General Terms and Conditions Dentalia Plus

as from 1 January 2018

General Terms and Conditions of the dental care insurance, Dentalia Plus, of the "MLOZ Insurance" health insurance company, voted by the Board of Directors on 28 September 2017 and the Extraordinary General Meeting on 27 October 2017

"MLOZ Insurance" is the health insurance company of the Independent Health Insurance Funds (OZ - Omnimut - Partenamut - Freie Krankenkasse - Partena Ziekenfonds). Approved under code OCM 750/01 for branches 2 and 18 by the Control Office of health insurance funds and national associations – Avenue de l'Astronomie, 1 – 1210 Brussels.
Head office: **route de Lennik 788A, 1070 Brussels** - Belgium (RPM Brussels) - www.mloz.be - Enterprise number: 422.189.629. - 15/01/2018

1. DEFINITIONS

1.1. Insurer: «MLOZ Insurance» HEALTH INSURANCE COMPANY, insurance company approved by the Control Office of health insurance funds and national associations, Avenue de l'Astronomie, 1 – 1210 Brussels by decision of 24 June 2013 to offer health insurances under branch 2 of appendix 1 of the royal decree of 22 February 1991 on general regulation of the supervision of insurance companies, as well as to cover, on a complementary basis, risks belonging to the assistance such as stipulated under branch 18 of appendix 1 of the above-mentioned royal decree, under code no OCM 750/01.

1.2. Policy holder: the person who subscribes the insurance for himself and/or for insured persons and who has to pay the premiums.

1.3. Sections : the sections of the HIC are the intermediaries which offer the insurance products: 501: OZ (www.oz.be) - 506: Omnimut (www.omnimut.be) - 509: Partenamut (www.partenamut.be) - 515: Freie Krankenkasse (www.freie.be) - 526: Partena OZV (www.partena-ziekenfonds.be), all members of the National Association of independent health insurance funds.

1.4. Medical dispensations: the term refers to the list of the dispensations of the nomenclature.

1.5. Prostheses and implants: everything that is regulatory approved in the context of dental care.

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

1.7. Preventive behaviour: the fact of having a dispensation for reimbursed dental care during the civil year that precedes any new payment request.

1.8. Dental Care:

- all the dispensations mentioned, either in the Royal Decree of 1 June 1934 laying down rules for the practice of dentistry, or in the Royal Decree of 9 November 1951 completing the Royal Decree of 1 June 1934 lying down rules for the practice of dentistry,
- administrated by one of the care providers listed in article 4, §1 of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of health dispensations regarding the compulsory insurance for health care and sickness benefits.

1.9. Minor oral surgery: the dispensations of article 14, I) of the appendix to the R.D. of 14 September 1984 establishing the nomenclature of health dispensations in the context of the compulsory insurance for Health Care and Sickness Benefits, of which the codes are followed by the sign «+».

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

2. ACCEPTANCE

To join and remain a member of the cover Dentalia Plus, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the five above-mentioned sections, outside of exceptions to the statutes (consult these sections). The policy holder has to affiliate his/her dependants within the meaning of the regulation on the compulsory insurance for Health Care and Sickness Benefits, except when the partner 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 limit to join the insurance is 64 years, except in case of transfer within the compulsory insurance for persons who were previously members of a similar «dental care» insurance of another Belgian health insurance fund and who had paid their premiums for this insurance.

3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion of the insurance policy

The insurance policy is composed by the acceptance letter and the general terms and conditions with additional clauses.

The insurance policy starts the first day of the month following the month during which the HIC received the duly completed "New affiliation request or request to change a product " (internal date or scanning as proof), if the HIC 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 the HIC receives the membership application before the end of the third month following the birth or adoption and that the HIC 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.

The decision of acceptance is communicated by letter to the candidate policy holder. The letter will detail the amount and the payment date of the first premium, the date of acceptance of the membership and the starting date of the membership, the duration of the waiting period, the annuity duration of the membership and the insurance product provided.

3.2. Ending of the insurance policy

The insurance policy is a life policy. It however 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, the delivery of the writ or the sending of the cancellation letter against deposit receipt, addressed either directly to the HIC or to one of the above-mentioned sections.
- fraud or attempt to fraud.
- voluntary caused injury to the interests of the HIC 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.
- 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.
- 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 Dentalia Plus, a 6-month waiting period starting at the joining date has to be accomplished. The waiting period is extended to 12 months for the reimbursement of prostheses, implants and orthodontic dispensations.
Dentalia Plus does not intervene for a dental care dispensation made 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 Dentalia Plus 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, 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 the HIC.
- Waiting period exemption in case of accident
  Dentalia Plus intervenes for every dental care dispensation resulting from an accident which has caused traumatic injuries for which the treatment is of such a nature that it is covered by the dispositions of this document if the accident occurred after the joining date.
- Waiting period exemption for similar dental care insurances
  The new policy holders proving with documents that they were covered for more than 12 months and until the date of joining Dentalia Plus by a similar dental care insurance will be exempted from the 6-month and 12-month waiting periods.

4.2. Exclusions of the guarantee

Are not covered the dental 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 voluntary participation in a crime or offence;
- 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. RIGHT TO BENEFITS

The HIC 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 01/01/2018, including all taxes, depending on the age

Affiliated to the product Dentalia Plus			
Before 01/01/2011, or affiliated, after that date, under 40 years old*		After 01/01/2011, between 40 and 44 years old*	
from 0 to 3 years	Free	from 40 to 44 years	12,31
from 4 to 6 years	3,03	from 45 to 59 years	17,34
from 7 to 17 years	5,88	60 years and over	18,55
from 18 to 29 years	6,72		
from 30 to 44 years	9,12		
from 45 to 59 years	12,85		
60 years and over	13,74		

After 01/01/2011, between 45 and 59 years old*		After 01/01/2011, between 60 and 64 years old*	
44 years**	13,68	59 years**	21,84
from 45 to 59 years	19,27	60 years and over	23,36
60 years and over	20,61		

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

An increase of the premium of respectively 35, 50 or 70% is calculated on the current rates for the policy holders who are respectively between 40 and 44 years, 45 and 59 years or 60 years and over at the joining date to the HIC.

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 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 demanding payment of the premium within 15 days as from the day after the delivery of the registered letter at the post office. 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 reaffiliate if he pays all overdue premiums and will have to complete a new waiting period to pretend to the benefits again.

9. SEGMENTATION

At the moment of affiliation to an insurance policy, the insurance companies apply segmentation criteria that influence the access to the insurance product, the determination of the premiums and the scope of the guarantee.
These criteria depend on the type of product.
The following criteria could be taken into consideration for Dentalia Plus..

At the beginning of the policy:

- The age of the insured person because, according to statistic data, the probabilities of sickness and hospitalisation increase with age. The insured person's age may have an impact on the occurrence of perils and/or on the amount of the expenditure. It is therefore taken into account for the fixation of the premium amount. Therefore, there could be a limit depending on the chosen product: the age limit for Dentalia Plus is 64 years.
- Affiliation after a certain age may lead to supplementary premiums, since the insured person's age may have an impact on the occurrence of perils and/or on the amount of the expenditure.

Our HIC does not make a distinction for the acceptance, the invoice and/or the scope of the cover based on the nature of the insurance (health fund or commercial insurance) by which the candidate policy holder was covered before his affiliation to our HIC.

During the policy:
The age of the insured person because, according to statistic data, the probabilities of sickness and hospitalisation increase with age. This criterion may have an impact on the occurrence of perils and/or on the amount of the expenditure. It is therefore taken into account for the fixation of the premium amount.

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

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

Without prejudice of the legal possibilities of premiums adaptation, a comparison will be made annually between the index rate of April of the current year and the index rate of the same month of the previous year. This variation of the index rate is expressed in percentage and can be applied to the premium and to the benefits in force before indexation. The premiums will nevertheless be increased in function of the different taxes applicable on that matter.

11. REIMBURSEMENTS OF DENTALIA PLUS

11.1. Dispensations

11.1.1. Preventive dental care
We mean by preventive dental care, the examinations of the mouth and teeth, the periodontal examination (DPSI test), the scaling, the prophylactic cleanings, the sealing of fissures and cavities, the consultations at the office of a practitioner with dental surgery degree, a dentist with a certificate of professional competence, a stomatologist or a doctor - dentist.
For these dispensations, the intervention amounts to 100% of the amount charged to the insured person, after deduction of other interventions from other regulations.

11.1.2. Curative dental care
We mean by curative dental care, the dental extraction, the denture maintenance treatment, the mouth radiology, the minor oral surgery and the supplements for urgent technical dispensations.

For these dispensations, the intervention amounts to 50% of the amount charged to the insured person, after deduction of other interventions from other regulations.
The rate reaches 80% if the insured person shows a preventive behaviour.

11.1.3. Periodontology
For periodontology dispensations, the intervention amounts to 50% of the amount charged to the insured person, after deduction of other interventions from other regulations. The rate reaches 80% if the insured person shows a preventive behaviour.

11.1.4. Prostheses and implants
For the supplies related to dentistry and the dispensations foreseen for the installation of those, the intervention amounts to 50% of the amount charged to the insured person, after deduction of other interventions from other regulations.
The rate reaches 80% if the insured person shows a preventive behaviour..

11.1.5. Orthodontics
For orthodontic dispensations, the rate is always fixed to 60% of the amount charged to the insured person, after deduction of other interventions from other regulations.

11.2. Interventions for dispensations realised in Belgium

In order to able the insurance to grant its interventions, all the dispensations must be mentioned, either in the Royal Decree of 1 June 1934 laying down rules for the practice of dentistry, or in the Royal Decree of 9 November 1951 completing the Royal Decree of 1 June 1934 lying down rules for the practice of dentistry.

11.3. Interventions for dispensations abroad

The dispensations are covered on the condition that they are given by registered practitioners on the metropolitan territories of the following bordering countries: France, the Netherlands, Germany and Luxembourg.

11.4. Exceptions

11.4.1. During the first year of membership, the rate of reimbursement of curative and periodontal care is fixed to 80% of the amount charged to the insured person.
11.4.2. The rate of reimbursement of the curative care for insured persons of 6 years and less is fixed to 80% of the amount charged.

12. INTERVENTION LIMITATIONS

1. Annual maximum

The annual maximum begins at the anniversary date of the conclusion of the contract and thus not on 1 January of the calendar year.

The intervention of the insurance is limited to € 350 per insured person during the first year of membership, to € 650 per insured person during the second year of membership and to € 1,250 per insured person during the third year of membership and the following years.

However, as from the third year of membership, the intervention of the insurance will be limited to € 1,050 per insured person for all the orthodontic, periodontal, prostheses and implants dispensations.

If the insured person was covered by a similar dental care insurance, the number of years of membership to this insurance is taken into account to establish the annual maximum of € 350, € 650 or € 1,250 that will be applied.

2. Dispensations not covered by Dentalia Plus

The cover of Dentalia Plus does not intervene for:

- the dispensations of article 14, l) of the appendix to the Royal Decree of 14 September 1984 establishing the nomenclature of health dispensations in the context of the compulsory insurance for Health Care and Sickness Benefits of which the codes are followed by the sign "+".
- the medicines;
- the dispensations of dental care related to aesthetics and cosmetics (bleaching, multiple facets), except prior agreement of the Medical Advisor and if the compulsory insurance for Health Care and Sickness Benefits intervenes.

13. CUMULATION OF COVERS

13.1. The costs are not taken into account if they can be covered by:

- the compulsory insurance for Health Care and Sickness Benefits, as it is organised by the law coordinated on 14 July 1994 and its executing R.D. and by the R.D. of 30 June 1964;
- the legislation related to work accidents (law of 10 April 1971 and executing R.D.) and to professional sicknesses (law of 3 June 1970 and executing R.D.);
- the European regulations n°1408/71, 574/72 and 883/04 or by a multilateral or bilateral convention of social security concluded by Belgium;
- the complementary insurance of the health insurance funds.
- the service "urgent foreign care" of the health insurance funds.

The supplements covered are thus determinated in reference to these interventions. If, for one or another reason, the policy holder is not allowed to request one or more of these interventions, the HIC intervenes in the same way as for an insured person entitled to these interventions.

13.2. When the amounts granted according to another regulation, the ordinary law of another insurance policy are lower than the benefits granted by the HIC, the beneficiary is entitled to the difference at the cost of the HIC. This information must be mentioned on the "Payment request". The intervention of the HIC 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, the HIC will be able to grant its benefits on temporary basis, while waiting compensation of the damage.
In this case, the HIC 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.

14. INTERVENTIONS

14.1. Prescription

The action in payment of dispensations as part of the benefits or any other action resulting from the insurance policy becomes prescribed by 3 years as from the day of the event which opens them, which means the day the covered peril happens.

14.2. Payment of the benefits

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

To have right to the benefits of Dentalia Plus, the policy holder must go and see a registered practitioner. He must submit the payment request form duly completed by the practitioner and himself, as well as a health care certificate filled in in the context of an intervention of the compulsory insurance for Health Care and Sickness Benefits. This certificate is replaced by an invoice of a fee bill if no intervention is foreseen by the compulsory insurance for Health Care and Sickness Benefits.

15. DATA HANDLING

The policy holder declares:

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

The insurer declares that the personal and medical information and data are only collected, handled and used on that purpose and that, regarding to that purpose, the collected information and data are appropriate, relevant and non-abusive.

16. COMMUNICATION MODE AND LANGUAGES

The HIC communicates with its insured persons through several canals:

- by normal post and per e-mail info@hospitalia.be
- by phone at number 02 778 92 11
- via its sections: to obtain the coordinates of the nearest agency: 501: OZ (www.oz.be) - 506: Omnimut (www.omnimut.be) - 509: Partenamut (www.partenamut.be) - 515: Freie Krankenkasse (www.freie.be) - 526: Partena OZV (www.partena-ziekenfonds.be)

Communication language

Every communication is done in French, Dutch, English or German, according to the choice of the policy holder.
All our documents are available in French, Dutch, English or German.

17. COMPLAINTS

For everything that is not stipulated in the insurance policy, the Belgian legal dispositions apply.
Every claim related to the insurance policy can:

- either be sent to the section of which the policy holder depends
- or be sent per e-mail at complaints@mloz.be
- Phone number MLOZ: 02 778 92 11

If we were not able to settle together a claim regarding the services we provide, you can get in touch with the service Ombudsman Assurances which head office is located:
square de Meeûs 35 in 1000 Brussels
Tel. 02 547 58 71 - Fax 02 547 59 75
info@ombudsman.as - www.ombudsman.as

18. CONFLICTS OF INTERESTS POLICY

According to the legislation, the HIC "MLOZ Insurance" developed a "Conflicts of interests policy" (www.dentaliaplus.be).

The HIC means to prevent conflicts of interests and notably conflicts of interests which may harm the interests of one or more of its customers by opposing them to the interests of one of its agents, other customers, the HIC itself or a co-worker of the HIC or its sections. Concerned with conforming itself to its obligations, the HIC elaborated a general frame describing the way it organises itself to manage conflicts of interests through:

- the identification of potential conflicts of interests,
- managing measures for existing or future conflicts of interests,
- information of its customers,
- the training of its co-workers,
- a register of conflicts of interests,
- the realisation and the regular evaluation of this policy.

This summary is for information purpose only. Only the statutes determinate the rights and obligations of the policy holders of the HIC. They are available for consultation at the head quarter of the HIC or on the www.mloz.be.