# General terms and conditions Medicalia

## as from 1 January 2018

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

**MLOZ Insurance** is the insurance company of the Independent Health Insurance Funds (OZ - Omnimut - Partenamut - Freie Krankenkasse - Partena Ziekenfonds) recognised under the CDZ code number 750/01 for the branches 2 and 18, at the Control office of health insurance funds and national associations - Sterrekundelaan 1, 1210 Brussel
Head office: **Lenniksebaan 788A, 1070 Brussel** - België (RPR Brussel) - www.mloz.be –
Company number: 422.189.629 - 12/02/2018

### 1. DEFINITIONS

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

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

**1.3. Sections:** the sections of the HIC are the intermediaries which offer the insurance products: 501 : OZ (www.oz.be) - 506 : Omnimut (www.omnimut.be) - 509 : Partenamut (www.partenamut.be) - 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. 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.

**1.6. Hospitalisation bill and fee bill:** the documents stipulated in article 10, § 1 of the regulation of 28 July 2003 implementing article 22, 11° of the law on the compulsory insurance for Health Care and Sickness Benefits, coordinated on 14 July 1994.

**1.7. Receipt:** the document used by the health insurance fund outside the third party payer system.

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

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

### 2. ACCEPTANCE

To join and remain a member of the cover Medicalia, the policy holder has to be affiliated to the compulsory insurance and to the complementary services under one of the four above-mentioned sections, outside of exceptions to the statutes (consult these sections). The policy holder has to affiliate his/her dependants within the meaning of the regulation on the compulsory insurance for Health Care and Sickness Benefits, except when the partner or cohabiting partner or the children are already covered by a similar insurance of the "actual costs" type. The cancellation or deregistration of a member implicitly leads to that of all the people whose affiliation is compulsory. An insured person can only be affiliated to one ambulatory insurance product. A member affiliated to Hospitalia Ambulatory cannot affiliate to Medicalia and conversely. There is no age limit to benefit from the advantages of Medicalia.

### 3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

#### 3.1. Conclusion of the insurance policy

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

The insurance policy starts the first day of the month following the month during which the HIC received the duly completed "membership application or request to change a product" (internal date or scanning as proof), if the HIC receives the first premium for each insured person at the latest on the last day of the third month following the joining date.

The membership of a newborn or an adopted child under 3 years old, not exempted from waiting period, starts the first day of the month following the birth or adoption, under the condition that the HIC receives the membership application before the end of the third month following the birth or adoption and that the HIC receives the first premium at the latest the last day of the third month following the joining date.

The spontaneous payment of a premium without being requested to do so is not worth membership. If the above-mentioned 3-month term is not respected, this premium will be reimbursed and a new membership procedure will have to be started.

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

#### 3.2. Ending of the insurance policy

The insurance policy is a life policy. It however ends in case of:

- cancellation by the policy holder, according to the terms stipulated in the law of 4 April 2014, with a prior notice of at least one month starting the first day of the month following the sending of the registered letter, the delivery of the writ or the sending of the cancellation letter against deposit receipt, addressed either directly to the HIC or to one of the above-mentioned sections. This prior notice is not required in case of a change of ambulatory cover within MLOZ Insurance.
- 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 Medicalia, a 6-month waiting period starting at the joining date has to be accomplished. There's a waiting period of 12 months for the birth package.
Medicalia does not intervene for 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 Medicalia before the birth or adoption, the newborn is covered as from its birth and the adopted child under three years old as from the date of its adoption, against delivery of a copy of the birth or adoption certificate before the end of the third month following its birth or adoption and provided that the first premium is received at the latest 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
Medicalia intervenes for every ambulatory care dispensation resulting from an accident which has caused traumatic injuries for which the treatment is of such a nature that it is covered by the dispositions of this document if the accident occurred after the joining date. This intervention is submitted to the positive advice of the Medical Advisor of the HIC.

• Waiting period exemption for similar ambulatory care insurances The new policy holders proving with documents that they were covered until the date of joining Medicalia by a similar ambulatory care insurance will be exempted from the 6-month or 12-month waiting periods.

### 4.2. Exclusions of the guarantee

Are not covered the care costs related to an illness or an accident:
- resulting from acts of war, with the exception of 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 behavior 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, with the exception of 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, depending on the age**

| Affiliated to the product Medicalia | |
|---|---|
| from 0 to 6 years | Free |
| from 7 to 17 years | 13.00 |
| from 18 to 29 years | 14.50 |
| from 30 to 44 years | 15.00 |
| from 45 to 59 years | 23.00 |
| 60 years and older | 39.00 |

## 8. TERMS OF PAYMENT OF THE PREMIUM

The policy holder has to pay his premium on due date, following the agreed periodicity (quarter, semester, year).
The premium can be asked and paid in advance. It is sent to the last known address of the policy holder. Is considered as in advance, any premium received before the first day of the first month of the quarter, semester or year, or, in case of direct debit, within the first 10 days of the month, quarter, semester or year.
The policy holder who did not pay his premium before the first day of the quarter, receives a formal notification by registered letter demanding payment of the premium within 15 days as from the day after the delivery of the registered letter at the post office. This formal notification informs him of the suspension of the guarantee in case of non-payment within the stated term. It starts a 45-day term at the end of which the membership will be cancelled automatically. The policy holder who did not pay his premium at the end of a quarter will automatically be charged for a fixed allowance of € 15 as reminder costs.
The disaffiliated policy holder will only be able to reaffiliate if he pays all overdue premiums and will have to complete a new waiting period to pretend to the benefits again.

## 9. SEGMENTATION

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

These criteria depend on the type of product.

The following segmentation criteria could be taken into consideration for Medicalia.

At the beginning of the policy:

- The age of the insured person because, according to statistic data, the probabilities of sickness increase with the age. The age of the insured 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. 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 increase with the 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 BY MEDICALIA

Intervention for ambulatory care that is prescribed and given in Belgium.

### 11.1. Alternative treatments

Treatment performed by speech therapists, occupational therapists, dieticians, psychologists, osteopaths, chiropractors, homeopaths, acupuncturists and remedial educationalists, as far as they are approved by the NIHDI or are on the lists which are published and used by the HIC. The intervention of the HIC aims at the dispensations for which the compulsory insurance does not intervene.

Under the terms of the Medicalia cover, the HIC reimburses 75 % of the bill amount charged to the insured (after deduction of the intervention of the complementary insurance).

*Justificatory documents to provide*

*To benefit from this intervention, the insured must submit a duly completed and signed "Medicalia payment request form", with the original bill of the treatment. The intervention will be calculated based on the original bill.*

### 11.2. Legal patient shares

- Consultations, visits, advice and technical dispensations of all general practitioners and specialists: dispensations of nomenclature: article 2
- Medical technical acts: dispensations of nomenclature: article 3
- Physical therapy: dispensations of nomenclature: article 7
- Nursing: dispensations of nomenclature: article 8
- Midwives: dispensations of nomenclature: article 9
- Special dispensations: dispensations of nomenclature: article 11
- Medical imaging: dispensations of nomenclature: articles 17, 17bis, 17ter, 17quater
- Radio and radium therapy, nuclear medicine: dispensations of nomenclature: article 18
- Internal medicine: dispensations of nomenclature: article 20
- Dermatology and venereology: dispensations of nomenclature: article 21
- Physiotherapy: dispensations of nomenclature: article 22
- Emergency supplements: dispensations of nomenclature: article 26
- Surgical truss maker: dispensations of nomenclature: article 27
- Orthopedics: dispensations of nomenclature: article 29
- Speech therapy: dispensations of nomenclature: article 36.

If there is an intervention of the compulsory insurance, the HIC offers an additional intervention.

The calculation 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.

Under the terms of the Medicalia cover, the HIC reimburses 75 % of the bill amount charged to the insured (after deduction of the intervention of the complementary insurance).

*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 compulsory insurance for health care and sickness benefits.*

*For the other insured, 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.*

### 11.3. Equipment

#### 11.3.1. Eye care

Includes corrective lenses, contact lenses, eye laser therapy and keratotomy prescribed by an approved ophthalmologist, charged and delivered within 12 months after the prescription date.

There is no intervention for frames of corrective glasses, or frames or lenses of sunglasses (with or without correction).

#### 11.3.2. Hearing aids

If prescribed by an approved otorhinolaryngologist, and charged and delivered by an approved audiologist within 12 months after the prescription date:

- hearing aids, except for cochlear implants and bone conduction devices (implant and (external) sound processor).

Batteries and other accessories for hearing aids are not compensated.

Under the terms of the Medicalia cover and as far as the conditions are met, the HIC reimburses 75 % of the bill amount charged to the insured (after deduction of the intervention of the compulsory and/of complementary insurance) for corrective lenses, contact lenses, laser treatment and keratotomy or hearing aids.

*Justificatory documents to provide*

*With or without legal intervention, the HIC offers an (additional) intervention based on a duly completed and signed "Medicalia payment request form", together with:*

- *either the prescription of the approved ophthalmologist or otorhinolaryngologist and the original and detailed bill of the approved optician or audiologist*
- *or the standard documents as provided by the compulsory insurance, and the original and detailed bill of the approved optician or audiologist.*

*The intervention will be calculated based on the justificatory documents.*

### 11.4. Birth package

In case of birth, the HIC offers a fixed intervention if the child is affiliated to Medicalia at the time of birth.

The intervention is granted on production of the birth certificate, which is delivered by the competent authorities.

This fixed intervention of € 250 per child is paid once to the child.

### 11.5. Cumulation of reimbursements

The reimbursements by Medicalia may be cumulated with the reimbursements 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.

The reimbursements by Medicalia may not be cumulated with the reimbursements by Hospitalia Ambulatory.

## 12. INTERVENTION LIMITATIONS

### 12.1. Yearly maximums

The intervention for dispensations is limited to € 1.500 per insured and per year of affiliation.

The limit for interventions granted for alternative therapies is of € 600 per insured per year of affiliation. The limit for interventions granted for material is also of € 600 per insured per year of affiliation.

### 12.2. Dispensations not covered by Medicalia

Under the terms of the Medicalia cover, the HIC does not intervene for:

- the costs of which billing is illegal/not allowed according to the Belgian law
- the medicines
- treatment performed by speech therapists, occupational therapists, dieticians, psychologists, osteopaths, chiropractors, homeopaths, acupuncturists and remedial educationalists that are not approved by the NIHDI or are not on the lists which are published and used by the HIC and its divisions
- for medical, pharmaceutical and hospital dispensations related to beauty care, and/or that are not necessary from a medical point of view
- general dental care (including all general dental care, dental implants, and dental prosthesis)
- the dispensations of "rejuvenation" type.

## 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 organized 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 multi-lateral or bilateral convention of social security concluded by Belgium;
- the complementary insurance of the health insurance organizations.
- the service "urgent foreign care" of the health insurance organizations.

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 or 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 insured.
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 of the HIC.

## 14. INTERVENTIONS

### 14.1. Prescription

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

### 14.2. Payment of the benefits

To be entitled to reimbursements the policy holder must have paid his premiums and provide the justificatory documents as described in the section "Reimbursements of Medicalia".
To have right to the benefits of Medicalia, the policy holder must go and see a registered practitioner.

## 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 by e-mail at 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) - 526: Partena OZV (www.partena-ziekenfonds.be)

### Communication language

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

## 17. 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 on which the policy holder depends
- or be sent by e-mail at complaints@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

## 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 organizes 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 realization 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 office of the HIC or on the website www.mloz.be.