General Terms and Conditions Hospitalia Continuity
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-CDZ no 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: r**oute de Lennik 788A, 1070 Bruxelles – Belgium** - (RPM Bruxelles)
Enterprise number: 422.189.629 - Version: 19/12/2017

Hospitalia CONTINUITY

END OF THE INSURANCE

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

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

1. DEFINITIONS

1.1. Insurer: "MLOZ Insurance" HEALTH INSURANCE COMPANY, 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-CDZ 750/01.

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

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

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

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

1.9. Medical questionnaire: this document aims to inform the Medical Advisor 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 during the possible transition from Hospitalia Continuity to Hospitalia or Hospitalia Plus.

1.10. 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 HIC, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the 5 above-mentioned sections, outside of exceptions to the statutes (consult these sections). Besides, the policy holder must be covered by a group hospitalisation insurance (provided by the employer or another group) and provide proof of it or, failing this, a sworn statement to subscribe to Hospitalia Continuity. The age limit is 64 years.

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 for a possible future transfer to Hospitalia or Hospitalia Plus) and the general terms and conditions with additional

clauses.

The insurance policy starts the first day of the month following the month during which 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 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 Advisor asks for further information before ruling on the membership application, the policy holder has 45 days to provide an answer.

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

The decision of acceptance, with or without limitation of intervention, is communicated by letter to the candidate policy holder. The letter will detail the amount and the payment date of the first premium, the date acceptance of the membership and the starting date of the membership, the duration of the waiting period, the annuity duration of the membership and the insurance product provided.

3.2. Ending of the insurance policy

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

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

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

In addition, the insurance policy ends in case of:

- cancellation by the policy holder, according to the terms stipulated in the law of 4 April 2014, with a prior notice of at least one month starting the first day of the month following the sending of the registered letter, 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 Advisor of the HIC..
- Waiting period exemption for similar continuity hospitalisation insurances
  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 "continuity" type, which means a waiting insurance which opens the right to be transferred to an individual hospitalisation policy.

4.2. Exclusions of the guarantee

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

Are not covered the hospitalisation 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. RIGHTS 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 arisen by the examination of the right to benefits. The insurer refrains from any measure which, regarding to the examination of the right to benefits is inappropriate, irrelevant or abusive.

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

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

If the policy holder can pretend to the compensation of damage, the insurer is subrogated to the rights of the policy holder in the extent of his benefits.

The conventions concluded by the policy holder with third parties regarding rights that exist according to the insurance policy or that start in execution of the insurance policy are only opposable to the insurer as from the date on which he approved them.

6. OBLIGATIONS OF THE POLICY HOLDER

The policy holder has to:

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

If the policy holder fails to comply with the obligations of the insurance policy or those arising with the execution of the policy, and if after a claim, this breach causes an injury, the insurer can reduce his benefits for the relevant amount.

7. PREMIUMS

Monthly amounts in € on 01/01/2018, including all taxes, depending on the age at the time of joining Hospitalia Continuity (10% taxes included).

Affiliated to the product Hospitatlia Continuity Depending on age on joining date:			
less than 18 years	2,76	from 40 to 45 years	6,51
from 18 to 24 years	3,40	from 46 to 49 years	7,28
from 25 to 29 years	4,30	from 50 to 54 years	8,17
from 30 to 34 years	5,13	from 55 to 59 years	15,49
from 35 to 39 years	5,89	dfrom 60 to 64 years	20,97

Premiums are calculated on the basis of the age at the time of joining Hospitalia Continuity.
In case of transfer from Hospitalia or Hospitalia Plus to Hospitalia Continuity, premium to Hospitalia Continuity will correspond to the premium for the age of joining one of these two products.

8. TERMS OF PAYMENT OF THE PREMIUM

The policy holder has to pay his premium on due date, following the agreed periodicity (quarter, semester, year).

The premium can be asked and 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 of the insured person 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 Continuity 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, except for the application of the pre-existing state (pregnancy).

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. REIMBURSMENTS OF HOSPITALIA CONTINUITY

The HIC intervenes in case of:

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

for a maximum of € 50 per hospitalisation day, up to the outstanding

balance charged to the insured person after intervention of the employer's hospitalisation insurance. The reimbursement is calculated on basis of the detailed invoice of the insurance intervention.

12. INTERVENTION LIMITATIONS

12.1. Daily maximum

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

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

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

During the first 24 months of membership to the product, the Medical Advisor can decide this limitation (exclusion of the covering of supplement in case of hospitalisation in a private room) invoking a non-intentional omission or inaccuracy related to the health condition on the medical questionnaire.

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

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

13. INTERVENTIONS

13.1. Prescription

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

13.2. Medical control

The benefits are only granted on the condition that the HIC has the right to ask the Medical Advisor at any time to control the health condition of the insured person and the validity of the dispensations.

13.3. Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums.
To obtain the benefits foreseen by Hospitalia Continuity the policy holder will fill in the form "Payment request" delivered by the HIC and will provide it with the original detailed invoice of the group insurer or a copy of it. The HIC can request any complementary document deemed necessary.

14. 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.

15. COMMUNICATION MODE AND LANGUAGES

The HIC communicates with its insured persons through several canals:

- by normal post and per e-mail via 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.

16. 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 by e-mail at jean.vigneron@mloz.be
- or be introduced by phone to MLOZ: 02 778 92 11

If we were not able to settle together a complaint 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

17. 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,
- training of its co-workers,
- a register of conflicts of interests,
- the realisation and the regular evaluation of this policy.

This overview is purely for information. Only the statutes determine the rights and obligations of the policy holders of the HIC. They are available at the head office of the HIC and on the site www.hospitalia.be.