General Terms and Conditions Hospitalia

as from 1 January 2024

General Terms and Conditions Hospitalia 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

Hospitalia

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. Hospitalisation: every hospitalisation of at least one night and day hospitalisation in a hospital approved as such by the Ministry of public health which uses scientifically tested diagnosis and therapeutic means.

1.6. Day hospitalisation:
Day hospitalisation should exclusively be understood as:

- an admission and stay in a recognised hospital without overnight stay in which the patient undergoes one or more plannable interventions. Such interventions require established procedures for the selection of patients, safety, quality supervision, continuity, post-hospital care, writing of reports and cooperation with the various medical-technical services under the supervision and direction of a medical specialist connected to the hospital with adequate supervision and administration of care.
- a function 'day surgery' acknowledged on the basis of stipulations in the RD of 25 November 1997 defining the norms that the function 'day surgery' should meet in order to be recognised.

The provisions of the National Agreement between hospitals and health insurance organisations, in force on the date of dispensation, will be applied. MLOZ Insurance assumes that the hospital invoice reflects the correct application of the Agreement.

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

1.8. Pharmaceutical products:
Pharmaceutical products should be understood as:

- every pharmaceutical specialty 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.

1.9. Implants and medical devices: everything that is regulatory approved, including delivery margin and safety margin.

1.10. Other supplies: products and dispensations that may legally be charged under section 5 of the hospitalisation bill as stipulated in appendix 37 and under section 3 of the hospitalisation bill as stipulated in appendix 37bis 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 1994.

1.11. Accident: 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.

1.12. 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.

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

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

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

1.16. 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, disorder or state.

1.17. Pre-existing disease, disorder or state: a disorder, disease or state (such as pregnancy) existing at the date of joining MLOZ Insurance or at the date of product transfer within MLOZ Insurance and leading to a hospitalisation or to ambulatory care.

1.18. Splint: a splint is a medical device consisting of metal and/or plastic to fix a joint or limb so that movement is reduced to a minimum. This is a temporary treatment to ease the pain or prevent further injuries. As regards refundable splints, these are the nomenclature codes in article

29 §1, A (except repair and maintenance), B (main groups I, II, III, IV, VI, VIII, XII) and C (all main groups except XVI).

2. ADMISSION

2.1. To join and remain a member of the coverage Hospitalia, 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.

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 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 (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 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 hospitalisation, and a refusal in case of serious illness, for the pre-existing disease, disorder or state 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 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. Cancelling the insurance Hospitalia 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 allocate compensations for hospitalisations or ambulatory care that 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

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.

4.2. Exclusions of the guarantee

For every cover and type of room

Are not covered: hospitalisation and care costs related to an illness or 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 product Hospitalia (10% taxes included)			
Before 01/01/1994 or affiliated, after that date, under 46 years old*		After 01/01/1994, between 46 and 49 years old*	
less than 18 years	4,11	from 46 to 49 years	11,98
from 18 to 24 years	5,38	from 50 to 59 years	14,80
from 25 to 49 years	11,41	60 years and over	32,47
from 50 to 59 years	14,10		
60 years and over	30,93		

After 01/01/1994, between 50 and 54 years old*		After 01/01/1994, between 55 and 59 years old*	
49 years**	12,55	from 55 to 59 years	21,15
from 50 to 59 years	15,51	60 years and over	46,40
60 years and over	34,02		
		After 01/01/1994 until 30/06/2014, at the age of 60 and over*	
		59 years**	23,97
		60 years and over	52,58

After 01/07/2014, between 60 and 70 years old*	60 years and over	52,58
After 01/07/2014, between 71 and 75 years old*	71 years and over	55,67
After 01/07/2014, at the age of 76 and and over*	76 years and over	58,77

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

An increase of the premium of respectively 5, 10, 50, 70, 80 and 90% is calculated on the basis rates for the policy holders who are respectively between 46 and 49 years, 50 and 54 years, 55 and 59 years, 60 and 70 years, 71 and 75 years and 76 years and over at the joining date to Hospitalia.

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 registered electronic 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 registered electronic 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 HOSPITALISATION 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 hospital insurances.

The following criteria are taken into consideration for Hospitalia:

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 and hospitalisation 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.

a) Access could be limited for certain products. There is no age limit for Hospitalia.

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 disorder/state/disease, because this might increase the risk of hospitalisation and ambulatory care as well as the amount of medical expenses. It can also justify that some medical costs related to a pre-existing state/disorder/disease are not covered.

9.1.3. 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, except for the application of the previous existing state of pregnancy (cf 9.1.2):

- for members who were previously covered by a similar hospital insurance at a health insurance fund, this restriction will only apply if they deliver within the first 9 months of affiliation, thus accumulating the insured period with the previous HIC and Hospitalia, without interruption.
- Members who were previously covered by a similar commercial insurance, are entitled to reimbursements for the delivery during the first 9 months of affiliation with Hospitalia, there is only one restriction: in case of a stay in a single room, fee and room supplements will not be reimbursed.

This distinction for Belgian health insurance fund entities is made for the following reasons:

- The specific nature of health insurance fund insurances, i.e. the fact that a change of health insurance fund leads to the termination of the insurance with the corresponding HIC, which justifies a flexible treatment of persons who were previously affiliated to another HIC, in view of the low anti-selection risk in this context.
- Maintenance of the possibility to change your health insurance fund (freedom of choice of health insurance fund).

9.2. During the policy:

9.2.1. Age of the insured person because, according to statistic data, the probabilities of treatment or hospitalization 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. Room type: in Hospitalia and Hospitalia Plus, a patient share of € 150 per hospitalisation will be charged for hospitalizations in a single room in a hospital charging more than 200% fee supplements compared to the convention rate. You may consult the list of these hospitals on www.hopitauxfranchise.be.

10. ADAPTATION 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 'Double or common room' for Hospitalia and 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. REIMBURSEMENTS OF HOSPITALIA

11.1. Compensations for hospitalisations in Belgium

The intervention is due in case of hospitalisation in the registered units, which are:

19	(n)	non-intensive neonatal care unit
21	(C)	diagnostic and surgical treatment unit
22	(D)	diagnostic and medical treatment unit
23	(E)	paediatric unit
24	(H)	general hospitalisation unit
25	(L)	contagious illnesses unit
26	(M)	maternity unit
27	(N)	intensive neonatal care unit
29		burns treatment unit
34	(K)	infantile neuropsychiatric unit (day and night)
35	(K1)	Day hospitalisation in K unit
36	(K2)	Night hospitalisation in K unit
37	(A)	neuropsychiatric unit (day and night)
38	(A1)	Day hospitalisation in A unit
39	(A2)	Night hospitalisation in A unit
41	(T)	psychiatric unit (day and night)
42	(T1)	Day hospitalisation in T unit
43	(T2)	Night hospitalisation in T unit
48	(IB)	intensive care unit for psychiatric patients
49	(I)	intensive care unit

and in the foreseen limits:

30	(G)	geriatric and revalidation unit
61 to 66	(Sp)	specialised units:
	61	cardiopulmonary disorders
	62	locomotor disorders
	63	neurological disorders
	64	chronic disorders requiring palliative care
	65	chronic polypathologies requiring extended medical care
	66	psychogeriatric disorders

1. In case of full hospitalisation in a double room or ward: on the basis of the patient invoice and the fee invoice, full reimbursement of the amount paid for costs that are mentioned in the following points 2.1 until 2.10, except for:

- prostheses, implants and non-implantable medical devices not reimbursable by the compulsory insurance up to € 2,500 per hospitalisation. It is possible for the Medical Counsellor to deviate from this maximum of € 2500 in serious medical situations, for evidence-based treatments on the basis of the insured's medical file. In case costs of € 10,000 or more are charged to the patient, € 5,000 can be reimbursed maximum once a year.

2. In case of hospitalisation in a single room, reimbursement:

2.1. of the room supplement charged up to € 80 per day.

2.2. of the accompaniment costs of the father or the mother in the room of his/her hospitalised child, under 19 years of age, up to € 25 per day.

2.3. of the stay expenses of the voluntary organ donor during the hospitalisation of the receiver, if the donation is medically necessary.

2.4. of the pharmaceutical products that are reimbursed by the compulsory insurance, at the hospital.

2.5. of the pharmaceutical products that are not reimbursed by the compulsory insurance, at the hospital, up to € 1,200 per hospitalisation. It is possible for the Medical Counsellor to deviate from this maximum in serious medical situations, for evidence-based treatments on the basis of the insured's medical file. In case of costs of € 2,500 or more charged to the patient, € 2,400 can be reimbursed maximum once a year.

2.6. of the user fees, including the medicine package, legally charged to the beneficiary, mentioned in the column "personal contribution patient" of the hospitalisation bill and the fee bill.
2.7. of the fee supplements up to 100% of the convention rate.
2.8. of the prostheses, implants, non-implantable medical devices and other supplies:

- prostheses, implants and non-implantable medical devices reimbursable by the compulsory insurance, limited to a maximum amount of € 2,500 per hospitalisation;
- prostheses, implants and non-implantable medical devices that are not reimbursable by the compulsory insurance, up to 50% of the amount of the costs on the bill, with a maximum of € 1,250 per hospitalisation, on the condition that the amount charged by the hospital can be identified as the price charged for a prosthesis, an implant or a non-implantable medical device. It is possible for the Medical Counsellor to deviate from this maximum in serious medical situations, for evidence-based treatments on the basis of the insured's medical file. In case of costs of € 10,000 or more charged to the patient, € 2,500 can be reimbursed maximum once a year.
- costs legally charged to the insured person for other supplies, limited to 100% of the convention rate.

2.9. of the miscellaneous costs up to € 6 per hospitalisation day, excluding phone costs, television, flowers and drinks.
2.10. of the compression stockings and/or compression sleeves up to 50% of the amount charged.
2.11. There is a franchise of € 150 per hospitalisation for a stay of at least one night in a private room in a hospital included in the list, established annually, of hospitals applying this franchise. This list contains the hospitals that charge more than 200 % fee supplements and have not signed a 200 % limitation convention with MLOZ Insurance. The amount of this € 150 patient share is deducted from the total reimbursement.
There is no patient share for hospitals that in their annual declaration committed themselves not to charge more than 200% fee supplements for the entire civil year following the aforesaid declaration.
The list of hospitals applying the patient share is drawn up each year and is effective as from 1st January.
The new list will be applicable for all insurance cases with a stay that begins on or after the date on which the new list enters into force.

List 2024 of hospitals charging more than 200%:
- C.H. EPICURA (RHMS) - Ath, Hornu, Baudour
- C.H.U. - J. BORDET - Brussels
- C.H.U. AMBROISE PARE - Mons
- C.M.P. LA RAMEE - Brussels
- CHIREC (Edith Cavell, Basilique, Parc Léopold, Ste-Anne/St-Remi, Braine l'Alleud-Waterloo and Delta) - Brussels and Braine l'Alleud
- CLINIQUE NOTRE DAME DE GRACE - Charleroi (Gosselies)
- CLINIQUES UNIVERSITAIRES ST-LUC - Brussels
- HOPITAL BRUGMANN - Brussels
- HOPITAUX D'IRIS SUD (Baron Lambert, Etterbeek-Ixelles, Bracops and Molière) - Brussels
- CENTRE DE SANTE DES FAGNES - Chimay
- CLINIQUE CHC MONT LEGIA - Liège
- C.H.C / CLINIQUE NOTRE-DAME - Hermalle/Argenteau
- C.H.C / CLINIQUE NOTRE-DAME - Waremme
- C.H.C / CLINIQUE SAINTE-ELISABETH - Verviers (Heusy)
- C.H.U. DE TIVOLI - La Louvière
- ASZ Aalst – Aalst, Geraardsbergen, Wetteren
- IMELDA Ziekenhuis – Bonheiden

You may consult the list of these hospitals on www.hopitauxfranchise.be

3. In case of hospitalisation or day hospitalisation in Belgium reimbursed by Hospitalia, compensation in the actual costs incurred for the emergency transportation (after calling 100/112) to the hospital, up to € 500 per year, after any other compensation. If it appears that this hospitalisation and urgent transport have been preceded on the same day by another urgent transport 100/112 to another hospital where the insured was not hospitalised, Hospitalia also intervenes for this urgent transport in accordance with the same terms and conditions.
4. Reimbursement of the legal deposits paid to the hospital, at the beginning of the hospitalization concerned at the earliest, on presentation of a justificatory document of the hospital proving the payment of such deposits, and on the condition that the policy holder can benefit from MLOZ Insurance compensations without limitations for pre-existing diseases, disorders or states. If it turns out afterwards that the hospitalisation cannot be covered, or if the amount of the deposit is higher than the compensation of MLOZ Insurance, or if the policy holder does not provide his bill, the unfounded amounts will be recovered.
The policy holder will have to pay a lump sum of € 15 for reminder costs if he does not reimburse the claimed overpayment.

Limitations in case of hospitalisation in units 30 (geriatric) and 61 to 66 (specialisations)
MLOZ Insurance intervenes in the costs according to the general rules described here above, up to the first 50 days in case of admission in a G or Sp unit, per hospitalisation, even in case of transfer between them.

In case of a new hospitalisation in a G or Sp unit, MLOZ Insurance will only intervene if a period of minimum 6 calendar days has passed since the end of the previous hospitalisation. However, if this period has not passed, MLOZ Insurance will intervene for the remaining 50 days which were not reimbursed during the previous hospitalisation.

Limitations in case of hospitalisation in units 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48
The intervention in units 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48 is limited to 20 days per year.

11.2. Interventions for day hospitalisations in Belgium
Same reimbursement as for hospitalisations without franchise (point 11.1).

11.3. Delivery at home in Belgium
Intervention according to a single package to cover all the costs related to the delivery, including the care given before and after the delivery (30 days before and 90 days after) at the rate of € 300.

11.4. Interventions for hospitalisations abroad
The intervention granted to cover the actual supported costs amounts maximum € 200 per day and this, as a complement to the possible intervention of the compulsory insurance, according to the Belgian rate or the rate of the country in which the hospitalisation took place. Students who stay abroad as part of their education, are also covered.
The duration of the intervention is limited to the number of days per hospitalisation or civil year in some units, as it is the case for hospitalisations in Belgium.
The day hospitalisation (one-day clinic) is not covered abroad. For pre-existing diseases, disorders or states, the intervention is only limited in case of hospitalisation in a private room: room and fee supplements charged excluded.

11.5. Pre-hospitalisation interventions
The pre-hospital care must be given in Belgium, in direct relation with the hospitalisation that followed, and covered by these general terms and conditions, as far as MLOZ Insurance also granted a compensation for the hospitalisation concerned. The care must be attested by a receipt.

The compensation aims:

- the complete reimbursement of the patient share in the cost of pharmaceutical products and magistral preparations reimbursable by the sickness insurance, if they were prescribed by a practitioner and if they were delivered within 30 days before the hospitalisation concerned.
- the coverage of the patient share and legal fee supplements, limited to 100% of the convention rate and related to the pre-hospital care.

By pre-hospitalisation care, we mean consultations and visits, and also remote consultations of general practitioners and specialists, fees for urgent care in a recognised function of specialised emergency care, medical technical acts, medical imaging, radio and radium therapy, nuclear medicine, internal medicine, dermatology and venereology, clinical biology, emergency supplements, anatomopathology, midwifery, physical therapy, nursing care with the following codes: 421072 - 421094 - 423054 - 423076 - 423091 - 423113 - 423253 - 423275 - 423290 - 423312 - 424491 - 424513 - 424535 - 425014 - 425036 - 425051 - 425176 - 425191 - 425213 - 425375 - 425412 - 425434 - 425456 - 425596 - 425611 - 425773 - 427416 - 427431 - 427475 - 427534, radio-isotopes, psychology sessions included in the agreement between the NIHDI and the adult mental health network on the creation of a first-line psychology care offer, teleconsultation by a psychiatrist/neuropsychiatrist covered by the temporary dispensations under COVID-19 which have been done in ambulatory care during the 30 days before the hospitalisation and provided that this care was given in Belgium and is directly related to it.

The codes related to psychology sessions, teleconsultation by a psychiatrist/neuropsychiatrist, psychotherapy and child psychiatry will be subject to a pre-hospitalisation intervention within 60 days only if they precede a hospitalisation in one of the following units: 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48.
Exclusion: pre-hospital care will not be reimbursed for hospitalisations in units 30 (geriatrics), units 34, 37, 41 and 48 (psychiatry) and units 61 to 66 (specialisations), except for ambulatory care at the emergency unit.

There is an intervention for pre-hospitalisation care related to a hospitalisation in the units 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48 only for the services listed under the heading "psychology sessions, teleconsultation and psychiatric".

11.6. Post-hospitalisation interventions

11.6.1. Post-hospitalisation care
The post-hospitalisation care must be given in Belgium, in direct relation with the hospitalisation that preceded and covered by these general terms and conditions, on the condition that MLOZ Insurance granted an intervention for the hospitalisation concerned. The care must be attested by a receipt.

The intervention of Hospitalia aims:

- the complete reimbursement of the user fees in the cost of pharmaceutical products and magistral preparations reimbursable by the sickness insurance, if they were prescribed by a practitioner and if they were delivered within 90 days after the hospitalisation concerned;
- the coverage of the legal patient share and fee supplements, limited to 100% of the convention rate and related to the post-hospitalisation care.

By post-hospitalisation care, we mean consultations and visits, and also remote consultations of 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, the emergency supplements, the anatomopathology, the obstetricians, the physical therapy, the nursing care, the speech therapy, the radio-isotopes, the cardiac rehabilitation, the locomotor rehabilitation for codes 776156-776171-773791-773776-773872-773754-773673-773813-773614-773732, psychology sessions included in the agreement between the NIHDI and the adult mental health network on the creation of a first-line psychology care offer, teleconsultation by a psychiatrist/neuropsychiatrist covered by the temporary dispensations under COVID-19, the installation of Baha electrodes such as defined in the nomenclature, which have been done in ambulatory care during the 90 days after the hospitalisation and provided that this care was given in Belgium and is directly related to it.

The sessions of physical therapy, physiotherapy and cardiac rehabilitation are limited to 20 for the 3 dispensation types together and must have been given within 90 days after the hospitalisation.

The reimbursement of the Baha electrodes is subordinated to the condition that a first Baha electrode was installed and reimbursed by MLOZ Insurance during a (day) hospitalisation.

The codes related to psychology sessions, teleconsultation by a psychiatrist/neuropsychiatrist, psychotherapy and child psychiatry will be subject to a post-hospitalisation intervention within 90 days only if they follow a hospitalisation in one of the following units: 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48.

The reimbursement of splints up to € 50 per hospitalisation, as long as they have been prescribed by a practitioner and have been delivered within 90 days after the hospitalisation, on the condition that they are directly related to this hospitalisation.

Exclusions: post-hospitalisation care is excluded after a hospitalisation in units 61 to 66 (specialisations).

There is an intervention for post-hospitalisation care related to a hospitalisation in the units 34, 35, 36, 37, 38, 39, 41, 42, 43 and 48 only for the services listed under the heading "psychology sessions, teleconsultation and psychiatric".

11.6.2. Post-hospitalisation admissions
A package of € 7.5 per day is granted for any temporary admission in a convalescence or rehabilitation institution.
The intervention is granted on the condition that the admission took place within 14 days after the end of the hospitalisation. It is limited to 15 days per civil year.

11.7. Warranty 'Serious illnesses' (as an option)

11.7.1 Compensations
Compensation 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, 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 Advisor, and up to € 7,000 per year.
The health care must be administrated in Belgium, medically necessary, 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 was granted by the Medical Counsellor.
However, the warranty 'Serious illnesses' is only acquired as long as the serious illness had not been diagnosed before affiliation to this warranty.
This warranty has the following benefits:
1. Consultations and visits of general practitioners and specialists, medical technical acts, medical imaging, radio and radium therapy, nuclear medicine, internal medicine, dermatology and venereology, physiotherapy, clinical biology, fees for urgent care in a recognised function of specialised emergency care, emergency supplements, surgical truss maker, orthopedics, optics, acoustics, anatomophatology, genetics, special dispensations, physical therapy, nursing care, speech therapy, radio-isotopes and cardiac rehabilitation are reimbursed up to the legal patient share and fee supplements, limited to 100% of the convention rate.

2. Allopathic pharmaceutical products, magistral preparations and wigs (hair prosthesis) on prescription are reimbursed up to the actual price paid by the patient if there is a compensation by the compulsory insurance.
3. Rental of medical material is reimbursed after a possible compensation of the health insurance funds' complementary services.

11.7.2 Compensation conditions
To benefit from this warranty, the insured person must ask the agreement of the Medical Counsellor. He will provide a doctor's certificate stating the diagnostic of the patient's serious illness, confirmed by biological or anatomopathological examinations, by medical imaging or by any other medical examination usually approved of in the medical world. On the basis of this certificate, the Medical Counsellor of MLOZ Insurance will accept or refuse the warranty benefit for one year per serious illness, beginning on the date of the doctor's certificate.
This agreement can be renewed for one year time for the same illness, directly or indirectly after the first period.
If the Medical Counsellor of MLOZ Insurance needs further information, the insured person has 45 days to provide an answer, as from the date on which the Medical Counsellor's request has been sent.

- If this term is respected, the warranty starts on the date of the doctor's certificate, in case of medical acceptance.
- If this term is not respected, and in case of medical acceptance, the warranty starts on the day after the day on which the additional documents are received.
- If the term exceeds 90 days, a new request must be introduced.

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

12. ASSISTANCE IN BELGIUM

MLOZ Insurance offers the hereunder mentioned assistance services to the policy holders Hospitalia entitled to the intervention of MLOZ Insurance in the context of a (day) hospitalisation in Belgium and who ended their waiting period.

12.1. Nursing after a day hospitalisation

MLOZ Insurance organises, within 24 hours, and supports the costs of nursing for the single policy holder 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.

To benefit from this service, the single policy holder must:

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

12.2. Child care at home

MLOZ Insurance organises, within 24 hours, and supports the costs of child care for the children of the policy holder, from 3 months to 14 years, in the following situations:

1) if the policy holder is hospitalised for more than two days after an unexpected and unforeseeable accident or disease, MLOZ Insurance intervenes in the care of his/her children, if no other person can take care of them. This care is granted for maximum 5 working days, from Monday to Saturday, between 8 am and 7 pm, up to 10 hours per day, while the partner is working.

2) In case of delivery reimbursed by MLOZ Insurance, MLOZ Insurance intervenes in the care of the children during maximum 3 working days during the hospitalisation of the mother or immediately after in case of a short admission (maximum 2 nights) of the mother at the hospital from Monday to Saturday, up to 10 hours per day, while the father is working.

3) In case of delivery at home reimbursed by MLOZ Insurance, MLOZ Insurance intervenes in the same conditions during maximum 3 working days after the delivery at home and the day of the delivery at home. This care aims to provide a watchful presence for maximum 3 children and to take care of the duties normally realised by the mother or the father, with the exclusion of household duties and transportation between school and home.
Those services are provided on simple phone call at the central support unit of MLOZ Insurance, reachable 24/7, at number: since april 2020, 02 560 47 90.

13. INTERVENTION LIMITATIONS

13.1. Annual maximum Hospitalia

The total of the interventions of MLOZ Insurance is limited to € 25,000 per insured person and per civil year during which the dispensations giving right to this intervention were given.

13.2. Intervention limitations for pre-existing diseases, disorders or states

The Medical Counsellor of MLOZ Insurance can, on basis of the medical questionnaire, inform the policy holder at the time of joining that the intervention is limited for (day) hospitalisations directly related to pre-existing diseases, disorders or states (such as pregnancy), by excluding the reimbursement of room and fee supplements charged in case of admission in private room. This intervention limitation is not applicable in case of hospitalisation in double room or ward.
During the first 24 months of membership to the product, the Medical Counsellor can decide this limitation (exclusion of the covering of supplement in case of hospitalisation in a private room) 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.
The notion of pre-existing state related to the pregnancy will be applied as follows:
- for deliveries during the first 6 months of membership, no reimbursement is foreseen. However, the hospitalisation costs are covered, with the exclusion of the room and fee supplements charged in case of admission in private room and if, at the time of the delivery, the mother was exempted from waiting period;
- for deliveries during the 7th, the 8th and the 9th month of membership, the hospitalisation costs are covered, with the exclusion of room and fee supplements charged in case of admission in private room.

The notion of pre-existing state related to the pregnancy will not be applied:
- to deliveries as from the 10th month of membership;
- to deliveries of insured women who were previously covered by a similar health insurance fund hospitalisation insurance or offering a larger coverage. In this case, the first 9 months, as described in the paragraph above, begin on the date of affiliation to this similar or more advantageous hospitalisation service.

13.3. Dispensations not covered by Hospitalia

MLOZ Insurance does not intervene:
- for personal care products, cosmetic products, food products, wines, mineral waters, non-essential expenditures (phone, television, flowers, fridge, etc.), except in the context of hospitalisations in double room or ward in Belgium. Overtaxed phone calls remain nevertheless excluded. However, Hospitalia doesn't reimburse the costs for phone, television, flowers, fridge and drinks charged in the context of a hospitalisation of at least one night;
- 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 dental implants and prostheses and every dispensations related to those;
- 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;
- for the costs related to medical treatments which are intentionally realised abroad and for which the Medical Advisor of the compulsory insurance did not give his agreement.

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 determined in reference to these compensations. If, for one reason or another, the policy holder is not allowed to request one or more of these compensations, MLOZ Insurance intervenes in the same way as for an insured person who is entitled to these compensations.

In order for MLOZ Insurance to grant these compensations, it is imperative that during hospitalization at least one medical dispensation is included on the list of compensations that are reimbursable by Hospitalia, and is reimbursed by the compulsory insurance.

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 compensations mentioned above. In that case, MLOZ Insurance intervenes in the same way as for an insured person who is entitled to these compensations.

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 after 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 Hospitalia, 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, amongst which the original hospitalisation bills. By justificatory document related to the hospitalisation costs, should be understood the original extract of the patient invoice and if applicable, of the fee invoice, or the invoice scanned by the hospital or the insured, or the invoice that has been delivered on another hard-wearing medium.
To obtain the benefits of the pre- and post-hospital care and the warranty 'Serious illnesses', the policy holder will provide all the original 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 policy holder declares:

- allowing MLOZ Insurance to collect and handle personal and medical data and information. Medical data are collected and handled under the supervision and the responsibility of a health care professional attached to MLOZ Insurance.
- allowing MLOZ Insurance to use medical data in order to conclude, manage and execute the insurance policy.

The insurer declares that personal and medical information and data are only collected, handled and used on that purpose and that, regarding to that purpose, the collected information and data are appropriate, relevant, and non-abusive.
The policy holder can take note of the privacy policy of MLOZ Insurance via this link www.mloz.be/fr/privacyMLOZInsurance or upon request in an agency or by mail (MLOZ - DPO, Route de Lennik 788A, 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.