General Terms and Conditions Hospitalia Care

as from 1 January 2026

General Terms and Conditions Hospitalia Care of the Health insurance company MLOZ Insurance voted by the Board of Directors on 17 September 2025 and the Extraordinary General Meeting on 15 October 2025

"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. - 11/2025

Hospitalia Care

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/750/011.

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:

- 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
- 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 2014.

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

1.12. 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).

1.19. Attempt suicide: it is an unusual behaviour, not resulting in death, that the person initiates and adopts expecting or risking death or physical damage in order to obtain desired changes.

1.20. Urgent patient transport : Urgent patient transport refers to any transport by ambulance or helicopter following a call to the unified 100/112 service and in accordance with the law of 8 July 1964 on urgent medical assistance and its implementing decrees, when it is immediately followed by a hospitalisation or day hospitalisation in Belgium for which MLOZ Insurance intervenes.

2. ADMISSION

2.1. To join and remain a member of the coverage Hospitalia Care the policy holder has to be affiliated to the compulsory insurance as well as to the complementary services at one of the 3 sections mentioned above. However, there are some statutory exceptions (cf those sections: Partenamut, Freie Krankenkasse, and Helan Onafhankelijk ziekenfonds). The policy holder has to affiliate and affiliate his/her dependants within the meaning of the regulation on the compulsory insurance for Health Care and Sickness Benefits, except when he/she, the partner or 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 limitation for affiliation to Hospitalia Care is fixed at 67 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 had paid their premiums for this insurance, or
- in case of a transfer from Hospitalia Continuity to Hospitalia Care, by the policy holder or the insured, where the age limit is set at 66 years (67 from 2030) provided the transfer conditions are met.

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 (in accordance with the conditions for new affiliation) 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 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 Care 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: 3-month waiting period

To benefit from the compensations of MLOZ Insurance, a 3-month waiting period starting at the affiliation date has to be accomplished. There will also be a 3-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 3 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

For every cover and type of room

Are not covered: the hospitalisation and 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. Attempted suicide and suicide are not considered as intentional acts.
- 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 01/01/2026, including all taxes, depending on the age on 01/01/2026

Aangesloten bij het product Hospitalia Care (taks 10% inbegrepen)			
Under 46 years old*		**Between 46 and 49 years old***	
less than 18 years	6,94	from 46 to 49 jaar	23,21
from 18 to 24 years	8,72	from 50 to 59 jaar	28,49
from 25 to 49 years	22,12	60 jaar and over	51,37
from 50 to 59 years	27,15		
60 years and over	48,93		
From 50 to 54 years old*		**From 55 to 59 years old***	
49 years**	24,32	from 55 to 59 jaar	40,63
from 50 to 59 jaar	29,84	60 years and over	73,31
60 years and over	53,81		
At the age of 60*			
59 years**	46,01		
60 years an over	83,07		

* 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 and 70% 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 to 67 years at the joining date to Hospitalia Care.

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 (in accordance with the conditions for new affiliation) 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. These criteria depend on the type of product.
The following criteria are taken into consideration for Hospitalia Care:

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) Access could be limited for certain products: the age limit for Hospitalia Care is 67 years included, as it is for the warranty 'Serious illnesses' in addition to Hospitalia Care. There is no age limit for Hospitalia. 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 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:
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 - insurance with a health insurance fund or private insurer (individual or collective) - 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 Care, without interruption.
- If the member was previously covered by a similar commercial insurance with a private insurer (individual/collective), then during the first 9 months of affiliation with Hospitalia, she is entitled to reimbursements for delivery with 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:

Age of the insured person because, according to statistic data, the probabilities of treatment and hospitalisation 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 'Single room' for Hospitalia Care 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. However, the premiums will be raised annually by 1.5% on top of the applied index for Hospitalia Care.
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 BY HOSPITALIA CARE

11.1. Interventions for hospitalisations in Belgium

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

17 (M) Newborn hospitalised in room with the mother in an M unit
18 (n) Newborn hospitalised in unit N*(n) while the mother is also a patient at the hospital
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 chronical polypathologies requiring extended medical care
66 psychogeriatric disorders

1. In case of full hospitalisation in a double room or ward: full reimbursement of the amount of the hospitaliastion bill and fee note, except for the 4 maximums 2.2.2, 2.5, 2.6 and 2.9 hereunder.

2. In case of hospitalisation in a single room, reimbursement based on the hospitalisation bill and fee note:

2.1. of all the room supplements up to € 125 per day
2.2.1. of the accommodation cost of the father or the mother in the room of his/her hospitalised child, under 19 years old.
2.2.2. costs related to a bed for an accompanying relative staying in the room of a hospitalised adult aged 19 or older, up to a maximum of € 30 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 costs of € 2,500 or more are charged to the patient, € 2,400 can be reimbursed maximum once a year.
2.6. of the para-pharmaceuticals products, at the hospital, up to € 250 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 € 5,000 or more charged to the patient, € 500 can be reimbursed maximum once a year.
2.7. 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.
2.8. of the fee supplements up to 200% of the convention rate.
2.9. of the prostheses, implants, medical devices and other supplies:

- prostheses, implants and medical devices, reimbursable by the compulsory insurance, up to the invoiced real price, on the condition that this amount can be identified as the price charged for an implant, a prosthesis or a medical device;
- prostheses, implants and medical devices, not reimbursable by the compulsory insurance, up to € 5,000 per hospitalisation, on the basis of the invoiced real price on the condition that this amount can be identified as the price charged for an implant, a prosthesis or a medical device. It is possible for the Medical Counsellor to deviate from this maximum in seri ous 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, € 10,000 can be reimbursed maximum once a year.

- costs legally charged to the patient for other supplies, up to 200% of the convention rate. For the supplies for which there is no intervention of the convention rate, there is a reimbursement up to the invoiced price.

2.10. of the miscellaneous costs up to the amount charged to the patient.
2.11. of the fees that are not reimbursed by the compulsory insurance, up to € 1,000 per hospitalisation.
3. Compensation of € 7 per day for the accompanying person who stayed in a hospital hospitality house or a hospital hotel during the hospitalization of the insured person reimbursed by MLOZ Insurance.
4. Intervention in the neonatal care after the hospitalisation, up to € 20 per day during maximum 7 days per delivery reimbursed by Hospitalia Care, as from the day after the hospitalization end date .
5. In case of hospitalisation or day hospitalisation in Belgium reimbursed by Hospitalia Care, compensation in the actual costs incurred for the emergency transportation (after calling 100/112) to the hospital, up to € 500 per civil year, after any other intervention. 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 or the same where the insured was not hospitalised, Hospitalia Care also intervenes for this urgent transport in accordance with the same terms and conditions.
6. Reimbursement of the legal deposits (as set out in the National Agreement between hospitals and health insurance organisations) paid to the hospital, at the beginning of the hospitalization concerned at the earliest, and on the condition that the policy holder can benefit from MLOZ Insurance interventions 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 intervention 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 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 50 days per year.

11.2. Interventions for day hospitalisations in Belgium

Same reimbursement as for hospitalisations (point 11.1), except for the reimbursement in private room of the hospitalisation costs limited to maximum € 100 and to maximum 100% of the convention rate for fee supplements.

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 (60 days before and 180 days after) at the rate of € 700.

11.4. Interventions for hospitalisations abroad

The intervention granted to cover the actual supported costs amounts maximum € 360 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. 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.
Students who stay abroad as part of their education, are also covered.
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-hospitalisation care must be given in Belgium, in direct relation with the hospitalisation that followed 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 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 60 days before the hospitalisation concerned;
- the coverage of the legal patient share and fee supplements, limited to 100% of the convention rate and related to the pre-hospitalisation care and if they were provided within 60 days before the concerned hospitalisation.

By pre-hospitalisation care, we mean consultations and visits, and also remote consultations of general practitioners and specialists, fees for urgent care in a recognized function of specialized emergency care, the medical technical acts, the medical imaging, the radio and radium therapy, the nuclear medicine, the internal medicine, the dermatology and venereology, the clinical biology, the emergency supplements, the anatomopathology, the obstetricians, the physical therapy, the 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 - 427490 - 427534 - 427556, the 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 which have been done in ambulatory care during the 60 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-hospitalisation care is excluded before a hospitalisation 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 Care 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 180 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 (the dispensations must have been given within 180 days after the hospitalisation).

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 which have been done in ambulatory care during the 180 days after the hospitalisation, 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 reimbursement of the Baha processor is subject to the condition that a first Baha electrode has been placed 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 intervention also aims splints, up to a maximum of € 50 per hospitalisation, when they are prescribed by a doctor and are delivered within 180 days after the hospitalisation, provided they are directly related to the hospitalisation.
The sessions of physical therapy, physiotherapy and cardiac rehabilitation are limited to 45 for the 3 dispensation types together and must have been given within 180 days after the hospitalisation.
If the post-hospitalisation care period overlaps with a pre-hospitalisation care period, the policy holder is entitled to the most attractive reimbursement.
Exclusion: post-hospitalisation care is excluded after a hospitalisation in units 61 to 66 (specialisations).

11.6.2. Post-hospitalisation admissions

A package of € 15 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.

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 Care 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 Care 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 as from April 2020), 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 Care 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.

1. During the hospitalisation

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 a maximum of 8 hours and can be provided between 8 a.m. and 7 p.m. from Monday to Saturday, 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 maximum of 8 hours and can be provided between 8 a.m. and 7 p.m. from Monday to Saturday, 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 € 250 per event.

2. After a reimbursed event (hospitalisation, serious illness)

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 a maximum of 8 hours and can be provided between 8 a.m. and 7 p.m. from Monday to Saturday, 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 maximum of 8 hours and can be provided between 8 a.m. and 7 p.m. from Monday to Saturday, 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 € 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 € 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, as well as the return home.

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. hospitalisation for a normal child birth (unless in the context of babysitting or in case of obvious and unforeseen complications)
b. all consequences of the exclusions that are mentioned in the product Hospitalia Care.
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, from April 2020 by phone : 02 560 47 90

13. INTERVENTION LIMITATIONS

13.1. No annual maximum

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 or ward room.

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 3 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 between the 4th and 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.

Attempted suicide cannot be taken into account by MLOZ Insurance in determining the insured's current health condition if the attempt occurred more than one year before the medical questionnaire was completed.

13.3. Dispensations not covered by Hospitalia Care

MLOZ Insurance does not intervene:

- for miscellaneous costs, e.g. room comfort costs, sanitary products, food and beverages, other products and services delivered on the patient's demand, costs for non-urgent transport and costs that are subject to VAT;
- 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, except for those realised in the context of a hospitalisation of at least one night in double or ward room and reimbursed by Hospitalia Care;
- 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 execut ing 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.

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 Care, 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 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 Hospitalia Care, 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 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.