General Terms and Conditions Forfait H

as from 1 January 2025

General Terms and Conditions Forfait H of the health insurance company MLOZ Insurance voted by the Board of Directors on 29 May and 18 September 2024 and the Extraordinary General Meeting on 19 June and 16 October 2024

MLOZ Insurance is the health insurance company of the Independent Health Insurance Funds (Helan Onafhankelijk ziekenfonds - Partenamut - Freie Krankenkasse). Approved under code OCM 750/01 for branches 2 and 18 by the Control Office of health insurance funds and national associations.
Head office: Route de Lennik 788A, 1070 Brussels - Belgium (RPR Brussels)
www.mloz.be - Enterprise number: 422.189.629. - 01/01/2025

Forfait H

1. DEFINITIONS

1.1. Insurer: "MLOZ Insurance" HEALTH INSURANCE COMPANY, insurance company approved by the Control Office of health insurance funds and national associations, 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 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. Insured: By insured we mean the person who bears the risk of the insured event occurring and who is the beneficiary of the insurance policy.

1.4. Sections: the sections of MLOZ Insurance are the intermediaries which offer the insurance products: 509 : Partenamut (www.partenamut.be) - 526: Helan Onafhankelijk ziekenfonds (www.helan.be), all members of the National Association of independent health insurance funds.

1.5. 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.

1.6. Day hospitalisation:
Day hospitalisation should exclusively be understood as:

- an admission and stay in a recognised hospital without overnight stay in which the patient undergoes one or more plannable interventions. Such interventions require established procedures for the selection of patients, safety, quality supervision, continuity, post-hospital care, writing of reports and cooperation with the various medical-technical services under the supervision and direction of a medical specialist connected to the hospital with adequate supervision and administration of care.
- a function 'day surgery' acknowledged on the basis of stipulations in the RD of 25 November 1997 defining the norms that the function 'day surgery' should meet in order to be recognised.

The provisions of the National Agreement between hospitals and health insurance organisations, in force on the date of dispensation, will be applied. MLOZ Insurance assumes that the hospital invoice reflects the correct application of the Agreement.

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

1.8. Patient invoice, fee invoice and invoice for ambulatory care in the hospital: the documents as stipulated in appendix 37, appendix 38 and appendix 37bis respectively 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.

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

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

1.11. Attempted suicide: it is an unusual behaviour, not resulting in death, that the person initiates and adopts expecting or risking death or physical damage in order to obtain desired changes.

2. ADMISSION

2.1. To join and remain a member of the cover Forfait H, the policy holder has to be affiliated to the compulsory insurance as well as to the complementary services under one of the two sections mentioned above. However, there are some statutory exceptions (cf those sections: Partenamut, and Helan Onafhankelijk ziekenfonds).
There is no age limit for Forfait H.
2.2. Impact on your affiliation to MLOZ Insurance if the contributions to the complementary services of your health insurance fund are not paid
It is important that all contributions for the complementary services of your health insurance fund are always paid.
If your payment is not in order, this can have serious consequences for your affiliation to MLOZ Insurance and for the covers of the insurances you contracted.
2.2.1. Consequences for the affiliation to MLOZ Insurance
You can only join MLOZ Insurance if you have not lost your rights to the complementary services of your health insurance fund due to non-payment of contributions for these services for a period of 24 consecutive months.
2.2.2. Consequences for maintaining your affiliation to MLOZ Insurance
If you are already affiliated to MLOZ Insurance, it is legally obliged to terminate your affiliation, and therefore all your covers, if you are sanctioned by the loss of your rights to the complementary services of your health insurance fund because you have not paid for these services during 24 consecutive months.
This automatic exclusion is independent of whether you have always paid the contributions for the insurances of MLOZ Insurance. You will then be able to reaffiliate with MLOZ Insurance (in accordance with the conditions for new affiliation) only if you resume regular payment of your contributions for the supplementary services provided by your health insurance fund. The period during which you must pay contributions without being able to claim dispensations under the supplementary services depends on whether you are or were in a situation worthy of consideration (e.g. (but not exhaustive) integration allowance, collective debt settlement, personal bankruptcy, etc.). Any interruption of 6 months in the payment of these contributions during the period referred to in the previous sentence will result in a new exclusion from MLOZ Insurance.

3. CONCLUSION AND ENDING OF THE INSURANCE POLICY

3.1. Conclusion of the insurance policy

All new affiliation requests must be submitted through the forms provided by MLOZ Insurance or via the website of the section to which the policy holder is linked.

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 MLOZ Insurance received the duly completed "New affiliation request or request to change a product" (internal date or

scanning as proof), if MLOZ Insurance 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 MLOZ Insurance 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 MLOZ Insurance receives the first premium at last the last day of the third month following the joining date.

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

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

3.2. Ending of the insurance policy

The insurance policy is a life policy.
However, it 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 or the qualified registered electronic mail (via digiconnect.be), or the delivery of the writ or the cancellation letter against deposit receipt, addressed either directly to MLOZ Insurance or to one of the sections mentioned above. This one month notice is not mandatory in case of a change of hospitalisation cover within Hospitalia.
- fraud or attempt to fraud.
  - the insurance guarantee is refused or reduced proportionally to the loss suffered by MLOZ Insurance;
  - and the policy is terminated
- voluntary caused injury to the interests of MLOZ Insurance 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, the insurance policy is null and void. It may also be decided to cancel the insured's affiliation. In both cases, premiums due up to the time when the insurer became aware of the omission or intentional inaccuracy of inaccurate data, revert to MLOZ Insurance.
- 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 (legal cancellation).
- 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 MLOZ Insurance, a 6-month waiting period starting at the joining date has to be accomplished. MLOZ Insurance 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 MLOZ Insurance 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 MLOZ Insurance.
- Waiting period exemption in case of accident
  MLOZ Insurance 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 MLOZ Insurance.
- Waiting period exemption for similar hospitalisation insurances
  MLOZ Insurance intervenes for the new policy holders proving with documents that they were covered until the date of membership to MLOZ Insurance and since 6 months by a similar hospitalisation insurance of "compensatory" type, which means an insurance of which the reimbursements are made according to a lump sum per hospitalisation day.

4.2. Exclusions of the guarantee

For every cover and type of room

Are not covered: hospitalisation and care costs related to an illness or 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 voluntarily participation in a crime or offence. 'Offence' also refers to offences that are afterwards redefined as violations;
- 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. Attempted suicide and suicide are not considered as intentional acts.
- 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

MLOZ Insurance 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 01/01/2025, including all taxes, depending on the age

Affiliated to the product Forfait H			
Under 46 years old*		Between 46 and 49 years old*	
less than 18 years	0.55	from 46 to 49 years	1.85
from 18 to 24 years	0.95	from 50 to 59 years	2.63
from 25 to 49 years	1.76	60 years and over	6.22
from 50 to 59 years	2.50		
60 years and over	5.92		

Between 50 and 54 years old*		Between 55 and 59 years old *	
49 years**	1.94	from 55 to 59 years	3.75
from 50 to 59 years	2.75	60 years and over	8.88
60 years and over	6.51		

At the age of 60 and over*	
59 years**	4.25
60 years and over	10.06

* 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 years and over at the joining date to Forfait H.

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 must be paid in advance. It is sent to the last known address of the policy holder.
Is considered as in advance, any premium received before the first day of the first month of the quarter, semester or year, or, in case of monthly direct debit, within the first 10 days of the month, quarter, semester or year.
The policy holder who did not pay his premium before the first day of the quarter, receives a formal notification by registered letter or qualified electronic registered mail, demanding payment of the premium within 15 days as from the day after the delivery of the registered letter at the post office or of the qualified electronic registered mail. 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 affiliate again (in accordance with the conditions for new affiliation) if he pays all overdue premiums. He will also 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 MLOZ Insurance uses for its hospital insurances.

The following criteria are taken into consideration for Forfait H:

9.1. At the beginning of the policy:

9.1.1. The age of the insured person because, according to statistic data, the probabilities of treatment and hospitalisation as well as the amount of the reimbursements increase with age. Therefore, this parameter is taken into account for the fixation of premium amount and access to the product.
a) Access could be limited for certain products. There is no age limit for Forfait H.
b) Depending on the chosen product, affiliation after a certain age may lead to supplementary premiums.
9.1.2. The previous existence of a similar insurance impacts the waiting period, that can be reduced or even cancelled for persons who were insured by a similar insurance until the date of affiliation to MLOZ Insurance. In that case, the waiting period will be reduced by the duration of that insurance. MLOZ Insurance does not make a distinction based on the nature of the insurance (commercial insurance vs. insurance with a health insurance fund) the insured person was covered by before joining MLOZ Insurance.

9.2. During the policy:

Age of the insured person because, according to statistic data, the probabilities of treatment or hospitalization increase with age. This criterion might influence the amount of the expenses. Therefore, the contribution amount increases with the age of the insured.

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

The premium, the pricing conditions and the conditions for the coverage of the benefits are defined by taking into account the parameters that are included in the technical plan the insurer compiles on the basis of actuarial criteria and insurance techniques.
Without prejudice to the statutory options for adjusting the premiums and regardless of their adjustment to the index on consumer prices, the contributions may not be increased.
For the application of the index, a comparison will be made between the index rate of April of the current year and the index rate of April of the previous year.
This index rate variation is expressed in percentage and can be applied to the premium and to the benefits in force before indexation.
MLOZ Insurance may decide annually not to apply the indexation possibilities for premiums based on this index, or to apply them only partially.
Nevertheless, the premiums will be increased in function of the different taxes applicable on that matter.
Premiums and coverage can be modified in accordance with article 504 of the Law of 13 March 2016.

11. REIMBURSEMENTS OF FORFAIT H

FORFAIT H intervenes in the supported costs during a hospitalisation or a day hospitalisation in Belgium according to a daily lump sum of € 12.35.

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

17	(M)	Newborn hospitalised in room with the mother in an M unit
18	(n)	Newborn hospitalised in unit N*(n) while the mother is also a patient at the hospital
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
30	(G)	geriatric and revalidation unit
34	(K)	infantile psychiatric unit (day and night)
37	(A)	neuropsychiatric unit (day and night)
41	(T)	psychiatric unit (day and night)
48	(IB)	intensive care unit for psychiatric patients
49	(I)	intensive care unit
61 to 66	(Sp)	specialised units:
	61	cardiopulmonary disorders
	62	locomotor disorders
	63	neurological disorders
	64	chronic disorders requiring palliative care
	65	polypathologies chroniques chronical polypathologies requiring extended medical care
	66	psychogeriatric disorders

Limitations:
In case of admission in a G or Sp unit, MLOZ Insurance intervenes in the costs up to the first 25 days per hospitalisation. In case of a new hospitalisation in a G or Sp unit, MLOZ Insurance will only intervene if a period of minimum 6 calendar days has passed since the end of the

previous hospitalisation. However, if this period has not passed, MLOZ Insurance will intervene for the remaining 25 days which were not reimbursed during the previous hospitalisation.
In case of admission in units 34, 37, 41 or 48, MLOZ Insurance intervenes in the costs up to 10 days per year.

12. DISPENSATIONS NOT COVERED

MLOZ Insurance does not intervene:

- for hospital dispensations related to beauty care, unless the Medical Counsellor gave is prior agreement and if the compulsory insurance intervenes;
- for the dispensations of "rejuvenation" type;
- for the dispensations to an insured person who refuses to receive the visit of a practitioner, a nurse or a social assistant committed by MLOZ Insurance.

13. COMPENSATIONS

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 MLOZ Insurance 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.

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 Forfait H, the policy holder will fill in the form "Payment request" delivered by MLOZ Insurance, and will provide it with all the justificatory documents proving his/her expenditures: either the original bill, or a copy of the original bill, or a certificate from the hospital about the duration of the hospital stay and the unit number.
MLOZ Insurance can request any complementary document deemed necessary.

Justificatory documents in order to receive a compensation may be delivered digitally to MLOZ Insurance. The digital copy must be of good quality (i. e. readable) and true to the original (no hand-written alterations or updates). MLOZ Insurance reserves the right to request the original from the insured, who must keep it or bear the costs of a duplicate.
The reimbursements will be granted to effectively insured persons or to any person empowered by the "Payment request", after receipt of the expenditures notes and the statement of the legal interventions.

14. DATA HANDLING

The personal data of the policy holder and their insured will be processed by MLOZ Insurance acting as data controller, and by the Onafhankelijke Ziekenfondsen (Independent Health Insurance Funds), as agent and processor for MLOZ Insurance, in the context of the allocation and management of the insurance product that the policy holder has subscribed to, and in accordance with the European Regulation of 27 April 2016 on data protection (GDPR). Medical data are collected and handled based on the insured's consent and under the supervision and the responsibility of the Medical Counsellor of MLOZ Insurance. The privacy policy of MLOZ Insurance is available via this link https://www.mloz.be/nl/content/privacy-mloz-insurance, or upon request in an agency, or by mail (MLOZ - DPO, Route de Lennik 788 A, 1070 Brussels).

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