General Terms and Conditions Hospitalia Continuity
as from 1 January 2024

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

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

Hospitalia Continuity

LIMITATION IN TIME OF THE INSURANCE

The insurance legally ends at the age of 65 or as soon as the insurance of your employer stops before the age of 65. Before your 65th birthday at the latest, you can apply for a transfer to Hospitalia, Hospitalia Medium or Hospitalia Plus.
As from 2025, this will be before your 66th birthday, and as from 2030 before your 67th birthday. This goes without any waiting period, medical questionnaire or extra premium, but is conditional upon an attestation from your employer confirming coverage under a group insurance policy since 6 months at the date of transfer. If the 6-month waiting period for Hospitalia Continuity is not achieved, the transfer to Hospitalia, Hospitalia Medium, Hospitalia Plus or Forfait H is still possible on condition that a waiting period of the number of months left to accomplish is achieved.

Attention: In your own interest, you must notify MLOZ Insurance of any change in your family composition or in your insurance policy with your employer (e.g. addition of a newborn or a partner, removal of a partner or a child who is no longer covered).
As soon as you or one of the insured persons cease(s) to benefit from the employer's group insurance, you must request your transfer to Hospitalia, Hospitalia Medium or Hospitalia Plus to continue to be covered in the event of a hospitalization. As Hospitalia Continuity intervenes solely as supplementary insurance for your group hospitalization cover, it will not be able to reimburse you.

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-CDZ 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 ([1]), 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. Accident : unexpected event, independent of the will of the insured person, involving a corporal injury of which (one of) the cause(s) is external to the organ. This accident must have involved traumatic injuries for which the treatment is of such a nature that it is covered by these dispositions.
1.8. Receipt: the document used by the health insurance fund, except for third parties.
1.9. Waiting period: period during which the insurer does not have to provide benefits and beginning at the starting date of the policy.
1.10. 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 during the possible transition from Hospitalia Continuity to Hospitalia, Hospitalia Medium or Hospitalia Plus.
1.11. 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.

2. ADMISSION

2.1. The policy holder who wants to affiliate to (or remain affiliated to) MLOZ Insurance, 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). Furthermore, to be affiliated to Hospitalia Continuity, the policy holder should be insured by a group insurance for hospitalization (offered by the employer or another group) and issue proof or, failing this, a sworn statement. The age limit for affiliation is 64 years included.
2.2. Impact on your affiliation to MLOZ Insurance if the contributions to the complementary services of your health insurance fund are not paid
It is important that all contributions for the complementary services of your health insurance fund are always paid.
If your payment is not in order, this can have serious consequences for your affiliation to MLOZ Insurance and for the covers of the insurances you contracted.
2.2.1. Consequences for the affiliation to MLOZ Insurance
You can only join MLOZ Insurance if you have not lost your rights to the complementary services of your health insurance fund due to

non-payment of contributions for these services for a period of 24 consecutive months.

2.2.2. Consequences for maintaining your affiliation to MLOZ Insurance

If you are already affiliated to MLOZ Insurance, it is legally obliged to terminate your affiliation, and therefore all your covers, if you are sanctioned by the loss of your rights to the complementary services of your health insurance fund because you have not paid for these services during 24 consecutive months. This automatic exclusion is independent of whether you have always paid the contributions for the insurances of MLOZ Insurance. You will then be able to reaffiliate with MLOZ Insurance only if you resume regular payment of your contributions for the supplementary services provided by your health insurance fund. The period during which you must pay contributions without being able to claim dispensations under the supplementary services depends on whether you are or were in a situation worthy of consideration (e.g. (but not exhaustive) integration allowance, collective debt settlement, personal bankruptcy, etc.). Any interruption of 6 months in the payment of these contributions during the period referred to in the previous sentence will result in a new exclusion from MLOZ Insurance.

3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion of the insurance policy

All new affiliation requests must be submitted through the forms provided by MLOZ Insurance or via the website of the section to which the policy holder is linked.

The insurance policy is composed by the acceptance letter (with or without limitation for a possible future transfer to Hospitalia, Hospitalia Medium or Hospitalia Plus) 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 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 for the pre-existing disease, disorder or state mentioned on the medical questionnaire.

The decision of acceptance, with or without limitation of intervention, is communicated by letter to the candidate policy holder. The letter will detail the amount and the payment date of the first premium, the date 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 ends as soon as your employer's insurance ends or automatically at the age of 65. It is on the day before your 65th birthday at the latest that you may request your transfer to Hospitalia, Hospitalia Medium or Hospitalia Plus. This goes without any waiting period, medical questionnaire or extra premium, but is conditional upon an attestation from your employer confirming coverage under a group insurance policy since 6 months at the date of transfer. If the 6-month waiting period for Hospitalia Continuity is not achieved, the transfer to Hospitalia, Hospitalia Medium, Hospitalia Plus or Forfait H is still possible on condition that a waiting period of the number of months left to accomplish is achieved.

If no proof can be provided, a new medical questionnaire must be submitted. The transfer will be done without waiting period and the premiums will be increased according to the age at the time of transfer.

In case of joining Hospitalia Continuity in the previous 12 months, the premiums will also be increased for transfers from the age of 46, except if the membership results from a transfer from Hospitalia, Hospitalia Medium or Hospitalia Plus to Hospitalia Continuity.

In addition, the insurance policy 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 letter (via digiconnect.be), or the delivery of the writ or the cancellation letter against deposit receipt, addressed either directly to MLOZ Insurance or to one of the sections mentioned above. This one month notice is not mandatory in case of a change of hospitalisation cover 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 interventions of MLOZ Insurance, a 6-month waiting period starting at the joining date has to be accomplished. 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 continuity hospitalisation insurances
  MLOZ Insurance intervenes for the new insured persons 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 "continuity" type, which means a waiting insurance which opens the right to be transferred to an individual hospitalisation policy.

4.2. Exclusions of the guarantee

MLOZ Insurance only grants an intervention if the employer's group insurance intervened for a hospitalisation in Belgium and abroad and a day hospitalisation in Belgium.

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 act will be retained when the policy holder voluntary and deliberately had a behaviour that caused a foreseeable damage without that it is required that he had the intention to cause the damage as it happened;
- resulting from drunkenness, alcoholism or drug addiction;
- resulting from nuclear reactions, except for terrorism.

4.3. End of the guarantee

The insurance guarantee ends with the insurance policy.

5. RIGHTS 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 arisen by 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.

The original detailed invoice of the group insurance or its copy must be introduced within 3 years after the cancellation date of the risk covered by the guarantee. Once this term is over, there is prescription.

The insurance benefits are settled by the beneficiary of the insurance policy.

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 claim, 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 at the time of joining Hospitalia Continuity (10% taxes included).

Affiliated to the product Hospitatlia Continuity Depending on age on joining date:			
less than 18 years	3,13	from 40 to 45 years	7,46
from 18 to 24 years	3,87	from 46 to 49 years	8,37
from 25 to 29 years	4,93	from 50 to 54 years	9,39
from 30 to 34 years	5,87	from 55 to 59 years	17,82
from 35 to 39 years	6,75	dfrom 60 to 64 years	24,16

Premiums are calculated on the basis of the age at the time of joining Hospitalia Continuity.

In case of transfer from Hospitalia, Hospitalia Medium or Hospitalia Plus to Hospitalia Continuity, premium to Hospitalia Continuity will correspond to the premium for the age of joining one of these two products.

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 HOSPITAL 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 Continuity

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 premium amount and access to the product.

a) The age limit for Hospitalia Continuity is 64 years included.

b) Depending on the chosen product, affiliation after a certain age may lead to supplementary premiums. This does not apply to Hospitalia Continuity.

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.

The rule on a pre-existing state only applies to the insured by Hospitalia Continuity if they transfer to Hospitalia, Hospitalia Medium or Hospitalia Plus.

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 health insurance fund 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 or hospitalization increase with age. This criterion might influence the amount of the expenses. However, the contribution amount for Hospitalia Continuity, that was fixed upon closure of the contract, will not increase based on the insured's age during the contract.

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

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

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

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

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

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

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

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

11. REIMBURSMENTS OF HOSPITALIA CONTINUITY

MLOZ Insurance intervenes in case of:

a) hospitalisation in Belgium or abroad
b) day hospitalisation in Belgium

for a maximum of € 50 per hospitalisation day, up to the outstanding balance charged to the insured person after intervention of the employer's hospitalisation insurance. The reimbursement is calculated on basis of the detailed invoice of the insurance intervention.

12. INTERVENTION LIMITATIONS

12.1. Daily maximum

€ 50 maximum per hospitalisation day, after intervention of the group hospitalisation insurance.

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

The Medical Counsellor of MLOZ Insurance can, on basis of the medical questionnaire, decide in case of pre-existing disease, disorder or state that a coverage limit (exclusion of supplement for hospitalisation in a private room) can be applied for the directly related hospitalisations when joining Hospitalia and, if applicable, Hospitalia Medium or Hospitalia Plus.

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.

The medical questionnaire will only be effective when joining Hospitalia, Hospitalia Medium or Hospitalia Plus if this last cover is higher than the cover the insured enjoyed before joining Hospitalia Continuity.

At the time of transfer, the Medical Counsellor will decide if this limitation must be maintained or not.

13. COMPENSATIONS

13.1. 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.

13.2. 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.

13.3. Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums.

To obtain the benefits foreseen by Hospitalia Continuity, the policy holder will fill in the form "Payment request" delivered by MLOZ Insurance, and will provide it with the original or a copy of the statement of the group insurer. MLOZ Insurance can request any complementary document deemed necessary.

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

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

14. 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 overview is purely for information. Only the statutes determine the rights and obligations of the policy holders of MLOZ Insurance. They are available at the head office of MLOZ Insurance and on the site www.mloz.be.