HOSPIMUT PLUS

General Terms and Conditions as of January 1, 202(*).

This document outlines the operation of the hispoitalization insurance contract and specifies our mutual commitments. It details the scope of coverage as well as the limitations and exclusions thereof.

Read it carefully.

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1. Définitions

1.0. Insurer

The Mutual Insurance Company Concordia-Health (SMACH) is a protected enterprise under registration number 350/03, as decided on March 24, 2025, by the Intellectual Property Office. It is authorized to provide health insurance as defined under branch 2 of Annex 1 of the Royal Decree of February 22, 1991, which establishes general regulations concerning the oversight of insurance companies, as well as to offer complementary coverage for risks associated with assistance as outlined in branch 18 of the aforementioned Royal Decree. .

1.1. Policyholder

The individual registered with Concordia-Health as the holder, who has entered into the contract and is responsible for the payment of the premium .

1.2. Insured

The policyholder and/or the designated dependent(s) as specified in the particular conditions, who benefit from the coverage under the contract according to these conditions.

1.3. Start date of coverage

The date from which the insured person is entitled to claim benefits in accordance with the description of the coverage, following the completion of the waiting period. .

1.4. Illness

Any non-accidental alteration of health that presents objective symptoms, making the diagnosis indisputable.

1.5. Accident

A sudden event that compromises the physical integrity of the insured due to the sudden action of an external force independent of their will

1.6. Hospital establishment

The institution legally recognized as a hospital, with the exception of the following psychiatric and neuropsychiatric services :

350	K1	Day hospitalization in service K
360	K2	Night hospitalization in service K
380	A1	Day hospitalization in service A
390	A2	Night hospitalization in service A
420	T1	Day hospitalization in service T
430	T2	Night hospitalization in service T
440	Tf	Foster placementTf in a hospital
760	-	Flat rate to psychiatric care

- Medical-educational institutions ;
- Facilities solely intended for accommodation of elderly individuals or children ;
- Rest homes ;

- Hospitals or parts of hospitals such as : nursing and care homes, rehabilitation centers and services (service 770) ;
- Pediatric medical centers

1.7. Hospitalization

In the context of hospitalization, the following should be considered :

- Any medically necessary stay for which at least one night has been billed by the hospital;

- Medically necessary day hospitalization in a hospital facility, provided that a "day surgical service" package (service 320), a mini-package (service 720), a maxi-

package (service 730), or a group 1 package has been applied.

- (service 720), a maximum package (service 730), a package from group 1, 2, 3, 4, 5, 6, or 7 (service 840), or a chronic pain package 1, 2, or 3 (service 840) may be billed, excluding day hospitalizations solely for the purpose of any form of dialysis.

- Services provided in the emergency department, provided that the stay in the emergency department is immediately followed by hospitalization

There is no reimbursement planned for the plaster room (service 710) or for the treatments carried out there.

1.8. Waiting period

The period commencing on the date the contract takes effect, during which the insured is not entitled to any benefits.

1.9 Legal intervention

Any reimbursement received under U.S. legislation relating to mandatory health insurance and indemnities (including the law charge), occupational diseases, and work-related accidents, as well as reimbursements received under a common law provision

1.10. Extra-legal intervention

Any reimbursement received under personal, family, or collective agreements that have the same purpose as the contract .

1.11. Prosthesis

A device that completely or partially replaces a limb or an organ .

1.12. Orthopedic device

A device intended to correct bodily deformities .

1.13. Pre-existing health condition, illness or affliction

A pre-existing health condition, illness, or affliction refers to any health condition (for example, pregnancy) or any affliction or illness that exists at the time of subscribing to the insurance and which necessitates hospitalization. .

1.14. Care hotel

Any accommodation center with a hospitality purpose designed for individuals whose health condition necessitates a stay in the center, along with curative and/or diagnostic treatment that requires observation, monitoring, and continuity that can only be organized within the cente .

1.15. Pre-hospital and post-hospital expenses

The costs incurred 30 days prior to and 90 days following a hospitalization for which insurance coverage applies, directly related to this hospitalization .

1.16. Accommodation costs

In the event of hospitalization, accommodation costs are the expenses borne by the insured, consisting of the legal co-payment established by the Mandatory Health Care and Compensation Insurance, to which any additional charges related to the type of room are added .

1.17. Dental care and treatment

Dental care and treatment services provided during a hospitalization, where the patient's general condition must constitute a formal medical indication for the necessity of these services during hospitalization .

1.18. Concordia-Health

Concordia-Health, an insurance intermediary

1.19. Emergency transport

Transport by ambulance or helicopter as part of urgent medical assistance following a call to Service (*) (law of July 8, 1964), when it is followed by hospitalization for which insurance coverage applies. .

1.20. An insurance offering similar coverage

A hospitalization insurance contract of the "indemnity" type, meaning an insurance policy that reimburses based on the actual costs listed on the hospitalization invoice and provides at least the following guarantees, regardless of the hospital in which the insured is admitted :

- Coverage in the event of hospitalization in a single room or in a multi-bed room ;

- In the case of a stay in a single room :

* Reimbursement of accommodation costs up to $125.00 or more per day for at least one night of hospitalization
*
Reimbursement of additional fee supplements up to a maximum of 300% of the mandatory health insurance intervention and allowances; deductible limited to $150.00 or, when not expressed as a specific amount, to 5% of the invoice .

2. Subscription

2.1. Subscription conditions

The subscription to the insurance contract and the entitlement to its benefits are reserved for members of Concordia-Health who are subject to mandatory health care and indemnity insurance and who benefit from its provisions, and whose eligibility for the advantages of supplementary insurance has not been revoked due to non-payment of contributions for a consecutive period of at least 24 months, or who are in good standing with payments since the period referred to in Article 2 quater, paragraph 3, of the Royal Decree of March 7, 1991, implementing Article 2, §§ 2 and 3, Article 14, § 3, and Article 19, paragraphs 3 and 4, of the law of August 6, 1990, concerning mutualities and national unions of mutualities, has commenced for the services mentioned therein.

Notwithstanding the provisions of the previous paragraph, no individual may obtain membership in Concordia-Health prior to January 1, 2022, if their eligibility for supplementary insurance has been revoked. In such cases, the individual retains membership status during the period from the 25th month of non-payment of supplementary insurance contributions until December 31, 2021, during which the eligibility for the advantages of supplementary insurance is suspended..

Under these conditions, the subscription to insurance cannot be refused, without prejudice to Article 206 of the law of April 4, 2014, regarding insurance..

The insurance contract begins on the first day of the month following the receipt of the completed and signed insurance proposal by the policyholder, provided that the premium (quarterly) is paid before the due date.

In the event of the enrollment of new dependents of a policyholder during the contract term, the mutual insurance company shall send the policyholder an insurance proposal to add such dependent(s) to the insurance contract.

In cases involving a newborn or an adopted child under the age of 3, coverage commences on the day of birth or adoption, provided that the completed and signed insurance proposal, along with the insurance premium, is submitted to the insurer by the end of the 3rd month following the birth or adoption.

2.2. Subscription formalities

At the time of subscription to the insurance, the policyholder is required to complete and sign a subscription application form..

Any changes in the household composition must be reported to the mutual insurance company within 30 days.

When a dependent person, who is insured, becomes a policyholder with Concordia-Health, the mutual insurance company will present them with an insurance offer. This individual has a period of 60 days to accept the insurance offer in writing.

3. Waiting period

3.1. The general waiting period is six months.

It is waived for :
a) Accidents occurring after the date of subscription to the insurance ;
b) Insured individuals who are legally dependent on the policyholder, in cases of birth or adoption, and who are added to the insurance contract in accordance with Article 2.1., provided that their father (adoptive) or mother (adoptive) is insured under this contract and has completed the waiting period. Once any part of the waiting period has been completed, these dependents are also considered to have completed that portion ;
c) the insured person who, on the day before the contract becomes effective, had a hospitalization insurance policy providing similar coverage. The duration of the waiting period already completed will be deducted from the waiting period that remains to be fulfilled. To benefit from this potential waiver of the waiting period, the application for subscription to the mutual insurance company must occur within 90 days from the end of the previous coverage. There must be no interruption between the end date of the previous coverage and the subscription to the mutual insurance company ;
d) dependents of a policyholder whose insurance has ended and who, having completed their waiting period, remain members of Concordia-Health as a policyholder or as a dependent of another policyholder, provided there is no interruption. If the waiting period has not been fully completed, it must be fulfilled.

3.2. The waiting period is extended to 12 months for the insured who has terminated their contract after receiving compensation and is requesting to subscribe again. This waiting period does not apply to the case referred to in point 3.1.a).

3.3. Provision applicable in the case of transitioning from Hospimut insurance - or from an insurance offering similar coverage - to Hospimut Plus insurance. .

The aforementioned waiting periods must be fulfilled. In the event of hospitalization during these new waiting periods (the date of hospital admission being authoritative), the intervention will be based on the Hospimut insurance.

3.4. Provision applicable in the case of transitioning from "Supplementary Hospitalization Indemnity" insurance (S.I.C.H.) or from an insurance offering similar coverage to Hospimut Plus insurance.

The aforementioned waiting periods must be fulfilled. During these waiting periods, the insured remains covered for a daily flat rate of USD 12 per day for maintenance, with the understanding that the compensation is limited to 180 days of maintenance. This coverage remains in effect if the transfer from one insurance to another occurs during a hospitalization period.

4. Suspension of insurance

In the event of detention and upon written request from the insured, the insurance may be suspended.

The insured may request the suspension of their insurance by means of a registered letter. In this case, the insurance will be suspended from the end of the month following the request for suspension (with the date of the postmark serving as proof). The premium corresponding to the period of insurance that is subject to suspension will subsequently be refunded to the policyholder.

The insurance will resume its effect from the first day of the month following the insured's request to terminate this period of suspension, provided that the request is made by registered letter within 90 days following the end of the reason for the suspension, and that the premium is paid within 15 days of the payment request from the mutual insurance company.

5. Territorial scope

The coverage of the insurance is valid worldwide. However, in the event of hospitalization abroad, the coverage is only applicable if the hospitalized individual is domiciled in USA and resides there habitually.

6. Description of coverage

6.1. The insurance covers instances where an insured individual undergoes hospitalization that results in reimbursement under the Mandatory Health Care and Benefits Insurance due to illness, accident (including workplace accidents), pregnancy, or childbirth.

The mutual insurance company commits to reimbursing the insured, according to the conditions mentioned below, for the following expenses incurred by the insured as a result of hospitalization, namely :

- Costs of stay and medically necessary healthcare following illness or accident;
- Treatment and examination costs that are medically necessary in cases of pregnancy or childbirth;
- Provision of glasses, hearing aids, orthopedic devices, or other prosthetics as defined in the nomenclature of health benefits (annex of the Royal Decree of September 14, 1984), directly related to hospitalization, provided there is legal coverage;
- Costs of dental implants and prostheses incurred or placed during hospitalization due to an accident, provided there is legal coverage;

•Costs of dental care and treatments as defined in point 1.17, provided there is legal coverage and that these services are directly related to the hospitalization;

•Costs of hospitalization abroad

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The insurance coverage is equal to the sum of the actual expenses incurred, reduced by the amount of legal and extra-legal interventions to which the insured may be entitled, excluding the hospitalization allowance paid under the "Supplementary Indemnity in Case of Hospitalization" (I.C.H.).

The calculation for the reimbursement of benefits is as follows::

6.1.1. In the event of hospitalization in a single room, room supplements and fees will not be reimbursed provided that the hospitalization occurs within three years from the effective date of the insurance, on the one hand, and that there is a causal link between this hospitalization and a pre-existing condition, injury, or disability as of the subscription date, on the other hand**.**

This restriction is lifted for the insured who, on the day before the effective date of the insurance, held a hospitalization insurance policy with similar coverage, provided that the insured maintained this policy for three years; otherwise, the years of coverage under the aforementioned insurances will be deducted from the aforementioned three-year period ;

6.1.2. In the event of hospitalization in a single room, room supplements and fees will not be reimbursed provided that the hospitalization occurs within nine months from the effective date of the insurance, on the one hand, and that there is a causal link between this hospitalization and a pregnancy, on the other hand. This restriction is lifted for the insured who, on the day before the effective date of the insurance, held a hospitalization insurance policy with similar coverage, provided that the insured maintained this policy for nine months; otherwise, the months of coverage under the aforementioned insurances will be deducted from the aforementioned nine-month period ;

In the case of transferring from the Hospimut insurance or a similar insurance to the Hospimut Plus insurance, the intervention for the cases mentioned in sections 6.1.1 and 6.1.2 will be based on the intervention conditions of Hospimut.

6.1.3. For all services that trigger an intervention from the mandatory health care and indemnities insurance, the insurance will reimburse up to a maximum of one time the amount of this legal intervention ;

6.1.4. The "admission" fees and the personal co-payments legally borne by the insured beneficiary will be fully reimbursed ;

6.1.5. In the event of hospitalization for at least one night, the fee supplements will be reimbursed up to a maximum of 300% of the intervention covered by the mandatory health care and indemnities insurance ;

6.1.6. Fee supplements in the case of day hospitalization will be reimbursed up to a maximum of 100% of the intervention covered by the mandatory health care and indemnities insurance ;

6.1.7. Supplementary accommodation costs will be reimbursed, in addition to the personal co-payment, up to an amount of USD 150.00 per day in the event of hospitalization for at least one night, and up to USD 80.00 in the case of day hospitalization
à concurrence de 80,00 EUR en cas d'hospitalisation de jour ;

6.1.8. For the costs of implants, prostheses, and medical devices, the insurance will reimburse up to the actual billed amount ;

6.1.9. Pharmacy and parapharmacy products will be reimbursed as follows :

- Medications with coverage from mandatory insurance and those classified as category D will receive full reimbursement.

- Parapharmacy products and supplies, such as compression stockings, compression sleeves, and thermometers, which are not covered by mandatory insurance but whose costs may legally be charged to the patient, will also receive full reimbursement.

6.1.10. For stays in service 340-K (Child Neuropsychiatry - Day and Night), 370-A (Neuropsychiatric Service - Day and Night), and 410-T (Psychiatric Service - Day and Night), reimbursement will be limited to a maximum of 30 days per calendar year ;

6.1.11. For the costs of other supplies legally chargeable to the patient, with or without intervention from mandatory insurance, the insurance will reimburse up to the billed price.

6.1.12. For the accommodation costs of a parent (rooming-in) who has spent the night at the bedside of a hospitalized child under the age of 19, the insurance will reimburse up to a maximum of 25.00 USD per day;

6.1.13. For stays in a care hotel related to hospitalization, the insurance will reimburse up to 6.50 USD per day. Only stays in a convalescence center will be eligible for this reimbursement ;

6.1.14. Costs related to in vitro fertilization and robotic surgery will be reimbursed up to 500 USD per calendar year for private room accommodations ;

6.1.15. Costs related to neonatal care after hospitalization will be reimbursed up to 20.00 USD per day for a maximum of 7 days, starting the day after the hospital discharge.

6.1.16. The insurance will cover the actual expenses incurred for urgent transport to the hospital, up to a maximum of 250.00 USD per calendar year, after any other interventions, including those provided by Concordia-Health supplementary insurance ;

6.1.17. In the event of a home birth, the insurance will provide a one-time payment to cover all related expenses, including care provided before and after the birth, amounting to 600.00 USD ;

6.1.18. The insurance will reimburse the legal deposits paid to the hospital upon presentation of a supporting document from the hospital confirming the payment of such deposits. If it is later determined that the hospitalization cannot be covered, or if the amount of the deposit exceeds the intervention of the mutual company, or if the insured fails to present their invoice, any undue amounts will be recovered**.** ;

6.1.19. For any hospitalization in the USA, excluding geriatric services (300), specialized services (610-S1 to 660-S6), and psychiatric services (340-K, 370-A, and 410-T), and for which insurance applies, pre- and post-hospitalization expenses will be covered as follows :

Pre-and Post-hospital care:

6.1.19.1. Reimbursement at 100% of the personal co-payments for the cost of pharmaceutical products and reimbursable magistral preparations within the framework of mandatory health care insurance and benefits, provided that they are prescribed by a licensed physician ;

6.1.19.2. Coverage of co-payments and legal fee supplements, limited to 100% of the mandatory health care insurance and benefits intervention.

Without prejudice to the above, in the event of hospitalization in a medical diagnostic and treatment service (220-D), a surgical diagnostic and treatment service (210-C), or an intensive care service (490-I) that continues in a geriatric service, the intervention of the aforementioned insurance shall apply to the entirety of this stay.

Pre- and post-hospital care must have been provided in the USA and directly related to the hospitalization covered by these general conditions, provided that the mandatory health care insurance and benefits were applicable to the referenced hospitalization.

6.1.20. In the event of a full hospitalization in a shared or double room, the insurance will fully reimburse the amount of the hospital bill..

6.1.21. In the case of hospitalization abroad, the intervention to cover the actual expenses incurred will be capped at a maximum of 360.00 USD per day. Day hospitalization is not covered abroad. For pre-existing illnesses or conditions, the intervention will be limited to a maximum of 20.00 USD per day of hospitalization.

6.2. As calculated, this reimbursement amount

- serves as the basis for the application of the deductible of 100.00 USD. This deductible applies to any hospitalization of at least one night in a private room in a hospital that charges more than 200% of the agreed tariff. The list of hospitals subject to the application of the deductible is established annually and takes effect on January 1st. It is published as an annex to the general conditions and is made available on the Concordia-Health website. The new list will be applicable to all insurance cases where the start of the stay coincides with or is subsequent to the effective date of the new list (see page 12). .

The amount will be reduced by any outstanding premium payments due.

7. Conditions of intervention

7.1. The intervention of the insurance is always subject to the conditions of the policy and the payment of the premium by the policyholder and their dependents, without prejudice to Article 69 of the law of April 4, 2014, relating to insurance.

7.2. Any hospitalization that may result in an intervention must be reported to the mutual society as soon as possible using the claim form provided by them.

The policyholder and their dependents must make every effort to provide the mutual society with all information related to claims and their outcomes The mutual society has the right to verify the declarations made to it and the responses to its requests for information.

Only original invoices will be accepted.
These documents must include:
- The identity of the insured ;
A detailed account of the services (I.N.A.M.I. nomenclature code) and their actual costs certified by the healthcare provider ;
- The date(s) of the service(s).

7.3. Pre- or Post-hospital care

The request for coverage of pre- or post-hospital care is submitted using the "Request for Intervention for Pre- or Post-Hospital Care" form.

Reimbursement is granted solely on the basis of: :

- he original receipt issued by the mutual insurance provider or an invoice;
- A (BVAC) certificate or Annex 30 for medications or an invoice.

Pre- or post-hospital care will only be eligible for reimbursement if the mutual insurance company has received the hospital or day hospital invoice.

7.4. In the event of the insured's death, reimbursement will be granted to :

- The surviving spouse or legally cohabiting partner;
- In the absence of the above, to individuals who can prove they are legal heirs. The reimbursement will then be paid either to the notary appointed to settle the estate, or to one of the heirs mentioned, based on a notarized power of attorney from all other mentioned heirs, or to the notarized deed, or to the certificate of inheritance;
- In the absence of the above, to individuals who have actually borne the costs of the hospitalization for which reimbursement is requested.

7.5. Prescription

Supporting documents for expenses eligible for reimbursement must be submitted to the mutual insurance company within three years from the date of the provision of care.

8. Non-reimbursement case

The insurance does not take effect for :

8.1. Any hospitalization resulting from :

- An intentional act by the insured, unless it is proven to be a case of legitimate defense or justified rescue of persons or property; an intentional act in the context of this clause is defined as a deliberate and conscious act that causes reasonably foreseeable damage; a suicide attempt is neither considered an intentional act nor an accident;
- An accident occurring to the insured while under the influence of alcohol or drugs, narcotics, or controlled substances used without a medical prescription, unless proof is provided that there is no causal relationship between the accident and these circumstances, or if the insured demonstrates that they consumed substances unknowingly or were coerced by a third party;
- Acts of war, civil war, or similar events; however, coverage remains in effect for 14 days after the onset of hostilities if the insured is caught off guard by the outbreak of war during travel in a foreign country;
- Voluntary participation in acts of collective violence;
- Participation in a crime or offense;
- The professional practice of any sport;
- The use of weapons or nuclear devices that may explode due to changes in atomic structure, nuclear reactions, radioactivity, or ionizing radiation, except for the use of radioactive substances for medical purposes;

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8.2. The following services :

- Aesthetic treatments and services related to plastic surgery are excluded, except for those resulting from an accident occurring after the effective date of coverage or those covered under mandatory health insurance legislation.

Costs for dental implants and prostheses are also excluded unless they directly result from a duly proven accident occurring after the date of subscription, for which the insurance will provide coverage.

Expenses for prostheses and orthopedic devices are excluded unless they are directly related to the cause of hospitalization covered by the insurance.

Comfort expenses (such as telephone, television, refreshments, toiletries, etc.) are also excluded unless hospitalization lasts at least one night in a multi-bed room or involves day hospitalization

3. Any hospitalization commencing prior to the contract's effective date or during the waiting period ;

4. All one-night stays and day hospitalizations solely for hemodialysis or any form of dialysis; ;

5. The mutual insurance company reserves the right to verify the legality of the amounts billed for the various components of its intervention. The intervention may be suspended for the time necessary to analyze the documents submitted by the insured and any additional information provided. The intervention is denied when the illegality of the billing is established ;

6. When the duration of stay in a hospital exceeds the medically necessary period, the mutual insurance company has the right to limit its benefits to an amount related to the medically necessary services.

9. Subrogation

When the insurer intervenes, or is required to intervene, under the contract, it is subrogated to all rights and actions belonging to the insured against third parties responsible for the event that requires its intervention.

Consequently, the insured cannot waive a claim without the prior written consent of the mutual insurance company.

Furthermore, they agree to renew this subrogation upon request. In all cases, the subrogated party has the discretion to decide whether to initiate legal action and how to proceed

10. Disputes - litigations

Reimbursement of services will only be granted subject to the right of the mutual company to have the insured's health status evaluated at any time by a medical examiner. Furthermore, the insured shall authorize the attending physician to provide the medical examiner with all relevant information regarding their health status.

Any medical dispute between the insured and the mutual company shall be submitted, on one hand, to the insured's attending physician, and on the other hand, to the medical examiner of the mutual company.

In the event of a disagreement, they shall jointly appoint a third physician who will make a binding decision. If there is a disagreement regarding the appointment of a third physician, the appointment shall be made at the request of the most diligent party by the president of the court of first instance.

Each party shall bear the fees and expenses of their respective physician. The fees and expenses of the third physician shall be shared equally..

Should the disagreement persist, the mutual company may propose to the insured to submit the dispute to the procedure outlined in Article 1678 of the Judicial Cod .

Only U.S. law shall apply to this insurance..

11. Termination – sanction

The mutual company, in addition to reserving the right to exclude a member from its society based on Article 5 of its statutes, reserves the right to terminate the contract in the event of fraud or attempted fraud aimed at obtaining undue reimbursements.

Failure to pay the premium by the due date will result in the termination of the contract, provided that the debtor has been formally notified in accordance with point 15.4 below.

The mutual company reserves the right to claim reimbursement of any indemnities paid unduly..

12. Duration of contrat and resiliation

12.1. The insurance is concluded for life, without prejudice to points 11 and 12.2.

12.2. The policyholder may terminate the contract at any time. The termination shall only take effect after the expiration of a three-month notice period commencing on the first day of the month following the date of notification, acknowledgment of receipt, or, in the case of a registered letter, its deposit in the post.

Notwithstanding the foregoing, the contract shall cease when the insured :

- is no longer a member of Concordia-Health; ;

The individual has lost the right to benefit from supplementary insurance due to non-payment of contributions for a consecutive period of at least 24 months, or is in arrears of payment for 6 months since the period referred to in Article 2 quater, paragraph 3, of the aforementioned Royal Decree of March 7, 1991, has commenced for the services specified therein. By way of exception to the provisions in the preceding paragraph, no individual may acquire the status of a member of Concordia-Health whose right to benefit from supplementary insurance has been revoked before January 1, 2022. If applicable, the individual retains membership status during the period from the 25th month of non-payment of supplementary insurance contributions until December 31, 2021, although their ability to benefit from supplementary insurance advantages is suspended.

- upon their death.

When the contract ends, it ceases to have effect, including for ongoing hospitalizations.

13. Administratives provision

The domicile of the parties is hereby elected as follows:

- that of the mutual society at its registered office;
- that of the policyholder at their last officially known address by the mutual society..

The policyholder is obligated to notify the mutual society of any change of residence; otherwise, any notification will be deemed validly made to the last known address of the mutual society.

14. Assistance in the USA

Hospimut Plus provides the following assistance services to insured individuals entitled to coverage under the insurance in the context of hospitalization or day hospitalization in the USA, provided they have completed their waiting period. These services are available with a simple call to the Concordia-Health Assistance Center, accessible 24 hours a day, Tel. (*).

Childcare at home

The insurance will organize and cover the costs of childcare for the insured's children, aged between 3 months and 14 years, within 24 hours, in one of the following three situations :

1. If the insured is hospitalized for more than two days due to an accident or sudden and unforeseen illness, the insurance will intervene in the care of their children during the first night following this hospitalization, from 7 PM to 8 AM, should no other person be available to take care of them. This childcare service is also provided for a maximum of 5 working days, from Monday to Saturday, between 8 AM and 7 PM, up to a maximum of 10 hours per day,while the spouse is engaged in their professional activities.

1) In the event of childbirth, the insurance covers childcare for a maximum of 3 working days during the insured's hospital stay, from Monday to Saturday, for a maximum of 10 hours per day, while the spouse is engaged in professional activities.

In the event of childbirth, the insurance covers childcare for a maximum of 3 working days, starting from the day after a short hospital stay (maximum of 2 nights) for the mother, from Monday to Saturday, for a maximum of 10 hours per day, while the spouse is engaged in professional activities. The interventions mentioned in points 2) and 3) above are not cumulative. .

This childcare service is intended to provide attentive supervision for a maximum of 3 children and to perform tasks typically handled by the mother or father, excluding household chores and transportation between school and home.

15. Premium

15.1. Amount

The premium for the contract is calculated based on the prevailing rate and the age of the insured individuals on the date the contract comes into effect.

It is recalculated at each annual renewal based on the prevailing rate and the age of the insured individuals on the anniversary of the contract's effective date.

The premium covers a period of 12 months.

In the event of changes regarding the insured individuals during the insurance year, the contract premium will be adjusted effective from the first day of the month in which the modification takes effect.

Any tax, fee, contribution, or levy imposed by law or any other regulatory provision is or will be the sole responsibility of the policyholder.

15.2. Indexation

Individual premiums are indexed annually, effective January 1st, according to the evolution of the specific index derived from values defined in Article 6, § 3, paragraph 2, and Article 6, § 4 of the Royal Decree of February 1, 2010, which establishes the specific indices referred to in Article 204, § 3, of the Insurance Act of April 4, 2014 (values independent of age categories), for the "individual room" coverage.

Premiums may be adjusted by a maximum percentage corresponding to the change between the last published specific index and the specific index of the preceding year, provided that this variation exceeds the change in the consumer price index during the same period. If this is not the case, premiums will be adjusted based on the change in the consumer price index for the month of September..

he resulting figures will be divided by twelve and rounded down to the nearest euro cent. These results will then be multiplied by twelve again.

If the mutual insurance company changes the terms or amounts of the premium, it will inform the policyholder by sending a written notification..

15.3. Revision

Aside from the annual indexation, the contract premium can only be adjusted after its conclusion at the request of the Office of Control of Mutualities if it determines or if the Mutual Insurance Company informs it that the application of the rate leads to or risks leading to losses, and it requires the insurer to bring this rate into balance, in accordance with Article 504 of the Act of March 13, 2016, concerning the status and control of insurance or reinsurance companies.

A rate increase will apply to the premiums of ongoing contracts that come due from the first day of the second month following the notification of the decision by the Office of Control of Mutualities, without prejudice to the policyholder's right to terminate the contract.

15.4. Payment

The premium is annual and payable in advance at the central office of the mutual insurance company.

However, payment can be divided quarterly, provided that a bank direct debit is established.

Payment dates and premium amounts will be communicated to the policyholder.

In the event of non-payment of the premium (annual or quarterly) by the due date, a formal notice of payment will be sent by registered mail to the policyholder. The sending of this notice initiates a payment period of 15 days from the day following the postmark date. If payment is not made within this period, the contract will be terminated.

Premiums paid for any period following a proper termination by the policyholder will be refunded in accordance with legal provisions.

15.5. Individual premiums