General terms and conditions Medicalia

as from 1 January 2024

General Terms and Conditions Medicalia 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 insurance company of the Independent Health Insurance Funds (Helan Onafhankelijk ziekenfonds - Partenamut - Freie Krankenkasse) recognised under the CDZ code number 750/01 for the branches 2 and 18, at the Control office of health insurance funds and national associations - Head office: Lenniksebaan 788A, 1070 Brussels - België (RPR Brussels) - www.mloz.be - Company number: 422.189.629 - 01/01/2024

Medicalia

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: dispensations included in the nomenclature (RD of 14/09/1984 and later modifications).

1.6. 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.

1.7. Patient invoice, fee invoice and invoice for ambulatory care in the hospital: the documents as stipulated in appendix 37, appendix 38 and appendix 37bis respectively of the regulation of 1 February 2016 implementing article 22, 11° of the law on the compulsory insurance for Health Care and Sickness Benefits, coordinated on 14 July 2014.

1.8. Receipt: the document used by the health insurance fund outside the third party payer system.

1.9. Ambulatory care: care provided outside of a (day) hospitalisation.

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

2. ADMISSION

2.1. To join and remain a member of the cover Medicalia, the policy holder has to be affiliated to the compulsory insurance as well as to the complementary services under one of the 3 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. An insured person can only be affiliated to one ambulatory insurance product. A member affiliated to Hospitalia Ambulatory cannot affiliate to Medicalia and conversely. There is no age limit to benefit from the advantages of Medicalia. No new affiliation or transfer to Medicalia will be made from 1 July 2022.
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.

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 "membership application or request to change a product" (internal date or scanning as proof), if MLOZ Insurance receives the first premium for each insured person at the latest on the last day of the third month following the joining date.
The membership of a newborn or an adopted child under 3 years old, 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 the latest 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. This one month notice is not mandatory in case of a change of ambulatory care cover within MLOZ Insurance.
- 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 Medicalia, a 6-month waiting period starting at the joining date has to be accomplished. There's a waiting period of 12 months for the birth package.
Medicalia does not intervene for ambulatory care which started 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 Medicalia before the birth or adoption, the newborn is covered as from its birth and the adopted child under three years old 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 the latest 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 in case of accident
Medicalia intervenes for every ambulatory care dispensation resulting from an accident which has caused traumatic injuries for which the treatment is of such a nature that it is covered by the dispositions of this document if the accident occurred after the joining date. This intervention is submitted to the positive advice of the Medical Counseller of MLOZ Insurance.

• Waiting period exemption for similar ambulatory care insurances
The new policy holders proving with documents that they were covered until the date of joining Medicalia by a similar ambulatory care insurance will be exempted from the 6-month or 12-month waiting periods.

4.2. Exclusions of the guarantee

Are not covered: ambulatory care costs related to an illness or accident:
- resulting from acts of war, with the exception of 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;
- resulting from the practice of a remunerated sport, including training;
- 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 behavior 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, with the exception of terrorism.

4.3. 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, depending on the age

Affiliated to the product Medicalia	
from 0 to 6 years	Free
from 7 to 17 years	17,55
from 18 to 29 years	19,58
from 30 to 44 years	20,24
from 45 to 59 years	31,06
60 years and older	52,71

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

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 ambulatory care insurance Medicalia.
The following criteria are taken into consideration for Medicalia

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 as well as the amount of the reimbursements increase with age. Therefore, this parameter is taken into account for the fixation of the premium amount. Access could be limited for certain products. There is no age limit for Medicalia.
9.1.2. The previous existence of a similar insurance impacts the waiting period, that 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 private insurer (individual/collective) vs. insurance with a health insurance fund) the insured person was covered by before joining MLOZ Insurance.

9.2. During the policy:

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.

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

11. REIMBURSEMENTS BY MEDICALIA

Material may be purchased in other member states of the European Union.

11.1. Alternative treatments

Treatment performed by speech therapists, occupational therapists, dieticians, psychologists, osteopaths, chiropractors, homeopaths, acupuncturists and remedial educationalists, as far as they are approved by the NIHDI or are on the lists which are published and used by MLOZ Insurance (https://www.mloz.be/fr/prestataires-reconnus). The intervention of MLOZ Insurance aims at the dispensations for which the compulsory insurance does not intervene.

Under the terms of the Medicalia cover, MLOZ Insurance reimburses 75% of the bill amount charged to the insured after deduction of the intervention of the compulsory and/of complementary insurance.
Justificatory documents to provide
To benefit from this intervention, the insured must submit a duly completed and signed "Medicalia payment request form", with the original bill of the treatment. The intervention will be calculated based on the original bill.

11.2. Legal patient shares

- Consultations, visits, advice and technical dispensations of all general practitioners and specialists: dispensations of nomenclature: article 2
- Medical technical acts: dispensations of nomenclature: article 3
- Physical therapy: dispensations of nomenclature: article 7
- Nursing: dispensations of nomenclature: article 8
- Midwives: dispensations of nomenclature: article 9
- Special dispensations: dispensations of nomenclature: article 11
- Medical imaging: dispensations of nomenclature: articles 17, 17bis, 17ter, 17quater
- Radio and radium therapy, nuclear medicine: dispensations of nomenclature: article 18
- Internal medicine: dispensations of nomenclature: article 20
- Dermatology and venereology: dispensations of nomenclature: article 21
- Physiotherapy: dispensations of nomenclature: article 22
- Emergency supplements: dispensations of nomenclature: article 26
- Surgical truss maker: dispensations of nomenclature: article 27
- Orthopedics: dispensations of nomenclature: article 29
- Psychology: pseudonomenclature dispensations: circular OA nr. 2019/59.

If there is an intervention of the compulsory insurance, MLOZ Insurance offers an additional intervention.

The calculation is exclusively made on basis of the medical codes of the official nomenclature. The health care providers have the obligation to mention those codes on the claim reimbursement receipts delivered to the patients.

Under the terms of the Medicalia cover, MLOZ Insurance reimburses 75% of the bill amount charged to the insured (after deduction of the intervention of the complementary insurance).

Justificatory documents to provide
For the policy holders affiliated to the same section in compulsory insurance and at MLOZ Insurance, the interventions are made against delivery of the claim reimbursement receipts, simultaneously with the interventions granted in the context of the compulsory insurance for health care and sickness benefits.
For the other insured, the interventions are paid on basis of a copy of the claim reimbursement receipts, with an original proof of the reimbursement by the sickness and invalidity insurance.

11.3. Equipment

11.3.1. Eye care

Includes corrective lenses, contact lenses, eye laser therapy and keratotomy prescribed by an approved ophthalmologist, charged and delivered within 12 months after the prescription date.
There is no intervention for frames of corrective glasses, or frames or lenses of sunglasses (with or without correction).

11.3.2. Hearing aids

If prescribed by an approved otorhinolaryngologist, and charged and delivered by an approved audiologist within 12 months after the prescription date:

- hearing aids, except for cochlear implants and bone conduction devices (implant and (external) sound processor).

Batteries and other accessories for hearing aids are not compensated.

Under the terms of the Medicalia cover and as far as the conditions are met, MLOZ Insurance reimburses 75% of the bill amount charged to the insured (after deduction of the intervention of the compulsory and/of complementary insurance) for corrective lenses, contact lenses, laser treatment and keratotomy or hearing aids.

Justificatory documents to provide
With or without legal intervention, MLOZ Insurance offers an (additional) intervention based on a duly completed and signed "Medicalia payment request form", together with:

- *either the prescription of the approved ophthalmologist or otorhinolaryngologist and the original and detailed bill of the approved optician or audiologist*
- *or the standard documents as provided by the compulsory insurance, and the original and detailed bill of the approved optician or audiologist.*

The intervention will be calculated based on the justificatory documents.

11.4. Birth package (no longer granted since 1 July 2022, date of the product's run-off)

In case of birth, MLOZ Insurance offers a fixed intervention if the child is affiliated to Medicalia at the time of birth.
The intervention is granted on production of the birth certificate, which is delivered by the competent authorities.

This fixed intervention of € 250 per child is paid once to the child.

11.5. Cumulation of reimbursements

The reimbursements by Medicalia may be cumulated with the reimbursements by Hospitalia and Hospitalia Plus for pre/post-hospitalisation care and the serious illnesses guarantee.
If applicable, the reimbursement may in no case exceed the amount of the covered guarantee and a fortiori the actual cost charged to the policy holder.
The reimbursements by Medicalia may not be cumulated with the reimbursements by Hospitalia Ambulatory.

12. INTERVENTION LIMITATIONS

12.1. Yearly maximums

The intervention for dispensations is limited to € 1,500 per insured and per year of affiliation.

The limit for interventions granted for alternative therapies is of € 600 per insured per year of affiliation. The limit for interventions granted for material is also of € 600 per insured per year of affiliation.

12.2. Dispensations not covered by Medicalia

Under the terms of the Medicalia cover, MLOZ Insurance does not intervene for:

- the costs of which billing is illegal/not allowed according to the Belgian law
- the medicines
- treatment performed by speech therapists, occupational therapists, dieticians, psychologists, osteopaths, chiropractors, homeopaths, acupuncturists and remedial educationalists that are not approved by the NIHDI or are not on the lists which are published and used by MLOZ Insurance and its divisions
- for medical, pharmaceutical and hospital dispensations related to beauty care, and/or that are not necessary from a medical point of view
- general dental care (including all general dental care, dental implants, and dental prosthesis)
- the dispensations of "rejuvenation" type.

13. CUMULATION OF COVERS

13.1. 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 organized 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 multi-lateral or bilateral convention of social security concluded by Belgium;
- the complementary insurance of the health insurance organizations;
- the service "urgent foreign care" of the health insurance organizations.

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 on the same way as for a policy holder entitled to these interventions.

13.2. When the amounts granted according to another regulation, the ordinary law or 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 insured.
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 of MLOZ Insurance.

14. COMPENSATIONS

14.1. 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.

14.2 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.

14.3. Payment of the benefits

To be entitled to reimbursements, the policy holder must have paid his premiums and provide the justificatory documents as described in the section "Reimbursements of Medicalia". In order to benefit from Medicalia compensations, the policy holder must go and see a registered practitioner.
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.
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.

15. 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 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 office of MLOZ Insurance or on the website www.mloz.be.