Supplementary Policy Conditions 2017

VGZ Eigen keuze

(VGZ Personal Choice)

Arrange everything online yourself with My VGZ

Welcome to VGZ

These are the policy conditions that apply to your supplementary VGZ healthcare insurance. For more information, for example about expense forms or our healthcare insurance packages, please visit www.vgz.nl.

Voor goede zorg zorg je samen

My VGZ
At My VGZ, you can
change your policy, check the status of your expense forms and pay your premium. Use your DigiD for safe and direct login on www.mijnvgz.nl.

Important information

Contact:
Check our contact information on www.vgz.nl/contact.

Contracted healthcare
Please find our contracted healthcare providers on www.vgz.nl/vergelijkenkies.

Requesting approval
If you would like to know which healthcare services and treatments are subject to our prior approval, please check our policy conditions. Would you like to request our approval? Then download the approval application form from www.vgz.nl. Please print, complete or have completed, sign and send the form to:
VGZ
Attn Approvals
PO Box 25150
5600 RS Eindhoven, the Netherlands

Easy online expense forms
It is easy to submit expense forms online through www.mijnvgz.nl. Logging in is safe using your DigiD. The amount to be reimbursed will be processed within 10 working days. If you prefer submitting expense forms by post, then please send the original invoice and the expense form to:
VGZ
PO Box 25030
5600 RS Eindhoven, the Netherlands

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I General Section

Article 1. Insured healthcare

1.1. Contents and scope of the cover

VGZ Personal Choice is an in-kind policy of the healthcare insurer, further referred to as 'the healthcare policy'. Pursuant to this healthcare policy, you are entitled to reimbursement of the cost of healthcare as set out in these policy conditions. You are also entitled to healthcare advice and healthcare mediation at request.

Healthcare Advice and Mediation

The Healthcare Advice and Mediation department advises you to which healthcare provider you can best turn for your care need. If you are experiencing unacceptably long waiting times for, for instance, a visit to the outpatients' department or admission to a hospital, you can also contact the Healthcare Advice and Mediation department. You can reach this department through our website.

1.2. Medical necessity

You are entitled to reimbursement of the cost of healthcare as set out in these policy conditions if you are in reasonableness relying on the relevant form and content of healthcare, provided that the form of healthcare is effective and efficient. A key factor in the content and scope of the healthcare form is 'what the relevant healthcare providers generally offer'. Other factors in the content and scope of the healthcare are the state of science and real statistics and experience. This is determined using the Evidence-Based Medicine (EBM) method. If information on the state of science and practice is not available, the content and form of the healthcare are determined by what is regarded in the relevant discipline as responsible and adequate care.

1.3. Authorised healthcare providers

You are free to choose a healthcare provider, subject to compliance with the other requirements in these policy conditions. One of these requirements is that your healthcare provider must comply with certain conditions. The relevant healthcare Article sets out which healthcare providers may provide the healthcare services, and the supplementary conditions that the healthcare provider must fulfil. If the healthcare provider does not comply with the conditions imposed, then you are not entitled to reimbursement of the cost.

1.4. Healthcare provided by a contracted healthcare provider

If you select a contracted healthcare provider for healthcare, we have agreed on fixed rates with the relevant healthcare providers which are in line with reasonable market prices in the Netherlands. The healthcare provider receives the fee for the healthcare provided from us directly.

We make agreements with healthcare providers on quality, price and service of the healthcare to be delivered. Your interests are our number one priority. And if you select a contracted healthcare provider, that will make a difference in costs for you and us. If you want to see a list of the healthcare providers that we contracted for certain healthcare types, please refer to our website.

1.5. Healthcare provided by a non-contracted healthcare provider

If you have selected a non-contracted healthcare provider, then you are entitled to reimbursement of healthcare costs up to the statutory Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands.

1.6. Submitting invoices

If you receive an invoice at home, please complete an expense form and submit it together with the original invoice. Please do not send us a copy or a reminder. We can only process originals. You may submit invoices latest up to three years after the start of your treatment.

Please check that the following details are listed in the invoice:
- your name, address and date of birth;
- type of treatment, the amount per treatment and the date of the treatment;
- the name and address of the healthcare provider.

These invoices have to be specified, ensuring that the reimbursements that we must pay out can be derived from the specifications directly and without any ambiguity. Any deductible and statutory personal contribution will be set off against the reimbursement amount. The exchange rates for converting foreign invoices into euros are based on

the historical rates on www.xe.com. This is based on the exchange rate on the date of treatment. Invoices must in Dutch, English, French, German or Spanish. If a translation is necessary to our discretion, we may request you to provide a certified translation of the invoice. We will not refund the translation expenses.

Online expense forms
Online submission of expense forms is easy and quick. Go to www.mijnvgz.nl. You must keep the original invoice for one year after submitting the expense form. We may request the invoices for inspection. If you are unable to show us the invoices, we reserve the right to recover the amounts paid out from you, or settle the amounts with any future reimbursements.

1.7. Direct payment

We reserve the right to pay the cost of healthcare directly to the relevant healthcare providers. Such direct payment cancels your right to reimbursement of the relevant invoices.

1.8. Settlement of costs

If we pay the healthcare provider directly, we do not factor in your deductible or personal contribution. These amounts will be subsequently invoiced to you as the policy holder. You have a legal obligation to pay such amounts. We may settle these amounts with any amounts to be paid out to you.

1.9. Referral, prescription or approval

For some forms of healthcare, you are required to obtain a referral, prescription and/or prior approval in writing, proving that this healthcare is necessary for you. Details are set out in the relevant healthcare article.
A prior referral, prescription and/or approval is not required for emergency healthcare, i.e. healthcare that cannot reasonably be postponed.

Referral or prescription
Does the healthcare article set out that you require a referral or a prescription? Then you can request one from the relevant healthcare provider referred to in the Article. This is generally the general practitioner.

Approval
In some cases you also require our permission prior to receiving the healthcare. This permission is referred to as prior approval. If you have not obtained prior approval where required, then you are not entitled to healthcare or to reimbursement of the cost of the relevant healthcare.

If you selected a healthcare provider that we have contracted for the relevant care, you do not require prior approval. Your healthcare provider will in such cases assess if you fulfil the conditions and/or requests prior approval from us on your behalf. Alternatively, you may submit a request for approval to us. Please find our address on the cover sheet of the conditions.

If you selected a healthcare provider that we have not contracted for the relevant care, you need to personally submit the request for approval to us.

If you have approval for insured healthcare, this also applies if you transfer to a different healthcare insurer or if you received approval from your previous insurer.

1.10. When are you entitled to reimbursement of the cost of invasive diagnostics?

You are entitled to reimbursement of the healthcare cost if the healthcare was provided during the term of your healthcare insurance policy.
Should these Policy Conditions refer to a year or calendar year, the actual date of treatment or date on which services/goods were provided as stated by the healthcare provider will determine the year or calendar year to which the relevant costs should be allocated. If a treatment falls in two calendar years and the healthcare provider may charge the cost as a single amount (for example the Diagnosis and Treatment Combination), we will reimburse these costs if the treatment was started within the term of the insurance policy and the cost will be allocated to the calendar year of the first treatment.

1.11. Exclusions

You are not entitled to:
- reimbursement of forms of healthcare or healthcare services that are funded pursuant to legal regulations, including the Wlz (Long-Term Healthcare Act), the Youth Act or the Wmo (Social Support Act) 2015;

- reimbursement of personal contributions or excess payable under the terms of the healthcare insurance, except if and where these policy conditions determine otherwise;
- reimbursement of fees for not appearing at your appointment with a healthcare provider (the 'no show fee');
- reimbursement of fees for written statements, mediation fees charged by third parties without our prior approval in writing, administrative fees or charges incurred by past-due payment of invoices from healthcare providers;
- pay-out on consequential loss claims resulting indirectly from our actions or omissions;
- reimbursement of healthcare costs caused by or resulting from armed conflict, civil war, uprising, civil disorder, riots or mutiny occurring in the Netherlands, as defined in Section 3.38 of the Wet op het financieel toezicht (Financial Supervision Act).

1.12. Right to reimbursement of costs of healthcare and other services as a result of terrorist acts

If you need healthcare as a result of one or more terrorist events, then the following rule applies. If the total amount of claims submitted within a year or calendar year for non-life, life or in-kind funeral insurers (including healthcare insurers) according to the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT or Dutch Reinsurance Company for Terrorism-related Claims) exceeds the maximum amount that this company annually reinsures, you are entitled to only a certain percentage of the cost or value of the healthcare. The NHT determines the exact percentage. This applies for non-life, life and funeral insurers (including healthcare insurers) that are subject to the Financial Supervision Act.
The exact definitions and provisions for the above-mentioned entitlement are included in NHT's Clauses Sheet Terrorism Cover.

If after a terrorist act an additional amount is provided under Section 33 of the Zvw (Healthcare Insurance Act) or Section 2.3 of the Besluit Zorgverzekering (Healthcare Insurance Decree), you are entitled to an additional scheme as set out in Section 33 of the Zvw or Section 2.3 of the Healthcare Insurance Act.

Guarantee pay-out on terrorism-related claims
In order to be able to guarantee that you will receive payment on terrorism-related claims, (almost all) insurers in the Netherlands are party to NHT (the Dutch Reinsurance Company for Terrorism-related Claims). We are also a member. NHT issued a scheme that ensures pay-out of at least part of any terrorism-related claim.
NHT capped the total amount to be paid out for terrorism-related losses. The maximum amounts to 1 billion euros per year for all insured together. If the total claim amount is higher, each insured that submitted a claim will receive pay-out at an equal percentage of the maximum amount. NHT set out the rules for due processing of loss claims in the Protocol for Processing Claims.
In reality, this may mean you are not paid out the full amount claimed. However, you are at least assured that you will receive payment of at least part of your claim.

Article 2. General provisions

2.1. Basis and contents of the healthcare insurance

The insurance contract was concluded based on the details you submitted in the application form or in writing. After taking out the healthcare insurance policy, you will receive a healthcare policy from us as soon as possible. Furthermore, you will receive a new healthcare policy prior to each new calendar year.

These policy conditions form an integral part of the healthcare policy. The policy cover will state the persons insured and the healthcare insurance taken out for them.

2.2. Scope of application

The healthcare policy is available to all persons subject to mandatory insurance, residing either in the Netherlands or abroad.

The healthcare insurer operates throughout the Netherlands. If you are subject to mandatory insurance, you may continue this healthcare policy. Persons subject to mandatory insurance residing abroad are also entitled to concluding this insurance.

2.3. Corresponding documents

These policy conditions refer to documents. These documents are part of the conditions. It concerns the following documents:

- Appendix 1 to the Healthcare Insurance Decree;
- Healthcare Insurance Scheme;
- Clauses Sheet Terrorism Cover;
- Premium Appendix;
- Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care);
- Overview of contracted healthcare providers;
- Overview exemption deductible;
- Healthcare Module Prevention Diabetic Foot Ulcers;
- Healthcare standards Diabetes mellitus, VRM, COPD and Asthma;
- Limitative list of DBCs (Diagnose Behandeling Combinaties or Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland to be requested in advance;
- Reglement farmaceutische zorg (Pharmaceutical Care Regulations);
- Reglement hulpmiddelen (Medical Aids Regulations);
- Nursing and care personal budget regulations;
- Reference guide assessment plastic surgery treatments;
- Dynamic overview mental healthcare.

You can find these documents on our website. Alternatively, you may request these documents from our customer service desk.

2.4. Fraud

Fraud (full or partial fraud) results in not receiving any reimbursement and/or recovering any amounts paid out. If you commit fraud, your entitlement to reimbursement of healthcare costs lapses. We will claim any amounts paid out from you in a recovery process. You will also be charged the cost ensuing from the fraud audit/inspections.
In the event of fraud, we will register your personal details and the personal details of the accessory/accessories to the fraud and/or fraud partners in our Incidents Register. This Incidents Register is reported to Autoriteit persoonsgegevens (CBP or Dutch Data Protection Authority) and is managed by our Security Affairs Department.
Your personal details and the personal details of the accessory/accessories to the fraud and/or fraud partners may also be registered in:

- Centrum Bestrijding Verzekeringsfraude (CBV or Centre for Countering Insurance Fraud) of Verbond van Verzekeraars (VvV or Dutch Association of Insurers);
- the external reference register of the CIS foundation (Stichting Centraal Informatiesysteem or Foundation Central Information System).

We may additionally decide on reporting the fraud to the police and other detection agencies.

Fraud with one of our insurance policies will result in termination of your healthcare policy/policies, and we will reserve the right to reject any applications for a new insurance for a period of five years. We also reserve the right to terminate any supplementary healthcare or other insurance policies. In that event, any applications for supplementary insurance will be rejected for a period of 8 years by any insurer that is a member of Coöperatie VGZ U.A.

2.5. Private data protection

We take your privacy very seriously. Collecting and processing your private data is necessary for concluding and performing your healthcare insurance and any supplementary policies. We will enter your private data in our system of insured
persons records.

Processing Private Data

Your personal details will be processed for the following purposes:

- for concluding and performing your insurance contracts or financial services;
- for inspections and/or checks among insured, healthcare providers and/or suppliers to ensure the healthcare services have actually been delivered;
- for research into the quality of healthcare delivered as perceived by our insured;
- for statistical analysis;
- for compliance with statutory requirements;
- in the context of the security and integrity of the financial sector (preventing and combating fraud);
- if you participate in a group agreement: for exchanging data with the contract party to the group contract for assessing your entitlement to premium discounts;

– promotion for this insurance and our own and similar services and products, and the associated marketing activities (up to 1 year after terminating the insurance contract).

Processing your personal details is subject to privacy legislation, including the Private Data Protection Act, the ZN Code of Conduct for Processing Private Data Healthcare Insurers, the Act general provisions BSN, the Act application of BSN in healthcare, and the Privacy Declaration of Coöperatie VGZ U.A. Please find the Code of Conduct and the Privacy Declaration on our website.

It is mandatory for us to use your BSN (citizen service number) in our administrative system, and in communications (data exchange) with the healthcare providers. The BSN is also used in data exchange on expense forms. Both are completed on a statutory basis.

We may decide to check your data at CIS Foundation for the security and integrity of the financial sector (CIS), www.stichtingcis.nl.

If you would like to receive more information, view or correct your personal details or submit objections, you can contact the Private Data Protection officer (FG) via the email address listed on our website in the section 'Privacy'.

Application of personal details by healthcare providers
If we receive your invoices directly from healthcare providers and pay out to them directly, your healthcare insurance is administered quicker and easier. This may require your healthcare provider to be able to see your type of insurance. For that reason, the healthcare providers may request secure access to your address and policy data and your BSN. They may do so only if they are actually treating you. If you have an urgent reason to not grant healthcare providers access to your address details, please notify us accordingly. We will then ensure that these data are not accessible.

2.6. Notifications

Any notifications sent to the most recent address in our system are deemed to have reached you.
If you wish to receive all notifications from us in digital format, please indicate this in 'My VGZ'.

Email
Where the policy conditions refer to 'in writing', this also includes 'by email' if you have chosen the email option. 'Address' in that context then also includes 'email address'.

2.7. Membership of the Cooperative Society

Upon acceptance to this healthcare insurance policy, you, as the policy holder, also become a member of Coöperatie VGZ U.A., the cooperative society VGZ U.A., unless you notify us in writing that you do not wish to do so. This Cooperative Society represents the interests of its members in the field of healthcare or other insurance. You may terminate your membership at any time, subject to a one-month notice period. The membership will in any case be terminated on the termination date of the insurance contract.

2.8. Cooling-off period

Upon taking out healthcare insurance, you have a 14-day cooling-off period as the policy holder. You are entitled to cancel the insurance policy in writing within 14 days of signing the contract. In that event, the insurance contract is deemed to have never been concluded.

2.9. Priority provisions

Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Health Insurance Act have or ought to have an effect on the healthcare policy, these will be deemed to form an integral part of these policy conditions. Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Zvw are conflicting with the provisions of this contract, the provisions of the Zvw will be leading, followed by the provisions of Title 7.17 of the Dutch Civil Code, followed by the provisions of this healthcare insurance.

2.10. Dutch law

This healthcare insurance contract is governed by Dutch law.

Article 3. Premium

3.1. Basis of premium and premium discounts

The basis of premium is the premium without premium discount for any voluntary deductible and/or group discount as agreed in a group health insurance contract. The premium basis and the premium discount for voluntary deductibles is set out in the premium Appendix as amended annually. Please find this premium Appendix on our website.

The premium basis and premium discounts applicable to you are set out in your policy cover.

3.2. Premium discount for group contract

3.2.1. If you participate in a group contract, you will receive a discount on the premium basis.

3.2.2. The premium discount and conditions as set out in the group contract will lapse on the date you can no longer participate in the group contract. From this date onwards, the healthcare insurance is continued on an individual basis.

3.2.3. You may not participate in more than one group contract at the same time.

3.3. Who pays the premium?

The policy holder has the obligation to pay premiums. No premium is due for an insured person under age 18 until the first day of the calendar month following the person's 18th birthday. Upon death of an insured, premium is due only up to the date of death. After a change of the insurance policy, we will recalculate the premium as per the effective date of the change.

Example
Someone who turns 18 on 1 July pays premium commencing on 1 August.

3.4. Payment of premium, statutory contributions, deductible and costs

3.4.1. Payment of the premium and domestic and/or foreign statutory contributions must be pre-paid for all insured in advance, unless agreed otherwise. If you pay the premium annually in advance, you will receive a term cash discount on the premium due. The amount of the discount is stated on the policy cover.

3.4.2. You pay the premium, excess, personal contributions and any reimbursement amounts paid out to you unjustified in the payment method as agreed with us.

No-fee payment options

a. You authorise us for automatic direct debit of the amounts due (see also Article 3.4.3).
b. You are making use of the option to receive a digital invoice through 'My VGZ' free of charge. In that case you are expected to personally ensure on-time payment. Direct online payment via iDeal is an option.
c. Your employer withholds the premium from your salary and transfers it to us. This payment option only applies to the premium.

These payment options are free of charge.

Fees for payment by paper invoice (payment order form)

If you are not making use of the free payment methods to pay your premium, you are charged a € 1.50 administrative fee for all expenses incurred for maintaining, preparing and providing a paper invoice and processing your payment. This also applies if you do not make use of the paper invoice. You will also receive a paper invoice if the direct debit transaction of your premium cannot be executed, or if you agree on a payment schedule with us with payment per acceptance giro. This is also subject to the € 1.50 fee for paper invoices. If you pay your premiums on a quarterly or annual basis and you selected payment based on a paper invoice, This form of payment is free of charge for you.

3.4.3. Your authorisation for direct debit is valid for payment of the premium, the excess, personal contributions and any reimbursement amounts paid out unjustified. Your authorisation is valid during and, if necessary, after termination of the insurance contract. We will inform you of the amount and date of the direct debit transaction at least 3 days in advance. If you disagree with a processed payment, you can have the payment reversed later. Please contact your bank within 8 weeks of processing the payment. The monthly amount to be automatically collected for your deductible, personal contributions and any reimbursement amounts paid out unjustified is capped at € 220 per month. For any amounts exceeding € 220, you will receive a paper invoice. If we choose to send you a paper invoice, this form of payment is free of charge for you.

3.5. Settlement

You may not settle any amounts due with any amounts payable to you.

3.6. Overdue payments

3.6.1. If you do not pay the premium, statutory contributions, personal contributions, the excess and any reimbursement amounts paid out unjustified in due time, we will send you a reminder. If you do not pay within the reminder period of at least 14 days as specified in the reminder, we may decide to suspend cover of this healthcare insurance policy. In that case you are not entitled to reimbursement of healthcare costs from the last premium due date before the reminder. Your obligation to pay the premium will continue during any period of suspension. Entitlement to reimbursement of costs of healthcare is restored on the date following the date on which the amount due plus any fees were received by us.
We reserve the right to terminate the healthcare insurance policy if payments are in arrears. The insurance will not be terminated with retroactive effect in that case.

3.6.2. We may charge the following fees in the event of overdue payment:
- statutory interest from the day following the due date of the original invoice;
- debt collection fees from the day following the due date of the original invoice.

3.6.3. If you already received a reminder for overdue payment of premiums, statutory contributions, excess, personal contributions, reimbursement amounts paid out unjustified or fees, we are not required to send a separate written reminder to you if a subsequent invoice is past due.

3.6.4. We reserve the right to settle any arrears in premiums, costs and statutory interest due with any healthcare expense forms or other amounts payable to you.

3.6.5. If we terminate the healthcare insurance policy due to overdue payment of the premium, we reserve the right to reject any applications from you for insurance contracts for five years.

3.6.6. If you have payment arrears amounting to two monthly premiums, we offer you a policy holder payment schedule. This is issued latest within 10 working days of detecting these arrears. Such a payment schedule consists of at least:

a. - your authorisation for automated direct debit of the new premium due, or;
   - your instructions to your employer, pension fund, social security agency or other third party from which you, as the policy holder, receive periodical payments to pay the new premiums due directly to us on your behalf;

b. agreements on the way you will pay us the amounts due, including interest and collection fees, and in which instalments;

c. our commitment that we will refrain from terminating, suspending or postponing your healthcare cover as long as you have not withdrawn your authorisation or payment order as set out under a, and as long as you fulfil the agreements as set out in the payment schedule.

We will give you 4 weeks to decide to accept our offer for a payment schedule. We will also inform you relating to the consequences of non-acceptance of our offer, and of your arrears running up to 6 or more monthly premiums; see Article 3.6.8.

You may have insured someone else for one of our healthcare insurance policies. In that case our payment schedule offer will also include a statement of intent to termination of this insurance policy effective on the date on which the payment schedule becomes effective, subject to the following conditions:
- that the insured has taken out insurance with another healthcare insurance policy latest effective on the same day;
- and that the insured has issued the authorisation or payment order as set out under a if the new healthcare insurance policy was also concluded with us.

We will send this insured a copy of all documents set out in this Article on the same date these documents are sent to you as the policy holder.

3.6.7. a. If you have payment arrears amounting to 4 monthly premiums, we will inform you, as the policy holder, that we intend to register you with Centraal Administratie Kantoor (CAK, Central Administrative Bureau) as set out in Article 3.6.8. If this healthcare policy was concluded for a different person, we will inform this insured accordingly.

b. Either you or the insured must notify us latest within 4 weeks if you dispute the existence or amount of the debt. If we receive your dispute in due order and time, we will start an investigation. If we inform you that we decided against adjusting our opinion, you may decide to present your dispute either to SKGZ (Stichting Klachten en Geschillen Zorgverzekeringen; Foundation Complaints and Disputes Relating to Healthcare Insurance) or to the competent court within 4 weeks.

c. If the payment schedule as set out in Article 3.6.6. becomes effective after payment arrears amounting to 4 monthly premiums, we will no longer send you any notifications as set out under a as long as you pay the new premiums due.

3.6.8. If you, as the policy holder, have payment arrears amounting to 6 or more monthly premiums, we will register you with the CAK. After the registration confirmation of the CAK, you are liable to payment of an administrative premium to the CAK amounting to at least 110% of the average market premium, capped at 130%. The CAK will collect this premium until you have paid all amounts due, including interest and collection fees.

We will refrain from registering you with the CAK if:

a. you disputed the premium arrears in due time, and if we have not yet responded to you with a statement of our opinion;
b. you presented the dispute to SKGZ or the competent court within 4 weeks of us informing you we decided against adjusting our point of view and intend to register the premium debt with the CAK, and as long as no irrevocable decision has been made regarding the dispute;
c. you registered with a professional administrator for restructuring your debt and you send a copy of a contract in writing aimed at stabilising your financial situation.

Our statement of compliance with Section 18b and the second paragraph of Section 18c of the Healthcare Insurance Act is part of the registration with the CAK.

3.6.9. We immediately notify both you and the CAK of the date on which:

a. the debt pursuant to the healthcare policy was fully paid or declared void;
b. the court declared that the statutory debt restructuring scheme for natural persons (WSNP) is applicable to you;
c. you will participate in an extrajudicial debt or debt restructuring scheme to which we are a party, negotiated by a professional administrator; or if we have agreed on a payment schedule with you based on full payment of the amount due; or:
d. you comply with the conditions to be determined by ministerial decree.

Your liability for payment of the administrative premium to the CAK will expire on the first day of the month following the aforementioned dates. From this moment on, your are subject to the obligation of paying the premium to us.

3.6.10. You are not liable for paying premiums to us on the period as referred to in Sections 18d, paragraph 1, or 18e of the Health Insurance
Act.

Article 4. Other obligations

You have a legal obligation:

- to inform us of any facts that mean (or could mean) that expenses may be recovered from third parties with actual or potential liability, and to provide us with the necessary information in this context. You may not make any arrangements with a third party without our prior approval in writing. You must refrain from any actions that may harm our interests;
- to cooperate with our medical advisor or employees in order to obtain all information required for inspection of the actual execution of the healthcare insurance cover;
- to ask the healthcare provider to disclose the reason for hospitalisation to our medical advisor;
- you must report any facts and conditions that may be relevant to correct execution of the insurance policy as soon as possible. This includes end of mandatory insurance, start and end of detention, separation or divorce, birth, adoption, or a change in bank or giro account number. We do not bear any risk relating to non-compliance with the above mandatory disclosures.

If you fail to fulfil your obligations and this harms our interests, we reserve the right to suspend your right to reimbursement of the costs of the covered healthcare.

Article 5. Changes in the conditions and premium/basis of premium calculation

5.1. Amendments to conditions

We reserve the right to change the conditions and the premium or premium basis of the insurance policy at any time. We will inform you, the policy holder, in writing accordingly. A change in the basis of the premium will only become effective 6 weeks after the date on which you were notified of such changes. A change in the conditions will only become effective one month after the date on which you were notified of such changes.

5.2. Cancellation right

If we change any conditions and/or the premium basis of the healthcare insurance policy to your disadvantage, you, as the policy holder, have the right to cancel the insurance contract as per the effective date of the change. You may cancel the contract during 1 month after having received notice relating to the change from us. However, you do not have this right to give notice if a change in the insured healthcare cover results directly from amendment of the provisions set out in Sections 11 through 14 of the Zvw.

Article 6. Start date, term and termination of healthcare cover

6.1. Start date and term

6.1.1. The insurance contract becomes effective on the date on which we receive your application or application form. You will receive a confirmation of receipt stating the date on which we received your application. If you are subject to mandatory insurance and you do not yet have a BSN (citizen service number), you can still be registered as an insured.

6.1.2. Sometimes we are unable to derive from the application whether or not concluding a healthcare policy with the person to be insured is mandatory for us. In such cases we will request information from you that would prove that concluding a healthcare policy with you is mandatory. The healthcare policy will only become effective on the day we receive such additional information. You will receive a confirmation of receipt stating the date on which we received your additional information.

6.1.3. If you have a different healthcare policy on the day as set out in Article 6.1.1 or 6.1.2, the healthcare insurance policy will become effective on the later date you indicated.

6.1.4. If the previous insurance policy is terminated effective 1 January of a calendar year or due to a change in the conditions, the new insurance policy will commence at the new insurer as per the termination date of the old insurance policy. In that case you must register with the new healthcare insurer within one month of termination of the previous insurance policy.

6.1.5. If the insurance contract becomes effective within 4 months of the start date of mandatory insurance, the healthcare policy will become effective on that start date.

Example
It is mandatory for you to insure your child within 4 months of childbirth, ensuring that your child is insured from the date it was born.

6.1.6. The Healthcare Insurance Act includes provisions relating to mandatory insurance. It is not mandatory for us to conclude a healthcare policy with or for a person subject to mandatory insurance if that person is already insured pursuant to the Healthcare Insurance Act.

6.2. Termination by operation of law

The healthcare insurance terminates by operation of law from the day following the day on which:

- the healthcare insurer is no longer permitted to offer or execute healthcare insurance policies due to a change in or suspension of its licence to operate a non-life insurance business. We will disclose any such changes at least 2 months in advance;
- the insured person dies;
- the insured person's obligation to take out insurance terminates.

You, as the policy holder, have the obligation to inform us of the death of an insured or of the end of mandatory insurance of an insured as soon as possible. If you do not notify us of the end of mandatory insurance of an insured on time and we pay the cost of healthcare to a healthcare provider, we will claim these costs from you. If we conclude that the healthcare insurance cover has terminated, we will send you a confirmation accordingly as soon as possible.

6.3. When can you cancel your insurance policy?

6.3.1. **Annual termination**

As the policy holder, you are entitled to terminate the healthcare insurance policy annually as per 1 January, subject to receiving your notice in writing latest by 31 December of the previous year. You will then have until 1 February to find another insurer who will insure you with retrospective effect to 1 January.

6.3.2. **Intermediate termination**

You, as the policy holder, are entitled to intermediate termination of the healthcare insurance policy in writing:

- of another insured if this insured has taken out a different healthcare policy. If you cancel the healthcare policy before the other healthcare policy becomes effective, the termination date will coincide with the start date of the new healthcare policy. If the cancellation notice was received later, the cancellation date will be the first day of the second calendar month after receipt of your cancellation notice;
- in the event of changes to the premium and/or conditions as set out in Article 5.2;
- if you participate in one of our group contracts with your former employer, and you are offered to participate in the group contract of your new employer. You may cancel the healthcare insurance at any time up to 30 days after the new employment commences. In that event both the cancellation and the registration become effective on the start date of the employment with the new employer if that is the first day of the calendar month, and, if not, then on the first day of the calendar month following the start date of the employment.

Cancellation for 18th birthday
You may cancel your child's insurance upon his/her 18th birthday. Your child may then conclude his/her own healthcare insurance policy.

6.3.3. Cancellation service
For cancellation of the insurance policy as set out in Articles 6.3.1 and 6.3.2, you may also make use of the cancellation service of the Dutch healthcare insurers. This means that you authorise the insurer of your new healthcare policy to cancel the healthcare policy with the previous insurer.

6.3.4. When is cancellation not possible?
If we sent you a reminder for arrears in premium payments, you are not permitted to cancel your healthcare policy during that period until full payment of the premium, interest and collection fees has been received. You may cancel the healthcare policy if we suspended cover or if we confirm your cancellation within 2 weeks.

6.4. When are we entitled to cancel, dissolve or suspend the insurance contract?
We are entitled to cancel, dissolve or suspend the insurance policy in writing:
- in the event of past-due payments as set out in Article 3.6;
- in the event of fraud (see Article 2.4);
- if you intentionally have not provided any, incomplete or incorrect information or documents that have or could have worked to our disadvantage;
- if you acted with the intention of misleading us or if we would not have entered into a healthcare policy if we had been aware of the true state of affairs. In such cases we reserve the right to cancel the healthcare policy within 2 months of detection and with immediate effect. In such cases we are not liable for paying out any amounts, or we may reduce the amount to be paid out. We reserve the right to set off such recovery claims against other payments.

6.5. Evidence of termination
Upon termination of the healthcare policy, you will receive a termination confirmation with the following details:
- name, address, place of residence and citizen service number (BSN) of the insured person;
- name, address and place of residence of the policy holder;
- the day on which the healthcare policy terminates;
- whether on that day a deductible applied and if yes, the amount of this deductible.

Upon termination of mandatory insurance, the end date is also stated in the confirmation.

6.6. Insuring non-insured persons
If the CAK concluded this healthcare policy on your behalf pursuant to Section 9d, paragraph 1 of the Healthcare Insurance Act, the following applies:

a. you may deem this healthcare policy null and void if you can demonstrate within 2 weeks to both us and the CAK that you already have healthcare insurance. This 2-week period starts on the date on which the CAK informed you that it concluded this healthcare policy on your behalf;

b. we may lawfully reverse this healthcare policy due to error if you demonstrate that you are not subject to mandatory insurance;

c. you are not permitted to cancel this healthcare policy during the first 12 months. After these 12 months, the customary termination options as stated in Article 6.3 become effective.

Article 7. Mandatory excess

7.1. Amount of mandatory deductible
If you are age 18 or older, a mandatory deductible of € 385 per calendar year applies. The costs of healthcare are charged to you up to this amount. If you reach age 18 in the course of a calendar year, the mandatory deductible applies from the first day of the calendar month following the calendar month after your 18th birthday. The amount of the mandatory deductible will then be determined in accordance with the calculation method stated in Article 7.4.

7.2. The relevant types of care to which the mandatory deductible is applicable
The mandatory deductible is applicable to all types of care as included in these policy conditions, with the exception of:
- general practitioner care. Please remember that any medications prescribed by the general practitioner do not

fall within the scope of general practitioner care. The same applies for laboratory testing related to general practitioner care. If such laboratory testing is conducted and invoiced by a different healthcare provider at the request of the general practitioner, then the mandatory deductible is charged to you for this healthcare service. See Article 11, General practitioner care;
- healthcare programmes as set out in Article 12, Healthcare programmes (chain healthcare). The excess is applicable to medications and laboratory tests;
- nursing and care as set out in Article 13;
- obstetric care by an obstetrician, general practitioner or gynaecologist. No deductible applies for prenatal screening, excepting for the NIPT. The deductible applies to NIPT. Any fees associated with obstetric care are also subject to the deductible. This means that medications, blood tests or patient transport are set off against the mandatory deductible. See Article 14.1, Obstetric care, and Article 15, Specialist medical care;
- maternity care; Please refer to Article 14.2.Maternity care;
- preferred medications as set out in the Pharmaceutical Care Regulations. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your deductible; See Article 34, Medications;
- the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar supplying the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your deductible; See Article 34, Medications;
- the preferred and selected liquid nutrition products as set out in the Pharmaceutical Care Regulations. See Article 35, Dietary Preparations;
- leased medical aids; Please refer to Article 36, Medical aids and bandaging
- post-op check-ups after a kidney or liver donation, after the period set out in Article 21, Tissue and organ transplants, under description, item d, has expired;
- transport of a donor as set out in Article 21, Tissue and organ transplants;
- any personal contributions and/or personal payments.

7.3. The relevant healthcare providers and healthcare arrangements to which the mandatory excess is not applicable

We have the option of appointing healthcare providers or healthcare arrangements where you are charged no amount or a smaller amount of mandatory deductible. This also applies to health-promoting or preventive healthcare arrangements to be specified further. This information is set out in the Overview exemption deductible. Please find this overview on our website.

7.4. Calculation method of amount of mandatory deductible

If the healthcare policy does not start or end on 1 January, we calculate the deductible as follows:

$$\text{Deductible} \times \frac{\text{number of days that the healthcare policy was effective}}{\text{the number of days in the relevant calendar year}}$$

This amount will be rounded off to the nearest whole euro.

Example

The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2017 has 365 days. The deductible is: € 385 x 30 divided by 365 is € 31.64 and is rounded off to € 32.

7.5. Calculation of mandatory deductible

When calculating the deductible, the costs of care or another service will be allocated to the calendar year in which the care was received. If a treatment falls in 2 calendar years and the healthcare provider may charge the costs as a single amount (for example the Diagnosis and Treatment Combination), these costs will be charged to the deductible of the calendar year in which the treatment started.

Article 8. Voluntary excess

8.1. Options for voluntary deductible

If you are age 18 and older, you may select a healthcare policy with a voluntary deductible amounting to: € 0, € 100, € 200, € 300, € 400 or € 500 per calendar year. The costs of healthcare are charged to you up to this amount. Depending on the selected amount of the voluntary deductible, you will receive a discount on the premium basis. The selected voluntary deductible and any discounts are stated on the policy cover.

8.2. The relevant types of care to which the voluntary deductible is applicable

The voluntary deductible is applicable to the same healthcare types as set out in Article 7.2.

8.3. Calculation method of amount of voluntary deductible

8.3.1. If the healthcare policy does not start or end on 1 January, we calculate the voluntary deductible as follows:

$$\text{Deductible} \times \frac{\text{number of days that the healthcare policy was effective}}{\text{the number of days in the relevant calendar year}}$$

This amount will be rounded off to the nearest whole euro.

Example

You selected a voluntary deductible of € 100. The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2017 has 365 days.
The voluntary deductible is: € 100 x 30 divided by 365 is € 8.22 and is rounded off to € 8. The mandatory excess is € 385 x 30 divided by 365
is € 31.64 and is rounded off to € 32. The total excess amounts to € 40 (€ 32 mandatory excess and € 8 voluntary excess).

8.3.2. If the healthcare insurance policy does not become effective on 1 January and you had taken out a healthcare policy with us with a different voluntary excess amount previously, then the total voluntary excess is calculated as follows:

a. each amount of voluntary excess x the number of days that the voluntary excess is applicable;
b. the sum of the amounts stated under a divided by the number of days in the relevant calendar year;
c. the result of this amount will be rounded off to the nearest whole euro.

8.4. Amendments to voluntary deductible

You may change the voluntary deductible annually as per 1 January. In that case, you should forward us the relevant change latest by 31 December of the previous calendar year in writing or via 'My VGZ'.

8.5. Calculation of mandatory and voluntary deductible

If a voluntary deductible applies, the healthcare costs will first be deducted from the mandatory deductible and subsequently from the voluntary deductible. The provisions set out in Article 7.5 apply for the calculation of the voluntary deductible amount relating to treatment spread over 2 calendar years.

Article 9. Abroad

9.1. If you are living in or residing in an EU/EER or treaty country outside the Netherlands

If you are living in or residing in an EU/EER or treaty country outside the Netherlands, you are entitled to the following healthcare:

- healthcare in accordance with the statutory insurance package in an EU/EEA country or treaty country, if applicable to you. This right to healthcare is set out in the EU social security regulations or a social security treaty;
- reimbursement of healthcare costs by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to a maximum of the market price perceived as reasonable in the Netherlands.

European health card (EHIC)

On the reverse of your healthcare card, you can find the EHIC. If you travel to an EU/EEA country or Switzerland, this card entitles you to necessary medical care abroad. You can use the EHIC in Australia for emergency medical care. You may use this EHIC only if you are insured with us. If you use this EHIC abroad, while you know or could reasonably know that it is no longer valid, the cost of healthcare will be charged to you.

9.2. If you are living in or residing in a non-EU/EER country or non-treaty country

If you are living in or residing in a non-EU/EER country or non-treaty country, you may choose healthcare in your country of residence or temporary residence and select:

- reimbursement of healthcare costs by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to a maximum of the market price perceived as reasonable in the Netherlands.

Please note
The costs of treatment abroad may be higher than the costs of the same treatment in the Netherlands. We will reimburse the costs up to the amount you would receive if you had the treatment in the Netherlands. Please take into consideration that you will likely have to pay for a (large) part of the bill yourself if you are having treatments abroad.

9.3. Requirement of approval for care abroad

Are you considering treatment abroad? If you are hospitalised in a hospital or a different institution for 1 or more nights, you will require our prior approval. You do not require prior approval if you are unexpectedly hospitalised and the treatment cannot reasonably be postponed until you have returned to your country of residence. If you are taken in for 1 or more nights, you must call, or have someone call, our emergency response unit. Please find the emergency response telephone number on both your healthcare card and our website.

9.4. Referral and/or approval requirements

If you require approval for making use of healthcare (Article 9.3) and also a specific referral, prescription and/or approval, you can find the details in the relevant healthcare article (also see Article 1.9).

Article 10. Complaints and disputes

10.1. Do you have a complaint? Please submit your complaint to the Complaints Management department

You may rest assured that we organise everything carefully relating to your healthcare insurance policy. However, one hundred percent satisfaction is not always achievable. We are open to hearing your complaints and suggestions. It is easy to submit your complaint via the online complaints form on our website. If you do not have the option of digital submission of your complaint, please feel free to submit your complaint in writing to the Complaints Management department, PO Box 1256, 5602 BG in Eindhoven, the Netherlands. The Complaints Management department acts on behalf of the board.

Tips for submission of a complaint
- Please indicate in as much detail as possible what happened, what you are dissatisfied with, what you think is the best solution and when you can best be reached.
- Please attach all relevant documents. Please do not send any originals with your complaint. After all, you may still need the originals.
- If you are unable or unwilling to submit your complaint, you can have someone else do this on your behalf and designate a proxy. However, for privacy reasons, we will require your permission in writing to deal with such a proxy. We cannot process the complaint until we receive your permission.

You will receive a response from us within 30 days. If you are not satisfied with the decision or if you have not received any response within 30 days, please feel free to submit your complaint or dispute to SKGZ (Foundation Complaints and Disputes Healthcare Insurance), PO Box 291, 3700 AG Zeist, the Netherlands, www.skgz.nl. Alternatively, you may submit the dispute to the competent court of law.

10.2. Complaints about our forms

If you feel one of our forms is superfluous or complicated, please submit your complaint via our website. Alternatively, you may submit your complaint in writing to the Complaints Management department, PO Box 1256, 5602 BG in Eindhoven, the Netherlands.

You will receive a response to your complaint about our forms from us within 30 days. If you are not satisfied with the decision or if you have not received any response within 30 days, please feel free to submit your complaint to the Dutch Healthcare Authority for the attention of the Information Line/the Notification Centre, PO Box 3017, 3502 GA Utrecht, the Netherlands,
email: info@nza.nl. The website of the Dutch Healthcare Authorities, www.nza.nl, sets out how to submit a complaint about forms.

II. Healthcare Provisions

MEDICAL CARE

Article 11. General practitioner care

Description

You are not entitled to reimbursement of the cost of:

1. medical care as offered by general practitioners including the associated laboratory tests. This also includes health advice, counselling for quitting smoking, pre-conception healthcare (pregnancy wish visit) and foot care if you have diabetes mellitus type 1 or 2.
   Counselling for quitting smoking is defined as:
   - short treatments, such as one-off short counselling sessions for quitting smoking;
   - intensive forms of treatment aimed at behavioural change (in a group or as an individual).

   If you attend a Quit Smoking programme with your general practitioner in accordance with the Healthcare Module Quit Smoking, please refer to Article 23. Your general practitioner can provide more details.

   Pre-conception healthcare (pregnancy wish visit) is defined as:
   - advice on healthy nutrition;
   - advice on intake of folate acid;
   - advice on intake of vitamin D;
   - advice on quitting smoking, alcohol and drugs, if necessary with active counselling to realise this;
   - advice on using medication;
   - advice on treatment of existing conditions and previous pregnancy complications;
   - advice on infectious diseases and vaccinations;
   - tracking risks based on your health history and offering genetic counselling if you are not (yet) pregnant.

   The aforementioned foot care for diabetes mellitus is defined as:
   - annual foot screening consisting of a review of the medical history, a risk assessment and determining the care profile;
   - from care profile 1: annual specific foot examination and advice on adequate footwear, foot care advice and advice relating to managing load and capacity;
   - from care profile 2: more frequent, specific foot examination, check-ups and diagnostics, treatment of skin and nail problems, foot shape and position deviations and other risk factors.

   These foot treatments do not include foot care such as removing hard skin for purely cosmetic or personal care reasons and general nail care such as clipping nails.

   The care profiles are set out in the Healthcare Module Prevention Diabetic Foot Ulcers. Care profiles give insight into the foot care required based on a risk classification of patients with diabetes mellitus. The Healthcare Module is available from our website. Your general practitioner can tell you which care profile applies to you.

Foot care as part of a healthcare programme

If you have diabetes mellitus type 2, and you are receiving healthcare through a healthcare programme as set out in Article 12, In that event you are not entitled to reimbursement of the cost of the foot care as described in this Article.

2. - Diabetes, assistance per year
   - Diabetes, setting up insulin;
   - chronic obstructive pulmonary disease (COPD; this is a group of lung conditions, such as chronic bronchitis and lung emphysema); structural healthcare per year;
   - Structured general practitioner care in the nursing home, and;
   - Structural general practitioner care in the social network.

   The general practitioner care as set out in the description can only be charged by your general practitioner subject to a contract with us.

Healthcare programme for diabetes mellitus type 2 or COPD
Do you have diabetes mellitus type 2 (DM type 2) or COPD? You can enquire with your general practitioner to see if yo are eligible for participating in a healthcare programme for your condition with a contracted healthcare group as set out in Article 12, Healthcare programmes.

3. medical specialist care bordering on the medical domain of the general practitioner. Examples of such healthcare include:
   - regular or minor surgery interventions;
   - ECG diagnostics (heart images);
   - lung function test (spirometrics);
   - diagnostics based on the Doppler test (testing the blood flow in the vascular system);
   - MRSA screening (screening for Meticillin Resistant Staphylococcus Aureus);
   - audiometrics (hearing system testing);
   - IUD (pessary) application or removal, implantation or removal etonogestrel implantation rod. If you are age 21 and up, you are not entitled to reimbursement of a contraceptive, excepting for treatment of endometriosis or menorrhagia (if suffering from anaemia);
   - medically necessary circumcision.
   - therapeutic injections (Cyriax).

Excess
No deductible applies for this healthcare. Please remember that any medications prescribed by the general practitioner do not fall within the scope of general practitioner care. The same applies for laboratory testing related to general practitioner care. If such laboratory testing is conducted and invoiced by a different healthcare provider at the request of the general practitioner, then the mandatory deductible is charged to you for this healthcare service. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
General practitioner or third parties who are medically qualified. Under the medical responsibility of a general practitioner, this care may also be administered by a medical receptionist, nurse, social worker, nurse practitioner (NP), physician assistant (PA) or practice assistant (GGZ).
For placing or removing a diaphragm, you may also choose an obstetrician certified for this service. Your obstetrician can provide more details.

Relating to the foot care set out in this Article, you may select a podotherapist who is a member of the Nederlandse Vereniging van Podotherapeuten (NVvP, Dutch Association of Podotherapists) and as such also has a registration in the Quality Register Paramedics.
The podotherapist will prepare the treatment plan and will determine which part of the treatment may be performed by a medical pedicure or pedicure with a certificate for Diabetic Feet who is registered in ProCert's Quality Register for Pedicures (KRP) if collaborating with the podotherapist.

An overview of the partnerships between podotherapists and pedicures is available from our website.

Authorised foot care providers
The foot care may be provided in the practice space of your healthcare provider or in a hospital, nursing home or convalescence home. If the healthcare provider treating you feels this is medically necessary, the care or treatment may be provided at home.

Notes
1. For foot care as part of the diabetes mellitus type 2 care programme, please refer to Article 12, Healthcare programmes.
2. For specialist medical care, please refer to Article 15, Specialist medical care.

VGZ Health Line
If you have any questions on your health, you can ask your general practitioner. Alternatively, you can call the VGZ Health Line. The VGZ Health Line is a medical advice line. You can talk to an experienced nurse on the phone. Based on a number of specific questions, this nurse determines the seriousness of your complaints and then gives you an advice, independently or in consultation with a general practitioner. This advice may range from a self-care advice ('the best thing might be to take a paracetamol tablet') to the advice to see your general practitioner immediately. The VGZ Health Line is available 24 hours per day, 7 days per week for health advice. The telephone number is available from our website.

Article 12. Healthcare programmes (chain healthcare)

Description
You are entitled to reimbursement of the cost of one of the following healthcare programmes (chain healthcare):
1. diabetes mellitus type 2 (DM type 2);
2. vascular risk management (VRM; this is about managing (the risk of) cardiovascular conditions);
3. chronic obstructive pulmonary disease (COPD; this is a group of lung conditions, such as chronic bronchitis and lung emphysema);
4. asthma (if you are age 16 or older).

All healthcare elements of the healthcare programme must comply with the healthcare standard for Diabetes mellitus, VRM, COPD or Asthma. Please find the healthcare standards on our website.

The healthcare programmes are funded in accordance with the policy guideline of the Dutch Healthcare Authority for funding performances of multidisciplinary healthcare relating to chronic conditions.

Healthcare programmes (chain healthcare)
Healthcare programmes are specifically developed to organise healthcare for chronic patients in a region better in terms of quality and effectiveness. The healthcare providers closely work together within a healthcare group, ensuring that the healthcare you need is better aligned. The healthcare programme is subject to an integral rate designed to fund all healthcare within the programme. This is why you can only select healthcare providers that are a member of a contracted healthcare group for healthcare within the healthcare programme.

Healthcare group
The healthcare group is a partnership of healthcare providers with various disciplines, with a general practitioner in charge. Together, they provide chain healthcare. In addition to the general practitioner, healthcare is also delivered by a nurse, physician's assistant, dietician, podotherapist or pedicure.

Excess
No deductible applies for this healthcare. The deductible is applicable to medications and laboratory tests. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
A contracted healthcare group.
An overview of contracted healthcare groups is also available from our website. Alternatively, you can ask your general practitioner for the available healthcare programmes and the healthcare group you can contact.
If you select a non-contracted healthcare group for one of the above-mentioned healthcare programmes, you are not entitled to reimbursement.

If you are not making use of a healthcare programme or healthcare programmes are not available in your area, you are entitled to reimbursement of the cost of healthcare provided by individual healthcare providers pursuant to the relevant healthcare articles, including general practitioner care (Article 11) and dietetics (Article 29).

Notes
Specialist medical care does not fall within the scope of the healthcare programme (chain healthcare). For this type of care, please refer to Article 15, Specialist medical care.

Article 13. Nursing and care

Description
Your right to reimbursement of the cost of nursing and care as nurses generally provide, such without hospitalisation in an institution. This healthcare includes coordination, detection, prevention, instruction and supporting the independent management and independence level of the clients, the client system and case management. The healthcare is related to the need of medical care as set out in Article 2.4 of the Healthcare Insurance Decree, or a high risk of needing such care.

Insured under age 18 are only entitled to reimbursement of the cost of healthcare in the case of care required due to complex somatic problems or a physical disability with:
- permanent supervision being required, or;
- 24/7 healthcare needing to be available nearby and such healthcare is related to one or more specific nurse-administered treatments.

Personal Budget (pgb)
You may be entitled to reimbursement of nursing and care in the form of a personal budget (pgb). This requires our prior approval. The Nursing and Care Personal Budget Regulations set out the terms and conditions that apply to having a pgb. The Nursing and Care Personal Budget Regulations are available from our website.

Excess
No deductible applies for this healthcare. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Nursing specialist, nurse, health care worker level 3 and healthcare worker in individual nursing healthcare (VIG staff).

Referral letter required from
1. general practitioner or medical specialist for: palliative terminal healthcare;
2. paediatrician: for nursing and care for insured persons under age 18 (intensive care for children);
3. medical specialist: for specialist medical nursing at home. The healthcare is provided under the responsibility of the medical specialist.

Notes
1. You are only entitled to reimbursement of the cost of this healthcare if you have an indication for nursing and care and a treatment plan was prepared for you. The indication is prepared by a nurse, level 5. The nurse consults with you to prepare a treatment plan in compliance with the guidelines of the occupational group Nursing & Caring in the Netherlands. The treatment plan describes the healthcare you need in terms of nature, scope and duration and the goals set.
2. The indication for nursing and care for insured persons under age 18 due to complex somatic problems or a physical disability (intensive care for children) will be provided under the responsibility of a paediatrician in the hospital. The paediatric nurse, level 5 consults with the parents and paediatrician to prepare a treatment plan. The treatment plan describes the healthcare you need in terms of nature, scope and duration and the goals set.

Article 14. Obstetric care and maternity care

14.1. Obstetric care

Description
You are entitled to reimbursement of the cost of obstetric care, including prenatal and postnatal care, as offered by obstetricians. Obstetric care includes the use of a delivery room if the delivery takes place in a hospital or birth clinic due to medical necessity.

This care also comprises:
- pre-conception healthcare (pregnancy wish visit):
  if you wish to get pregnant, you can make use of pre-conception healthcare. Article 11 under the description, item 1 indicates the elements included in this type of care;
- counselling:
  if you are pregnant and you are considering pre-natal screening for hereditary disorders, you will generally require an extensive consultation with your general practitioner, obstetrician or medical specialist first. This consultation visit is referred to as counselling. During this visit you will receive information on the content and scope of pre-natal screening. You are then well equipped to make a decision on such screening. This refers primarily to the twenty-week ultrasound examination and the combination test (SEO; Structural Echoscopic Testing);
- the combination test, the non-invasive pre-natal test (NIPT) and the invasive diagnostics if you have a medical

indication. You are also entitled to reimbursement of the cost of an NIPT if a combination test shows that you have a significant risk of having a child with chromosome anomalies. You are also entitled to reimbursement of the cost of invasive diagnostics if a combination test or NIPT shows that you have a significant risk of having a child with chromosome anomalies;
- twenty-week ultrasound (anomaly scan, SEO in Dutch):
  the anomaly scan can be used to check if your baby may have a physical anomaly, such as spina bifida, for example. This test is called the Structural Ultrasound Test (SEO in Dutch, second trimester). This test takes place around the twentieth week of pregnancy.

Prenatal diagnostics

The combination test, NIPT and invasive diagnostics (chorionic villus testing or amniocentesis)
If your medical healthcare provider indicates an elevated risk of a child with Down syndrome, Edwards syndrome or Patau's syndrome (trisomy 21, 18 or 13), you are entitled to reimbursement of the cost of diagnostics.

If you do not have a medical indication
If you do not have a medical indication for increased risk, you may decide on a combination test or NIPT at your own expense.
- If the combination test shows that you have a significant risk of having a baby with a chromosomal anomaly, you are entitled to reimbursement of the cost of an NIPT or invasive diagnostics.
- If the NIPT shows that you have a significant risk of having a baby with a chromosomal anomaly, then you are entitled to reimbursement of the cost of invasive diagnostics.

Excess
No deductible applies for obstetric care. No deductible applies for prenatal screening, excepting for the NIPT. The deductible applies to NIPT. Any fees associated with obstetric care are also subject to the deductible. This means that medications, blood tests or patient transport are set off against the mandatory deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Obstetrician or general practitioner with further training and who specialises in physiological obstetrics.

The combination test and the twenty-week ultrasound may only be performed by a healthcare provider with a permit pursuant to the Wet op het bevolkingsonderzoek (Population Screening Act), or a healthcare provider with a partnership agreement with a Regional Centre for Prenatal Screening. As soon as there is a medical indication, the examination may be performed without such a permit. You can select a university centre for the NIPT and a centre for pre-natal diagnostics for the invasive diagnostics.

Notes
For obstetric care provided by a gynaecologist, please refer to Article 15, Specialist medical care.

14.2. Maternity care

Description
You are entitled to reimbursement of the cost of nursing as generally offered by maternity assistants to the mother and child in connection with a delivery, during a period of no more than 10 days counting from the day of the delivery.

Personal contribution
You are charged a statutory personal contribution amounting to:
- € 4.30 per hour for maternity care at home or in a contracted birth clinic;
- € 17 per day for both mother and child if the delivery takes place in a contracted hospital or birth clinic without medical necessity. In addition to the personal contribution, you are charged the cost difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of € 121 per day for both mother and child.

Excess
No deductible applies for this healthcare.

Authorised healthcare providers
A qualified maternity assistant or a nurse working as such.

Notes
1. The obstetrician or general practitioner providing the obstetric care determines the number of maternity care hours based on the Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care). You are entitled to reimbursement of the cost of at least 24 hours up to a maximum of 80 hours, divided over a maximum of 10 days. Please find this protocol on our website.
2. Did you select a non-contracted maternity assistant or nurse? Please send a copy of the following with your invoice for maternity care:
   - the indication in accordance with the Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care);
   - if a maternity assistant provided the care: the Maternity Assistant Certificate.

   These copies can be requested from the relevant maternity care organisation and/or the independent maternity assistant or nurse.
3. For every day of hospitalisation during which maternity care was provided in hospital for some part, we will deduct the average number of hours of maternity care (this is the number of indicated hours of maternity care divided over 10 days) per day from the number of maternity care hours as indicated.
4. If more than one healthcare institution (for example hospital and maternity care organisation) have charged maternity care for the same day, you are also entitled to reimbursement of the cost of maternity care on this 'double day'.

Please note
Request maternity care at least 5 months prior to the expected due date via our website. Then you can be assured that your request will be processed in time.

Which obstetric care and maternity care are included in your healthcare policy?

Delivery and maternity care at home	
Delivery at home	Yes. For assistance by the maternity assistant during home delivery (partus assistance), a personal contribution of € 4.30 per hour applies.
Maternity care at home	Maximum of 10 days, counting from the delivery date. Subject to a personal contribution for maternity care amounting to € 4.30 per hour.
Delivery and maternity care in birth clinic or hospital with medical necessity	
Delivery in birth clinic or hospital with medical necessity	Yes.
Maternity care in a birth clinic	Maximum of 10 days, counting from the delivery date. Subject to a personal contribution for maternity care amounting to € 4.30 per hour.
Maternity care in hospital after childbirth with medical necessity	Yes This is not subject to a personal contribution.
Delivery without medical necessity and maternity care in birth clinic or hospital	
Delivery in birth clinic delivery room without medical necessity	Yes. The maximum reimbursement for mother and child together amounts to € 208 per day. This reimbursement is calculated as follows: - Maximum reimbursement is 2 x € 121: € 242 per day Less: personal contribution is 2 x € 17: € 34 per day € 208 per day The difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of € 208 per day is charged to you personally.
Delivery and maternity care without medical necessity for stay in a hospital	
Maternity care in a birth clinic	Maximum of 10 days, counting from the delivery date. Subject to a personal contribution for maternity care amounting to € 4.30 per hour.

Medical necessity
Your obstetrician or general practitioner providing obstetric care determines whether or not there is a medical necessity for delivery in a hospital or birth clinic.

The healthcare costs charged to you personally may be reimbursed if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

Integral maternity care
Obstetricians, maternity care nurses and gynaecologists collaborating in a maternity care organisation are permitted to agree on an integral rate for maternity care with us starting in 2017. Integral maternity care is designed to lubricate the collaboration between the various healthcare providers, resulting in improved quality of healthcare for both mother and child. This maternity care may be charged by the maternity care organisation only subject to a contract with us. An overview of such organisations is available from our website.
You may changes healthcare providers during pregnancy, maternity and aftercare.

Article 15. Specialist medical care

Description
You are entitled to reimbursement of the cost of medical care as generally offered by a medical specialist including the associated laboratory tests, medications, bandaging and medical aids. Specialist medical care also includes:
- care provided by a thrombosis unit;
- second opinion from a medical specialist. This is subject to a referral from the healthcare provider treating you. This may concern the relevant general practitioner, obstetrician or medical specialist, for example. The second opinion must relate to the medical care that you already discussed with your first healthcare provider. You are required to return to your original healthcare provider with the second opinion, as the first person will remain the leading provider in your treatment;
- dialysis in a dialysis centre, hospital or at home;
- chronic intermittent respiration and the required equipment;
- counselling for quitting smoking. This includes one-off short advice for quitting smoking;
- medically necessary circumcision.

Specialist medical care also comprises:
a. up to 1 January 2016, treatment of chronic a-specific low back complaints (complaints for which no clear cause can be found), with application of anaesthesiological pain management methods, insofar as you are participating in research as outlined below;
b. up to 1 January 2017, treatment of therapy-resistant hypertension (elevated blood pressure) with application of percutaneous renal denervation, insofar as you are participating in research as outlined below;
c. up to 1 January 2017, treatment of a cerebral infarct with application of intra-arterial thrombolysis if you participate in the randomised multi-centre study 'Multicenter Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands (MR CLEAN)' or if you participate in observational research into this healthcare type as outlined below;
d. up to 1 January 2018, treatment based on transluminal endoscopic step-up approach of an infected pancreatic necrosis, insofar as you are participating in research as outlined below;
e. up to 1 January 2018, treatment based on autologus stem cell transplants for severe therapy refractory morbus Crohn, insofar as you are participating in research as outlined below;
f. up to 1 January 2019, treatment of colon carcinoma with adjuvant hyperthermic intraperitoneal chemotherapy (HIPEC), insofar as you are participating in main research as outlined below;
g. up to 1 July 2019, treatment with belimumab of adult patients with active auto-antibody-positive systemic lupus erythematosus with a high degree of disease activity and a history of therapy resistance to the standard treatment, insofar as you are participating in the research into the effectiveness of this healthcare type, or observational research into this healthcare type as outlined below, which are stated in the advice issued by the Healthcare Institute on 29 April 2015;
h. up to 1 July 2019, treatment with tumour-infiltrating lymphocytes of metastasised melanoma irresectable stage IIIc and stage IV insofar as you are participating in research as outlined below;
i. up to 1 April 2020, mammary reconstruction after breast cancer with autologous fat transplants, insofar as you are participating in main research as outlined below;
j. from 1 January 2016 to 1 January 2020, treatment of lumbosacral radicular syndrome for lumbar hernia with percutaneous transforaminal endoscopic discectomy, insofar as you are participating in research as outlined below;

k. from 1 January 2016 to 1 January 2020, occipital nerve stimulation treatment of chronic cluster headaches for which medications are ineffective, insofar as you are participating in research as outlined below;
l. from 1 April 2016 to 1 August 2021, dendritic cell vaccinations in patients with stages IIIB and IIIC melanoma after complete resection, insofar you are participating in research as outlined below;
f. from 1 October 2016 to 1 July 2021, sacral neuromodulation for therapy resistance, functional obstipation with delayed intestinal passage, insofar you are participating in research as outlined below.

Research is defined as:
- main research into the effectiveness of the healthcare funded by the Dutch organisation for healthcare research and healthcare innovation (ZonMW); and/or
- supplementary national observational research into the healthcare set up and performed in collaboration with the main research if you:
  1. fulfil all criteria relating to the content of the healthcare, but you do not fulfil other criteria for participation in the research; or
  2. have not participated in the main research and the inclusion for the main research has been completed; or
  3. have participated in the main research without having received the healthcare and participation to the main research is completed for you.

The Minister of Health, Wellbeing and Sport has the option of classifying healthcare as conditionally admitted healthcare four times per year. The above list may not be up to date. It merely indicates the status as per 1 January 2017 insofar as known at the moment of preparing and printing these policy conditions. For the most recent list, please refer to Article 2.2 of the Healthcare Insurance Regulations. The Healthcare Insurance Regulations document is available from our website.

You are not entitled to reimbursement of the cost of:
a. treatments with uvuloplastic surgery for snoring;
b. treatments aimed at sterilisations (for both male and female);
c. treatments aimed at reversing sterilisations (for both male and female);
d. treatment of plagiocephaly and brachycephaly without craniosynostosis with a cranial band;
e. fertility-related care if you are a woman age 43 or older, unless it concerns an in-vitro fertilisation attempt that was started before reaching age 43.

Excess
This healthcare is set off against the deductible.
No deductible applies for obstetric care by a gynaecologist. No deductible applies for prenatal screening, excepting for the NIPT. The deductible applies to NIPT. Any fees associated with obstetric care are also subject to the deductible. This means that medications, blood tests or patient transport invoiced separately are set off against the mandatory deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Medical specialist. The care may also be provided by a clinical physician audiologist, geriatric medical specialist, emergency aid physician, KNMG emergency aid doctor, specialist nurse or physician assistant if the indicated care falls within the area of expertise of that healthcare provider.

Referral letter required from
General practitioner, specialist nurse, physician assistant (PA), SEH doctor KNMG (emergency aid physician), audiologist, company doctor, youth healthcare doctor, geriatric medical specialist, doctor for mentally handicapped, dentist, obstetrician, ophthalmologist, medical specialist or dental surgeon.

Approval
Some treatments are subject to prior approval if specific conditions apply. Such treatments are included in the Limitative list of DBCs (Diagnose Behandeling Combinaties or Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland to be requested in advance; Please refer to our website to see this list. The approval procedure is set out in Article 1.9 of these conditions.

Which type of care is subject to prior approval?
Some treatments in the context of Ophthalmology, Otorhinolaryngology,
Surgery and Dermatology are subject to our prior approval because specific conditions apply.

Ophthalmology:	refractory surgery (eye laser treatments or lens implants aimed at reducing dependency on spectacles or contact lenses), eyelid corrections.
Otorhinolaryngology:	ear treatments and treatment of nasal shape deviations.
Surgery:	gynaecomasty (breast formation in men), mammary hypertrophy (abnormal breast size), abdominal wall corrections.
Dermatology:	benign (non-malignant) tumours, pigment disorders, vascular dermatosis (wine spots).

If in doubt, we recommend contacting us to check if prior approval is required for any treatment.
Your medical specialist must notify you that you need to pay the cost of healthcare personally unless prior approval was issued.

Please note
Reimbursement of the cost of any treatments with a plastic surgery nature is always subject to prior approval. For details, please refer to Article 20, Plastic and/or reconstructive surgery.

Notes
1. The equipment and accessories used to measure coagulation times of your blood fall within the scope of medical aids, see Article 36, Medical aids and bandaging.
2. Please find more information on home dialysis on our website.
3. The Healthcare Insurance Regulations may exclude certain forms of medical care as generally offered by specialists.
4. For specialist medical care provided by a general practitioner, see Article 11, General practitioner care.
5. For care as generally offered by psychiatrists and clinical psychologists, see Article 25, Specialist mental health care (GGZ).
6. For oral care provided by a dental surgeon, see Article 31, Specific dental care and Article 32, Dental surgery for insured age 18 and older.

Article 16. Rehabilitation

16.1. Rehabilitation

Description
Your right to reimbursement of the cost of medical care as referred to in Article 11 (General practitioner care) and Article 15
(Specialist medical care) during rehabilitation includes: examination, advice and treatment of a combined medical-specialist, paramedical, scientific-behavioural and technical rehabilitation nature, exclusively if and insofar as:
- this care is indicated as the most efficient for you to prevent, reduce or overcome a handicap resulting from impairments or restrictions in the ability to move or a handicap which is the result of a disorder of the central nervous system leading to limitations in communication, cognition or behaviour, and;
- this care enables you to achieve or maintain a degree of independence which, given your restrictions, is reasonably possible.

The rehabilitation as set out above also includes:
- the quick scan as part of early interventions for long-term a-specific complaints of the position and locomotor system. A-specific complaints refers to complaints for which no clear cause can be found;
- cancer rehabilitation. This healthcare is aimed at functional, physical, psychological and social problems relating to cancer, including post-treatment healthcare and rehabilitation that is part of the oncology healthcare. This concerns advice and counselling where necessary relating to managing the disease, recovery, improving and maintaining the health condition. Cancer rehabilitation must be aimed at all phases you may be in (diagnosis - treatment - aftercare).

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Multi-disciplinary team of experts attached to a rehabilitation institution or hospital under the guidance of a medical specialist. The quick scan as set out above must be performed with a rehabilitation doctor in charge.

Referral letter required from
General practitioner, company doctor or medical specialist.

16.2. Geriatric rehabilitation

Description
Your right to reimbursement of the cost of geriatric rehabilitation includes integral and multi-disciplinary rehabilitation healthcare such as geriatric medicine specialists generally offer in the context of vulnerability, complex multi-morbidity (simultaneous presence of 2 or more conditions) and reduced learning and training ability, aimed at reducing the functional limitations to such extent that it enables returning to the home situation. You are entitled to reimbursement of the cost of geriatric rehabilitation for a maximum of 6 months. In special cases, we may allow for a longer rehabilitation period.

You are only entitled to reimbursement of the cost of this healthcare if:
1. the healthcare is consecutive within a week to hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree (see Article 37, Stay), where the hospitalisation was not preceded by a stay as set out in Section 3.1.1 of the Long-term Healthcare Act;
2. you have an acute condition that caused acute mobility disorders or reduced independence, and you received prior specialist medical care for the same condition. The geriatric assessment is performed by a geriatrician, clinical geriatrician or geriatic internist at the first aid department or during an emergency visit at the geriatric polyclinic. The geriatric rehabilitation must be consecutive within a week to the geriatric assessment, also if you were not hospitalised.
3. the healthcare is initially paired with hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree.

Geriatric rehabilitation
Geriatric rehabilitation is aimed at vulnerable elderly people undergoing specialist medical treatment. For example due to a stroke, bone fracture or a replacement joint. Such elderly clients need a multidisciplinary rehabilitation programme adjusted to their individual rehabilitation possibilities and
training pace, taking any other conditions into consideration (complex multi-morbidity). The aim is to help them return to their home situation and continued participation in society.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Multi-disciplinary team of experts relating to geriatric rehabilitation with a geriatric medical specialist in charge.

Article 17. Genetic research

Description
Your right to reimbursement of the cost of medical care as set out in Article 15 (Specialist medical care) in the context of genetic research includes: research into and testing of genetic disorders by means of family tree research, chromosome testing, biochemical diagnostics, ultrasound testing and DNA testing, genetic counselling and the psychosocial counselling associated with this form of care. If required for the advice to you, the research will also include research with regard to persons other than the insured. In that case those persons may also receive advice.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Centre for genetic counselling. This is an institution admitted as such and holds a licence for the application of clinical genetic research and genetic counselling.

Referral letter required from
General practitioner or medical specialist.

Article 18. In-vitro fertilisation (IVF) and other fertility treatments

18.1. In-vitro fertilisation (IVF)

Description
Your right to reimbursement of the cost of medical care as set out in Article 15 (Specialist medical care) in the context of in-vitro fertilisation (IVF), includes the first, second and third IVF attempts for each intended pregnancy as a maximum, subject to the condition that you are age 42 or younger. If you started with a first, second or third IVF attempt, you may complete this attempt after your 43rd birthday with cover of your healthcare policy. If you are under age 38, you are only entitled to reimbursement of the cost of the first and second IVF attempts if 1 embryo is placed each time.
A realised pregnancy is defined as an ongoing pregnancy of at least 10 weeks from the date of the follicular puncture. Fertilisation of the egg cell takes place immediately consecutive to the puncture. For cryos (cryo-preserved embryos), a term of at least 9 weeks and 3 days after the implantation date applies to define an ongoing pregnancy.

An IVF attempt, being healthcare in accordance with the in-vitro fertilisation method, comprises:
a. the maturation of egg cells in the woman's body by means of hormonal treatment;
b. acquiring mature egg cells (follicular puncture);
c. the fertilisation of egg cells and cultivation of embryos in the laboratory;
d. the implantation (once or several times) in the womb of one or two embryos in order to cause pregnancy.

An IVF attempt does not count until successful follicular puncture has been performed in phase b (acquiring mature egg cells). Only attempts completed or broken off beyond this point will count as attempts. Placing the embryos obtained from a previous treatment phase (whether or not cryopreserved) is part of the IVF attempt with which the embryos were acquired. If any embryos remain after an ongoing pregnancy was achieved, you are entitled to reimbursement of the cost of having the embryos placed pursuant to Article 18.2, Other fertility treatments.

When are you entitled to reimbursement of the cost of another 3 IVF attempts?
After an ongoing (realised) pregnancy or (successful) childbirth, either with or without IVF, another right to reimbursement of the cost of 3 attempts for a new pregnancy wish arises in the event of undesired infertility. Also after having a new partner, another right to reimbursement of the cost of an IVF treatment process of 3 attempts arises in the event of double infertility.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Gynaecologist in an institution licensed to this end.

Referral letter required from
Gynaecologist or urologist.

Notes
If an IVF treatment, including an ICSI treatment (intracytoplasmic sperm injection), is based on egg cell donation, the above IVF conditions also apply. You are not entitled to reimbursement of the cost of the egg cell donation.

IVF treatment abroad
Your eligibility for reimbursement of the cost of IVF treatment depends on your personal situation, for example your age and how long you have attempted to become pregnant. If you want to have IVF treatment abroad, please contact us prior to your decision. Please find our telephone number on our website.

18.2. Other fertility treatments

Description
With regard to other fertility treatments, your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes: gynaecological or urological treatments and fertility-enhancing surgery. This healthcare also includes artificial insemination and intra-uterine insemination. If you are a woman age 43 and up, then you are not entitled to reimbursement of the cost of fertility-enhancing treatments.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Gynaecologist or urologist.

Referral letter required from
General practitioner or medical specialist.

Article 19. Audiological care

Description
With regard to audiological care, your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes care in connection with:
- hearing tests;
- advice about the hearing aid to be purchased;
- information about the use of the equipment;
- psycho-social care if required in connection with problems with impaired hearing;
- assistance in making a diagnosis in cases of speech impediments and language or language development disorders in children.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Multi-disciplinary team of experts attached to an audiology centre under the responsibility of a medical specialist. The audiological centre must be duly accredited under the Wet toelating zorginstellingen (Care Institutions Accreditation Act).

Referral letter required from
General practitioner, audiologist, company doctor or medical specialist.

Notes
1. For hearing aids, please refer to Article 36, Medical aids and bandaging.
2. For diagnostics of language development disorders in children and young adults up to age 23, please refer to Article 22, Sensory disability care.

Article 20. Plastic and/or reconstructive surgery

Description
Your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes treatment of a plastic surgery nature only if this serves to:
1. correct abnormalities in appearance accompanied by demonstrable physical functional disorders;
2. correct disfigurement caused by a disease, an accident or a medical procedure;
3. correction of paralysed or weakened upper eyelids if resulting in serious limitation of the visual field, or is a result of a congenital deformity or a chronic disorder present at birth. Serious limitation of visual field due to paralysed or weakened upper eyelids is defined as:

- the weakening/paralysis of the upper eyelid causes the vertical eyelid split to decrease to 7 mm or less. This means a situation where the lower edge of the upper eyelid or the overhanging skin fold hangs above the centre of the pupil by 1 mm or more. In other words, if the distance between the lower edge of the overhang and the centre of the pupil is 1 mm or less. The measurement is made near the centre of the pupil while you look straight ahead without straining (relaxed and measured in primary position). It must be plausible that correction of the upper eyelid will resolve the decreased visual field;
- this must concern a visual impairment that forms an impediment in daily routines. Subjective complaints only, such as tired eyes, pressure on eyeballs, headaches, looking tired etc. are not sufficient reason or indication for limited visual field;

4. correction of congenital deformities in connection with lip, jaw and palate clefts, deformities of the facial bones, benign proliferations of blood vessels, lymphatic vessels or connective tissue, birthmarks and deformities of the urinary tract and sexual organs;
5. primary sexual characteristics where transsexuality has been established;

c. surgical insertion and surgical replacement of a breast prosthesis other than after a full or partial breast amputation;

7. surgical insertion and surgical replacement of a breast prosthesis in the event of agenesis/aplasia of the breast (lack of breast forming), in women and in man-woman transgenders, subject to the following criteria:
   - absence of an infra-mammary fold (fold under the breast) and;
   - gland tissue of less than 1 cm, shown by an echo.

What is the definition of plastic surgery treatments?
Plastic surgery treatments are defined as: intervention in the way you look by changing a shape or aspect. Such interventions are not limited to plastic surgery specialists.

When are you entitled to reimbursement of the cost of plastic surgery treatments?
Please find more details on eligibility for this type of healthcare in the 'Reference guide assessment plastic surgery treatments'. This reference guide was prepared by the Vereniging van artsen (Doctors Association), dentists and pharmacists working with healthcare and other insurers (VAGZ - Dentists and pharmacists working with healthcare insurers), Zorgverzekeraars Nederland (ZN, Healthcare Insurers Netherlands) and the CAK (Healthcare Institute Netherlands). This reference guide is available from our website.

You are not entitled to reimbursement of the cost of:

a. treatment of paralysed or weakened upper eyelids other than listed under the description in item 3;
b. abdominal liposuction;
d. surgical insertion of a breast prosthesis without medical necessity or for cosmetic reasons.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Medical specialist.

Referral letter required from
General practitioner, company doctor, medical specialist or dental surgeon.

Approval
You require our prior approval. The application must be accompanied by an explanation from your leading medical specialist. The approval procedure is set out in Article 1.9 of these conditions.

Article 21. Tissue and organ transplants

Description
Your right to reimbursement of the cost of medical care as referred to in Article 15 (Specialist medical care) includes tissue and organ transplants, exclusively if the transplant procedure is performed in an EU or EER member state. If the transplant procedure is performed in a different country, you are entitled to reimbursement of the cost of such healthcare only if the donor is your spouse, registered partner or relative in the first, second or third degree and the relevant person resides in that country.

The care mentioned in this Article also includes reimbursement of the costs of:
a. specialist medical care in connection with the selection of the donor;
b. specialist medical care in connection with the surgical removal of the transplant material from the selected donor;
c. the examination, preservation, removal and transport of the post-mortem transplant material in connection with the intended transplant;
d. the care of the donor arranged in these policy conditions for a maximum period of thirteen weeks, or in the case of a liver transplant for a maximum period of six months, after the date of discharge from the institution in which the donor was hospitalised for selection or removal of the transplant material insofar as this care is associated with this hospitalisation;
€. the transport of the donor in the lowest class of a means of public transportation within the Netherlands or, if due to medical necessity, transport by car within the Netherlands, in connection with the selection, hospitalisation and discharge from the hospital together with the care as referred to under d;
f. the transport to and from the Netherlands of a donor residing abroad, in connection with a transplant of a kidney, a liver or bone marrow with regard to an insured person in the Netherlands plus other costs involved in the transplant which are related to the fact that the donor resides abroad. The cost of staying in the Netherlands and any loss of income are not eligible for reimbursement.

If the donor concluded a healthcare policy, the cost of transportation referred to under e and f will be charged to the donor's healthcare insurer.

Excess
This healthcare is set off against the deductible. The deductible does not apply for:
- post-op check-ups of a kidney or liver donor after the period set out under d has expired;
- transport of a donor such as set out under e and f.

For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Medical specialist.

Article 22. Sensory disability care

Description
You are not entitled to reimbursement of the cost of sensory disability care. This type of healthcare is defined as multi-disciplinary healthcare relating to a visual impairment, auditive impairment or communicative impairment due to a language development disorder, or a combination of the above impairments and disorders. This healthcare is aimed at learning how to manage, reverse or compensate for the disability, with the purpose of optimising independence in daily life.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Institution specialised in treating people with a sensory disability, with a multi-disciplinary treatment team.

Healthcare relating to a visual impairment: the ophthalmologist or healthcare psychologist has final responsibility for the healthcare delivered and the treatment plan. The clinical physician or other disciplines may also bear this responsibility. The activities of the clinical physician or other disciplines are limited in that case to the healthcare as set out in Section 2.5a of the Healthcare Insurance Decree, and the requirements and conditions imposed on sensory disability healthcare.

Healthcare relating to an auditive impairment or communicative impairment due to a language development disorder: the healthcare psychologist has final responsibility for the healthcare delivered. The orthopedagogist or other disciplines may also bear this responsibility. The activities of the orthopedagogist or other disciplines are limited in that case to the healthcare as set out in Section 2.5a of the Healthcare Insurance Decree, and the requirements and conditions imposed on sensory disability healthcare.

Referral letter required from
Medical specialist or general practitioner. Referral to healthcare relating to an auditive or communicative impairment may also be performed by a clinical physician-audiologist in an audiology centre.

Article 23. Stop Smoking programme

Description
You are entitled to reimbursement of the cost of healthcare in accordance with the Stop Smoking programme. This Stop Smoking programme comprises healthcare focusing on behavioural change. You are also entitled to reimbursement of the cost of medications if prescribed as part of the programme, to support behavioural change. You may attend the programme in a group or as an individual. The objective of the programme is for you to quit smoking. You may attend a Stop Smoking programme maximum once per calendar year.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Healthcare providers who work in compliance with the Healthcare Module Stop Smoking.
The medications may only be supplied by the National Pharmacy, pharmacist or dispensing general practitioner. Please find more information on the National Pharmacy on our website.

MENTAL HEALTHCARE (GGZ)

Article 24. General basic mental healthcare for insured persons age 18 and older

Description
If you are age 18 or older, you are entitled to reimbursement of the cost of generalist basic GGZ (mental healthcare) as generally offered by clinical psychologists. This healthcare includes diagnostics and specialist treatment of light to moderate, non-complex psychological conditions/disorders or stable chronic issues. Together with the leading healthcare professional, you prepare a treatment plan, agreeing on the healthcare you require and the expected term of treatment. The leading healthcare professional then determines the healthcare you are entitled to.

Generalist basic GGZ
The generalist basic GGZ is aimed at people with a light to moderate, non-complex psychological problem or disorder, or people with chronic, stable but low-risk problems.
Generalist basic GGZ is always provided on an ambulatory basis. This means you frequently visit your healthcare provider for your treatment. Alternatively, the healthcare provider may treat you at home or in combination with a digital form of treatment.

The treatment (intervention) must comply with the state of science and real statistics and experience. Please find information on the treatments that are in compliance with these requirements in the dynamic GGZ overview on our website. Alternatively, contact your healthcare provider for more information.

You are not entitled to reimbursement of the cost of:
- treatment of adjustment disorders;
- assistance in work-related or relationship problems;
- psycho-social assistance;
- treatment for learning disorders;
- self-help;

- leading towards healthcare;
- prevention and service provision;
- psychological assistance relating to physical conditions;
- intelligence tests.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
A healthcare provider with a GGZ quality certificate and a registration with the Quality Institute.

Quality certificate GGZ
The quality certificate contributes to ensuring that the right aid is delivered by the right healthcare professionals at the right place. All healthcare providers of generalist basic GGZ and specialist GGZ have the obligation of having their own GGZ quality certificate prepared and having it registered with the Quality Institute. The healthcare provider's quality certificate sets out who is responsible for the coordination of healthcare. This is the leading healthcare professional. The quality certificate enables you to make a well-considered choice when selecting a healthcare provider.

Leading healthcare professional
The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. The leading healthcare professional determines the team for treatment with these healthcare providers. Also, the leading healthcare professional ensures that you have a voice in your treatment options.

1. Leading healthcare professionals GB GGZ independent practice may include: clinical psychologist/ neuropsychologist, psychotherapist, healthcare psychologists.
2. Leading healthcare professional GB GGZ in an institution may include: clinical psychologist/ neuropsychologist, psychotherapist and healthcare psychologists, geriatric medical specialist, addiction doctor with KNMG profile registration, clinical geriatric medical specialist and nursing specialist. Some of the healthcare may be provided by a co-professional under the final responsibility of the leading healthcare professional.
3. Leading healthcare professional GB GGZ for a treatment started pursuant to the Youth Act may include: paediatric or youth psychologist NIP and ortho-paedagogist NVO. They may perform the role of leading healthcare professional only if the first treatment was performed after your 18th birthday.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, geriatric medical specialist, doctor mental disabilities or street doctor. If you received GGZ healthcare pursuant to the Youth Act and you had your 18th birthday, then you will need a new referral.

A street doctor is a medical doctor registered with an association of street doctors, for example the Dutch Straatdokters Groep (Street Doctors Group), and only in the area where he/she works as a doctor. The street doctor may issue referrals only if the client does not have a general practitioner.

Article 25. Specialist mental healthcare (SGGZ) for insured persons age 18 and over

Description
If you are age 18 or older, you are entitled to reimbursement of the cost of medical care as generally offered by psychiatrists and clinical psychologists, including the associated medications, medical aids and bandaging. This healthcare includes diagnostics and specialist treatment of complex or very complex psychological conditions/ disorders.

Counselling activities may be part of the medical care if these are an integral part of your treatment. Such activities must in that case ensue from the treatment plan and be necessary to achieve the treatment objective. Also, the activities must be performed under direct management of the leading healthcare professional. Your leading healthcare professional receives feedback on such activities. For such activities, expertise at the level of the leading healthcare professional is necessary. This may include a paramedical, medical or behavioural science expertise.

Specialist mental health care
Specialist mental healthcare is about diagnostics and specialist treatment of (highly) complex psychological conditions. Specialist mental health care may be provided on an ambulatory basis for most psychological conditions. This means you frequently visit your healthcare provider for your treatment. Alternatively, the healthcare provider may treat you at home or in combination with a digital form of treatment. In some situations, hospitalisation in a GGZ institution is a medical necessity. For details, please refer to Article 37, Stay.

The treatment (intervention) must comply with the state of science and real statistics and experience. Please find information on the treatments that are in compliance with these requirements in the dynamic GGZ overview. Alternatively, contact your healthcare provider for more information.

You are not entitled to reimbursement of the cost of:
- treatment of adjustment disorders;
- assistance in work-related or relationship problems;
- psychosocial assistance;
- treatment for learning disorders;
- self-help;
- leading towards healthcare;
- prevention and service provision;
- psychological assistance relating to physical conditions.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
A healthcare provider with a GGZ quality certificate and a registration with the Quality Institute.

Quality certificate GGZ
The quality certificate contributes to ensuring that the right aid is delivered by the right healthcare professionals at the right place. All healthcare providers of generalist basic GGZ and specialist GGZ have the obligation of having their own GGZ quality certificate prepared and having it registered with the Quality Institute. The healthcare provider's quality certificate sets out who is responsible for the coordination of healthcare. This is the leading healthcare professional. The quality certificate enables you to make a well-considered choice when selecting a healthcare provider.

Leading healthcare professional
The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. The leading healthcare professional determines the team for treatment with these healthcare providers. Also, the leading healthcare professional ensures that you have a voice in your treatment options.

1. Leading treatment provider SGGZ (specialist mental healthcare) self-employed can be: psychiatrist, clinical psychologist, clinical neuropsychologist or psychotherapist.
2. Leading treatment professional SGGZ in an institution may include: psychiatrist, clinical psychologist, clinical neuropsychologist, psychotherapist, healthcare psychologist, geriatric medical specialist, addiction doctor with KNMG profile registration, clinical geriatrician or specialist GGZ nurse. Some of the healthcare may be provided by a co-professional under the final responsibility of the leading healthcare professional.
3. Leading treatment provider SGGZ relating to treatment started pursuant to the Youth Act may include: paediatric or youth psychologist NIP and ortho-paedagogist NVO. They may perform the role of leading healthcare professional only if the first treatment was performed after your 18th birthday.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, geriatric medical specialist, doctor mental disabilities or street doctor.

A street doctor is a medical doctor registered with an association of street doctors, for example the Dutch Straatdokters Groep (Street Doctors Group), and only in the area where he/she works as a doctor. The street doctor may issue referrals only if the client does not have a general practitioner.

If you received GGZ healthcare pursuant to the Youth Act and you had your 18th birthday, then you will need a new referral.

Approval
You only require prior permission for specialist GGZ with hospitalisation (see Article 37, Stay). If the permitted term is about to expire, you need to personally submit a new application. You can complete the approval form for specialist GGZ together with your healthcare provider. This form is available from our website. Please submit the application at least 2 months before the expiration date. Then you can be assured that your request will be processed in time. The address to send the application to is included in the first section of these conditions. The approval procedure is set out in Article 1.9 of these conditions.

PARAMEDICAL CARE

Do you suffer from Parkinson and you require physiotherapy, speech therapy or occupational therapy?
Then you can see specialist healthcare providers that are members of ParkinsonNet.
You can then be assured of adequate healthcare, as these healthcare providers are specifically trained to provide expert counselling and healthcare to persons suffering from Parkinson disease. Such healthcare providers are members of a national network. This means:
- you can receive optimal treatment at home or close to home;
- that the member healthcare providers collaborate and exchange knowledge, including your Parkinson nurse and neurologist.

This allows for better alignment of the healthcare you need. For more information on ParkinsonNet, please visit our website.

Article 26. Physiotherapy and Cesar/Mensendieck remedial therapy

Description
You are entitled to reimbursement of the cost of healthcare as generally offered by physiotherapists and remedial therapists.

Up to age 18:
- from the first treatment onwards, you are entitled to reimbursement of the cost of treatment of conditions requiring long-term or chronic treatment. These are specified in the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree). Please take into consideration that the duration of treatment is limited according to this list in some cases;
- if you have a condition that is not specified in the List of conditions for physiotherapy and remedial therapy, you are entitled to reimbursement of the cost of a maximum of 9 sessions per condition per calendar year. If you still have problems with the relevant condition after these 9 treatments, you are entitled to reimbursement of the cost of another series of maximum 9 sessions for such a condition. In total, you are entitled to reimbursement of the cost of a maximum of 18 treatments per condition per calendar year.

Age 18 and older:
- you are entitled to reimbursement of the cost of the first 9 treatments for pelvic physiotherapy in the context of urine incontinence;
- from the first treatment onwards, you are entitled to reimbursement of the cost of supervised remedial therapy (walking training) for peripheral arterial conditions in stage 2 Fontaine (claudication, hardening of the arteries in the leg) up to 37 sessions during a maximum of 12 months;
- from the 21st treatment onwards, you are entitled to reimbursement of the cost of treatment of conditions requiring long-term or chronic treatment. These are specified in the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree). Please take into consideration that the duration of the treatment is limited according to this list in some cases.
  The cost of the first 20 treatments for each condition is charged to you personally. The amount for these treatments charged to you personally may be reimbursed if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

You are not entitled to reimbursement of the cost of:
- occupational curative care. This concerns healthcare focusing on healing and treating both acute and chronic occupational physical disorders;
- Reintegration processes. Reintegration is the system of measures designed to ensure the occupationally disabled employee's return to the labour process;
- treatments and treatment programmes with the aim of improving physical condition, such as medical training therapy, physio fitness, movement exercises for seniors, movement exercises for obese persons and cardio training.

Chronic List

The list of conditions for physiotherapy and remedial therapy is also referred to as the 'Chronic List'. This name is not fully appropriate, as not all chronic conditions are listed. Listed conditions include certain conditions of the nervous system or the locomotor system, certain vascular and lung-related conditions, lymph oedema, soft tissue tumours and scar tissue on the skin. In some cases it also includes treatment of a condition after hospitalisation to accelerate recovery. Are you uncertain if your condition is listed? Please contact us in advance. Please find our telephone number on our website.
Please find the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree) on our website. Alternatively, contact us by telephone to request a copy of the list. Please find our telephone number on our website.

Please find the healthcare that is covered in the schedule below:

Description	Up to age 18	Over age 18
Pelvic physiotherapy for urine incontinence	9 treatments with possible extension by a maximum of 9 extra sessions. In total, you are entitled to reimbursement of costs for a maximum of 18 sessions per calendar year.	9 treatments (from the 1st treatment)
Supervised remedial therapy (walking training) for peripheral hardening of the arteries in the leg stage 2 Fontaine (claudication)	9 treatments with possible extension by a maximum of 9 extra sessions. In total, you are entitled to reimbursement of costs for a maximum of 18 sessions per calendar year.	max 37 sessions during a maximum period of 12 months (from the first treatment onwards)
Your condition is on the List of conditions Please note Please note: for some conditions the number of treatments covered is limited	full	from the 21st treatment
Your condition is not on the List of conditions	9 treatments with possible extension by a maximum of 9 extra sessions. In total, you are entitled to reimbursement of costs for a maximum of 18 sessions per calendar year.	no cover

Excess

This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers

1. Physiotherapy: physiotherapist, remedial gymnastics teacher/masseur or specialist physiotherapist.
   A specialist physiotherapist is a paediatric physiotherapist, pelvic physiotherapist, geriatric physiotherapist or manual therapist.

The specialist physiotherapist must be registered as such in the Central Quality Register (CKR) of the Royal Dutch Association for Physiotherapy or the Physiotherapy Certificate Register.
2. Oedema therapy: oedema therapist or physiotherapist or skin therapist.
   The oedema therapist or physiotherapist must be registered as such in the Central Quality Register (CKR) of the Royal Dutch Association for Physiotherapy or the Physiotherapy Certificate Register.
   The skin therapist must be registered in the Quality Register Paramedics (KP).
3. Cesar/Mensendieck remedial therapy: Cesar/Mensendieck remedial therapist or paediatric remedial therapist. The paediatric remedial therapist Cesar/Mensendieck must be registered in the Quality Register Paramedics (KP).

Do you need supervised remedial therapy (walking training) for peripheral hardening of the arteries in the leg stage 2 Fontaine (claudication)
Then you can see specialist healthcare providers that are members of ClaudicatioNet. This ensures you can count on excellent healthcare.
Healthcare providers participating in the ClaudicatioNet are specifically trained to provide specialist care for the treatment of claudication, hardening of the arteries in the leg.
This provides:
- optimal walking training, taking into consideration any other restrictions that may obstruct the walking motion;
- expert supervision and advice to maximise the results of the walking training.

For more information on ClaudicatioNet, please visit our website.

Where may the care be provided?
The care may be provided in the practice space of your healthcare provider or in a hospital, nursing home or convalescence home. If the healthcare provider treating you feels this is medically necessary, the care or treatment may be provided at home.

Approval
You only require our prior approval if you are treated for a condition specified in the List of conditions for physiotherapy and remedial therapy (Appendix 1 to the Healthcare Insurance Decree). You will require a statement from your general practitioner, company doctor or medical specialist demonstrating that you need treatment for a condition specified in this List. The approval procedure is set out in Article 1.9 of these conditions.

Article 27. Speech therapy

Description
You are entitled to reimbursement of the cost of healthcare as generally offered by speech therapists if this care serves a medical purpose and recovery or improvement of the speech function or the power of speech can be expected from the treatment. The Hanen Parent Course is also covered.

You are not entitled to reimbursement of the cost of speech therapy treatments in the context of:
- dyslexia;
- impaired language development in connection with a dialect or a different mother tongue;
- speaking in public;
- the art of declamation.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Speech therapist.
Speech therapy treatments that deviate from regular treatments may be provided only by a speech therapist registered in one of the following sub-registers of the Dutch Association for Speech therapy and Phoniatrics (NVLF):
- Aphasia;
- Hanen senior programme;
- Integral healthcare for stuttering;
- Preverbal speech therapy (eating and drinking);
- Stuttering.

Stammer therapy may also be given by a stammer therapist registered with the Nederlandse Vereniging voor Stottertherapie (NVST - Dutch Association for Stammer Therapy).

Authorised healthcare providers
The care may be provided in the practice space of your speech therapist or stammer therapist or in a hospital, nursing home or convalescence home. If the healthcare provider treating you feels this is medically necessary, the care or treatment may be provided at home.

Article 28. Occupational therapy

Description
You are entitled to reimbursement of the cost of healthcare as generally offered by an occupational therapist on the condition that this care aims to encourage or restore your self-care and the ability to cope, up to a maximum of 10 treatment hours in each calendar year.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Occupational therapist.

Authorised healthcare providers
The care may be provided in the practice space of your healthcare provider or in a hospital, nursing home or convalescence home. If the healthcare provider treating you feels this is medically necessary, the care or treatment may be provided at home.

Article 29. Dietetics

Description
Your right to reimbursement of the cost of dietetics includes healthcare as generally offered by dieticians, if this healthcare has a medical purpose, and up to a maximum of 3 treatment hours per calendar year.
Dietetics is defined as education with a medical purpose and treating patients with diet-related therapy, focusing on eliminating, reducing or compensating for diseases or complaints that are related to or can be influenced with nutrition.

Dietetics as part of a healthcare programme
If you have diabetes mellitus type 2, COPD (chronic obstructive pulmonary disease), increased vascular risk or asthma, and you are receiving healthcare through a healthcare programme as set out in Article 12, then dietetics for these or related conditions are provided via this healthcare programme.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Dietician.

ORAL CARE

Article 30. Dental care for insured persons under the age of 18

Description
If you are under age 18, you are entitled to reimbursement of the cost of healthcare as generally offered by a dentist. The care includes the following provisions/treatments:

1. check-ups (periodical preventive dental examination); once annually. If necessary, you are entitled to reimbursement of the cost of such check-ups more than once per year;
2. incidental visit;
3. removing plaque;
4. fluoride treatment from the date the first element of the adult teeth has broken through; twice annually. If necessary, you are entitled to reimbursement of the cost of such treatment more than once per year;
5. sealing (sealing pits and grooves in teeth and molars);
6. gum treatment (periodontal treatment);
7. anaesthetics;
8. root canal treatment (endodontic treatment);
9. fillings (restoration of teeth and molars with plastic materials);
10. treatment after maxillary complaints (gnathological treatment);
11. full dental prosthesis for upper and/or lower jaw, plate prosthesis or frame prosthesis (removable prosthetic devices);
12. specialist dental surgery with the exception of the insertion of dental implants;
13. X-ray examinations. You are not entitled to reimbursement of the cost of X-ray examinations for orthodontic care.

If you are under age 23, Then you are entitled to reimbursement of the cost of crowns, bridges and implants to replace if it concerns replacement of one or more permanent incisor or canine teeth that have not grown or are missing due to an accident. The necessity of this healthcare must be determined before reaching age 18.

Excess
If you are age 18 and up, Then this healthcare service will be set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Dentist, dental surgeon, prosthodontist or dental hygienist. The dentist or dental hygienist may work in an institution for paediatric dental care.

Approval
You only require our prior approval for crowns, bridges and implants as set out under the description for insured under age 23.
The approval procedure is set out in Article 1.9 of these conditions.

Article 31. Specific dental care

Specialist dentistry is dental care for people with a specific condition. Such dental care takes more time and more expertise. You are only entitled to reimbursement of the cost of special dental care if you can retain or obtain a dental function equivalent to the dental function you would have had if you had not incurred the relevant condition.

31.1. Dental and orthodontic care in special cases

Description
You are entitled to reimbursement of the cost of healthcare as generally offered by dentists and orthodontists which is necessary:

1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system;
2. if you have a non-dental physical or mental condition;

3. if you must undergo a medical treatment and this treatment would have inadequate results without such special dental care. This generally concerns eliminating inflammation in the mouth. Examples of eliminating inflammation in the mouth are treatment of the gums, extracting teeth or molars, or administering antibiotics.

You are only entitled to reimbursement of the cost of orthodontic care if you have a very severe developmental or growth impairment in your mouth or teeth, where diagnostics or treatment by disciplines other than dental in team context is required.

Please note
Having a few adult teeth or molars missing due to a hereditary disorder is a frequent occurrence. You are entitled to reimbursement of the cost of special dental care if you have at least 6 teeth and molars missing (this does not include wisdom teeth).

Personal contribution
You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if special cases do not require dental care.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
1. Dental healthcare in specific cases:
   dentists, authorised oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon.
2. Orthodontic care in specific cases:
   dentists, authorised oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon.

Where may the care be provided?
The healthcare may be provided in:
1. dental care practice;
2. hospital;
3. centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthetics? Then the healthcare may be provided only in a hospital or centre for specific dental care.
A centre for specific dental care is:
1. an institution for specific dental care recognised by Nza;
2. a centre that complies with the following requirements:
   - a positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - the centre works with an anaesthesiologist who is an NVA member;
   - there is a contract document with an ambulance service or hospital for transport to a hospital if required;
   - a contract document with a hospital near the centre for taking in patients if required;
   - the centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
   - when treating children, the dentist must be a recognised dentist-paedo-dontologist.

   Please refer to our website to see a list of such centres.

Referral letter required from
Dentist, orthodontist or a dental surgeon.

Approval
You require our prior approval. The approval procedure is set out in Article 1.9 of these conditions.

31.2 Dental implants

Description
You are entitled to reimbursement of the cost of having a dental implant placed in the context of specific dental care:
1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system.
2. if you have a deformation in the dental/maxillary/oral system with later onset in the form of a highly severely lapsed toothless jaw and implants serve to affix a removable prosthesis.

Implants in a very severely lapsed toothless jaw
If you have had a full dental prosthesis (dentures) for a long time, your jaw may lapse so severely that your dental prosthesis hardly has any grip. In such a case, implants can be a solution. This generally concerns 2 implants in the lower jaw with 2 buttons or a rod screwed in that serve to click on the dentures. The dentures remain removable. For prosthetic devices for insured persons of 18 and over, please refer to Article 33.

Personal contribution
You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if special cases do not require dental care.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Dentists, authorised oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon. In the event of implants in a severely lapsed toothless jaw, this healthcare may also be provided by a dental implantologist.

Where may the care be provided?
The healthcare may be provided in:
1. dental care practice;
2. hospital;
3. centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthetics? Then the healthcare may be provided only in a hospital or centre for specific dental care.
A centre for specific dental care is:
1. an institution for specific dental care recognised by Nza;
2. a centre that complies with the following requirements:
   - a positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - the centre works with an anaesthesiologist who is an NVA member;
   - there is a contract document with an ambulance service or hospital for transport to a hospital if required;
   - a contract document with a hospital near the centre for taking in patients if required;
   - the centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
   - when treating children, the dentist must be a recognised dentist-paedo-dontologist.

Please refer to our website to see a list of such centres.

Referral letter required from
Dentist, orthodontist or a dental surgeon.

Approval
You require our prior approval. The approval procedure is set out in Article 1.9 of these conditions.

Article 32. Dental surgery for insured persons age 18 and older

Description
If you are age 18 or older, you are entitled to reimbursement of the cost of dental surgery and associated X-rays as generally offered by dentists. You are not entitled to reimbursement of the cost of surgery treatment of gums (periodontal surgery), applying implants and non-complex extractions. Non-complex extractions concerns teeth or molars that your dentist could also perform.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Dental surgeon.

Referral letter required from
General practitioner, company doctor, dentist, obstetrician, medical specialist or dental surgeon.

Article 33. Prosthetic devices for insured persons of 18 and above

Description
If you are age 18 or older, you are entitled to reimbursement of the cost of a removable full dental prosthesis for the upper and/or lower jaw, whether or not placed on implants. A removable full dental prosthesis to be placed on dental implants also includes applying the fixed part of the supra structure (the mesostructure).
You are also entitled to reimbursement of the cost of filling up (re-basing) and repair of such dental prosthesis.

Personal contribution
You are charged a statutory personal contribution amounting to:
- 10% of the cost for an implant-based prosthesis in the lower jaw;
- 8% of the cost for an implant-based prosthesis in the upper jaw;
- 25% of the cost for a regular dental prosthesis;
- 10% of the cost for repairing and re-basing your dental prosthesis.

Personal contribution dental prosthesis
You are entitled to reimbursement of the cost of a (dental) prosthesis for the upper and/or lower jaw. This is subject to a personal contribution. The personal contribution also applies to the cost of placing the fixed part of the supra structure (mesostructure). A mesostructure is the non-removable construction between implants and the dentures (the click system). The costs of extracting teeth and molars are not eligible for reimbursement, but may be reimbursed if you have a supplementary (dental) cover.
Please refer to Article 31.2 for an implant for full dental prosthesis if you have a severely lapsed toothless jaw.

Please note
In addition to a personal contribution, a deductible may apply.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Dentist, dentist/implantologist or prosthodontist. The dental prosthodontist may provide the dental prosthesis on implants only under the medical supervision of a dentist or dental implantologist. Your dentist or dentist / implantologist will charge your the costs in that event.

Approval

1. You require our prior approval for a conventional (regular) dental prosthesis:
   a. if the total cost (including the technology expenses) of the dental prosthesis exceeds:
      - € 675 for an upper or lower jaw;
      - € 1,350 for an upper and lower jaw jointly;
   b. if you want to replace your dental prosthesis within 5 years of acquiring them;
2. You require our prior approval for:
   a. dental prosthesis on implants;
   b. rebasing (filling) or repairing dental prosthesis on implants;
   c. a bar or buttons (meso structure).

The approval procedure is set out in Article 1.9 of these conditions.

PHARMACEUTICAL CARE

Article 34. Medications

Description

Your right to reimbursement of the cost of pharmaceutical care comprises delivery of medications or advice and counselling as pharmacists generally offer for medication assessment and responsible use of medications.
This care also comprises:

- issuing a drug subject to prescription;
- issuing a drug subject to prescription with an instruction talk if the drug is new to you;
- instructions for a medical aid to be used for a drug subject to prescription;
- medication assessment of chronic use of medications subject to prescription.

Registered medications

With the exception of active ingredients for which we listed preferred medications, you are entitled to reimbursement of the cost of delivery of medications registered as preferred by the Minister of Health, Welfare and Sport. Please find the list of medications registered as preferred by the Minister in Appendix 1 of the Healthcare Insurance Scheme. Some of these medications are subject to a number of additional conditions. You are entitled to reimbursement of the cost of such medications only if you fulfil such conditions. Please find the list of such medications and the conditions in Appendix 2 of the Healthcare Insurance Regulations.

Preferred medications

We may designate the medications listed in Appendix 1 of the Healthcare Insurance Scheme as preferred medications. Please find a list of such medications in the Pharmaceutical Care Regulations. If we designate certain medications for active substances with a specific administration method, with the exclusion of other medications with the same active ingredient and specific administration method, you are entitled to reimbursement of the cost of our preferred medications. If you do not use the preferred medications, the medications you selected are in principle not covered. Only if your doctor indicates that treatment using the preferred drug is not medically responsible in your case are you entitled to reimbursement of the cost of a different medication.
We reserve the right to amend the list of preferred medications at any time. You will be notified accordingly. Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website.

Preferred medications policy (preferred policy)

Preferred means to have a preference for certain items. For medications this means that we have a preference for lower priced medications. We can designate a certain product as preferred within a group of equivalent medications (with the same active ingredient). Please find a list of such preferred medications in the Pharmaceutical Care Regulations. The mandatory and voluntary deductibles do not apply to these preferred medications. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your deductible.

Self-care medications
You are entitled to reimbursement of the cost of self-care medications if you are to use such medications for a period longer than 6 months. You are only entitled to reimbursement of the cost of laxatives, calcium tablets, anti-allergy substances, anti-diarrhea substances, substances for emptying your stomach and substances against dry eyes that are included in Appendix 1 of the Healthcare Insurance Scheme. In the first 15 days, the cost of the medications is charged to you.

Non-registered medications
You are entitled to reimbursement of the cost of non-registered medications in the event of rational pharmaco therapy. Rational pharmaco therapy is treatment with a drug in a form suitable for you of which the effectiveness and action are determined based on scientific research and testing, and which is also the most economical for the healthcare policy.
You are not entitled to reimbursement of the cost of the following non-registered medications:
- pharmacy preparations;
- medications your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medications Act;
- medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you. You are only entitled to reimbursement of the cost of such medications if you have a rare condition with an incidence of less than 1 in 150,000 in the Netherlands.

You are not entitled to reimbursement of the cost of:
- pharmaceutical care relating to a medication not covered by insurance;
- education on pharmaceutical self-management for a patients group;
- advice pharmaceutical self-care;
- advice use of medications subject to prescription during travel;
- advice risk of disease when travelling;
- pharmaceutical care in the cases indicated in the Healthcare Insurance Regulations;
- preventive travel kit of medications and vaccinations;
- medications for research as referred to in Section 40, third paragraph, under b, of the Wet op de geneesmiddelen (Medications Act);
- medications that are equivalent or virtually equivalent to a registered medication not on the preferred list of the Minister of Health, Welfare and Sport;
- medications as referred to in Section 40, third paragraph, under e, of the Medicines Act.

Personal contribution
Some medications are subject to a statutory personal contribution.

Personal contribution medications
The Minister of Health, Welfare and Sport determines which medications are covered by the Health Insurance Act and which medications are subject to a personal contribution. If you must pay part of the cost of a medication, this personal contribution does not count towards your deductible. For more information, please check our website. Alternatively, contact your pharmacist for more information.

Excess
This healthcare is set off against the deductible. Do you use preferred medications as set out in the Pharmaceutical Care Regulations? Then the deductible does not apply. The deductible also does not apply to the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar supplying the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. You may also choose other lung medication that is not preferred by us. But this is subject to your mandatory and voluntary deductibles.

Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your deductible.
For more information, please check Articles 7 and 8 of these policy conditions.

Authorised healthcare providers
Pharmacist or dispensing general practitioner.

Prescription
General practitioner, obstetrician, dentist, orthodontist, medical specialist or a dental surgeon.

Approval
Some of these medications are subject to a number of additional conditions. These conditions are set out in Appendix 2 of the Healthcare Insurance Regulations. Some of the medications listed in Appendix 2 are subject to prior approval. Please find a list of such medications in the Reglement farmaceutische zorg [Pharmaceutical Care Regulations]. We reserve the right to amend the list of preferred medications at any time. You will be notified accordingly. To apply for approval, your doctor may download and complete a doctor's statement from www.znformulieren.nl.
If you selected a pharmacist or dispensing general practitioner that we have contracted for the relevant care, then you can hand in the form completed by your doctor with the prescription. Your pharmacist assesses your compliance with the conditions. If you do not wish to submit the form directly to your pharmacy for privacy reasons, you may choose to directly send or have sent the form to us.

If you selected a pharmacist or dispensing general practitioner that we have not contracted for the relevant care, you should request prior approval by submitting the doctor's statement to us directly. The address is available in the first section of the conditions and from our website.

Notes
1. Add-on medications and OZP congealing factors included in Appendix 5 of the Policy Regulation Performances and Rates Specialist Medical Care of the Dutch Healthcare Authority are reimbursed exclusively as part of specialist medical care.
2. Pharmaceutical counselling during hospitalisation, day treatment or polyclinic visits and pharmaceutical counselling in the context of discharge from hospital are reimbursed exclusively as part of specialist medical care.

Contraceptives
If you are under age 21, you are entitled to reimbursement of the cost of contraceptives, including the contraceptive pill, a contraceptive rod, diaphragm, ring or cervical cap. Some items are subject to a personal contribution.

If you are age 21 and up, you are only entitled to reimbursement of the cost of contraceptives if these items are used to treat endometriosis or menorrhagia (if suffering from anaemia).
If you are not entitled to such reimbursement, you may be reimbursed for the cost of the contraceptive if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

Irrespective of your age, you are entitled to reimbursement of the cost of having a contraceptive such as a diaphragm or
implanon rod placed or removed by a general practitioner or by a medical specialist. For placing or removing a diaphragm, you may also choose an obstetrician certified for this service.

Article 35. Dietary preparations

Description
You are entitled to reimbursement of the cost of polymeric, oligomeric, monomeric and modular dietary preparations.
You are only entitled to reimbursement of the cost of such dietary preparations if adjusted regular nutrition and other special nutrition products are not working for you, and you are:
a. suffering from a digestive disorder;
b. suffering from a food allergy;
c. suffering from a resorption disorder;
d. suffering from disease-related malnutrition or risk of malnutrition as indicated based on a validated screening instrument; or
e. you are reliant on this product in accordance with the guidelines accepted by the relevant professional groups in the Netherlands.

Preferred liquid nutrition (preferred products)
We may select preferred products for some groups of liquid nutrition that you are entitled to based on this Article. This means we will prefer liquid nutrition at a lower price (of a certain manufacturer and/or brand).
Please find a list of such preferred liquid nutrition in the Pharmaceutical Care Regulations on our website. We reserve the right to amend the list of preferred liquid nutrition (preferred products) at any time. You will be notified accordingly.

Your benefit
If you are using the preferred liquid nutrition we selected, You enjoy a benefit, as this is not subject to any mandatory and voluntary deductibles. You may also choose liquid nutrition that is not preferred by us. But this is subject to your mandatory and voluntary deductibles.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised dietary preparations providers
Pharmacist, dispensing general practitioner or a preferred healthcare provider. For catheter-administered nutrition, you may only buy from a specialist medical supply store, also referred to as a facilities company.

Please note
If you are buying a dietary preparation in a general store such as a supermarket or chemist, you are not entitled to reimbursement.

Approval
You require our prior approval. To apply for approval, the doctor or dietician who is treating you may download and complete a Dietary Preparations Statement from our website.
If you selected a healthcare provider that we have contracted for the relevant care, you can submit the Dietary Preparations Statement as completed by your doctor or dietician. Your healthcare provider will assess your compliance with the conditions. If you do not wish to submit the form directly to your healthcare provider for privacy reasons, you may choose to directly send or have sent the form to us. If you selected a healthcare provider that we have not contracted for the relevant care, you may request prior approval by sending or having sent us the Dietary Preparations Statement directly. The address is available in the first section of the conditions and from our website.

Dietary products (no cover)
A dietary product is a nutrition product with an adjusted formula. Examples are gluten-free or low-sodium products. We do not refund such products.

MEDICAL AIDS AND CARE

Article 36. Medical aids and bandaging

Description
You are entitled to reimbursement of the cost of functional medical aids and bandaging as set out in the Healthcare Insurance Decree and the Healthcare Insurance Regulations. In the Medical Aids Regulations we set out further conditions for obtaining such medical aids. The Healthcare Insurance Decree, the Healthcare Insurance Regulations and the Medical Aids Regulations are available from our website. Certain groups of medical aids are included in the Healthcare Insurance Regulations with a functional description. This means that the healthcare insurer can determine which medical aids are covered in the Medical Aids Regulations. If you want a medical aid that is part of the group of functional descriptions of medical aids, but the specific medical aid is not included in the Medical Aids Regulations, you may submit an application form to us.

Most medical aids and bandaging are given to you under direct ownership. If you receive a medical aid as such, you simply own the medical aid permanently. In derogation of reimbursement of the cost you paid, we may provide some medical aids under a lease contract. Lease means that you may use the medical aid as long as you need and as long as you remain insured with us. You can conclude a lease contract with us or with the healthcare provider. This contract sets out your rights and obligations. Leased medical aids can only be obtained from a contracted healthcare provider.

The following information is available from the Medical Aids Regulations:
- whether you are entitled to reimbursement of the cost of the medical aid you will lease or own;
- the quality standards the healthcare provider must meet;
- whether or not you require a referral, and, if yes, who issues it;
- if you require our prior approval (for first procurement, repeat or repair);
- term of use of the relevant medical aid. This term of use is indicative. If required, you may ask us to deviate;

- maximum number of pieces to be delivered. Such numbers are indicative. If required, you may ask us to deviate;
- specific details such as maximum budgets or statutory personal contributions.

You will receive the medical aids ready for use. If applicable, you receive the medical aid including the first batteries, chargers and/or user instructions.

Information relating to contracted healthcare providers
We make agreements with healthcare providers on quality, price and service. If you selected a healthcare provider that we have contracted for the relevant care, you may expect a quality product and excellent service. Also, you do not need to apply for approval or advance any amounts. We will directly pay the healthcare provider.

Personal contribution/maximum reimbursement
The Medical Aids Regulations set out the statutory personal contribution or maximum reimbursement amounts, if any, for the relevant medical aids.

Excess
This healthcare is set off against the deductible. The deductible does not apply to medical aids on a lease basis. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised medical aids and bandaging providers
A healthcare provider for medical aids.
The Medical Aids Regulations specify if this healthcare provider must meet certain quality standards.

Incontinence Care Service for women
With this service you will be able to make a key step towards a possible solution for undesired urine loss - in a short time, and with the assistance of an incontinence nurse. After completing a digital questionnaire, you will receive a medical conclusion with recommendations online. The digital questionnaire is available from: www.incontinentiezorgservice.nl. Subsequently you can make use of personal assistance from an incontinence nurse. This type of care is provided in your home.

Lease
If you selected a healthcare provider that we have not contracted for the relevant care and it concerns leased equipment, then please take into consideration that you will likely have to pay part of the bill yourself. In that case, you are entitled to reimbursement of the cost of the average cost per user per year. The amount of the average cost is equivalent to the costs that we would have paid for providing a leased medical aid.

Referral letter required from
The Medical Aids Regulations set out which medical aids require a referral. This referral letter must include the indication.

Approval
The Medical Aids Regulations set out which medical aids require prior approval. The approval procedure is set out in Article 1.9 of these conditions.

Notes
1. Take good care of the medical aid. Within the normal average term of use, you will receive approval for replacement of a medical aid only if the current medical aid is no longer adequate. You may submit an application for replacement to us with a motivation within the term of use, modification or repair.
2. You may obtain approval for reimbursement of the cost of a second piece of the medical aid if you are reasonably relying on it.
3. Leased medical aids may be subject to inspection. If, in our opinion, you are not or no longer reasonably relying on the medical aid, we may claim the medical aid from you.

STAY IN AN INSTITUTION

Article 37. Stay

Description
You are entitled to reimbursement of the cost of hospitalisation for 24 hours or longer if due to medical necessity in connection with general practitioner care (Article 11), obstetric care (Article 14.1), specialist medical care (Articles 15 through 22), specialist mental health care (Article 25) and specialist dental surgery (oral hygiene, Articles 31 and 32), as set out in these policy conditions, during an uninterrupted period of no more than 3 years (1095 days) as set out in Article 2.12 of the Healthcare Insurance Decree. A stay also includes the necessary nursing, care and paramedical care.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Which institutions are covered for stays?
The hospitalisation may take place in a hospital, in a psychiatric ward of a hospital, in a GGZ mental healthcare institution, or in a recovery/rehabilitation institution. First-line stay is permitted in an institution performing medical care under the responsibility of the general practitioner, geriatric medical specialist or doctor for mentally handicapped.

Subject to prescription by
General practitioner, obstetrician, medical specialist, psychiatrist or dental surgeon. They will determine whether or not hospitalisation is a medical necessity due to medical healthcare, or a medical necessity due to specialist surgery as set out in Article 32, Dental surgery for insured persons age 18 and older.

Approval
You will need prior approval for stays in connection with specialist medical care (Article 15), plastic and/or reconstructive surgery (Article 20), specialist GGZ (Article 25) and oral hygiene (Articles 31 and 32) if this is indicated in the relevant healthcare article. For more information, please refer to the relevant Articles.

Notes
1. Interruptions of no more than thirty days are not regarded as interruptions, but these days do not count towards the calculation of the 3-year (1095-day) period as set out in this Article under description. Interruptions for weekend and holiday leave do count towards the calculation of the 3-year period.
2. Were you entitled to first-line hospitalisation pursuant to the CIZ medical indication decree as at 31 December 2016 as set out in Article 1.2, second paragraph, of the First-Line Hospitalisation 2016 Subsidy scheme? You are entitled to continued healthcare with the same healthcare provider. Continued healthcare applies from the effective date of the medication indication decision for a period of:
   - 3 years for first-line stay for palliative terminal care;
   - 3 months for other first-line stay.

   If your health situation is changing and the care load changes, you will need a prescription as set out in this Article.

TRANSPORT OF THE PATIENT

Article 38. Transport by ambulance and seated transport of the patient

Description
You are not entitled to reimbursement of the cost of:
1. transport by ambulance due to medical necessity as referred to in Section 1, first subsection, of the Tijdelijke Wet ambulancezorg (Temporary Ambulance Healthcare Act), over a distance of no more than 200 km, single journey:
   a. to a healthcare provider or institution for healthcare of which the cost is fully or partially covered under the healthcare insurance policy;
   b. to an institution where you will stay with the costs fully or partially covered pursuant to the Wlz;
   c. if you are under age 18, to a healthcare provider or institution where you will receive mental healthcare, of which the cost is fully or partially covered under the competent Council of Mayor and Councillors pursuant to the Youth Act;

d. from a Wlz institution as set out in this Article under description, item 1b, to:
   - a healthcare provider or institution for examination or treatment that is fully or partially covered by the Wlz;
   - a healthcare provider or institution for measuring and fitting a prosthesis that is fully or partially covered by the Wlz;

e. to your home or a different residence if your home does not reasonably allow for the required healthcare if you come back from one of the healthcare providers or institutions as referred to in this Article under description, items 1a through d;

2. seated transport of the patient over a distance of no more than 200 km, single journey. Seated transport of the patient includes transport of the patient by car, other than by ambulance, or transport in the lowest class of a means of public transport to and from a healthcare provided, institution or home as referred to under item 1. You are exclusively entitled to such transport in the following situations:
   a. you need to undergo kidney dialyses;
   b. you need to undergo oncological treatments with chemotherapy or radiotherapy;
   c. you are only able to move about in a wheelchair;
   d. your vision is restricted to such an extent that you are not able to move about without assistance;

When are you eligible for seated transport of the patient based on a visual impairment?
Your visual impairment must be such that you are not capable of travelling by public transport. This is determined by your visus (how sharp you can see) and your visual field (angle of your vision). You are entitled to reimbursement of the cost of seated transport if the vision in both your eyes is below 0.1 or if your visual field is impaired to less than 20 degrees. Some people have a combination of low visus and a very serious visual field impairment. In such cases, individual assessments are required to assess your right to reimbursement of the cost of transport.

   e. if you are under age 18 and you rely on care due to complex somatic problems or due to a physical disability as set out in Article 2.10 of the Healthcare Insurance Decree (intensive paediatric care);
   f. if, in connection with the treatment of a long-term illness or disorder, you must rely on transport for a long period of time and not supplying or reimbursing this transport would be predominantly unfair to you (hardship clause). This hardship clause is granted on an annual basis.

When may you apply for a hardship clause?
If the outcome of the sum 'number of consecutive months (maximum 12) that transport is necessary X number of times per week X number of km, single journey' exceeds or is equal to 250. For instance: you had to go to hospital twice per week for 5 months. The single journey was 25 km. In this case you may apply for the hardship clause, as 5 months x 2 times per week x 25 km makes 250.

The transport of the patient as included in this Article also includes the transport of someone assisting the patient if assistance is necessary or if the patient is under the age of 16. In special cases we may allow for reimbursement of the cost of transportation of 2 assistants.

Personal contribution
You are charged a statutory personal contribution amounting to a maximum of € 100 per calendar year for seated transport of the patient. This is not subject to a personal contribution.

Excess
This healthcare is set off against the deductible. For more information, please check Articles 7 and 8 of these policy conditions.

Authorised ambulance transport and seated transport of the patient providers
1. Transport by ambulance: a licensed ambulance service.
2. Seated transport of the patient:
   - taxi driver/company;
   - public transport company. Reimbursement is based on public transport pass, 2nd class;
   - private transportation using a private car, of yourself or family care providers (family members, people from the immediate environment): reimbursement of € 0.28 per km. The distance is calculated based on the quickest route as provided by the ANWB route planner. The two single journeys (there and return) are calculated separately.

Subject to prescription by
General practitioner or medical specialist. Seated transportation of a patient as stated under description, item 2e (intensive paediatric care) is subject to prescription of the paediatrician.
Transportation by ambulance in cases of emergency is naturally not subject to prescriptions.

Approval
You only require our prior approval for seated transport of the patient. You may request approval using the form Medical Declaration for Seated Transport of the Patient. This form is available from our website.
Approval for seated transportation of a patient for kidney dialysis and oncological treatments with chemotherapy or radio therapy can also be requested by telephone via the transportation desk. The approval for seated transportation of a patient for intensive childcare as set out under Description item 2e from and to a children's nursing care center can also be requested by telephone via the transportation desk. The telephone number is available from the transportation desk on our website.

Notes
1. If we grant you approval to go to a certain healthcare provider or institution, the 200-km limitation does not apply.
2. In cases where transport of the patient by ambulance, car or a public means of transport is not possible, we may allow the transport of the patient to take place by another means of transport to be designated by us.

HEALTHCARE MEDIATION

Article 39. Healthcare advice and mediation

Description
You are entitled to mediation for care in the event of an unacceptably long waiting list for treatment by a healthcare provider who may provide this care according to this healthcare insurance policy. You may use the services of our Healthcare Advice and Mediation department for such mediation services. You can reach this department through our website.
You may also approach this department for general questions on care, such as relating to looking for a healthcare provider with a certain area of expertise or help in navigating through the care sector. We will be happy to review the options with you.

III. Definitions

Acute healthcare: if acute healthcare or crucial healthcare can be classed as is set out in the Availability Contribution Wmg Decree. This concerns ambulance services, emergency aid, acute obstetric services, crisis assistance mental healthcare. If it concerns healthcare provided abroad, then acute healthcare also includes any healthcare that cannot reasonably be postponed until your return home.

CAK: Centraal Administratie Kantoor (CAK - Central Administrative Bureau).

Group health insurance contract: a group healthcare insurance contract (group contract) concluded between the healthcare insurer and an employer or legal entity with the object of offering associated participants the option of obtaining a healthcare insurance policy and any supplementary covers under the conditions as set out in this contract.

Diagnose Behandeling Combinatie (DBC or Diagnosis Treatment Combination): by means of a DBC code, which is determined by the NZa (Dutch Healthcare Authority), a DBC describes the closed and validated regimen of specialist medical care and specialist mental healthcare (second-line curative mental healthcare). This includes part of the process or the full process of the diagnosis as made by the healthcare provider up to the ensuing treatment (if any). The DBC regimen begins at the moment that the insured person registers with the care need, and ends at the end of the treatment or after 120 days for medical specialist care and after 365 days for specialist mental healthcare.

Personal contribution: a fixed amount/share of the rights to care or reimbursement of the costs of care referred to in these policy conditions that the insured person him/herself must pay before becoming entitled to reimbursement of the cost of the remaining part of the healthcare.

Deductible:

1. mandatory deductible: an amount towards the costs of care or other services as referred to in or pursuant to Section 11 of the Health Insurance Act, which will be borne by the insured person;
2. voluntary deductible: an amount towards the costs of healthcare or other services as agreed between you, as the policy holder, and the healthcare insurer, as set out in or pursuant to Section 11 of the Health Insurance Act, that is payable by you.

European Union and EEA Member State: includes the following countries other than the Netherlands in the European Union: Austria, Belgium, Bulgaria, Cyprus (the Greek area), the Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Martinique, St. Barthélemy, St. Martin and La Réunion), Germany, Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal (including Madeira and the Azores), Romania, Slovakia, Slovenia, Spain (including Ceuta, Mellilla and the Canaries), Sweden and the United Kingdom (including Gibraltar). Under convention provisions Switzerland is considered as equivalent to these countries. EEA countries (Member States who are a party to the Agreement on the European Economic Area) are also included: Iceland, Liechtenstein and Norway.

Fraud: the intentional commission or attempted commission of forgery, deception, injuring the rights of debt collectors or title holders and/or misappropriation and embezzlement in the process of entering into and/or performing an insurance contract or healthcare insurance contract, with the objective of obtaining a benefit, reimbursement or performance to which the party is not entitled, or obtaining insurance cover under false pretences.

Birth clinic: first-line birth clinic for facilitating natal care (healthcare during childbirth) and postnatal care (healthcare during the first 10 days after delivery), of which the management and operations are performed by healthcare providers of first-line maternity care. The management and operations of the first-line birth clinic may also be performed by healthcare providers other than first-line obstetricians, such as maternity care institutions.

GGZ: Mental healthcare.

GGZ institution: an institution providing medical care pertaining to a psychiatric condition, and that is licensed as such under the Care Institutions Accreditation Act.

Institution:

1. an institution as referred to in the Care Institutions Accreditation Act;
2. a legal entity with its primary place of business abroad providing care in the country concerned according to the social security system existing in that country or which is aimed at providing care to specific groups of public officials.

KNMG: the Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG - Royal Dutch Company to Promote Medicine) is a federation of professional associations of medical doctors and the association The Medical Student, and represents the interests of doctors in the Netherlands.

NZa: Nederlandse zorgautoriteit - Netherlands Healthcare Authority.

In writing: where the policy conditions refer to 'in writing', this also includes 'by email'.

Approval (authorisation): approval in writing for receiving certain care provided to you by or on behalf of the healthcare insurer, prior to receiving the relevant healthcare service.

You: policy holder and/or insured.

Stay (hospitalisation): a stay of 24 hours or longer.

Treaty country: a country not being a Member State of the European Union or the EEA, with which the Netherlands has entered into a social security convention including provisions for rendering medical care. This includes the following countries: Australia (for holidays/temporary stay), Bosnia-Herzegovina, Cape Verde Islands, Macedonia, Morocco, Serbia-Montenegro, Tunisia and Turkey.

Insured: a person whose risk of needing medical care as referred to in the Health Insurance Act is covered by a healthcare insurance policy and who is stated as such on the policy cover as issued by the healthcare insurer.

Policy holder: the person who concluded an insurance contract with the healthcare insurer. These policy conditions refer to the policy holder and the insured as 'you'. Provisions referring only to the policy holder specifically state this in the relevant article.

Person subject to statutory insurance: a person who is subject to mandatory insurance pursuant to the Zvw; the person must take out a healthcare insurance or have this taken out.

Policy Conditions VGZ Personal Choice/policy conditions: the healthcare insurer's model contract as referred to in Section 1j of the Health Insurance Act.

VGZ Personal Choice: a healthcare insurance policy taken out by the policyholder with the healthcare insurer for a person subject to statutory insurance. These policy conditions refer to the VGZ Personal Choice as 'the healthcare policy'.

Wlz: Long-Term Healthcare Act.

Wmg rates: rates as established by or pursuant to the Wet marktordening gezondheidszorg (Wmg or Healthcare Market Organisation Act).

Hospital: an institution for specialist medical care that is duly licensed under the Wet toelating zorginstellingen (WTZi - Care Institutions Accreditation Act). Hospital stays of 24 hours or longer are covered.

Healthcare: care, healthcare or other services.

Healthcare provider: the natural person or legal entity providing healthcare professionally as set out in Section 1, preamble and subsection c, section 1 of the Wmg. Healthcare provider also includes all treatment professionals who are involved in delivering healthcare at the healthcare provider's risk and expense.

Healthcare item: medical aid, an item related to certain healthcare. See Section II, Healthcare Provisions.

Healthcare Policy: the instrument in which the healthcare insurance taken out by the policy holder with the healthcare insurer is laid down.
The Healthcare Policy consists of a policy cover and these policy conditions.

Zorgverzekeraar, VGZ, the healthcare insurer: VGZ Zorgverzekeraar N.V. (VGZ Healthcare Insurer, VGZ) with its registered office in Arnhem, Chamber of Commerce number: 09156723.
The healthcare insurer is registered in the Insurers Register of AFM (Financial Markets Authorities Netherlands) and DNB (the Dutch Central Bank), licence number: 12000666. The healthcare insurer is part of Coöperatie VGZ U.A.
These policy conditions refer to the healthcare insurer as 'we' and 'us'.

Healthcare insurance: a non-life insurance or healthcare non-life insurance contract concluded between a healthcare insurer and a policy holder for a person subject to mandatory insurance as set out in Section 1 subsection d of the Health Insurance Act, of which these conditions form an integral, inseparable part.

www.vgz.nl

for more information and contact information

Voor goede zorg zorg je samen

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