatment.

13. GENERAL EXCLUSIONS AND LIMITS

13.1. General exclusions

Are not covered: dental care costs related to an illness or an accident:
· resulting from acts of war, except for terrorism: still the guarantee remains granted during 14 days after the beginning of the hostilities if the policy holder was taken by surprise by the bursting of a state of war during a trip in a foreign country;
· following a riot, civil disorder, any act of collective violence of political, ideological or social origin, whether or not accompanied by a revolt against a government or any established authority, except if
the policy holder brings the proof that he was not taking active and voluntary part to this events;
· arising when the policy holder is under influence of narcotics, hallucinogens or other drugs;
· resulting from voluntarily participation in a crime or offence. 'Offence' also refers to offences that are afterwards redefined as violations;
· resulting from an intentional act of the policy holder, except in case of rescue of persons or goods, or the voluntary aggravation of the risk by the policy holder. The intentional act will be retained when
the policy holder voluntary and deliberately had a behaviour that caused a foreseeable damage without that it is required that he had the intention to cause the damage as it happened.
· resulting from drunkenness, alcoholism or drug addiction;
· resulting from nuclear reactions, except for terrorism.

13.2 Not covered dispensations

The cover of Dentalia Up does not intervene for:
· Orthodontic treatments:
1) not eligible for reimbursement under compulsory insurance for health care for members of the Belgian compulsory insurance for health care and sickness benefits
2) do not meet the intervention criteria of Belgian compulsory insurance for health care, for non-members of Belgian compulsory insurance for health care and sickness benefits
3) initiated or begun during the waiting period or prior to Dentalia Up affiliation. These treatments will not be covered even after the waiting period.
· Dental prostheses and implants initiated or begun during the waiting period or prior to Dentalia Up affiliation. These treatments will not be covered even after the waiting period.
· the dispensations of article 14, I) of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of health dispensations in the context of the compulsory insurance for Health
Care and Sickness Benefits of which the codes are followed by the sign "+";
· the medicines;
· materials, instrumentation, equipment, dental drug products or any other pharmaceutical supplies and any procedure closely related to the main procedure
· dental prostheses such as veneers, inlays, onlays and overlays, whatever the reason
· thermoformed aligners for any purpose other than orthodontic retention
composite resin injection techniques, using an indirect gutter to modify the anatomy, volume and shade of one or more teeth
· any treatment for ronchopathy or sleep apnea, or any other treatment not related to oral health
composite resin injection techniques, using an indirect gutter to modify the anatomy,
volume, and shade of one or more teeth
· any treatment for ronchopathy or sleep apnea, or any other treatment not related to oral health
expenses resulting from the practice of a paid sport, including training, as well as expenses resulting from an injury sustained during the practice of sports for which it is customary or compulsory to wear facial, oral or dental protection according to the regulations of the sports federation concerned;
· costs caused by the insured's participation in a brawl
· costs that are not specific to the supply of the main equipment in leasing or subscription formulas
· dental care dispensations related from aesthetic/cosmetic nature
· dispensations and supplies of goods which may be subject to VAT
· charges billed in contravention of the Belgian regulation
· costs that are not necessary from a diagnostic or therapeutic point of view because they do not cure a pathology
· dispensations or treatments that are not medically necessary
· exaggerated procedures or treatments (over-treatment) in relation to the pathology
· dispensations which are not recognized as sufficiently therapeutic or which are not taught in at least one of the Belgian faculties giving access to one of the professions listed in art. 4, § 1 of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of dispensations in terms of compulsory insurance for health care and sickness benefits
· dispensations for an insured who refuses to undergo an examination by an expert dentist appointed by MLOZ Insurance
· dispensations in case of an obvious falsification by the care provider and/or the policy holder or his representative concerning the dates of dispensation, the amounts requested, or the description of the dispensations

14. SPECIFIC RULES FOR TRANSFERRING FROM DENTALIA PLUS TO DENTALIA UP

14.1. Admission

Any Dentalia Plus policy holder may request a transfer to Dentalia Up without age limit. His dependants within the meaning of the regulation on the compulsory insurance for health care and sickness benefits, who are insured by Dentalia Plus, are obliged to follow him. The transfer must be requested by submitting a request for affiliation/change of product, and takes effect on the first day of the month following that in which the Health Insurance Company received the request for affiliation/change of product. The date taken into account to determine the start of the Dentalia Up waiting period will be the date of affiliation to Dentalia Plus.

14.2. Premiums

In case of transfer from Dentalia Plus to Dentalia Up no additional premium will be applied.

14.3. Reimbursements

14.3.1. Calculation of maximum start date

For preventive and curative dental care, dental prostheses and implants, periodontology and orthodontic treatment as described in points 12.1.1, 12.1.2 and 12.1.3, the date of affiliation to Dentalia Plus is taken into account to determine the start date of Dentalia Up maximums.

14.3.2. Impact of reimbursements already granted in Dentalia Plus

The reimbursements already granted in Dentalia Plus are taken into account as follows in the maximums of Dentalia Up:
· reimbursements for preventive and curative care within the current Dentalia Plus maximum will be charged to the Dentalia Up 'Preventive and curative care' maximum
· orthodontic treatment reimbursements within the current Dentalia Plus maximum will be charged to the Dentalia Up 'Orthodontic treatment' maximum
· reimbursements granted for prostheses, implants and periodontology within the current Dentalia Plus maximum will be charged to the Dentalia Up 'Prostheses, implants and periodontology' biennial maximum.

15. CUMULATION OF COVERS

15.1. The costs are not taken into account if they can be covered by:
· the compulsory insurance for Health Care and Sickness Benefits, as it is organised by the law coordinated on 14 July 1994 and its executing R.D. and by the R.D. of 30 June 1964;
· the legislation related to work accidents (law of 10 April 1971 and executing R.D.) and to professional sicknesses (law of 3 June 1970 and executing R.D.);
· the European regulations n°1408/71, 574/72 and 883/04 or by a multilateral or bilateral convention of social security concluded by Belgium;
· the service "urgent foreign care" of the health insurance funds.

The supplements covered are thus determinated in reference to these interventions. If, for one or another reason, the policy holder is not allowed to request one or more of these interventions, MLOZ Insurance intervenes in the same way as for an insured person entitled to these interventions.

15.2. When the amounts granted according to another regulation, the ordinary law of another insurance policy are lower than the benefits granted by MLOZ Insurance, the beneficiary is entitled to the difference at the cost of MLOZ Insurance. This information must be mentioned on the "Payment request". The intervention of MLOZ Insurance can never be higher than the amount of the actual costs supported by the policy holder.
When the damage is likely to be covered by the ordinary law or another regulation, MLOZ Insurance will be able to grant its benefits on temporary basis, while waiting compensation of the damage.
In this case, MLOZ Insurance will be subrogated in all the rights the insured person can exercise against the debtor of the compensation.
The insured person may not conclude any arrangement with the debtor of the compensation without prior agreement.

16. COMPENSATIONS

16.1. Prescription

The action in payment of dispensations as part of the benefits or any other action resulting from the insurance policy becomes prescribed by 3 years as from the day of the event which opens them, which means the day the covered peril happens.

16.2. Medical control

The dispensations are only granted on the condition that MLOZ Insurance has the right to ask the Medical Advisor at any time to control the health condition of the insured person and the validity of the dispensations. By affiliating to Dentalia Up, the policy holder agrees to allow MLOZ Insurance to verify the legitimacy of billing with the care provider or its subcontractor. By affiliating to Dentalia Up, the policy holder authorizes MLOZ Insurance's Medical Advisor, or the expert dentist appointed by MLOZ Insurance, to verify the legitimacy of the care provided by the care provider or subcontractor, if there is any doubt about the legitimacy of the care provided.

16.3.Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums.
In order to benefit from Dentalia Up compensations, the policy holder must go and see a registered practitioner. He must submit a document "Dispensations of dental care - justificatory document for treatment(s)", duly completed by the practitioner.

All dispensations performed for the same procedure/day must be listed on a single document. If supplements are only entered globally, they will be allocated in proportion to the rate for each dispensation. Justificatory documents must be entered in the same chronological order as the care provided. MLOZ Insurance reserves the right to make its intervention conditional upon receipt of a copy of the duly completed claim reimbursement receipt given in the context of an intervention by the compulsory insurance for health care and sickness benefits.

The policy holder undertakes to inform the insured person that by subscribing to this product, the SMA MLOZ Insurance may contact his health insurance company or the National Association of Independent Health Insurance Funds directly in order to optimize his reimbursements on the basis of the data they have received in the context of the compulsory and complementary insurance.

Justificatory documents in order to receive a compensation may be delivered digitally to MLOZ Insurance. The digital copy must be of good quality (i. e. readable) and true to the original (no hand-written alterations or updates). MLOZ Insurance reserves the right to request the original from the insured, who must keep it or bear the costs of a duplicate.

The reimbursements will be granted to effectively insured persons or to any person empowered by the 'Payment request', after receipt of the expenditures notes and the statement of the legal interventions.

17. DATA HANDLING

The personal data of the policy holder and their insured will be processed by MLOZ Insurance acting as data controller, and by the Onafhankelijke Ziekenfondsen (Independent Health Insurance Funds), as agent and processor for MLOZ Insurance, in the context of the allocation and management of the insurance product that the policy holder has subscribed to, and in accordance with the European Regulation of 27 April 2016 on data protection (GDPR). Medical data are collected and handled based on the insured's consent and under the supervision and the responsibility of the Medical Counsellor of MLOZ Insurance. The privacy policy of MLOZ Insurance is available via this link https://www.mloz.be/nl/content/privacy-mloz-insurance, or upon request in an agency, or by mail (MLOZ - DPO, Route de Lennik 788 A, 1070 Brussels).

This summary is for information purpose only. Only the statutes determinate the rights and obligations of the policy holders of MLOZ Insurance.
They are available for consultation at the head quarter of MLOZ Insurance or on the www.mloz.be.