General Terms and Conditions Hospitalia Ambulatory

as from 1 January 2018

General Terms and Conditions of the HIC voted by the Board of Directors on 28 September 2017
and the Extraordinary General Meeting on 27 October 2017

«MLOZ Insurance» health insurance company 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 Bruxelles** - Belgium (RPM Brussels) – Enterprise number: 422.189.629 Version: 03/02/2018

Hospitalia AMBULATORY

1. DEFINITIONS

1.1. Insurer: «MLOZ Insurance» HEALTH INSURANCE COMPANY, commonly named HOSPITALIA, 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) - 526: Partena OZV (www.partena-ziekenfonds.be), all members of the National Association of independent health insurance funds.

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

1.5. 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.

1.6. Implants and medical devices: everything that is regulatory approved.

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

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

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

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

1.11. Medical questionnaire: this document aims to inform the Medical Counsellor of the HIC 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.

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

2. ACCEPTANCE

To join and remain a member of the cover Hospitalia Ambulatory, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the four sections, outside of exceptions to the statutes (consult Partenamut, Omnimut, Partena or OZ). 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 for Hospitalia Ambulatory.

3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion of the insurance policy

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 the HIC received the duly completed "New affiliation request or request to change a product" and "medical questionnaire" (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 and the medical questionnaire (when it is required) 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.

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

The decision of acceptance, with or without limitation of intervention, is communicated by letter to the candidate policy holder. The letter will detail the amount and the payment date of the first premium, the date 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 the HIC, a 6-month waiting period starting at the joining date has to be accomplished. The HIC 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 the HIC 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 the HIC.
- Waiting period exemption in case of accident
  The HIC 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 the HIC.
- Waiting period exemption for similar hospitalisation insurances
  The HIC intervenes for the new policy holders proving with documents that they were covered until the date of membership to the HIC and since 6 months by a similar hospitalisation insurance of "compensatory" type, which means an insurance of which the reimbursements are made according to the real costs mentioned on the hospitalisation bill.

4.2. Exclusions of the guarantee

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

4.3. End of the guarantee

The insurance guarantee ends with the insurance policy.

5. RIGHT TO BENEFITS

The insurer 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.

The expenditure notes must be introduced within 3 years following the date on which the risk covered by the guarantee occurred. Once this term is over, there is prescription.
The insurance benefits are settled by the beneficiary of the insurance policy.
If the policy holder can pretend to the compensation of damage, the insurer is subrogated to the rights of the policy holder in the extent of his benefits.
The conventions concluded by the policy holder with third parties regarding rights that exist according to the insurance policy or that start in execution of the insurance policy are only opposable to the insurer as from the date on which he approved them.

6. OBLIGATIONS OF THE POLICY HOLDER

The policy holder has to:

- make statements and communications by letter or electronic communication to the head office of the insurer or its sections;
- inform the insurer as soon as possible of the date on which the prior conditions for maintaining the policy are no longer met;
- inform the insurer as soon as possible of any convention covering a similar or identical risk, either totally or partially;
- provide the insurer or its sections with every requested information.

If the policy holder fails to comply with the obligations of the insurance policy or those arising with the execution of the policy, and if after a 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,

Affiliated to the product Hospitalia Ambulatory (9.25% taxes included)			
Before 01/01/1994 or affiliated, after that date, under 46 years old*		After 01/01/1994, between 46 and 49 years old*	
less than 18 years	8,10	from 46 to 49 years	17,91
from 18 to 24 years	8,33	from 50 to 59 years	25,78
from 25 to 49 years	17,07	60 years and over	40,53
from 50 to 59 years	24,56		
60 years and over	38,60		

After 01/01/1994, between 50 and 54 years old*		After 01/01/1994, between 55 and 59 years old*	
49 years**	18,77	from 55 to 59 years	36,84
from 50 to 59 years	27,02	60 years and over	57,90
60 years and over	42,45		

After 01/01/1994, at the age of 60 and over*	
59 years**	41,75
from 60 to 64 years	65,62

* On the starting date of the membership

** Age on 1 January of the membership year

depending on the age

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 years and over at the joining date to Hospitalia Ambulatory.

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 considerated 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.

Underneath, you will find an overview of all the criteria that the HIC MLOZ Insurance uses for its hospitalisation insurances. These criteria depend on the type of product.

The following criteria could be taken into consideration:

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 Hospitalia Ambulatory is 64 years.
- Depending on the chosen product, 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.
- The health condition, and more specifically every pre-existing disorder/state/disease, because the risk of hospitalisation and ambulatory care may increase.
- The insured person's health condition at the time of joining may have an impact on the frequency of the perils and the amount of medical costs. It can also justify that some medical costs related to a pre-existing state/disorder/disease are not covered.

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 or commercial) 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 HOSPITALIA AMBULATORY IN BELGIUM

Outside a period of (day) hospitalisation and if the dispensations or products are prescribed and given in Belgium.

11.1. Medical fees - Consultations - Visits - Technical dispensations

The HIC reimburses: the consultations and visits of the general practitioners and specialists, the medical technical acts, the medical imaging, the radio and radium therapy, the nuclear medicine, the internal medicine, the dermatology and venereology, the physiotherapy, the clinical biology, the emergency supplements, the surgical truss maker, the orthopedics, the optics, the acoustics, the anatomophatology, the genetics, the obstetricians, the special dispensations, the dentistry, the physical therapy, the nursing care, the speech therapy, the radio-isotopes and the cardiac rehabilitation, on the condition that there is an intervention of the compulsory insurance for Health Care and Sickness Benefits up to 50% of the patient share.

The calculation of the interventions is exclusively made on basis of the medical codes of the official nomenclature. The health care providers have the obligation to mention those codes on the health care provided certificates delivered to the patients.

Justificatory documents to provide
For the policy holders affiliated to the same section in compulsory insurance and at the HIC, the interventions are made against delivery of the health care provided certificates, simultaneously with the interventions granted in the context of the sickness and invalidity insurance.
For the other policy holders, the interventions are paid on basis of a copy of the health care provided certificates, with an original proof of the reimbursement by the sickness and invalidity insurance.

11.2. Pharmaceutical costs paid outside the hospital

Pharmaceutical products and magistral preparations are reimbursed up to 50% of the actual cost paid by the patient if they were prescribed by a registered practitioner or dentist.

Do not give right to a reimbursement of the HIC:

- homeopathic, dietary and hygiene medicines;
- products without therapeutic effect sold in pharmacy, such as: food, drinks, soaps, salts, toothpaste, etc.
- phytotherapy.

Justificatory documents to provide
Delivery to the HIC of a "Certificate of pharmaceutical dispensations reimbursable by a complementary insurance" (BVAC) established by the pharmacist, duly filled in by the pharmacist and countersigned by the policy holder or an ambulatory bill of the hospital.

11.3. Prostheses

With or without legal intervention, the HIC intervenes in the following limits and conditions:

11.3.1. Dental prostheses delivered outside of the hospital.

The prostheses are reimbursed in the following limits:
a) Full prosthesis

- superior or inferior: € 500 maximum per prosthesis, with a renewal term of 5 years.

b) Partial prosthesis

- per tooth: € 25 maximum;
- per base plat: € 50 maximum;
- per hook: € 20 maximum.

The intervention of the HIC is limited to € 250 per civil year.

c) Other dental prostheses
Such as bridges, pivot teeth, crowns, addition of teeth to an existing prosthesis: € 250 maximum per civil year.

11.3.2. Ophtalmological prostheses
The glasses, lenses, intraocular lenses and surgical corrections (corrections of the eyesight - keratotomy, laser therapies), with the exclusion of frames and sunglasses, are reimbursed up to € 250 per civil year.

11.3.3. Others
With or without legal intervention, the intervention of the Health Insurance Company stays limited to € 500 maximum per civil year for hearing aid, orthopedic soles, wigs, breast prostheses, splints (in other words: medical orthopedic brace on prescription by a specialist) and dental implants, without purely aesthetic purpose.

Justificatory documents to provide for prostheses
Delivery to the HIC of the Hospitalia form named "Prostheses - Payment request" duly filled in by the health care provider and countersigned by the policy holder. For ophthalmologic prostheses: also enclose the original bill of the optician.

For other prostheses: also enclose the original bill of the prosthetist and the medical prescription for hearing aid, orthopedic soles, wigs and breast prostheses.

11.4. Cumulation of reimbursements

The reimbursements foreseen by Hospitalia Ambulatory may be cumulated with the reimbursements foreseen by HOSPITALIA and HOSPITALIA PLUS for pre/post-hospitalisation care and the serious illnesses guarantee. If applicable, the reimbursement may in no case exceed the amount of the covered guarantee and a fortiori the actual cost charged to the policy holder.

12. INTERVENTION LIMITATIONS

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

For Hospitalia Ambulatory, the medical questionnaire aims to possibly limit the intervention by refusing the reimbursement of ambulatory dispensations related to this pre-existing disease, disorder or state.

During the first 24 months of membership to the product, the Medical Counsellor can decide this limitation, invoking a non-intentional omission or inaccuracy related to the health condition on the medical questionnaire.

This limitation is fixed for a minimum duration of 5 years at the end of which the policy holder who wants it can ask the reassessment of his/her situation on basis of a new medical file.

2. Dispensations not covered by HOSPITALIA

The HIC does not intervene:

- for medical, pharmaceutical and hospital dispensations related to beauty care, unless the Medical Counsellor gave his prior agreement and if the compulsory insurance intervenes;
- 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 the HIC.

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 organisations;
- the service "urgent foreign care" of the health insurance organisations.

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 on the same way as for a policy holder 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 policy holder 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. Medical control

The benefits are only granted on the condition that the HIC 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.

14.3. Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums. 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.
To obtain the benefits foreseen by Hospitalia Ambulatory the policy holder will provide the justificatory documents as described in the section "Reimbursements of Hospitalia Ambulatory".
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.

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) - 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.hospitalia.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 website www.mloz.be.