General Terms and Conditions Warranty "Serious illnesses"

as from 1 January 2024

General Terms and Conditions Warranty "Serious illnesses" 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" 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.
Registered office: route de Lennik 788A, 1070 Brussels - Belgium (RPM Brussels)
www.mloz.be - Enterprise number: 422.189.629. - 01/01/2024

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 n° 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. Pharmaceutical products: pharmaceutical products should be understood as:

- every pharmaceutical speciality registered to the Ministry of public health according to article 6 of the law of 25 March 1964 and the RD of 3 July 1969, modified by later decrees
- the pharmaceutical specialty that has been imported by a foreign hospital, in accordance with the stipulations of article 105 of the RD of 14 December 2006 regarding drugs for human and veterinary use
- magistral preparations that are delivered during a day hospitalisation
- contrast mediums.

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

1.8. Receipt: document used by the health insurance fund, except for third parties.

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.

1.11. Medical questionnaire: this document aims to inform the Medical Counsellor of MLOZ Insurance on the past and present health condition of the insured person and has for consequence to possibly limit the intervention, in case of pre-existing disease.

1.12. Pre-existing disease: a disease existing at the date of joining MLOZ Insurance or at the date of product transfer within MLOZ Insurance and leading to ambulatory care.

2. ADMISSION

2.1. To join and remain a member of the warranty serious illnesses, as a complement to Hospitalia, Hospitalia Medium or Hospitalia Plus, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the three sections, outside of exceptions to the statutes (consult these sections: Partenamut, Freie Krankenkasse, 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 additional warranty 'Serious illnesses' is 65 years included, except in case of transfer within the compulsory insurance for persons who were previously members of a similar hospitalisation 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 premiums 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, DURATION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion and duration 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 (with or without limitation) 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" and "medical questionnaire" (internal date or scanning or online 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 and the medical questionnaire (when it is required) 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.

If, on basis of the medical questionnaire, the Medical Counsellor asks for further information before ruling on the membership application, the policy holder has 45 days to provide an answer.

If this term is not respected or if no further information is received, the membership automatically starts according to the rules defined here above with a limitation of intervention in case of serious illness, for the pre-existing disease, mentioned on the medical questionnaire.

The decision about the acceptance, with or without limited compensation in case of hospitalisation, and a refusal in case of serious illness, will be communicated to the candidate policy holder by mail. 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 (via digiconnect.be) or the qualified registered electronic mail, 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. Cancelling the insurance Hospitalia Medium implies automatically the cancellation of the warranty 'Serious illnesses'. This one month notice is not mandatory in case of a change of hospitalisation coverage within Hospitalia.
- 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 compensations of MLOZ Insurance, a 6-month waiting period starting at the affiliation date has to be accomplished. There will also be a 6-month waiting period applicable to the coverage extension as from the affiliation date to this coverage extension. MLOZ Insurance does not intervene for a hospitalisation or 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 MLOZ Insurance 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, without medical questionnaire, 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 in case of accident

MLOZ Insurance intervenes for every hospitalisation and ambulatory care 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 Counsellor of MLOZ Insurance.

• Waiting period exemption for similar hospitalisation insurances and additional warranty 'Serious Illnesses'

MLOZ Insurance intervenes for the new policy holders proving with documents that they were covered until the date of membership to MLOZ Insurance and since 6 months by a similar hospitalisation insurance of "compensatory" type, which means an insurance of which the reimbursements are made according to the real costs mentioned on the hospitalisation bill and by a similar additional warranty 'Serious illnesses'.

4.2. Exclusions of the guarantee

Are not covered: 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;
- 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 disaster is the one resulting from a behaviour "voluntary and deliberately" adopted by the insured person and which caused "reasonably foreseeable" damage. It is however not required that the insured person had the intention to cause the damage as it happened.
- resulting from drunkenness, alcoholism or drug addiction;
- resulting from nuclear reactions, except for 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, including all taxes, depending on the age on 01/01/2024

Affiliated to the Warranty 'Serious Illnesses' (9,25% taxes included) It is only possible to subscribe to the warranty serious illnesses as a complement to Hospitalia, Hospitalia Medium or Hospitalia Plus.			
less than 18 years	0,32	from 50 to 59 years	1,28
from 18 to 24 years	0,39	60 years and over	2,34
from 25 to 49 years	1,05		

There is no increase in the premium for the Warranty 'Serious Illnesses'.

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 AMBULATORY INSURANCES

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 insurances.

The following criteria are taken into consideration for the Warranty "Serous Illnesses":

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 premium amount and access to the product.
a) Access could be limited for certain products: the age limit for the warranty 'Serious illnesses' is 65 years included. This age limit does not apply to insured parties who were in order with their premiums to a similar insurance with another HIC.

b) Depending on the chosen product, affiliation after a certain age may lead to supplementary premiums.
9.1.2. The health condition, and more specifically every pre-existing disease, because this might increase the risk and ambulatory care as well as the amount of medical expenses. It can also justify that some medical costs related to a pre-existing disease are not covered.
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 premiums to a similar insurance with another HIC.
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 (or private insurer (individual or 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 criterium 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 to the medical index regarding the warranty 'Ambulatory care' for the warranty 'Serious illnesses', the premiums 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. Warranty serious illnesses (optional warranty)

11.1. Interventions

Intervention for health care that was given without hospitalisation for the following 31 serious illnesses: *cancer, leukaemia, Parkinson's disease, Hodgkin's disease, Alzheimer's disease, AIDS, tuberculosis, multiple sclerosis, amyotrophic lateral sclerosis, cerebro-spinal meningitis, poliomyelitis, progressive muscular dystrophy, encephalitis, tetanus, mucoviscidosis, Crohn's disease, brucellosis, cirrhosis of the liver following a hepatitis, scleroderma with organ damage, diabetes type I, ulcerative colitis, Pompe disease, malaria, exanthematic typhus, typhoid and paratyphoid disorders, diphtheria, cholera, anthrax, Creutzfeldt-Jakob disease, kidney insufficiency that needs dialysis, organ transplantation except skin grafts and cornea transplantation* after the agreement of the Medical Counsellor, and up to € 7,000 per year.
The health care must be supported in Belgium, medically needed, prescribed by a practitioner, mentioned in the nomenclature, in direct relation with the serious illness and provided during the period during which the guarantee was granted, as it is granted by the Medical Counsellor.
The warranty serious illnesses is only granted if it had not been diagnosed before the affiliation.

This warranty has the following benefits:
1. The consultations and visits of the general practitioners and specialists, the medical technical acts, the medical imaging, the radio and radium therapy, the nuclear medicine, the internal medicine, the dermatology and venereology, the physiotherapy, the clinical biology, fees for urgent care in a recognised function of specialised emergency care, the emergency supplements, the surgical truss maker, the orthopedics, the optics, the acoustics, the anatomophatology, the genetics, the special dispensations, the physical therapy, the nursing care, the speech therapy, the radio-isotopes and the cardiac rehabilitation are reimbursed up to the legal patient share and fee supplements, limited to 100% of the convention rate.
2. The allopathic pharmaceutical products, magistral preparations and wigs (hair prosthesis) on prescription are reimbursed up to the actual price paid by the patient if the compulsory insurance intervenes.
3. The medical material rental is reimbursed, after a possible intervention of the complementary services of the health insurance funds.

11.2. Intervention conditions

To benefit from this warranty, the insured person must ask the agreement of the Medical Advisor of the health insurance company MLOZ Insurance. He will provide a doctor's certificate stating the diagnosis and the date of this diagnosis of the serious illness of the patient, confirmed by biological or anatomopathological examinations, or by medical imaging or by any other medical examination usually approved in the medical world.
On the basis of this certificate, the Medical Advisor of the health insurance company MLOZ Insurance will accept or refuse the warranty benefit for one year per serious illness, from the date of diagnosis of the serious illness, provided that no more than 3 years have elapsed between the date of diagnosis of the serious illness and the date of request for the Warranty Serious Illnesses. If a period of 3 years or more has elapsed between the date of diagnosis of the serious illness and the date of request for the Warranty serious illness, a maximum of 3 years will be taken into account from the date of request for the warranty serious illness to determine the start date of the Warranty serious illness. This agreement can be renewed for one year time for the same illness, directly or indirectly after the first period. For serious incurable illnesses (Parkinson's disease, Alzheimer's disease, AIDS, multiple sclerosis, amyotrophic lateral sclerosis, poliomyelitis, progressive muscular dystrophies, cystic fibrosis, Crohn's disease, cirrhosis of the liver following hepatitis, scleroderma with organ damage, type I diabetes, ulcerative colitis, Pompe disease, Creutzfeldt-Jakob disease, kidney failure requiring dialysis, organ transplants (except skin and corneal transplants), the warranty 'Serious Illnesses' will be granted for life.
If the Medical Advisor of the health insurance company thinks he has to ask for further information, the insured person has 45 days to provide an answer, as from the date on which the request of the Medical Advisor has been sent.

- If this term is respected, for a medical acceptance, the warranty starts on the date of diagnosis of the serious illness, provided that no more than 3 years have elapsed between the date of diagnosis and the date of request for the warranty serious illnesses. If a period of 3 years or more has elapsed between the date of diagnosis of the serious illness and the date of request for the Warranty serious illness, a maximum of 3 years will be taken into account from the date of request for the warranty serious illness to determine the start date of the Warranty serious illness.
- If this term is not respected, for a medical acceptance, the warranty starts the day after the date of agreement.
- A new request must be introduced if the term exceeds 90 days.

The decision of acceptance or refusal to grant the warranty is communicated by letter to the insured person, and mentioning the period covered by the warranty serious illnesses.

12. ASSISTANCE IN BELGIUM - 'Hospitalia Assist'

12.1. Goal and scope of the assistance

'Hospitalia Assist' offers the hereunder listed services, up to the indicated limitations (all amounts include all taxes), to Hospitalia, Hospitalia Medium or Hospitalia Plus policy holders who have ended their waiting period and who are entitled to MLOZ Insurance compensations in the context of a hospitalisation, a day hospitalisation or a serious illness, in Belgium, covered by Hospitalia, Hospitalia Medium or Hospitalia Plus or by the

warranty 'Serious illnesses'.

These services are offered on the condition that the insured person is immobilised and physically or mentally dependent for their daily activities, and that the insured's actual or legal cohabiting partner is physically or mentally incapable of taking charge of the described services.

The services, that are organised and financed by Hospitalia Assist, are limited to € 1,000 per insured per event (hospitalisation or serious illness), and to maximum 2 events per year for all hereunder listed services. These services can be combined.

'Event' should be understood as a hospitalisation or the beginning of the treatment of a serious illness that makes the insured dependent for their daily activities.

'Intervention' should be understood as the intervention of the assistance or sit-in service agent.

12.2. Territorial validity

The assistance is only valid on Belgian territories.
Unless stated otherwise, the assistance will be provided at the insured's legal place of residence, or at the residence of their choice.

12.3. Obligations of the insured

The insured person is obliged to make use of Hospitalia Assist and to follow its instructions so that the latter can organise the services described below. The assistance, costs or services are only eligible for reimbursement if the prior permission of Hospitalia Assist has been requested and if the latter has given its permission.
The costs, incurred on the occasion of assistance organised by the insured, will in any case only be reimbursed after presentation of the cost statements and of all evidence for the facts that entitle the guarantee.
The costs incurred on the occasion of the assistance organised by the insured are only reimbursed up to the amounts stated in the General Terms and Conditions and within the limits of the costs that Hospitalia Assist would have reimbursed if it had organised the assistance itself. The insured must take all necessary measures to obtain reimbursement of their costs from the social security and any other insurance company. If the insured person has other insurance policies that cover the same risk, they must inform Hospitalia Assist of the guarantees and the identity of these insurers.
The insured undertakes to comply with the obligations agreed with Hospitalia Assist for the organization of the assistance. If the insured fails to comply with one of the above obligations and if there is a causal link between the non-compliance with the obligation and the claim, with adverse consequences for Hospitalia Assist, the latter may refuse to intervene and limit its compensations in proportion to the amount of damage suffered. Any fraudulent purpose, deliberate omission or intentional inaccuracy in the statement will always result in the loss of all rights to the benefits provided by the insurance.

12.4. Conditions of the assistance service

The insured person or, if impossible, a close relative contacts Hospitalia Assist on 02 560 47 90 (24/7), so that the agreed services can be arranged. Assistance, costs or services are only eligible for reimbursement if the prior permission of Hospitalia Assist has been requested and if the latter has given its permission.
The application must be formulated within 30 days following the end of the hospitalisation, or of the treatment that is covered by the Hospitalia, Hospitalia Medium ou Hospitalia Plus insurance in the context of a serious illness.
The insured must provide Hospitalia Assist immediately, and in any case within 30 days of the request for assistance, all useful information and answer the questions asked to determine the circumstances and extent of the needs and the supplies to be provided.
The insured undertakes to comply with the obligations agreed with Hospitalia Assist for the organization of the assistance. If the insured fails to comply with one of the above obligations and if there is a causal link between the non-compliance with the obligation and the claim, with adverse consequences for Hospitalia Assist, the latter may refuse to intervene and limit its compensations in proportion to the amount of damage suffered. Any fraudulent purpose, deliberate omission or intentional inaccuracy in the statement will always result in the loss of all rights to the benefits provided by the insurance.
If it appears that the event that gave rise to the benefits is not a covered claim, Hospitalia Assist will ask the insured person to reimburse the costs incurred.

12.5 Assistance guarantees

For all dispensations in the field of assistance and sit-in, the compensation by Hospitalia Assist is limited to a maximum of 8 consecutive hours per intervention, and to 5 interventions per event. However, the compensation of a maximum of 40 hours in total for education and pedagogical support is limited in sessions of a minimum of 2 hours and a maximum of 4 hours per session, with a maximum of 5 sessions on site, the other sessions being held in video conference. For the application of this maximum, account is taken of the year in which the hospitalisation or the serious illness takes place.

<u>1. During the hospitalisation</u>

During a covered hospitalisation, Hospitalia Assist will organise and/or pay for the services described below.

1.1. Home help

If no close relative can give home help to the hospitalised insured person, Hospitalia Assist organises and finances the home help that serves to provide the following services: cleaning (domestic help), ironing, meals at home for people living under the same roof.
Each performance lasts at least 4 (four) hours, including the travel time to the place of residence of the beneficiary, and can be granted from Monday to Saturday between 8 am and 7 pm, excluding public holidays.

1.2. Babysitting

If an insured person, father or mother of one or more minor children, is unable to take care of their child(ren) and no close relative can jump in for taking care of this (these) child(ren), Hospitalia Assist will organise and finance the babysitting for the child(ren) of the hospitalised insured person.
Each childcare service lasts a minimum of 4 (four) hours a day, including the travel time to the place of residence of the beneficiary, and can be provided from Monday to Saturday between 8 am and 7 pm, excluding public holidays.
The mission consists of the home care of the child of the hospitalised insured person, the preparation of meals and the daily care of the child. During their hours of attendance, the babysitter can accompany the children to the daycare center, to school or to their extracurricular activities and collect them again.
This benefit is also granted in the event of a home birth reimbursed by the Health Insurance Company, or in the event of a birth reimbursed by the Health Insurance Company, during the mother's stay in the hospital or immediately after a short stay (maximum 2 nights) of the mother in the hospital. After delivery, this benefit is only granted in the 5 days following the birth.

1.3. Animal sitting

Hospitalia Assist organises and finances the shelter, including food costs, or the transport of pets (dogs and cats) to a relative designated by the hospitalised insured, living in Belgium. The animals in question must have had all legally required vaccinations.

1.4. Education and pedagogical support

Hospitalia Assist organises and finances pedagogical support and education for underage children who, due to a hospitalisation of more than 14 consecutive days, are unable to attend the lessons.
This support is subject to the explicit permission of the care institution and is granted for the effective duration of the current school year, during the normal school days and is stopped as soon as the child has resumed normal education or at the end of the school year.

1.5. Transport of a person designated by the insured

If, during the covered hospitalisation:

- children/grandchildren who live under the same roof as the insured must go to school and/or to a relative
- the relatives wish to go to the sickbed of the insured person or to take care of the children/grandchildren who live under the same roof as the insured person Hospitalia Assist will organise and finance the transport there and back if they cannot travel by their own means.

For all transport services, the Hospitalia Assist reimbursement is limited to € 125 per transport and € 250 per event.

<u>2. After a reimbursed event (hospitalisation, serious illness)</u>

If, as a result of a covered event, the insured person is immobilised on medical prescription or is dependent for their daily activities, Hospitalia Assist will organise and pay for the services described below.

2.1. Sit-in after a day hospitalisation

Hospitalia Assist organises within 24 hours and finances sitting-in for a single insured who is admitted in day hospitalisation, during the night that directly follows this day hospitalisation, for maximum 12 hours, between 7 pm and 8 am.
In order to benefit from this service, the single insured must:

- provide the sitter with a medical attestation from the attending practitioner stipulating that a day hospitalisation took place and that sitting-in, without medical care, is required
- be in possession of a phone.

2.2. Home help

If no close relative can help, Hospitalia Assist will organise and finance the home help that provides the following services: cleaning (domestic help), ironing, meals at home. Each performance lasts at least 4 (four) hours, including the travel time to the place of residence of the beneficiary, and can be granted from Monday to Saturday between 8 am and 7 pm, excluding public holidays.

2.3. Delivery of essential purchases

If the insured cannot travel and if no relative can help, Hospitalia Assist will organise and finance the delivery of medicines on medical prescription since less than 24 hours and that the insured absolutely needs immediately. Ditto for the essential supplies, subject to their availability. The costs relating to the purchase itself remain at the expense of the insured. If necessary, Hospitalia Assist advances the money for the purchase of medicines, but the insured will have to repay this amount upon delivery.

2.4. Babysitting

If an insured person, father or mother of one or more minor children, is unable to take care of their child(ren) and no close relative can jump in for taking care of this (these) child(ren), Hospitalia Assist will organise and finance the babysitting for the child(ren).
Each childcare service lasts a minimum of 4 (four) hours a day, including the travel time to the place of residence of the beneficiary, and can be provided

from Monday to Saturday between 8 am and 7 pm, excluding public holidays. The mission consists of the home care of the child of the insured, the preparation of meals and the daily care of the child. During their hours of attendance, the babysitter can accompany the children to the daycare center, to school or to their extracurricular activities and collect them again. This benefit is also granted in the event of a home birth reimbursed by the Health Insurance Company, or in the event of a birth reimbursed by the Health Insurance Company, during the mother's stay in the hospital or immediately after a short stay (maximum 2 nights) of the mother in the hospital. After delivery, this benefit is only granted in the 5 days following the birth.

2.5. Animal sitting

In the context of a covered hospitalisation, Hospitalia Assist will organise and finance the sitting or daily walk of pets (cats and dogs only, no other animals).

2.6. Education and pedagogical support

Hospitalia Assist organises and finances pedagogical support and education for underage children who are unable to attend the lessons during more than 14 consecutive days.

This support is granted for the effective duration of the current school year, during the normal school days and is stopped as soon as the child has resumed normal education or at the end of the school year.

2.7. Transport with an eye to taking care of children or grandchildren

If an insured person, father or mother of one or more minor children, is unable to care for their child(ren), Hospitalia Assist organises and finances the return journey of:

- either a close relative or person who resides in Belgium and who is designated by the insured to care for their dependent minor children or grandchildren;
- or minor children or grandchildren to a relative, designated by the insured and living in Belgium, if necessary under the supervision of a relative designated by the insured or by Hospitalia Assist.

2.8. Transport of the children to school

If the insured is unable to drive their children to school, Hospitalia Assist organises and finances the transport of minor children to and from school.

For all transport services, the Hospitalia Assist reimbursement is limited to € 125 per transport and € 250 per event.

2.9. Non-urgent transport of the insured

If the insured cannot travel by their own means, Hospitalia Assist organises and finances their return journey:

- to a hospital or medical center for check-ups;
- to a medical, paramedical or pharmaceutical institution;
- to their workplace.

For all transport services, the Hospitalia Assist reimbursement is limited to € 125 per transport and € 250 per event.

In case of an emergency hospitalisation, the insured must first call on the national emergency services.

3. Additional assistance

3.1. Non-urgent hospitalisation

In case of a non-urgent hospitalisation on prescription from a doctor, Hospitalia Assist will organise and finance the following at the request of the insured:

- the search for (and the reservation of) a place in a public or private hospital in Belgium, within the availability limits of these hospitals ;
- the transport of the insured and the transport of the relatives who live under the same roof to a hospital in Belgium near the place of residence of the insured, as well as the return home.
  The financial costs of the transport are reimbursed in addition to the reimbursements by the social security or by any other insurance company the insured would be affiliated to..

In case of an emergency hospitalisation, the insured must first call on the national emergency services.

3.2. Assistance by phone in case of a hospitalisation or serious illness

Hospitalia Assist offers the insured the following assistance over the phone:

- telephone assistance by a translator when the insured person experiences language problems to communicate with the medical authorities (hospital, medical care providers and paramedics)
- the sending of messages to relatives in the event of a sudden, unexpected event
- the provision of contact details:

- of paramedical care organizations
- of the pharmacy and doctor on duty to be contacted
- of home care organizations
- of companies renting out medical equipment.

3.3. Psychological assistance

Following a reimbursed event (hospitalisation or serious illness) that led to a psychological trauma, Hospitalia Assist offers the insured and the persons living under the same roof a telephone emergency service that is available 24/7, that can offer the insured and the persons living under the same roof an initial 'online' psychological support and that, if necessary, refers them to a specialised support organization.

Hospitalia Assist also organises the psychological support of the insured and the persons living under the same roof and pays, if necessary, a maximum of 3 consultations with a psychologist recognised in Belgium and a follow-up of 3 telephone consultations for a maximum of 3 months.

At the request of the insured, Hospitalia Assist will, after any private or professional problem, provide the contact details of the self-help associations that specialise in psychological support.

The reimbursement of psychological assistance is limited to € 500 per event.

12.6. Subrogation

Hospitalia Assist assumes the rights and claims of the insured vis-à-vis third parties up to the amount of the costs paid. If, due to the actions of the insured, the subrogation cannot be applied, Hospitalia Assist may request reimbursement of the payments made up to the amount of the damage that Hospitalia Assist has suffered.

12.7. Exclusions

In addition to the exclusions that MLOZ Insurance stated in article 65, the following situations are excluded as well:

a. suicide (attempts)

b. hospitalisation for a normal child birth (unless in the context of babysitting or in case of obvious and unforeseen complications)

c. all consequences of the exclusions that are mentioned in the Warranty "Serious Illness".

Hospitalia Assist cannot be held liable in the event of a delay or non-execution of the agreed services, provided that this delay or non-execution is due to:

- force majeure
- an unexpected event
- a strike
- a government decision

These services are offered by simple call to Hospitalia Assist, accessible 24 hours a day by phone : 02 560 47 90

13. INTERVENTION LIMITATIONS

13.1. Annual maximum

The total of the interventions of MLOZ Insurance is limited to € 7,000 per civil year.

13.2. Intervention limitations for pre-existing serious illnesses

For the warranty serious illnesses, the medical questionnaire aims to possibly limit the intervention by refusing the reimbursement of ambulatory dispensations related to this pre-existing serious illness. During the first 24 months of membership to the product, the Medical Counsellor can decide this limitation, invoking a non-intentional omission or inaccuracy related to the health condition on the medical questionnaire. This limitation is fixed for a minimum duration of 5 years at the end of which the policy holder who wants it can ask the reassessment of his/her situation on basis of a new medical file.

13.3. Dispensations not covered by the Warranty "Serious Illness".

MLOZ Insurance does not intervene:

- for medical, pharmaceutical and hospital dispensations related to beauty care or refractive surgery, and/or that are not necessary from a medical point of view, and the VAT costs;
- for the dispensations of "rejuvenation" type;
- for the dispensations to an insured person who refuses to receive the visit of a practitioner, a nurse or a social assistant committed by MLOZ Insurance;
- for the costs related to experimental treatments and medicines and/or that are not "evidenced-base", which have no scientific basis;
- for the costs of which billing is illegal/not allowed according to the Belgian law.

14. CUMULATION OF COVERS

14.1. 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 complementary insurance of the health insurance organisations;
- the service "emergency care abroad" of the health insurance organisations.

The supplements covered are thus determinated in reference to these interventions. If, for one reason or another, 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 who is entitled to these interventions.

From this last condition can be deviated if, for one reason or another, the policy holder is not allowed to request one or more of the interventions mentioned above. In that case, MLOZ Insurance intervenes in the same way as for an insured person who is entitled to these interventions.

14.2. 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.

15. COMPENSATIONS

15.1. 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.

15.2. Medical control

The benefits are only granted on the condition that MLOZ Insurance has the right to ask the Medical Counsellor at any time to control the health condition of the insured person and the validity of the dispensations.

15.3. Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums.
To obtain the benefits foreseen by "Warranty Serious illnesses", the policy holder will fill in the form "Payment request" delivered by MLOZ Insurance, and will provide it with all the justificatory documents proving his/her expenditures.
To obtain the benefits of the warranty 'Serious illnesses', the policy holder will provide all the original invoices or their copies, and the reimbursement statement of the claim reimbursement receipts from the health insurance fund, or a copy of those.
The reimbursement of the pharmaceutical costs will be done on presentation of a "Certificate of pharmaceutical dispensations reimbursable by a complementary insurance" established by the pharmacist or a (ambulatory) bill of the hospital.
The reimbursements will be granted to effective insured persons or 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.

16. 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 quarter of MLOZ Insurance or on the website www.mloz.be.