General Terms and Conditions Hospitalia Plus

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" 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.
Registered office: **route de Lennik 788A, 1070 Brussels** - Belgium (RPM Brussels) - www.mloz.be - Enterprise number: 422.189.629. - 20/12/2017

We mean by Hospitalia Plus, the cumulation of the products Hospitalia and Hospitalia Plus.

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/750/011.

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. 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. 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.

1.5. Day hospitalisation:
One-day hospitalisation without night:

- non-surgical day hospitalisation: billing of the dispensation «urgent care or intravenous infusion» (= mini package until 31/12/2013), maxi package, packages day hospitalisation (groups 1 to 7 included), packages «chronic pain», «plaster room» and «portacath manipulation».
- surgical day hospitalisation: dispensations from list A, enclosed to RD of 25/04/2002.

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

1.7. 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.

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

1.9. 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.

1.10. 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.

1.11. Hospitalisation bill and fee bill: the documents stipulated in appendix 37 and 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.

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

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

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

1.15. 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.

1.16. 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. ADMISSION

To join and remain a member of the cover Hospitalia Plus, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the five sections, outside of exceptions to the statutes (consult these sections: OZ, Omnimut, Partenamut, Freie Krankenkasse, Partena). 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 65 years, 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.

3. CONCLUSION, DURATION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion and duration 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. This one month notice is not mandatory in case of a change of hospitalisation cover within Hospitalia.
- 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

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 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 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 Hospitalia and Hospitalia Plus (10 and 19,25% taxes included)

It is only possible to subscribe to Hospitalia Plus as a complement of Hospitalia

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	5,94	from 46 to 49 years	20,41
from 18 to 24 years	7,48	from 50 to 59 years	25,07
from 25 to 49 years	19,44	60 years and over	44,89
from 50 to 59 years	23,87		
60 years and over	42,77		

After 01/01/1994, from 50 to 54 years old*		After 01/01/1994, from 55 to 59 years old*	
49 years**	21,39	from 55 to 59 years	35,81
from 50 to 59 years	26,25	60 years and over	64,15
60 years and over	47,02		

After 01/01/1994, at the age of 60 and over*	
59 years**	40,58
from 60 to 65 years	72,70

* 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 65 years at the joining date to Hospitalia Plus.

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 HOSPITALISATION INSURANCES

At the moment of affiliation to an insurance policy, the insurance companies apply segmentation criteria that influence the access to the insurance product, the determination of the premiums and the scope of the guarantee.

Underneath, you will find an overview of all the criteria that 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 Plus is 65 years. There is no age limit for Hospitalia.
- 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, except for the application of the pre-existing state (pregnancy).

If the member was previously covered by a similar commercial insurance, 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.

For members who were previously covered by a health hospitalization insurance, this restriction will only apply if she delivers within the first 9 months of affiliation, thus accumulating the insured period with the previous insurance and Hospitalia without interruption.

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. COMBINED REIMBURSEMENTS HOSPITALIA AND HOSPITALIA PLUS

11.1. Interventions for hospitalisations in Belgium

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

19	(n)	non-intensive neonatal care unit
21	(C)	diagnostic and surgical treatment unit
22	(D)	diagnostic and medical treatment unit
23	(E)	paediatric unit
24	(H)	general hospitalisation unit
25	(L)	contagious illnesses unit
26	(M)	maternity unit
27	(N)	intensive neonatal care unit
29		burns treatment unit
34	(K)	infantile neuropsychiatric unit (day and night)
37	(A)	neuropsychiatric unit (day and night)
41	(T)	psychiatric unit (day and night)
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 hospitalisation bill except for the 3 maximums 2.4, 2.5 and 2.9 hereunder.

2. In case of hospitalisation in private room, reimbursement:

2.1. of all the room supplements up to € 125 per day
2.2. of the accommodation cost of the father or the mother in the room of his/her hospitalised child, under 19 years old.
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 of the health insurance company 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 300 % of the convention rate.
2.9. of the prostheses, implants, non-implantable medical devices and other supplies:

- prostheses, implants and non-implantable 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 non-implantable medical device;
- prostheses, implants and non-implantable 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 non-implantable medical device. It is possible for the medical counsellor of the health insurance company to deviate from this maximum in serious medical situations, for evidence-based treatments on the basis of the insured's medical file.
In case of costs of € 10.000 or more charged to the patient, € 10.000 can be reimbursed maximum once a year.

- costs legally charged to the patient for other supplies, up to 300 % 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 € 12 per hospitalisation day.
2.11. of the compression stockings and/or compression sleeves.
2.12. of the fees that are not reimbursed by the compulsory insurance, up to € 1.000 per hospitalisation.
2.13. of the costs for robot-assisted surgery, up to € 500 per civil year.
2.14. of the costs for vitro-fertilisation, up to € 500 per civil year.
2.15. There is a franchise of € 150 per hospitalisation for a stay of at least one night in a private room in a hospital charging more than 200% fee supplements compared to the convention rate. The amount of this franchise of € 150 is deducted from the total of the reimbursements.

There is no franchise for the hospitals that committed in their annual declaration to not to charge more than 200% fee supplements for the entire civil year following the aforesaid declaration.

The list of the hospitals applying the franchise is drawn up each year and is effective as from 1st January.

The new list will be applicable for all insurance cases with a stay that begins on or after the date on which the new list enters into force.

The 2018 list of the hospitals charging more than 200% is the following:

- C.H. EPICURA (RHMS) - Ath, Hornu, Baudour
- C.H.U DE TIVOLI - La Louvière
- C.H.U. - J. BORDET - Brussels
- C.H.U. AMBROISE PARE - Mons
- C.M.P. LA RAMEE - Brussels
- CHIREC (Edith Cavell, Basilique, Parc Léopold, Ste-Anne/St-Remi, Braine l'Alleud-Waterloo and Delta) - Bruxelles and Braine l'Alleud
- CLINIQUE NOTRE DAME DE GRACE - Charleroi (Gosselies)
- CLINIQUE SAINT JEAN - Brussels
- CLINIQUES DE L' EUROPE - Brussels
- CLINIQUES UNIVERSITAIRES ST-LUC - Brussels
- HOPITAL BRUGMANN - Brussels
- HOPITAUX D'IRIS SUD (Baron Lambert, Etterbeek-Ixelles, Bracops and Molière) - Brussels
- CENTRE DE SANTE DES FAGNES - Chimay
- C.H.C / CLINIQUE SAINT-VINCENT - Liège (Rocourt)
- C.H.C / CLINIQUE SAINT-JOSEPH - Liège
- C.H.C / CLINIQUE DE L'ESPERANCE - Montegnée
- C.H.C / CLINIQUE NOTRE-DAME - Hermalle/Argenteau
- C.H.C / CLINIQUE NOTRE-DAME - Waremme
- C.H.C / CLINIQUE SAINTE-ELISABETH - Verviers (Heusy)

This list is available on www.hopitauxfranchise.be

3. Intervention of € 7 per day for the insured persons who stayed in a **hospital hospitality house or a hospital hotel**, after the hospitalisation reimbursed by the HIC.

4. Intervention in the **neonatal care** after the hospitalisation, up to € 20 per day during maximum 7 days, as from the day after the hospitalization end date.

5. In case of hospitalisation or day hospitalisation, intervention in the actual costs incurred for the **emergency transportation** (service 100/112) to the hospital, up to € 500 per civil year, after any other intervention.

6. **Reimbursement of the legal deposits** paid to the hospital, on presentation of a justificatory document of the hospital proving the payment of such deposits, on the condition that the policy holder can benefit from the interventions of the HIC without limitations for pre-existing diseases, disorders or states. If it turns out afterwards that the hospitalisation can't be covered or if the amount of the deposit is higher than the intervention of the HIC or if the policy holder doesn't provide his bill, the unfounded amounts will be recovered.

Limitations in case of hospitalisation in units 34, 37 and 41

The intervention in units 34, 37 and 41 is limited to 40 days per year.

11.2. Interventions for day hospitalisations in Belgium

Same reimbursement as for hospitalisations without franchise (point 11.1), except for the reimbursement in private room of the hospitalisation costs limited to maximum € 80 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 (30 days before and 90 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 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. Warranty serious illnesses

11.5.1. Interventions

Intervention for health care that was given without hospitalisation for the following 31 serious illnesses: cancer, leukaemia, Parkinson's disease, Hodgkin's disease, Alzheimer's disease, AIDS, tuberculosis, multiple sclerosis, amyotrophic lateral sclerosis, cerebro-spinal meningitis, poliomyelitis, progressive muscular dystrophy, encephalitis, tetanus, mucoviscidosis, Crohn's disease, brucellosis, cirrhosis of the liver following a hepatitis, scleroderma with organ damage, diabetes type I, ulcerative colitis, Pompe disease, malaria, exanthematic typhus, typhoid and paratyphoid disorders, diphtheria, cholera, anthrax, Creutzfeldt-Jakob disease, kidney insufficiency that needs dialysis, organ transplantation except skin grafts and cornea transplantation after the agreement of the Medical Advisor, and up to € 7.000 per year.
The health care must be supported in Belgium, medically needed, prescribed by a practitioner, mentioned in the nomenclature, in direct relation with the serious illness and provided during the period during which the guarantee was granted, as it is granted by the Medical Counsellor.
The warranty serious illnesses is only granted if it had not been diagnosed before 01/01/2004 (date of the entry into force of this warranty) nor before the affiliation.

This warranty has the following benefits:
1. 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 special dispensations, the physical therapy, the nursing care, the speech therapy, the radio-isotopes and the cardiac rehabilitation are reimbursed up to the legal patient share and fee supplements, limited to 100% of the convention rate.
2. The allopathic pharmaceutical products, magistral preparations and wigs (hair prosthesis) on prescription are reimbursed up to the actual price paid by the patient if the compulsory insurance intervenes.
3. The medical material rental is reimbursed, after a possible intervention of the complementary services of the health insurance funds.

11.5.2. Intervention conditions

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

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

The decision of acceptance or refusal to grant the guarantee is communicated by letter to the insured person, and mentioning the period covered by the warranty serious illnesses.

11.6. 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 the HIC 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 30 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.

By pre-hospitalisation care, we mean consultations and visits 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 - 427534, the radio-isotopes which have been done in ambulatory care during the 30 days before the hospitalisation. If the 30 days period before the hospitalisation overlaps with a post-hospital care period, the insured person is entitled to the most attractive reimbursement.

Exclusion: pre-hospitalisation care is excluded before a hospitalisation in units 30 (geriatric), 34, 37 and 41 (psychiatric) and units 61 to 66 (specialisations), except for ambulatory care at the emergency unit.

11.7. Post-hospitalisation interventions

11.7.1. 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 the HIC granted an intervention for the hospitalisation concerned.

The care must be attested by a receipt.

The intervention of HOSPITALIA PLUS aims:
- the complete reimbursement of the user fees in the cost of pharmaceutical products and magistral preparations reimbursable by the sickness insurance, if they were prescribed by a practitioner and if they were delivered within 90 days after the hospitalisation concerned;
- the coverage of the legal patient share and fee supplements, limited to 100% of the convention rate and related to the post-hospitalisation care (the dispensations must have been given within 90 days after the hospitalisation).

By post-hospitalisation care, we mean 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 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 which have been done in ambulatory care during the 90 days after 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 30 (geriatric), 34, 37 and 41 (psychiatric) and units 61 to 66 (specialisations).

11.7.2. 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

The HIC offers the hereunder mentioned assistance services to the policy holders HOSPITALIA/HOSPITALIA PLUS entitled to the intervention of the HIC in the context of a (day) hospitalisation in Belgium and who ended their waiting period.

12.1. Nursing after a day hospitalisation

The HIC organises, within 24 hours, and supports the costs of nursing for the single policy holder who is admitted in day hospitalisation during the night that directly follows this day hospitalisation, for maximum 12 hours, between 7 pm and 8 am.

To benefit from this service, the single policy holder must:
- provide the nurse with a medical attestation from the attending practitioner stipulating that a day hospitalisation took place and that nursing, without care, is required;
- be in possession of a phone.

12.2. Child care at home

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

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

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

3) In case of delivery at home reimbursed by the HIC, the HIC intervenes in the same conditions during maximum 3 working days after the delivery at home and the day of the delivery at home.

This care aims to provide a watchful presence for maximum 3 children and to take care of the duties normally realised by the mother or the father, with the exclusion of household duties and transportation between school and home.

Those services are provided on simple phone call at the central support unit of the HIC, reachable 24/7, at number: 02 778 92 93.

13. INTERVENTION LIMITATIONS

13.1. No annual maximum

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

The Medical Counsellor of the HIC 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 6 months of membership, no reimbursement is foreseen. However, the hospitalisation costs are covered, with the exclusion of the room and fee supplements charged in case of admission in private room and if, at the time of the delivery, the mother was exempted from waiting period;
- for deliveries during the 7th, the 8th and the 9th month of membership, the hospitalisation costs are covered, with the exclusion of room and fee supplements charged in case of admission in private room.

The notion of pre-existing state related to the pregnancy will not be applied:
- to deliveries as from the 10th month of membership;
- to deliveries of insured women who were previously covered by a similar health insurance fund hospitalisation insurance or offering a larger coverage.

13.3. Dispensations not covered by Hospitalia

The HIC does not intervene:
- for personal care products, cosmetic products, food products, wines, mineral waters, non-essential expenditures (phone, television, flowers, fridge, etc.), except in the context of hospitalisations in double or ward room in Belgium, as well as for day hospitalisations. Overtaxed phone calls remain nevertheless excluded. However, HOSPITALIA doesn't reimburse the costs for phone, television, flowers and drinks charged in the context of a hospitalisation of at least one night;
- for medical, pharmaceutical and hospital dispensations related to beauty care, unless the Medical Advisor gave his prior agreement and if the compulsory insurance intervenes;
- 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 PLUS;
- 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;
- 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. 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 complemantary 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 an insured person 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 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.

15. INTERVENTIONS

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 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.

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 PLUS the policy holder will fill in the form "Payment request" delivered by the HIC 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 we mean the original extract of the hospitalisation bill. The HIC can request any complementary document deemed necessary.

To obtain the benefits of the pre- and post-hospitalisation care, the policy holder will provide all the original bills and the statement of the reimbursement of the health care provided certificates by 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.

16. 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.

17. 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 your section: 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.

18. COMPLAINTS

For everything that is not stipulated in the insurance policy, the Belgian legal dispositions apply.

Every complaint 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

19. 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.