Insured in 2022

It is easy
to arrange it
yourself with
Mijn VGZ

Policy Conditions
VGZ Eigen Keuze

COÖPERATIE VGZ
Voorop in gezondheid en zorg.
Voor iedereen.

Welcome to VGZ

These are the policy terms and conditions of your healthcare insurance policy with your healthcare insurer, VGZ. Please refer to www.vgz.nl for more information, for example about claims and our healthcare insurance range.

My VGZ

Via Mijn VGZ, you can change your policy, check your claim forms and pay your premium. You can directly log in securely on mijn-vgz.nl with your DigiD.

VGZ Zorg app

Did you hear about the VGZ Zorg app (VGZ Healthcare app)? With this app, claim forms are submitted super fast, you can see all your budgets and reimbursements, and it is easy to pay bills with iDeal. You always have your healthcare card and key phone numbers at hand. The app has secure DigiD login.

Contact

We are ready to assist you. For our contact details, visit vgz.nl/contact.

Contracted care providers

You can find healthcare providers that have a contract with VGZ on vgz.nl/zorgzoeker.

Requesting approval

Would you like to know which healthcare services and treatments are subject to our prior approval (authorisation)? Please check these policy conditions. Go to vgz.nl/machtiging for full details.

Easy online claim forms

You can easily submit your claims online via mijnvgz.nl. Or even faster with the VGZ Zorg app. You log in securely with your DigiD. You will receive your reimbursement in your account 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

Contents

I. General section

Article 1. Insured care

1.1. Content and scope of the insured care

The VGZ Eigen Keuze is an in-kind insurance policy of the healthcare insurer, hereinafter to be referred to as 'the healthcare insurance'. Pursuant to this healthcare insurance, you are entitled to reimbursement of the cost of healthcare as set out in these policy terms and conditions. You are also entitled to care advice and care mediation at your request.

Healthcare Advice and Mediation

Our Healthcare Advice and Mediation department advises you about the healthcare provider you can consider for your healthcare issue. You can also contact the Healthcare Advice and Mediation department if you are confronted with unacceptably long waiting times, for example for a visit to the outpatient clinic or admission to a hospital. You can reach this department through our website.

1.2. Medical necessity

Medical necessity is the case if it is fair and reasonable to state that you are dependent on the type of care in terms of content and scope and if the type of care is efficient and effective. 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 status of science and medical practice. This is determined using the Evidence-Based Medicine (EBM) method. If a standard of care (the status of science and medical practice) is not available, the content and form of care are determined by what is considered responsible and adequate care within the discipline concerned.

1.3. Who may provide the care

You are free to choose a care provider, provided that the other requirements in these insurance conditions are met. One of these requirements is that your healthcare provider must comply with certain conditions. The relevant healthcare provision sets out which healthcare providers may provide the healthcare services and the supplementary conditions the healthcare provider must fulfil. If the care provider does not meet the applicable conditions, you are not entitled to reimbursement.

1.4. Care provided by a contracted healthcare provider

If you go to a contracted healthcare provider for care, rates have been agreed with the relevant care providers that are in line with the reasonable market rates applicable in the Netherlands. The healthcare provider receives the fee for the healthcare provided from us directly.

We make agreements with healthcare providers on the 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, this will make a difference in costs for you and us. Would you like to know which care providers have a contract with us, and for which care? You can find this information on our website.

1.5. Care provided by a non-contracted care 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.

Prohibition on assignment

You cannot transfer your claim on us for Nursing and Care (article 14), Mental Healthcare (articles 25, 26 and 38) and Pharmaceutical care (article 35 Medications) to care providers or others with whom we have not concluded a contract for this care (prohibition of assignment). This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code.

1.6. Submission of invoices

If you have received an invoice, you can submit your claims online via the Mijn-omgeving or via the Zorg app. You must retain the original invoice for at least one year after submitting the relevant claim form. We may request the invoices for inspection. If you are unable to submit the invoices, we may recover the amounts paid out to you, or settle the relevant amounts with amounts due to you. Submitting claim forms by post is also possible. You can complete a claim form and submit it to us. Please attach the original invoice. Please don't send a copy or a reminder. We can only process originals. You can submit invoices up to a maximum of 3 years after the start of treatment.

The invoice should at least list the following details:

- The date of the invoice being issued by the care provider and the invoice number (sequential numbers, and each invoice number may only occur once)
- Your name, address and date of birth
- Type of treatment, amount per treatment and date of treatment
- The name and address of the healthcare provider.

The invoices and any relevant documents must be itemised allowing for directly and unambiguously deducing which amount of reimbursement we are required to pay. We deduct any excess and statutory personal contribution from the reimbursement. For conversion of foreign invoices in currencies other than euros, we use the historical rates available from www.XE.com This is based on the rate on the day you were treated. Invoices and other relevant documents must be written in Dutch, German, English, French 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.

1.7. Direct payment

We reserve the right to directly pay the healthcare costs to the healthcare provider. This payment voids your right to reimbursement.

1.8. Settlement of costs

If we pay directly to the healthcare provider and reimburse more than we are required to pay based on your healthcare insurance policy, or the costs are otherwise at your expense, the costs are payable to you, the policyholder. We will charge such amounts to you in arrears. You have a legal obligation to pay such amounts. We reserve the right to settle such amounts with amounts due to you.

1.9. Referral, prescription or approval

For some forms of healthcare, you require a referral, prescription and/or prior approval in writing demonstrating that you are dependent on this healthcare. 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 (authorisation)

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 received such an authorisation beforehand, you are not entitled to reimbursement of the costs of care.

Do you visit a care provider with whom we have concluded a contract for the relevant care? Then you do not require prior approval. Your healthcare provider will in such cases assess if you fulfil the conditions and/or requests approval from us on your behalf. An overview of contracted healthcare providers is available from our website. You can also submit your request directly to us. Please find our address on our website.

Are you going to a care provider that does not have a contract with us for the care that concerns you? then 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 costs of insured care?

You are entitled to reimbursement of the cost of care if the care has been provided during the term of your healthcare insurance. 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 a Diagnosis 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;
- Reimbursement of losses that are an indirect result of our actions or omissions;
- Reimbursement of the costs of care caused by or arising from armed conflict, civil war, insurrection, domestic disorder, rioting and mutiny occurring in the Netherlands, as stipulated in Article 3.38 of the Wft Act (Financial Supervision Act).

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

Do you need care resulting from one or more terrorist acts? 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 reinsures annually, 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 we receive an additional contribution after a terrorist act pursuant to Section 33 of the Healthcare Insurance Act or Section 2.3 of the Healthcare Insurance Decree, then in addition to this percentage, you are entitled to a supplementary scheme as set out in Section 33 of the Healthcare Insurance Act or Section 2.3 of the Healthcare Insurance Decree.

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 participate in the NHT.
The NHT issued regulations that ensure pay-out of at least part of any terrorism-related claim.

The NHT has set a maximum to the total amount to be paid out relating to terrorist actions. 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. But it also means that you are assured that you will at least be compensated some or all of the losses or cost.

Article 2. General provisions

2.1. Basis and contents of the healthcare insurance

The insurance contract has been concluded on the basis of the information that you have entered on the application form or that you have provided to us in writing. After taking out the healthcare insurance policy, you will receive a policy from us as soon as possible. Furthermore, you will receive a new policy prior to each new calendar year.

These policy conditions form an integral part of the policy. The policy schedule lists the insured and the healthcare insurance policy or policies taken out for them.

2.2. Place of work

The healthcare insurance policy can be taken out by any person subject to mandatory healthcare insurance residing 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. Relevant documents

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

- Healthcare Insurance Decree
- Appendix 1 to the Healthcare Insurance Decree
- Clauses Sheet Terrorism Cover
- Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care)
- List GGZ Therapies (Mental Healthcare)
- Limitative List Authorisations Specialist Medical Care
- Limitative List Authorisations Dental Surgery
- Overview of contracted healthcare providers
- Premium Appendix
- Healthcare Insurance Scheme
- Pharmaceutical Care Regulations
- Medical Aids Regulations
- Nursing and care personal budget regulations
- Reference guide assessment plastic surgery treatments
- Healthcare Module Prevention Diabetic Foot Ulcers
- Standard of care for Obesity.

You can find these documents on our website. You can also request the documents via our customer service.

2.4. Fraud

Fraud (full or partial) will result in claims not being paid out, and/or recovery of claims already paid out. If you commit fraud, your right to reimbursement of the costs of care expires. 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.

Police report and registration

In the event of fraud, we reserve the right to report the event to the police. Additionally, we may have your information and details of the co-perpetrators and accessories registered:

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

Termination of insurance

If you commit fraud, we will terminate your healthcare insurance policy. In that event, you will not be accepted for a new healthcare insurance policy for 5 years. We will also terminate your supplementary insurance. In that case, you cannot take out supplementary insurance cover with the insurers of Coöperatie VGZ for 8 years.

2.5. Protection of your private data

We process your private data when we administer your insurance policies. This is completed in compliance with legislation and regulations, including the General Data Protection Regulation (GDPR). Please find more details about this in the privacy statement on our website. The privacy statement also states your rights. If you have any questions about how your private data are processed, please contact the Data Protection Officer.
For more information about privacy, please check the Privacy page on our website.

2.6. Announcements

Any notifications sent to the most recent address in our system are deemed to have reached you. If you want to receive all our messages in electronic format, please tick the relevant option in the Mijn-omgeving or in the Zorg app.

2.7. Membership of Coöperatie VGZ

Upon acceptance to this healthcare insurance policy, you, as the policyholder, also become a member of the cooperative society Coöperatie VGZ U.A., unless you notify us in writing that you do not wish to do so. This Coöperatie 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. Membership ends in any case on the date the insurance contract ends.

2.8. Cooling-off period

As a policyholder, you have a cooling-off period of 14 days when you take out the health insurance. 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 clause

Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Healthcare 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 Healthcare Insurance Act are conflicting with the provisions of this contract, the provisions of the Healthcare Insurance Act 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 is governed by Dutch law.

Article 3. Premium

3.1. Premium base and premium discounts

The premium base is the premium without premium discount for any voluntary excess and/or discount as agreed in a group contract. The premium base and premium discounts that apply to you are stated on your policy schedule.

Premium discount for voluntary excess

If you opt for a voluntary excess, you will receive a discount on the premium. The premium base and the premium discount for the voluntary excess can be found on the premium annex as amended annually. The premium annex is available from our website.

Premium discount with group contract

If you participate in a group contract, you will receive a discount on the premium base. You may not participate in more than one group contract at the same time.

From the day you can no longer participate in the group contract, the premium discount and the policy conditions set out in the group contract no longer apply. From that date onwards, the healthcare insurance will be continued on an individual basis.

3.2. Who pays the premium?

The policyholder has the obligation to pay premiums. For an insured person younger than 18 years of age, no premium needs to be paid until the first day of the calendar month following the 18th birthday. Upon death of an insured, premium is due only up to the date of death. In the event of a change to the healthcare insurance, we will recalculate the premium with effect from the date of the change.

Example

Someone who turns 18 on 1 July pays the premiums as of 1 August.

3.3. Payment of premium, statutory contributions, excess and fees

3.3.1. 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 an annual premium in advance, you will receive a payment discount on the premium due. The amount of the discount is stated on the policy schedule.

3.3.2. If you do not make use of the free digital post, you will be charged a fee for paper post. You don't pay any fees for the policy and the European health card (EHIC). Please check our website for more details and the fees for paper post.

3.3.3. You pay the premium, excess, personal contributions, fees for paper post and any unjustified reimbursements paid out to you based on the payment method agreed with us.

No-fee payment options

a. You authorise us for automatic direct debit of the amounts due (see also Article 3.3.4).
b. You make use of the option of receiving a digital invoice free of charge via Mijn Omgeving. 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.

No extra fees are charged for the above payment options.

Fees for payment by paper invoice (acceptgiro)

If you do not make use of the free payment options, you will be charged a € 1.50 fee for each paper invoice. This amount serves to cover all costs we incur for maintaining the system, preparing and offering a paper invoice and processing your payment. Even if you do not use the paper invoice to make your payment. You will also receive a paper invoice if the direct debit transaction cannot be executed, or if you agree on a payment schedule with us with payment per paper invoice. This is also subject to the € 1.50 fee for paper invoices. If you pay your premium 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.

3.3.4. Your authorisation for direct debit applies to payment of the premium, excess, personal contributions and any unjustified reimbursements. Such an authorisation applies during and if necessary after expiration of the insurance contract. Please refer to your policy schedule to check the date of direct debit collection of the premium for the entire calendar year. For the other costs, we will notify you at least 3 days before the date on which the amount is collected, stating the amount to be taken out of your account and the direct debit transaction date. If you disagree with a processed payment, Then you can have the amount refunded. Please contact your bank within 8 weeks of processing the payment.

3.4. Settlement

You may not set off the amounts due against an amount that you still expect from us.

3.5. Overdue payment

3.5.1. If you do not pay the premium, statutory contributions, personal contributions, the excess and any unjustified reimbursements paid out to you in due time, we will send you a reminder. If you do not pay within the 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 the costs of care 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 the costs of care will resume from the day following the day on which we received the amount due and any costs.

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.

3.5.2. We will charge the following fees to you if your payment is overdue:

- 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.

3.5.3. If you have received a reminder for overdue payment of premiums, statutory contributions, excess, personal contributions or reimbursements paid out to you that prove unjustified, then we do not have a legal obligation to send you a separate written reminder if payment for the subsequent invoice is overdue.

3.5.4. We reserve the right to directly settle the premium due, fees and statutory interest with any amounts of claimed healthcare costs or other amounts payable to you.

3.5.5. 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.

3.5.6. Consequences of non-payment of two monthly premiums or more

a. If you have payment arrears amounting to two monthly premiums, we offer you as policy holder a 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 your arrears run up to 6 or more monthly premiums.
b. If you have payment arrears amounting to four monthly premiums, you will receive a warning that we will register you with the CAK for the defaulters scheme once the payment arrears amount to six monthly premiums, unless we conclude a payment scheme with you after all.
c. If you as policy holder have payment arrears amounting to six monthly premiums or more, we will register you with the CAK for the defaulters scheme and you will be obliged to pay the CAK an administrative premium. For the period you owe the CAK an administrative premium, you will not owe us any premium. The administrative premium to the CAK is higher than the premium you would normally pay us.

If you have other insured on your policy and payment arrears arose for them, they will receive copies of our messages to you about the premium arrears.

You can read the consequences of non-payment of the premium and the administrative premium in Sections 18a to 18g of the Healthcare Insurance Act.

3.5.7. You are not liable for paying premiums to us on the period as referred to in Section 18e of the Healthcare Insurance Act.

Article 4. Other liabilities

You have the following obligations:

- 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;
- 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;
- Ask the healthcare provider to disclose the reason for hospitalisation to our medical advisor;
- Report to us 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 are not liable for any risks in the event of non-compliance with the above provisions.

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. Change to premium/premium base and conditions

5.1. Change to conditions

We reserve the right to change the conditions and the premium or premium base of the insurance policy at any time. We will inform you, the policyholder, accordingly in writing. A change in the premium base will only become effective 7 weeks after the date on which you were notified of such change. A change in the conditions will only become effective one month after the date on which you were notified of such change.

5.2. Right of cancellation

If we change any conditions and/or the premium base of the healthcare insurance policy to your disadvantage, you, as the policyholder, have the right to cancel the insurance contract as per the effective date of the change. You can cancel the agreement in any case during 1 month after the change has been communicated to you. However, you do not have this right to give notice if a change in the insured healthcare cover results directly from an amendment of the provisions set out in Sections 11 through 14a of the Healthcare Insurance Act.

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

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 has been terminated effective 1 January of a calendar year or due to a change in the conditions, the 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**
>
> You are required 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 insurance policy expires automatically on the day following the day:

- 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, are required 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 determine that the insurance policy has terminated, we will send you a termination certificate as soon as possible.

6.3. When can you change or cancel your insurance?

6.3.1. Change

Do you want to change your basic insurance policy to a different basic insurance policy? Then please send us the instructions latest by 31 January. Your new insurance policy will start on 1 January (with retroactive effect).

6.3.2. Annual cancellation

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 retroactive effect to 1 January.

6.3.3. Intermediate cancellation

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;
- Within 6 weeks after receiving a notification from us as referred to in Section 78c, second subsection, or Section 92, first subsection, of the Healthcare (Market Regulation) Act. 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 policy 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 then 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 at 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 on 18th birthday

When your child reaches age 18, you can cancel your child's insurance policy. Your child can then take out an independent health insurance policy.

6.3.4. **Cancellation service**

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

6.3.5. **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 health insurance policy if we have suspended cover or confirm your cancellation within 2 weeks.

6.4. When can we cancel, dissolve or suspend your insurance?

We are entitled to cancel, dissolve or suspend the healthcare insurance policy/policies:

- 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 intent of misleading us, or if we had not accepted your application for healthcare insurance if we had known the actual circumstances. 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 may offset the resulting claims against other amounts payable.

6.5. Proof of termination

If the health insurance policy ends, you will receive a certification of cancellation with the following information:

- Name, address, place of residence and citizen service number (BSN) of the insured;
- Name, address and place of residence of the policy holder;

- The day on which the healthcare policy terminates;
- Whether on that day an excess applied and if yes, the amount of this excess.

If insurance is no longer mandatory, this will also be stated on the certification of cancellation.

6.6. Insurance of uninsured persons

If the CAK concluded this healthcare policy on your behalf pursuant to Section 9d, subsection 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. The 2-week period starts on the date on which the CAK has informed you that it has started this healthcare insurance 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 insurance during the first 12 months. After this 12-month period, the regular cancellation options as set out in Article 6.3 apply.

Article 7. Mandatory excess

7.1. Amount of statutory excess

If you are age 18 or older, you have a statutory excess of €385 per calendar year. 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 statutory excess applies from the first day of the calendar month following the calendar month after your 18th birthday. The amount of the statutory excess will then be determined in accordance with the calculation method stated in Article 7.4.

7.2. Which types of care are subject to the statutory excess?

The statutory excess is applicable to all forms of care as included in these policy conditions, with the exception of:

- General practitioner care. The excess is applicable to medications. The excess is also applied for laboratory tests and diagnostics conducted by a different healthcare provider at the request of the general practitioner and charged to you. See Article 11, General practitioner care;
- A combined lifestyle intervention as set out in Article 13;
- Nursing and care as set out in Article 14;
- Obstetric care by an obstetrician, general practitioner or gynaecologist. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport are set off against the statutory excess. See Article 15.1, Obstetric care, and Article 16, Specialist medical care;
- Insertion and removal of an IUD (coil) by a general practitioner or obstetrician. The excess does apply to the IUD. See article 35, Medications, and the Medical Devices Regulations for reimbursement of the IUD;
- Maternity care. See Article 15.2, Maternity care;
- The Stop Smoking programme as set out in Article 24;
- Preferred medications as set out in the Pharmaceutical Care Regulations. Please take into consideration that the services of the pharmacy, for example the issue fees, the instructions for a new drug or inhaling instructions, are not exempt from your excess. See Article 35, Medication;
- The healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar as they supply the preferred lung medication we selected. Please find the selected care providers and preferred lung medication in the Pharmaceutical Care Regulations in appendices D and E. Please note that the services provided by the pharmacy, for example the costs of dispensing medications, the counselling interview for a new medicine or an inhalation instruction, are not exempt from this policy excess. See Article 35, Medication;
- The liquid nutrition selected as a preferred product as referred to in the Pharmaceutical Care Regulations. See Article 36, Dietary preparations;
- Leased medical aids. Please refer to Article 37, Medical aids and bandaging;

- Post-op check-ups after a kidney or liver donation from a living person, after expiration of the period set out in Article 22, item d, Tissue and organ transplants;
- Transport of a donor as set out in Article 22, items e and f, Tissue and organ transplants if the donor has concluded a healthcare insurance;
- Any personal contributions and/or personal payments.

7.3. To which care providers and care arrangements does the statutory excess not apply?

We have the option of appointing healthcare providers or healthcare arrangements where you are charged no amount or a smaller amount of statutory excess. This also applies to health-promoting or preventive healthcare arrangements to be specified further. Please find this information on our website.

7.4. Calculation of the amount of statutory excess

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

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

The calculated amount will be rounded off to whole euros.

Example

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

7.5. Calculation of statutory excess

When calculating the excess, 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 Treatment Combination), these costs will be charged to the excess of the calendar year in which the treatment started.

Article 8. Voluntary excess

8.1. Variations of voluntary excess

If you are age 18 or older, you can choose a healthcare insurance policy with a voluntary excess of: € 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 excess, you will receive a discount on the premium basis. The selected voluntary excess and any discounts are stated on the policy schedule.

8.2. Which types of care are subject to the voluntary excess?

The voluntary excess is applicable to the same healthcare forms as set out in Article 7.2.

8.3. Calculation of voluntary excess amount

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

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

The calculated amount will be rounded off to whole euros.

Example

You selected a voluntary excess of € 100. The healthcare insurance runs from 1 January to 30 January. That is a total of 30 days. The calendar year has 365 days. The voluntary excess is: € 100 x 30 divided by 365 is € 8.22 and is rounded off to € 8. The statutory excess is € 385 x 30 divided by 365 is € 31.64 and is rounded off to € 32. The total excess amounts to € 40 (€ 32 statutory 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 previously with a different voluntary excess amount, 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 excess

You may change the voluntary excess annually as per 1 January. You are required to forward us such changes latest by 31 January. The change will then become effective as per 1 January (with retroactive effect).

8.5. Calculation of statutory and voluntary excess

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

Article 9. Abroad

9.1. You live or reside in an EU/EEA country or treaty country outside the Netherlands

If you live in or are temporarily residing in an EU/EEA 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 the market price perceived as reasonable in the Netherlands.

European Healthcare Insurance 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 only use this EHIC 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. Do you not have an EHIC healthcare card? You can request one free of charge.

9.2. You live or reside in a non-EU/EEA country or non-treaty country

If you are living in or residing in a non-EU/EEA 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 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. Therefore 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. Approval and/or referral

You would like to be treated abroad? If you are hospitalised in a hospital or a different institution for 1 or more nights, you will require our prior approval. You also need permission for receiving care abroad if this is stated in the healthcare provisions (Articles 11 up to and including 40). These healthcare provisions also set out if you need a referral or prescription.
If you do not require our approval, but you would like to know in advance if your treatment abroad were eligible for reimbursement, you can contact us and ask us for an assessment. For more information, see our website.
You do not require 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 in the Zorg App, on your healthcare card and on our website.

Article 10. Complaints and disputes

10.1. Do you have a complaint? 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. Please contact our customer service. The telephone number is available from our website. Please feel free to submit your complaint in writing to the Complaints Management department, PO Box 1256, 5602 BG Eindhoven, the Netherlands. The Complaints Management Department acts on behalf of the Executive Board.

Tips for submitting 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 yourself.
- 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 are unable to process your complaint without such permission.

You will receive a response to your complaint from us within 30 days. If you are not satisfied with the decision or have not received a response within 30 days, you can submit your complaint or dispute to Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ), PO Box 291, 3700 AG Zeist, the Netherlands, www.skgz.nl. Alternatively, you may submit the dispute to the competent court.

10.2. Complaints about our forms

If you feel one of our forms is superfluous or complicated, Please contact our customer service. The telephone number is available from our website. Alternatively, you may submit your complaint in writing to the Complaints Management department, PO Box 1256, 5602 BG Eindhoven, the Netherlands.

You can also submit your complaint to the Dutch Healthcare Authority for the attention of the Informatielijn/het Meldpunt, PO Box 3017, 3502 GA Utrecht, the Netherlands, email: info@nza.nl. The website of the Dutch Healthcare Authority, www.nza.nl, indicates how you can submit a complaint about forms.

II. Healthcare Provisions

Your insurance is an in-kind insurance policy. Pursuant to this insurance policy, you are entitled to reimbursement of the cost of healthcare. Articles 11 through 40 set out the details of the care to which you are entitled.

MEDICAL CARE

Article 11. General practitioner care

1. General practitioner care is medical care as general practitioners tend to provide and the accompanying examinations and diagnostics. Healthcare provided by general practitioners 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.

Coaching for quitting smoking
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).

Information on the quit smoking programme is set out in article 24.

Preconception care
Pre-conception healthcare (pregnancy wish visit) is defined as:
- Advice on healthy nutrition
- Advice on intake of folic 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.

Foot care relating to diabetes mellitus
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.

Foot care is part of general practitioner care or multi-disciplinary care as described in paragraph 3.1. 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 aforementioned care profiles stated above 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 GP can tell you which care profile you have.

2. Specialist medical care that borders on the GP domain.
   Examples of this care 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 (coil) insertion or removal, implantation or removal of etonogestrel implantation rod.
  Are you age 21 or older? Then you are not entitled to reimbursement of the cost of contraceptives, unless these items are used to treat endometriosis or menorrhagia (if suffering from anaemia). See Article 35
- Medically necessary circumcision
- Therapeutic injections (Cyriax).

3.1. Multi-disciplinary care (chain care) in connection with:
- Diabetes mellitus type 2 (DM type 2)
- Chronic obstructive pulmonary disease (COPD; this is a group of lung conditions, such as chronic bronchitis and lung emphysema)
- Cardiovascular diseases (care if you are a patient with a cardiovascular condition).

3.2. Contracted multi-disciplinary care (chain care) in connection with:
- Increased vascular risk management (care if you have an increased risk of cardiovascular diseases)
- Asthma (if you are age 16 or older)
- Programmatic care for vulnerable elderly.

Your healthcare group may charge you for this care only based on a contract concluded with us.

Multi-disciplinary care (chain care)

Multidisciplinary care specifically developed to organise healthcare for chronic patients in a region better in terms of quality and effectiveness. The healthcare providers work closely together within a healthcare group, ensuring that the healthcare you need is better aligned. The healthcare is based on a standard of care. This is a description agreed by the relevant healthcare providers that an insured person must receive in the event of a certain disorder. This standard forms the starting point for care the insured person receives and who provides this care. If no standard of care is described, care is provided on the basis of the professional standards of the professional groups involved.

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, podiatrist or pedicurist, for example.

Excess

No excess applies for this healthcare. The excess is applicable to medications. The excess is also applied for laboratory tests and diagnostics conducted by a different healthcare provider at the request of the general practitioner and charged to you. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. For general practitioner care (points 1 and 2) and multi-disciplinary care (point 3.1)
   A general practitioner, care group or third parties who are medically competent. Under the medical responsibility of a general practitioner, this care may also be provided by a doctor's assistant, nurse practitioner (NP), physician assistant (PA) or practice support worker (GGZ).
   For the implantation or removal of an IUD, you may also go to a certified obstetrician.
   Your obstetrician can inform you about this.
2. For foot care for diabetes mellitus:
   - A podiatrist who is registered with the Quality Register Paramedics
   - A medical pedicurist registered in ProCert's KRP (Quality Register for Pedicures)
   - A pedicurist with the certification 'Diabetic foot'
   - A pedicurist registered in the Stipezo Register Paramedische Voetzorg (RPV or Register Paramedic Foot care)
   - A pedicurist registered in the Kwaliteitsregister Medisch Voetzorgverleners (KMV or Quality Register Medical Foot care Providers) of Nederlandse Maatschappij Medisch Voetzorgverleners (NMMV or Dutch Association of Medical Foot care Providers).

The podiatrist will prepare the treatment plan and will determine which part of the treatment may be performed by a medical or other pedicurist.
3. For contracted multi-disciplinary care (section 3.2):
   A contracted healthcare group.

An overview of the partnerships between podotherapists and pedicurists is available from our website.
You can also ask your general practitioner's clinic about the possibilities for multi-disciplinary care.

If you select a non-contracted healthcare group for contracted multidisciplinary care as described in item 3.2, you are not entitled to reimbursement.
If you are not making use of multidisciplinary care or this care is not available in your region, You are entitled to healthcare provided by individual healthcare providers pursuant to the relevant healthcare provisions, including general practitioner healthcare services (items 1 and 2) and dietetics (Article 30).

Article 12. Medical care for specific patient groups

1. Medical care for specific patient groups is medical care such as general practitioners and clinical psychologists tend to offer. This is general medical care aimed at vulnerable elderly people, people with chronic progressive degenerative diseases, non-congenital brain injuries or a mental disability.
2. This care also comprises:
   a. Day treatment in a group of vulnerable patients aimed at learning how to deal with and compensate for impairments in order to allow the patient to live at home for as long as possible. This would include elderly people with multiple problems, people with Parkinson's, Korsakov, Multiple Sclerosis (MS) or with a mental disability
   b. Day treatment in a group for people with a physical disability or non-congenital brain injury
   c. Day treatment in a group for people with Huntington's disease
   d. Care for people with severe behavioural impairments and a mild mental disability
   The leading treatment professional will draw up your treatment plan and lead the multidisciplinary team. The treatment plan sets out the care and the number of half-day sessions of care in a group.

Excess
The excess applies to this healthcare.

This is where to go
1. For care as referred to under 1: a geriatric specialist, a doctor for the mentally disabled, a healthcare psychologist or a general remedial educationalist.
2. For care as referred to under 2: a multi-disciplinary team headed by a primary doctor/therapist.
   The primary care provider is a geriatric specialist, a doctor for the mentally disabled, a healthcare psychologist or a general remedial educationalist.

Referral letter required from
General practitioner or medical specialist. Referral for care as referred to under 2 may also be issued by a geriatric specialist, a doctor for the mentally disabled, a healthcare psychologist or a general remedial educationalist.

Approval
You require our prior approval for:
- Day treatment in a group of vulnerable patients as set out in 2a
- Day treatment in a group for people with a physical disability or non-congenital brain injury as set out in 2b.

More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 13. Combined lifestyle intervention

A combined lifestyle intervention (CLI or GLI) is an accredited programme about healthy food, eating habits and more exercise to acquire and maintain a healthy lifestyle. If you are age 18 and up, then you may qualify for an accredited programme starting with a moderately elevated weight-related health risk (WRH or GGR). The GGR is determined based on the standard of care for obesity. Are you age 16 or 17? Then you are eligible for an CLI if you have a moderately elevated WRH and your GP estimates that you could benefit from a CLI for adults. A list of the accredited programmes is available from our website. A programme takes 24 consecutive months to complete. You are not entitled to reimbursement of the cost of exercise or assistance with exercise.

Excess
No excess applies for this healthcare.

This is where to go
1. A lifestyle coach registered with the Professional Association of Lifestyle Coaches Netherlands (BLCN)
2. A physiotherapist, remedial therapist, dietician or occupational therapist registered as a lifestyle coach.

Referral letter required from
General practitioner.

Article 14. Nursing and care (district nurses)

Nursing and care is care such as nurses tend to provide without the need for a stay in an institution. The care is related to the need for or a high risk of medical care as set out in article 2.4 of the Healthcare Insurance Decree. This healthcare includes nursing, care, coordination, detection, prevention, instruction and supporting the independent management and independence level of the clients, the client system and case management. This care also includes care such as a nurse would provide if you were to make use of an emergency call via a personal alarm (for example if you had fallen at home).

This healthcare also includes nursing day care intensive child care in a nursing children's day care or children's hospital. Intensive child care (ICC or IKZ) is care provided to children up to age 18 that involves a need for care such as nurses tend to provide in connection with medical care or a high probability of needing such care. These children also have a need of permanent supervision or 24-hour care in the vicinity.

You need an indication for nursing and/or care and a care plan must be prepared. The indication is prepared by a nurse, level 5, or a nursing specialist. 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 health-care you need in terms of nature, scope and duration and the goals set.
The indication for nursing and care for insured persons under age 18 is prepared by a paediatric nurse, level 5, or a nursing specialist. The nurse 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.

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 excess applies for this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. A home care or other institution relating to nursing and care with a level 5 paediatric nursing specialist or nursing specialist with a permanent contract. The level 5 paediatric nursing specialist or nursing specialist prepares the medical indication and remains involved in the implementation and evaluation of the care plan. The healthcare is provided by a level 4 or 5 nursing specialist, nurse, healthcare worker level 3 or healthcare worker in individual nursing healthcare (VIG staff).
2. An independent level 5 paediatric nursing specialist or nursing specialist relating to the medical indication and provision of care. The healthcare can also be provided by a level 4 or 5 nursing specialist, nurse, healthcare worker level 3 or healthcare worker in individual nursing healthcare (VIG staff). This is permitted only if this healthcare provider collaborates with the level 5 paediatric nursing specialist or nursing specialist who prepared the medical indication. The healthcare provider who prepared the medical indication remains involved in the implementation and evaluation of the care plan. The collaboration is set out in writing and we receive a copy of this record.

You cannot transfer your claim on us for nursing and care to care providers or others with whom we have not concluded a contract for this care (prohibition of assignment). This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

Approval

You require our prior approval for such healthcare. You do not need prior approval for the medical indication. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 15. Obstetric and maternity care

15.1. Obstetric care

Obstetric care, including pre and after care, is care as obstetricians tend to provide. 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, item 1 indicates the elements included in this type of care.
- Counselling
  If you are pregnant and you are considering pre-natal screening for birth defects, 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.
- 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 an NIPT if a combination test shows that you have a significant risk of having a child with a chromosome anomalies.
- Invasive diagnostics (chorionic villus testing or amniocentesis) if a combination test or NIPT shows that you have a significant risk of having a child with a chromosomal abnormality (such as Down's syndrome).
- Twenty-week ultrasound (anomaly scan, or SEO):
  the anomaly scan can be used to check if your baby may have a physical anomaly, such as spina bifida. This test is called the Structural Ultrasound Test (SEO in Dutch, second trimester). The examination takes place around the 20th week of pregnancy.

Do you have no medical indication for prenatal diagnosis?

Then you can request an NIPT at your own expense.

Excess
No excess applies for obstetric care. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport are set off against the statutory excess.
No excess applies for the placement and removal of an IUD (coil) by the obstetrician. The excess does apply to the IUD. See article 35, Medications, and the Medical Devices Regulations for reimbursement of the UID.
For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
An obstetrician or general practitioner with further training and who specialises in physiological obstetrics. Integral birth care may be provided by an Integral Birth Care Organisation (IGO) that has a contract with us.

Integral maternity care
Obstetricians, maternity care nurses and gynaecologists collaborating in an Integral Maternity Care Organisation are permitted to agree on an integral rate for maternity care with us. 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. The Integral Maternity Care Organisation (IMCO or IGO) may charge you for this care only based on a contract concluded with us. An overview of our contracted IGOs is available from our website.
You may change care providers during pregnancy, birth and aftercare.

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. For the NIPT, you can go to a university centre and for invasive diagnostics, you can visit a prenatal diagnostics centre.

15.2. Maternity care

Maternity care is care such as maternity carers tend to provide for mother and child for a maximum of 10 days in connection with childbirth, counting from the day of delivery. 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). The number of hours of maternity care is a minimum of 24 hours and a maximum of 80 hours, spread over a maximum of 10 days. Please find this protocol on our website.

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. If several care institutions (e.g. hospital and maternity care organisation) charge for maternity care on the same day, you are also entitled to 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 sure that your request will be processed on time.

Personal contribution
You are charged a statutory personal contribution amounting to:
- € 4.70 per hour for maternity care at home or at a birth clinic;
- € 19 per day for both mother and child in the event of delivery in a birth clinic or hospital, without a medical need. In addition to the personal contribution, you must pay the difference in costs between the rate charged by the birth clinic or hospital and the maximum reimbursement of € 134 per day for both mother and child.

Excess
No excess applies for this healthcare.

This is where to go

A qualified maternity nurse who is registered with the Maternity Care Knowledge Centre or nurse. Maternity care as a part of integral birth care may be provided by an Integral Birth Care Organisation (IGO) that has a contract with us. More information about integral maternity care is set out in Article 15.1, Obstetric Care.
An overview of contracted Integral Maternity Care Organisations is available from our website.

Additional information

Are you using a non-contracted maternity nurse or nurse? Please enclose a copy of the indication in accordance with the LIP (Landelijk Indicatie Protocol Kraamzorg - National Referral Protocol Maternity Care).
You can request a copy from your maternity care organisation and/or from the independent maternity nurse or nurse.

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

Delivery and maternity care at home	
Delivery at home	Yes.
Maternity care at home	Maximum 10 days counting from the day of delivery. A personal contribution of € 4.70 per hour applies to maternity care.
Delivery with medical necessity and maternity care in a birth clinic or hospital	
Delivery in a birth clinic or hospital with medical necessity	Yes.
Maternity care in a birth clinic	Maximum 10 days counting from the day of delivery. A personal contribution of € 4.70 per hour applies to maternity care.
Maternity care in hospital after delivery with medical necessity	Yes. This is not subject to a personal contribution.
Delivery without medical necessity and maternity care in a hospital or birth clinic	
Childbirth without medical necessity in the delivery room of a birth clinic Delivery and maternity care in a hospital without medical necessity of staying	Yes. The maximum reimbursement for mother and child together is € 230 per day. This fee is calculated as follows: Maximum reimbursement is 2 x € 134: € 268 per day Less: personal contribution is 2 x € 19: € 38 per day € 230 per day You must pay the difference in costs between the rate charged by the birth clinic or hospital and the maximum reimbursement of € 230 per day for both mother and child.
Delivery without medical necessity in a birth clinic or hospital as part of integral maternity care by an Integral Maternity Care Organisation contracted by us	Yes. The personal contribution is € 433 for mother and child together.
Maternity care in a birth clinic	Maximum 10 days counting from the day of delivery. A personal contribution of € 4.70 per hour applies to maternity care.

Medical need

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.

Article 16. Specialist medical care

Specialist medical care is medical care such as medical specialists tend to provide, including the relevant laboratory and other tests, medications, dressings and medical devices. Specialist medical care also includes:

- Care provided by a thrombosis unit;
- Second opinion by 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. Please find more information regarding dialysis in the home situation and the allowance for additional costs (electric power) on our website;
- Chronic intermittent respiration and the required equipment. Please find more information regarding an allowance for electric power costs of mechanical breathing equipment in the home situation on our website;
- Medically necessary circumcision.

Specialist medical care also includes:

a. Up to 1 July 2022, treatment with tumour-infiltrating lymphocytes of metastasised melanoma irresectable stage IIIc and stage IV insofar as you are participating in research as outlined below;
b. Up to October 2022, mammary reconstruction after breast cancer with autologous fat transplants, insofar as you are participating in main research as outlined below;
c. From 1 July 2021 to 1 August 2025, bladder instillation with bladder flushing fluids containing chondroitin sulfate and/or hyaluronic acid for the treatment of patients with bladder pain syndrome with non-transurethral treatable Hunners lesions insofar as you are participating in research studies as listed below;
d. From 1 April 2016 to 1 August 2022, dendritic cell vaccinations in patients with stages IIIB and IIIC melanoma after complete resection, insofar as you are participating in research as outlined below;
e. From 1 October 2016 to 1 January 2022, sacral neuromodulation for therapy-resistant, functional obstipation with delayed intestinal passage, insofar as you are participating in research as outlined below;
f. From 1 January 2017 to 1 January 2023, intensified, alkylating chemotherapy with stem cell transplant for the treatment of patients of ages 18 to 65 who have BRCA1-like, stage III breast cancer, insofar as you are participating in research as outlined below;
g. From 1 October 2017 to 1 October 2022, combination treatment of cytoreductive surgery and hypertherm intraperitoneal chemotherapy in patients with both stomach cancer and synchronous peritoneum cancer or tumour-positive stomach fluid, insofar as you are participating in research as outlined below;.
h. From 1 April 2019 to 1 August 2023, CardioMEMS arteria pulmonalis monitoring for patients with chronic heart failure New York Heart Association class III with recurring hospitalisation, insofar as you are participating in main research as outlined below;
i. From 1 October 2019 to 1 October 2023, treatment of Binamed medical silver clothing or Derrmacura anti-bacterial bandage clothing for children and adults with medium to high constitutional eczema, insofar as you are participating in main research as outlined below;
j. From 1 January 2020 to 1 January 2027, intraperitoneal hyperthermal chemotherapy added to primary debulking in patients with stage III ovarian carcinoma if you are participating in main research as outlined below;
k. From 1 January 2020 to 1 January 2027 nusinersen for the treatment of patients with 5q spinal muscular atrophy who are 9.5 years of age and older, provided you are participating in the research study as listed below;
l. Until 1 January 2025, larotrectinib for the treatment of adult and pediatric patients with solid tumors that exhibit neurotrophic tyrosine receptor kinase gene fusion, provided you participate in studies as listed below;
m. Until 1 January 2025 entrectinib for the treatment of adult patients and children 12 years of age and older with solid tumors that exhibit neurotrophic tyrosine receptor kinase gene fusion, provided you are participating in studies as listed 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. participated in the main research without having received the healthcare and participation to the main research has completed for you.

The Minister of Health, Welfare 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 indicates the status 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 Scheme on our website.

This is not insured:
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
The excess applies to this healthcare.
No excess applies for obstetric care by a gynaecologist. No excess applies for prenatal screening, excepting for the NIPT. The excess applies to NIPT. Any fees associated with obstetric care are also subject to the excess. This means that medications, blood tests or patient transport invoiced separately are set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A medical specialist. The care may also be provided by a clinical physician audiologist, clinical technologist, geriatric medical specialist, emergency aid physician, KNMG emergency aid doctor, specialist nurse or physician assistant (PA), if the indicated care falls within the area of expertise of that healthcare provider.

Integral maternity care
Obstetricians, maternity care nurses and gynaecologists collaborating in an Integral Maternity Care Organisation are permitted to agree on an integral rate for maternity care with us. The IGO may charge you for this care only based on a contract concluded with us. An overview of our contracted IGOs is available from our website.

Referral letter required from
General practitioner, nursing specialist, physician assistant (PA), SEH doctor KNMG (emergency room doctor), audiologist, company doctor, paediatrician/doctor in youth health care, geriatric specialist, doctor for the mentally disabled, dentist, obstetrician, optometrist, orthoptist, medical specialist, oral surgeon, Municipal Health Service doctor, clinical physicist audiologist, clinical technologist or physician assistant.

Approval
Some treatments are subject to prior approval. Please find such treatments in the Limitative List Authorisations Specialist Medical Care on our website. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Which types of care are subject to prior approval?

You need approval for all treatments stated in the Limitative List Authorisations Specialist Medical Care. This includes:

Ophthalmology:	Refractive surgery (laser eye treatments or lens implants) and eyelid corrections
ENT:	Auricle corrections and treatment of nose deformities
Surgery:	Gynaecomastia (male breast development), mammary hypertrophy (abnormal size of the breasts) and abdominoplasty
Dermatology	Benign (non-malignant) tumours, pigmentation disorders and vascular dermatoses (birth-marks)
Gynaecology:	Vulvar and vaginal abnormalities
Plastic surgery:	See Article 21 Plastic and/or reconstructive surgery

We advise you to ask us for permission to treat in advance if you are in any doubt.
Your medical specialist must notify you that you need to pay the cost of healthcare personally unless prior approval was issued.

Additional information

The Healthcare Insurance Scheme may exclude certain forms of medical care and medication for treatment of one or more new referrals. The Healthcare Insurance Scheme is available from our website.

Article 17. Rehabilitation

17.1. Rehabilitation

Rehabilitation is medical care as referred to in Article 11 (General practitioner care) and Article 16 (Specialist medical care). Rehabilitation includes research, advice and treatment of a combined medical specialist, paramedical, behavioural science and rehabilitation-technical nature, only if and insofar as:

- This care is indicated as the most efficient for you to prevent, reduce or overcome a disability resulting from impairments or restrictions in the ability to move or a disability that 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 refer 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 aftercare 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

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A multidisciplinary team of experts attached to a rehabilitation institution or hospital under the guidance of a medical specialist. The quick scan should be conducted under the direction of a rehabilitation specialist.

Referral letter required from

General practitioner, company doctor or medical specialist.

Approval

You require our prior approval. More information about applying for approval is set out in Article 1.9 of these policy conditions.

17.2. Geriatric rehabilitation

Geriatric rehabilitation care (GRC or GRZ) comprises integral and multi-disciplinary rehabilitation care as provided by specialists in geriatric medicine in connection with vulnerability, complex multi-morbidity (the co-occurrence of two or more diseases) and reduced learning and training ability. GRZ is aimed at improving your functional limitations to the extent that returning to your home situation is possible. GRZ is provided for a maximum of 6 months. In special cases, we may allow for a longer rehabilitation period.

GRZ is covered only if:

1. The care is provided within one week of a hospital stay as referred to in Article 2.12 of the Healthcare Insurance Decree (see Article 38, Stay), and this stay was not preceded by a stay as referred to in Article 3.1.1 of the Long-Term Care 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 assessment (geriatric assessment) is performed by a geriatrician, clinical geriatrician, geriatric internist or geriatric specialist. 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 continue to participate in society.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A multidisciplinary team of experts in geriatric rehabilitation led by a specialist in geriatric medicine.

Article 18. Genetic testing

Hereditary testing is medical care as referred to in Article 16 (Specialist Medical Care) and includes testing of hereditary defects by means of genealogical tests, chromosome tests, biochemical diagnostics, ultrasound tests and DNA tests, the provision of hereditary advice and the psychological-social assistance relating to this 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

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A 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 19. In vitro fertilisation (IVF) and other fertility-related care

19.1. In vitro fertilisation (IVF)

In vitro fertilisation (IVF) is medical care as referred to in Article 16 (Specialist Medical Care) and includes a maximum of the first, second and third IVF attempts per pregnancy to be realised if 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, the first and second IVF attempts will only be reimbursed if one 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 there are any embryos left over after an ongoing pregnancy has been established, you are entitled to have them re-placed on the grounds of Article 19.2, Other fertility-related care.

When are you entitled to another set of 3 IVF attempts?
After a continued (achieved) pregnancy or a (live) child born, whether or not as a result of IVF, a new entitlement to three attempts in the event of a new unsuccessful attempt at pregnancy arises due to unwanted infertility. Even after a change of partner, you are entitled to a new set of an IVF treatment course of 3 attempts if there is joint infertility.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A gynaecologist in an institution licensed to this end.

Referral letter required from
Gynaecologist or urologist.

Additional information
If egg donation is used in an IVF treatment, including an ICSI treatment (intracytoplasmatic sperm injection), the above conditions for IVF also apply.
You are not entitled to reimbursement of the cost of the egg cell donation.

IVF treatment abroad
Your eligibility for IVF treatment depends on your personal situation, for example your age and how long you have attempted to become pregnant. Would you like to go abroad for IVF treatment? Please contact us in advance.
You can find our telephone number on our website.

19.2. Other fertility-related care

Other fertility-related care is medical care as referred to in Article 16 (Specialist Medical Care) and includes gynaecological or urological treatments and operations to promote fertility. This healthcare also includes artificial insemination and intra-uterine insemination. Fertility-related care is not reimbursed for women age 43 or older.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A gynaecologist or urologist.

Referral letter required from
General practitioner or medical specialist.

Article 20. Audiological care

Audiological care is medical care as referred to in Article 16 (Specialist Medical Care) and includes care relating to:
- Hearing tests
- Advice about the hearing aid to be purchased
- Information about the use of the equipment
- Psychosocial 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
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A multidisciplinary team of experts attached to an audiology centre under the responsibility of a medical specialist.

Referral letter required from
General practitioner, audiologist, company doctor, medical specialist, paediatrician, geriatric medical specialist or doctor for mentally disabled.

Article 21. Plastic and/or reconstructive surgery

Plastic and/or reconstructive surgery is medical care as referred to in Article 16 (Specialist Medical Care) and includes treatments of a plastic-surgical nature, if it concerns:
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. Correct paralysed or weakened upper eyelids if resulting in serious limitation of the visual field, or if it is a result of a congenital deformity or a chronic disorder present at birth;.
4. Correct 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. Correct primary sexual characteristics where transsexuality has been established;
6. Surgically insert and replace a breast prosthesis other than after a full or partial mastectomy;

7. Surgically insert and surgically replace a breast prosthesis in the event of agenesis/aplasia of the breast (lack of breast formation) in women and in male-female transgenders, subject to the following criteria:
   - Absence of an inframammary fold (fold under the breast) and;
   - Gland tissue of less than 1 cm, shown by an ultrasound.

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.
The 'Reference Guide assessment plastic surgery treatments' sets out a further explanation of when you are entitled to this care in accordance with the criteria listed. This guide was compiled by the Association of Public Health Physicians (Vereniging Artsen Volksgezondheid, VAV), the Dutch Health Insurers (Zorgverzekeraars Nederland, ZN) and the Netherlands Healthcare Institute (Zorginstituut Nederland). This reference guide is available on our website.

This is not insured:

a. Treatment of paralysed or weakened upper eyelids other than listed in item 3 of this Article;
b. Abdominal liposuction;
c. Surgical insertion and/or removal of a breast prosthesis without medical necessity or for cosmetic reasons.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A 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 treating medical specialist. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 22. Tissue and organ transplants

Tissue and organ transplants are classed as medical care as referred to in Article 16 (Specialist Medical Care) only if the transplant is performed in a country of the European Union or EEA member state. If the transplant is carried out in another country, the donor must be your spouse, registered partner or blood relative in the first, second or third degree and reside in that country.

Care also includes reimbursement for:

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;
e. 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 costs of staying in the Netherlands and any loss of income are not covered.

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

The excess applies to this healthcare. The excess does not apply for:

- Care related to a living organ donation after the period referred to under d has expired.
- Transport of a donor such as set out under e and f, provided the donor has healthcare insurance.

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

This is where to go

A medical specialist.

Article 23. Sensory disability care

Care for the sensory disabled is multi-disciplinary care in connection with a visual, auditory or communicative impairment resulting from a language development disorder or a combination of these impairments. 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

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

An institution specialised in treating people with a sensory disability, with a multidisciplinary 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 for care in connection with an auditory or communicative disability may also be made by a clinical physicist-audiologist at an audiology centre.

Article 24. Quit Smoking Programme

The quit smoking programme comprises medical care to support behavioural change with the aim of quitting smoking. Medications can also be part of this care 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 care is not subject to a policy excess. For more information, see Articles 7 and 8 of these insurance terms and conditions.

This is where to go
Healthcare providers who work in compliance with the Healthcare Module Tobacco Addiction.
The medications may only be supplied by a pharmacist or dispensing general practitioner.

MENTAL HEALTHCARE (GGZ)

Article 25. General Practice GGZ (GB GGZ, Municipal Mental Health Service) for insured age 18 and older

Generalist basic GGZ is medical care such as clinical psychologists tend to provide for insured age 18 and older. This healthcare includes diagnostics and specialist treatment of light to moderate, non-complex psychological conditions/disorders or stable chronic issues. Together with your primary care provider, you draw up a treatment plan, setting out the care you need and how long it will take. Your care provider will then determine to which care you are entitled.

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. Your treatment involves regular visits to your healthcare provider. It is increasingly possible to choose full or partial digital treatment. Sometimes you will be treated at home.

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 GGZ Therapies Overview on our website. This overview states which therapies do or do not comply and in which situations they may be applied. You can also contact your healthcare provider for information.

This is not insured:
- 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
- Intelligence tests.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A care provider that has an approved GGZ quality statute, registered via the GGZ Quality statute website.

National Quality Charter GGZ

The National Quality Statute for Mental Health Care contributes to the fact that the right care is provided at the right place by the right care professionals. All care providers of generalist basic GGZ and specialist GGZ are required to draw up their own GGZ quality statute. The website www.zorginzicht.nl, in the section Public Data, offers an overview showing which care providers have an approved GGZ quality statute and where you can view the statute. In the quality statute, the care provider must indicate how the quality standards are structured and specified. The care provider's quality statute also sets out who is responsible for the indication and/or coordination of care. This is the leading treatment professional. The quality certificate can help you select your healthcare provider.

Primary care provider

The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. Among other things, the coordinating primary care provider determines the cooperation with these care 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 psychologist.
2. The following persons may be appointed as the primary care provider regarding GB GGZ in an institution: clinical psychologist/neuropsychologist, psychotherapist and healthcare psychologist, geriatrics specialist, addiction specialist with KNMG profile registration, clinical geriatrician and GGZ nursing specialist. Under the final responsibility of the primary care provider, some of the care may also be provided by a care provider included in the NZa list of other professions.
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 generalist NVO. They may only be the primary care provider for a maximum period of 365 days after your 18th birthday.

You cannot transfer your claim on us for Generalist Basic GGZ to care providers or others with whom we have not concluded a contract for this care. This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

Referral letter required from

General practitioner, company doctor, medical specialist, psychiatrist, geriatric specialist, doctor for the mentally disabled, KNMG emergency aid doctor or street doctor. The street doctor is a doctor registered in the municipal area/areas where he/she works and with an association of street doctors (e.g. the Nederlandse Straatdokters Groep). The street doctor may only issue referrals if the client does not have a general practitioner.
Did you receive GGZ on the basis of the Youth Act and do you not have a referral letter from a referrer mentioned above? Then you need a new letter of referral.

Article 26. Specialist mental healthcare (SGGZ) for insured age 18 and older

Specialised mental healthcare (GGZ) is medical care such as psychiatrists and clinical psychologists tend to provide for insured age 18 and older, including the associated medications, medical devices, dressings and bandages. This healthcare includes diagnostics and specialist treatment of complex or very complex psychological conditions.

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. The activities must be provided at the instructions of your primary care provider.
Your leading healthcare professional receives feedback on such activities. For such activities, expertise at the level of the leading healthcare professional is necessary.

Specialist mental healthcare

Specialist mental healthcare is about diagnostics and specialist treatment of complex and very 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.

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 this in the GGZ Therapies Overview on our website. This overview states which therapies do or do not comply and in which situations they may be applied. You can also contact your healthcare provider for information.

This is not insured:

- 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

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A care provider that has an approved GGZ quality statute, registered via the GGZ Quality statute website.

National Quality Charter GGZ

The National Quality Statute for Mental Health Care contributes to the fact that the right care is provided at the right place by the right care professionals. All care providers of generalist basic GGZ and specialist GGZ are required to draw up their own GGZ quality statute. The website www.zorginzicht.nl, in the section Public Data, offers an overview showing which care providers have an approved GGZ quality statute and where you can view the statute. In the quality statute, the care provider must indicate how the quality standards are structured and specified. The care provider's quality statute also sets out who is responsible for the indication and/or coordination of care. This is the leading treatment professional. The quality certificate can help you select your healthcare provider.

Primary care provider

The leading healthcare professional performs the treatment personally in an independent practice. The treatment in an institution may involve more than one healthcare provider. Among other things, the coordinating primary care provider determines the cooperation with these care 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. The following professionals may be appointed as primary care provider SGGZ in an institution: psychiatrist, clinical psychologist/neuropsychologist, psychotherapist, healthcare psychologist, geriatrics specialist, addiction specialist with KNMG profile registration, clinical geriatrician and GGZ nursing specialist. Under the final responsibility of the primary care provider, some of the care may also be provided by a care provider included in the NZa list of other professions.
3. Leading healthcare professional SGGZ for a treatment started pursuant to the Youth Act may include: paediatric or youth psychologist NIP and ortho-paedagogist generalist NVO. They may only be the primary care provider for a maximum period of 365 days after your 18th birthday.
4. For highly specialised mental healthcare you must go to a care provider contracted by us. If you go to a non-contracted care provider for this care, you will not be entitled to reimbursement.

You cannot transfer your claim on us for Specialist GGZ to care providers or others with whom we have not concluded a contract for this care (prohibition of assignment). This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, geriatric specialist, doctor for the mentally disabled, KNMG emergency aid doctor or street doctor. The street doctor is a doctor registered in the municipal area/areas where he/she works and with an association of street doctors (e.g. the Nederlandse Straatdokters Groep). The street doctor may only issue referrals if the client does not have a general practitioner.
Did you receive GGZ on the basis of the Youth Act and do you not have a referral letter from a referrer mentioned above? Then you need a new letter of referral.

Approval
- You need our prior consent for Esketamine (nasal spray)
- You need our prior approval for specialist mental healthcare with a stay (see Article 38, 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 sure that your request will be processed on time. The address to send the application to is included in the first section of these conditions.

More information about applying for approval is set out in Article 1.9 of these policy conditions.

PARAMEDICAL CARE

Article 27. Physiotherapy and Remedial Therapy

Physiotherapy and remedial therapy is care such as physiotherapists and remedial therapists tend to provide. This care includes:

Up to age 18
- Treatment of conditions requiring long-term or chronic treatment. This is set out in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). Please take into consideration that the duration of the treatment of certain conditions is limited to a certain term.
- 9 sessions per calendar year for a disorder not included in the List of Disorders for Physiotherapy and Remedial Therapy. A maximum of 9 additional sessions if you are still suffering from the disorder: in total a maximum of 18 treatment sessions per disorder per calendar year.

Age 18 and older
Pelvic physiotherapy for urine incontinence
One-off 9 treatments in pelvic physiotherapy in connection with urine incontinence.

Remedial therapy for claudication (peripheral arterial vascular condition)
A maximum of 37 treatments of remedial therapy under the supervision of a physiotherapist or remedial therapist (walk training) for peripheral arterial vascular disease in stage 2 Fontaine (claudication) in a period of a maximum of 12 months.

Remedial therapy for arthrosis of the hip or knee joint
A maximum of 12 treatment sessions for remedial therapy under the supervision of a physiotherapist or remedial therapist in the case of arthrosis of the hip or knee joint in a period not exceeding 12 months.

Remedial therapy for COPD
Remedial therapy under the supervision of a physiotherapist or remedial therapist in COPD (Chronic Obstructive Pul-

monary Disease) GOLD class II and higher. The number of treatments depends on the severity of the complaints and the risk of lung attacks according to the GOLD group A, B, C or D. Group B is then subdivided into:
- B1: moderate disease level or sufficient physical capacity
- B2: high disease level and limited physical capacity

Group	A	B1	B2 and C	D
The first 12 months The maximum number of sessions in the 12-month period after start of treatment is:	5	27	70	70
After the first 12 months The maximum number of sessions in each 12-month period after the first year is:	0	3	52	52

Treatment of chronic conditions

Treatment of conditions requiring long-term or chronic treatment. This is set out in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). Please take into consideration that the duration of the treatment of certain conditions is limited to a certain term. The first 20 treatment sessions will not be reimbursed.

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. You can find our phone 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. You can find our telephone number on our website.

All ages

Arthritis physiotherapy

Insofar as you participate in main research into the effectiveness of the healthcare funded by the Dutch organisation for healthcare research and healthcare innovation (ZonMW), physiotherapy also includes:
a. from 1 October 2019 through 1 October 2023, long-term active physiotherapy from the twenty-first session for patients with axial spondyloarthritis with severe functional limitations.
b. from 1 October 2019 through 1 October 2023, long-term active physiotherapy from the twenty-first session for patients with rheumatoid arthritis with severe functional limitations.

Physical and remedial therapy focused on the direct recovery care of patients with severe COVID-19

You can claim until 1 August 2022:
a. A maximum of 50 physiotherapy and/or remedial therapy treatments in a maximum period of 6 months after the first treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start physical and/or remedial therapy within one month after the referral letter has been issued.
b. A maximum of 50 physiotherapy and/or remedial therapy sessions in a period of a maximum of another 6 months following on from the period referred to under a. You will need a referral from your GP or medical specialist. You must start physical and/or remedial therapy within one month after the referral letter has been issued.

You are entitled to physiotherapy and remedial therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research is defined as top line research into the effectiveness of care financed by the Dutch organisation for health research and care innovation (ZonMW) and supplementary national observational research into the healthcare, prepared and performed in collaboration with the top line research.

This is not insured:

- Occupational curative care. This concerns healthcare aimed at healing and treating acute and chronic physical occupational conditions;
- 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 overweight persons and cardio training.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. Physiotherapist, paediatric physiotherapist, pelvic physiotherapist, psychosomatic physiotherapist, geriatric physiotherapist and a manual therapist
2. Cesar/Mensendieck remedial therapist or paediatric remedial therapist
3. Oedema therapy may only be performed by an oedema therapist or oedema physiotherapist, or skin therapist.

ParkinsonNet

Do you have Parkinson's syndrome and do you need physiotherapy or remedial therapy? Then you can see physiotherapists or remedial therapists that are members of the national network ParkinsonNet. For more information, see our website.

Chronic Care Network

Do you need exercise therapy (walking training) for peripheral arterial vascular conditions in the legs (intermittent claudication)? Then you can see an occupational therapist who is a member of the national network ParkinsonNet. For more information, see our website.

Approval

You require our prior approval only if you are treated for a condition stated in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). You need a statement from your general practitioner, company doctor, medical specialist, nursing specialist or physician assistant to the effect that you must be treated for a disorder included in this list. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 28. Speech therapy

Speech therapy is care such as speech therapists tend to provide, if this care has a medical purpose and the treatment can be expected to result in restoration or improvement of the speech function or speech ability.

This is not insured:

Speech therapy treatments related to:

- Dyslexia
- Impaired language development in connection with a dialect or a different mother tongue
- Speaking in public
- The art of declamation.

Speech therapy focused on direct recovery care of patients with severe COVID-19

You can claim until 1 August 2022:

a. Speech therapy in a maximum period of 6 months after the first treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start speech therapy within one month of the referral letter being issued.
b. Speech therapy in another maximum period of 6 months following the period referred to in a. You will need a

referral from your GP or medical specialist. You must start speech therapy within one month of the referral letter being issued.

You are entitled to speech therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research is defined as top line research into the effectiveness of care financed by the Dutch organisation for health research and care innovation (ZonMW) and supplementary national observational research into the healthcare, prepared and performed in collaboration with the top line research.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A speech therapist.

Speech therapy treatments that deviate from regular treatments may only be provided by a speech therapist registered in one of the following sub-registers of the Dutch Association for Speech Therapy and Phoniatrics (NVLF):

- Aphasia
- Hanen programmes
- Integral healthcare for stuttering
- Preverbal speech therapy (eating and drinking)
- Stuttering.

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

ParkinsonNet

Do you suffer from Parkinson and you require speech therapy? Then you can see speech therapists that are members of the national network ParkinsonNet. For more information, see our website.

Article 29. Occupational therapy

Occupational therapy is care such as occupational therapists tend to provide, subject to the condition that the purpose of this care is to promote or restore your self-care, autonomy and independence, up to a maximum of 10 treatment hours per calendar year.

Occupational therapy focused on the direct recovery care of patients with severe COVID-19

You can claim until 1 August 2022:

a. Up to 10 hours of occupational therapy in a maximum period of 6 months after the first treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start occupational therapy within one month of the referral letter being issued.
b. Maximum 10 hours of occupational therapy in another period of 6 months following the period referred to in a. You will need a referral from your GP or medical specialist. You must start occupational therapy within one month of the referral letter being issued.

You are entitled to occupational therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research is defined as top line research into the effectiveness of care financed by the Dutch organisation for health research and care innovation (ZonMW) and supplementary national observational research into the healthcare, prepared and performed in collaboration with the top line research.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A occupational therapist.

ParkinsonNet
Do you suffer from Parkinson and you do require occupational therapy? Then you can see occupational therapists that are members of the national network ParkinsonNet. For more information, see our website.

Article 30. Dietetics

Dietetics is care such as dieticians tend to provide, if this care has a medical purpose, up to a maximum of 3 treatment hours per calendar year. Dietetics is defined as patient education with a medical purpose and the treatment of patients by means of diet therapy aimed at eliminating, reducing or compensating for food-related or nutritionally influenceable diseases or complaints.

Dietetics focused on the direct recovery care of patients with severe COVID-19
You can claim until 1 August 2022:

a. A maximum of 7 hours of dietetics in a period of up to 6 months after the initial treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start dietetics within one month of the referral letter being issued.
b. A maximum of 7 hours of dietetics for a maximum of another 6 months following on from the period referred to under a. You will need a referral from your GP or medical specialist. You must start dietetics within one month of the referral letter being issued.

You are entitled to dietetics aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research is defined as top line research into the effectiveness of care financed by the Dutch organisation for health research and care innovation (ZonMW) and supplementary national observational research into the healthcare, prepared and performed in collaboration with the top line research.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dietician.

Dietetics as part of multi-disciplinary care (chain care)
If you have diabetes mellitus type 2, COPD (chronic obstructive pulmonary disease), increased vascular risk or asthma, and you are receiving multidisciplinary healthcare as set out in Article 11, then dietetics for these or related conditions are provided via this multidisciplinary healthcare.

ORAL CARE

Article 31. Dental care for insured under age 18

Dental care is care as dentists tend to provide it. For insured persons under age 18,
the care includes the following operations/treatments:

1. Check-ups (periodical preventive dental examination): once annually. If necessary, you are entitled to 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 such check-ups more than twice per year;
5. Sealing (sealing pits and grooves in teeth and molars)
6. Gum treatment (periodontal treatment)
7. Anaesthetics
8. Root canal treatment (endodontic assistance)
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 X-ray tests for orthodontics.

If you are under age 23, then you are entitled to reimbursement of the cost of crowns, bridges and implants 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 excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental surgeon, prosthodontist or dental hygienist. The dentist or dental hygienist may work in an institution for paediatric dental care.
For an autotransplant with a multi-disciplinary treatment team where the surgical part is carried out by a periodontist, dental implantologist or oral surgeon and the dental treatment part by a dentist. The healthcare provider who performs the surgical part.

Approval
You require our prior approval for:

- Crowns, bridges and implants
- Jaw overview pictures
- Autotransplants
- The 11th sealing or more
- Extracting a front tooth, baby tooth or baby tooth in a difficult situation where the gums have to be pushed aside
- The surcharge for a severely shrunken jaw in the case of a dental prosthesis

More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 32. Specialist dental care

Specialist dental care is for people with a specific condition. Such dental care takes more time and more expertise. You are only entitled to 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.

32.1. Dental care in special cases

Dental care in special cases is care as dentists tend to provide, 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.

The care referred to under 1. includes orthodontic care if you have a very serious development or growth disorder of the mouth or teeth which requires co-diagnostics or co-treatment by disciplines other than dentistry.

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 it is not a matter of special cases requiring dental care.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. Dental care in special cases:
   Dentists, certified oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon.
2. Orthodontic care in special cases:
   A certified oral hygienist working in a centre for specialist dental care, dental surgeon, orthodontist in collaboration with a dental surgeon or a dentist registered in the Quality Register Orthodontic Association (OK register) in collaboration with a dental surgeon. Patients with a cleft lip or cleft palate may only be treated by an orthodontist in collaboration with a dental surgeon.

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 anaesthesia? Then the healthcare may only be provided in a hospital or centre for specific dental care.
A centre for specific dental care is:

1. An institution for specific dental care accredited by the Nza (Netherlands Healthcare Authority)
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;
   - There is 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 an accredited 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. More information about applying for approval is set out in Article 1.9 of these policy conditions.

32.2. Dental implants

The care includes the placement of a dental implant in the context of special dental care if you:

1. Have a severe developmental disorder, growth disorder, or acquired abnormality of the dental-oral system;
2. Have an acquired defect of the jaw-mouth system in the form of a very severely shrunken toothless jaw and the implants serve to secure a removable prosthesis.

Implants in a very severely shrunken 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 34.

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 it is not a matter of special cases requiring dental care.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

Dentists, certified 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 very severely lapsed toothless jaw, this healthcare may also be provided by a dental implantologist.

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 only be provided in a hospital or centre for specific dental care.

A centre for specific dental care is:

1. An institution for specific dental care accredited by the Nza (Netherlands Healthcare Authority)
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;
   - There is 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 an accredited 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. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 33. Oral surgery for insured age 18 and older

Oral surgery is surgical dental care of a specialist nature and the accompanying X-ray examination as dentists tend to provide if you are age 18 or older.

This is not insured:
- Surgical treatment of gums (periodontal surgery)
- Placement of an implant
- Uncomplicated extractions. These extractions involve teeth or molars that your dentist can also pull.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dental surgeon.

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

Approval
Some treatments are subject to prior approval. Please find such treatments in the Limitative List Authorisations Dental Surgery on our website. You also need prior approval for an autotransplant. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Article 34. Prosthetic devices for insured age 18 and older

The care includes a removable complete dental prosthesis for the upper and/or lower jaw, whether or not to be placed on implants if you are age 18 or older. The care also includes fitting the fixed part of the supra-structure (the meso-structure) for a removable complete dental prosthesis to be placed on dental implants. Repairing and filling (rebasing) these dentures is also part of this care.

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

Your personal contribution is 17% of the cost of making a normal denture on one jaw and an implant-supported denture on the other jaw at the same time (code J50).

Personal contribution dental prosthesis

You are entitled to 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 (meso structure). A meso structure 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 or other cover. In addition to a personal contribution, a policy excess may also apply.
For an implant for a complete dental prosthesis if you have a severely shrunken toothless jaw, see Article 32.2.

Excess
The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental implantologist or dental prosthodontist.

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:
      - € 600 for an upper or lower jaw
      - € 1,200 for an upper and lower jaw jointly
   b. If you want to replace your dentures within 5 years after purchase
   c. For the supplement very severely shrunken jaw
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)

More information about applying for approval is set out in Article 1.9 of these policy conditions.

PHARMACEUTICAL CARE

Article 35. Medications

Pharmaceutical care includes the supply of medications, or advice and guidance such as pharmacists tend to provide for medication assessment and responsible use of medication and drugs.
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
The care includes medications registered as preferred in the Healthcare Insurance Regulations. These are set out in Appendices 1 and 2 of the Healthcare Insurance Scheme.

Preferred medications
Appendix 1 of the Healthcare Insurance Scheme sets out groups of medications with the same active ingredient. We select a preferred medication for certain active ingredients. You are only entitled to such preferred medications. Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website. We do not reimburse any other medications with the same active ingredient. In certain rare cases, treatment with a preferred medication is not medically safe and your doctor will state 'medical necessity' on the prescription. You have the right to choose a different medication.

Medical need

Your doctor may only state 'medical necessity' on the prescription if he/she can substantiate the reason. If the pharmacist has doubts about the medical necessity, for example because you have not used the medication before, the pharmacist will contact your doctor. If your doctor's explanation shows that there is a medical necessity, you are entitled to alternative medication. Your pharmacist will select the active ingredient prescribed by your doctor based on your doctor's explanation of the medication he/she recommends for you. This may concern different generic medication. In some cases, the pharmacist may decide on giving you the preferred medication if there is no medical necessity for an alternative product.

Preferred medications and your excess

The excess does not apply for preferred medication. Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website. The excess does apply to pharmacy services. This may include the fees for supplying a medication and assistance regarding the use of new medications. If you are using a medication other than the preferred medication because of medical necessity, the excess applies.

Self-care products

Care includes self-care medications if you need to use these medications for more than 6 months. You are only entitled to 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

Care includes non-registered drugs if rational pharmacotherapy is involved. Rational pharmaco therapy is treatment, prevention or diagnostics 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 entitled to the following non-registered medications:

- Pharmacy preparations;
- Medications that 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 such medications if you have a rare condition with an incidence of less than 1 in 150,000 in the Netherlands.

Temporary shortage of medication

If a registered medicine cannot be supplied in the Netherlands or cannot be supplied in sufficient quantities, the care will include a replacement medicine from abroad. This medication must be imported from abroad with prior permission of the Healthcare Sector Inspectorate or based on temporary permit issued by the Drugs Assessment Council.

This is not insured:

- Pharmaceutical care relating to a medication not covered by insurance
- Education on pharmaceutical self-management for a patient 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 Scheme
- Preventive travel kit of medications and vaccinations
- Medications for research as referred to in Section 40, third subsection, under b, of the Wet op de geneesmiddelen (Medications Act)
- Medications that are equivalent or virtually equivalent to a non-preferred registered medication, unless classed differently by ministerial regulation
- Medications as referred to in Section 40, third subsection, under f, of the Medicines Act

The Healthcare Insurance Scheme is available from our website.

Please note:
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.

Personal contribution
Some medications are subject to a statutory personal contribution.
Your statutory personal contribution amounts to a maximum of € 250 per calendar year.

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

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

The calculated amount will be rounded off to whole euros.

Personal contribution for medications

The Minister of Health, Welfare and Sport determines which medications are covered by the Healthcare Insurance Act and which medications are subject to a personal contribution. Your maximum personal contribution amounts to € 250 per calendar year. In addition to a personal contribution, an excess may apply. For more information, see our website.

Excess
The excess applies to this healthcare. Do you use preferred medications as set out in the Pharmaceutical Care Regulations? Then the excess does not apply. The excess also does not apply to the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar as they supply the preferred lung medication we selected. You can find the selected care providers and preferred lung medication in the Pharmaceutical Care Regulations in Appendices D and E. You can also opt for other lung medication that has not been selected as preferred lung medication. But this is subject to your statutory and voluntary excess.

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 excess.
For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
Pharmacist or dispensing general practitioner.

You cannot transfer your claim on us for pharmaceutical care as referred to in this article to care providers or others with whom we have not concluded a contract for this care (prohibition of assignment). This is a clause as referred to in Article 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

Prescription
General practitioner, obstetrician, dentist, orthodontist, medical specialist, dental surgeon, physician assistant or nurse.

For how many days can your pharmacist issue medication to you?

Your pharmacist may give you drugs for a certain period. The period depends on your prescription, the specific medication and the period during which you are required to use the medication.

New medication

- A maximum of 15 days or
- The smallest package if this contains more than you need for 15 days

Medication based on repeat prescription

- 1 month for a drug that costs over € 1,000. If you are well adjusted to the medication after a consecutive period of 6 months, your pharmacist may issue this medication to you for a period of 3 months.

- 1 month for sleeping drugs
- 1 month for medications that reduce anxiety and unrest (with the exception of anti-depressant class medications)
- 1 month for medications listed in the Opium Act.
- At least 3 months and maximum 12 months for a drug to treat a chronic condition.

Reasons to issue a drug for a shorter period

- The drug has limited shelf life
- The drug has limited availability

Contraceptives and insulin

For contraceptive pills and for insulin, you will require a prescription only for the first issue.

Approval

1. You need our prior permission for a number of registered medications listed in Appendix 2 of the Healthcare Insurance Regulations. Please find a list of such medications in the Pharmaceutical Care Regulations. We reserve the right to amend the list of preferred medications at any time. You will receive information about it. To apply for permission, your doctor can obtain a doctor's certificate from www.znformulieren.nl or download and fill out an approval form from our website.
   If you use a pharmacist or dispensing general practitioner with whom we have concluded a contract 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.
   Do you visit a pharmacist or dispensing general practitioner with whom we have not concluded a contract for the relevant care? You can then request approval in advance by submitting the form directly to us. Look for the address on our website.
2. You need our prior approval for the following non-registered medications:
   - A number of pharmacy preparations (custom medication) supplied. These are preparations your pharmacy makes and delivers to your pharmacy;
   - Medications that 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.

More information about applying for approval is set out in Article 1.9 of these policy conditions.

Contraceptives

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

Are you age 21 or older? You are only entitled to 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 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 36. Dietary preparations

Dietary preparations are polymeric, oligomeric, monomeric and modular dietary preparations. Dietary preparations are only part of the care if you cannot manage with adapted normal food and other products of special nutrition 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 dependent on this product in accordance with the guidelines accepted by the relevant professional groups in the Netherlands.

Dietary preparations

A dietary preparation is a medical food with a different form and a different composition than normal food.
There are different types, including liquid nutrition and tube feeding.
Liquid nutrition contains, for example, extra energy, proteins, fats or vitamins and minerals.
Catheter-administered nutrition (tube feeding) is special nutrition directly taken into your stomach or digestive system via a thin tube (catheter).

Dietary product

A dietary product is a nutrition product with an adjusted formula. Examples are gluten-free or low-sodium products. We do not reimburse such products.

Excess

The excess applies to this healthcare. The Pharmaceutical Care Regulations set out a list of preferred products for liquid nutrition, puddings and custards with various flavours. The excess does not apply to such preferred products. You may also choose alternative products. Then the excess does apply. Please find the Pharmaceutical Care Regulations on our website. We reserve the right to amend the list of preferred products at any time. For more information about excess, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A pharmacist, dispensing general practitioner or a preferred healthcare provider. You can only obtain tube feeding from a medical specialist shop or facilitating company.

Please note

If you are buying a dietary preparation in a general store such as a supermarket or chemist, Then you don't get any compensation.

Prescription

General practitioner, medical specialist, dental surgeon, physician assistant, nurse or dietician.

Permission

You require our prior approval. You can apply for permission on the basis of the prescription issued by your general practitioner or the Statement on Dietary Preparations (ZN Statement on Polymeric, Oligomeric or Modular Dietary Preparations) filled in by your medical specialist, oral surgeon, physician assistant, nurse or dietician. More information about applying for approval is set out in Article 1.9 of these policy conditions.

MEDICAL AIDS

Article 37. Medical aids and dressings

Medical aids and dressings are functional support aids and dressings materials as referred to 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 Scheme and the Medical Aids Regulations are available from our website. Certain groups of medical aids are included in the Healthcare Insurance Scheme 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. As an exception to the reimbursement of costs (in kind), we provide medical aids on loan in certain cases. 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. Medical aids and devices on loan can be obtained only from a care provider with whom we have concluded a contract.

The following information is available from the Medical Aids Regulations:
- Whether you will lease or own the medical aid;
- 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 from it;
- Maximum number of pieces to be delivered. Such numbers are indicative. If required, you may ask us to deviate from it;
- Specific details such as maximum reimbursements or statutory personal contributions.

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

Information about contracted care providers

We make agreements with healthcare providers on quality, price and service. If you go to a care provider with whom we have a contract for the relevant care, you can expect a good product and excellent service. Also, you do not need to apply for approval or advance any amounts. We will pay the healthcare provider directly.

Personal contribution/maximum reimbursement

The Medical Aids Regulations set out the statutory personal contribution or maximum reimbursements for the relevant medical aids.

Excess

The excess applies to this healthcare. The excess does not apply to medical aids on a lease basis.
For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A healthcare provider for medical aids. Please refer to the Medical Aids Regulations to see if the healthcare provider is required to meet certain quality requirements.

Items on loan

If you selected a healthcare provider that we have not contracted for the relevant care, and it concerns leased equipment issued to you based on the Medical Aids Regulations, 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 average cost per user per year. The amount of the average cost is equivalent to the costs 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. More information about applying for approval is set out in Article 1.9 of these policy conditions.

Additional information

1. You are required to 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 within the term of use, modification or repair to us with a motivation.
2. You may obtain approval for a second piece of the medical aid if you are reasonably dependent on it.
3. Leased medical aids may be subject to inspection. If we are of the opinion that you are not (or no longer) reasonably dependent on the medical aid, we may reclaim the aid.

STAY IN AN INSTITUTION

Article 38. Stay

A stay in an accommodation is a medically necessary stay of 24 hours or longer in connection with general practitioner care (article 11), obstetric care (article 15.1), specialist medical care (articles 16 up to and including 23), specialist mental healthcare (article 26) and specialist dental care (oral care, articles 32 and 33) as referred to in these insurance terms and conditions, for an uninterrupted period of up to 3 years (1095 days), as described in article 2.12 of the Healthcare Insurance Decree. 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. Interruptions for weekend and holiday leave do count towards the calculation of the 3-year period. A stay also includes the necessary nursing, care and paramedical care.
Stay is also possible for insured under age 18 who require intensive childcare as set out in Article 14, Nursing and care.

Reimbursement for a stay in the vicinity of a hospital is possible if this is necessary in connection with specialist medical care. The maximum reimbursement is € 77.50 per day.

When are you entitled to an allowance for a stay in the vicinity of a hospital?

Are you receiving CAR T-cell therapy and do you live more than 60 minutes away from the expert hospital where you are receiving the treatment? If so, we can provide a reimbursement for accommodation near the hospital at your request. Reimbursement begins on the day you leave the hospital and stops after 14 days, unless you need to stay longer due to medical complications. The maximum reimbursement is € 77.50 per day.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
The stay 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 disabled.
The stay related to intensive child care may take place in a children's care home.

You cannot transfer your claim on us for a stay in a GGZ institution to care providers or others with whom we have not concluded a contract for this care (prohibition of assignment). This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

At the instructions of
General practitioner, obstetrician, medical specialist, psychiatrist or dental surgeon. For the stay related to intensive paediatric care, a paediatrician or paediatric nurse, level 5, may provide a prescription.
They determine whether stay is medically necessary in connection with the medical care or is medically necessary in connection with surgical help of a specialist nature as set out in Article 33, Dental surgery for insured persons age 18 and older.

Approval
You will need prior approval for stays in connection with specialist medical care (Article 16), rehabilitation (Article 17.1), plastic and/or reconstructive surgery (Article 21), specialist GGZ (Article 26) and oral care (Articles 32 and 33) if this is indicated in the relevant healthcare provision. For more information, please refer to the relevant healthcare provision.
You also need our permission for a stay in the vicinity of a hospital if this is necessary in connection with specialist medical care.

TRANSPORT OF THE PATIENT

Article 39. Ambulance and patient transport

Ambulance and patient transport includes:
1. Transport by ambulance due to medical necessity as referred to in Section 1, first subsection, of the Wet ambulancevoorzieningen (Ambulance Facilities Act), over a maximum distance of 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 Municipal Executive pursuant to the Youth Act;
   d. From a Wlz institution as set out in this article under 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 items 1a through 1d;
2. Patient transport over a distance of no more than 200 kilometres, one way. This is patient transport by car, other than by ambulance, or transport in the lowest class of a public means of transport to and from a care provider or institution as referred to under point 1a, 1b or 1d or a home as referred to under point 1e.
   You are exclusively entitled to such transport in the following situations:
   a. For kidney dialyses and for the visits, tests and check-ups necessary for the treatment;

b. For oncology treatments with chemotherapy, immunotherapy or radiotherapy and for the visits, tests and check-ups necessary for the treatment;
c. If you are only able to move about in a wheelchair;
d. If your vision is restricted to such an extent that you are not able to move about without assistance.

When are you eligible for patient transport on the basis of a visual disability?

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 patient transport if your vision in both eyes is less than 0.1 or if you have a field of vision 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 transport.

e. If you are under age 18 and you are dependent on nursing and care due to complex somatic problems or due to a physical disability, with a need for permanent supervision or the availability of 24/7 care in the vicinity (intensive paediatric care);
f. If you are dependent on geriatric rehabilitation as referred to in Article 17.2;
g. If you are dependent on day treatment in a group as part of medical care for specific patient groups as referred to in Article 12 under point 2a, 2b or 2c;
h. If, in connection with the treatment of a long-term illness or disorder, you are dependent on transport for a long period of time and not supplying or reimbursing this transport would be predominantly unfair to you (hardship clause). This includes patient transport for medical visits, check-ups and examinations which are necessary for the treatment.

When can you invoke the hardship clause?

If the outcome of the sum 'number of consecutive months 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 one-way distance was 25 kilometres (km). In this case you may apply for the hardship clause, as
5 months x 2 times per week x 25 km single journey makes 250.

The patient transport set out in this article also includes the transport of an accompanying person, if support is necessary, or if it concerns support for children younger than 16 years of age. In special cases, we can allow the transportation of 2 escorts.

Lodging costs

Are you dependent on transportation as referred to in 2a through 2g for at least three consecutive days? In that case, we can, at your request, provide you with an allowance for lodging expenses of up to € 77.50 per day. You are then entitled to transport or a mileage allowance for the journey to and from the treatment location and to reimbursement for two or more nights spent in the vicinity of the treatment location. The lodging allowance therefore partly replaces the transport allowance.

Personal contribution

You are charged a statutory personal contribution of up to € 111 per calendar year for patient transport.
This is not subject to a personal contribution for ambulance transportation and accommodation costs.

Excess

The excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. For ambulance transport: a licensed ambulance transporter.
2. For patient transport:
   - A taxi driver/transportation firm
   - A 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 € 0.32 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.

At the instructions of

General practitioner or medical specialist. For patient transport as referred to in item 2e (intensive child care) you will need a prescription from a paediatrician or a level-5 professional child care nurse. For patient transport as referred to in item 2g (medical care for specific patient groups) you will need a prescription from a general practitioner, medical specialist, geriatric specialist, a doctor for the mentally disabled, a healthcare psychologist or remedial educationalist generalist.
You do not need a prescription for ambulance transport in emergencies.

Approval

You need our prior consent for patient transport and reimbursement of lodging expenses. For more information, see our website.

Call the Transportation Desk to request approval for:
- Patient transport for kidney dialysis and oncological treatments
- Patient transport to and from a nursing home or children's home in the case of intensive child care
- Allowance for the cost of accommodation.

The telephone number of the transportation desk is available on our website.

Additional information

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 40. Healthcare Advice and Mediation

You are entitled to mediation for care in the event of a non-acceptable long waiting time 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. Together with you, we will look into the possibilities.

III. Definitions

Acute care: Healthcare that cannot reasonably be postponed. Acute healthcare is also referred to as emergency care. If it concerns care provided abroad, acute care also concerns care that cannot reasonably be postponed until you have returned to your country of residence.

Audiological centre: Hearing and language diagnostics and treatment and advice for hearing aids.

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

Group contract: A group contract for healthcare insurance (group contract) concluded between the healthcare insurer and an employer or legal entity, aiming to offer the members or participants the option of closing a healthcare insurance policy and any supplementary insurance policies as set out in this contract.

Diagnosis Treatment Combination (DTC): A DTC (Diagnosis-Treatment Combination (dbc)) describes the completed and validated process of specialist medical care by means of a dbc code that is determined by the Dutch Healthcare Authority (NZa). This includes part of the care process or the full care process of the diagnosis as made by the healthcare provider up to the ensuing treatment (if any). The dbc regimen begins the moment that the insured person registers with the care need, and ends at the end of the treatment or after 120 days.

Personal contribution: A fixed amount/share of reimbursement of the costs of healthcare referred to in these policy conditions that you must pay before becoming entitled to reimbursement of the cost of the remaining part of the healthcare.

Excess

1. Statutory excess: an amount of healthcare costs or other services as referred to in or pursuant to Article 11 of the Zorgverzekeringswet (Health Insurance Act) that you must pay yourself.
2. Voluntary policy excess: an amount agreed between you, as the policyholder, and the healthcare insurer as part of the healthcare insurance policy in respect of costs of care or other services, as referred to in or pursuant to Article 11 of the Zorgverzekeringswet that you must pay yourself.

European Union and EEA Member State: Includes the following countries other than the Netherlands in the European Union: Austria, Belgium, Bulgaria, Croatia, Cyprus (the Greek area), the Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Germany, Martinique, St. Barthélemy, St. Martin and La Réunion), Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal (including Madeira and the Azores), Romania, Slovenia, Slovakia, Spain (including Ceuta, Melilla and the Canary Islands), Czech Republic and Sweden. On the basis of treaty provisions, Switzerland is classed as equivalent to the above countries in this context. 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 beneficiaries and/or misappropriation or 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 delivery) 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 natal healthcare. 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: Institution that provides medical care in connection with a psychiatric disorder.

GGR (Weight-Related Health Risk): The GGR indicates to what extent the person has an increased health risk. This factor is based on the BMI (Body Mass Index) in combination with the presence of risk factors for a certain condition or existing conditions.

Institution

1. An institution within the meaning of the Accreditation of Healthcare Providers Act.
2. A legal entity established in a foreign country that provides care within the framework of the social security system existing in that country, or that focuses on 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 - Dutch Healthcare Authorities.

Policy: The healthcare insurance policy as set out in Section 1 paragraph 1 under i of the Healthcare Insurance Act; i.e. the instrument in which the healthcare insurance taken out by the policy holder with the healthcare insurer has been laid down. The healthcare policy consists of a policy schedule and these policy conditions.

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

Permission (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: 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 holiday/temporary stay), Bosnia-Herzegovina, Cape Verde, Macedonia, Morocco, Serbia-Montenegro, Tunisia, Turkey and the countries of the United Kingdom (England, Northern Ireland, Scotland and Wales).

Insured: A person whose risk of needing medical care as referred to in the Healthcare 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 statutory insurance pursuant to the Healthcare Insurance Act; the person must take out a healthcare insurance or have this taken out.

Policy Conditions VGZ Eigen Keuze/policy conditions: The healthcare insurer's model contract as referred to in Section 1j of the Healthcare Insurance Act.

VGZ Eigen Keuze: A healthcare insurance policy taken out by the policyholder with the healthcare insurer for a person subject to statutory insurance. The healthcare insurer is referred to as 'we' and 'our' in these policy conditions.

Wlz: Long-Term Healthcare Act.

Wmg rates: Rates as determined pursuant to the Market Regulation Healthcare Act (Wmg Act).

Hospital: Institution for specialist medical care where stays of 24 hours or longer are offered.

Healthcare: Care, healthcare or other services.

Healthcare provider: A natural person or legal entity providing healthcare professionally as set out in Section 1, preamble and subsection c, part 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 provision: Provision relating to certain healthcare. See Section II, Healthcare Provisions.

Healthcare insurer/VGZ: VGZ Zorgverzekeraar N.V., having its registered office in Arnhem, the Netherlands 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. The healthcare insurer is referred to as 'we' and 'our' in these policy conditions.

Healthcare Insurance: A non-life insurance agreement relating to healthcare entered into between a healthcare insurer and a policyholder for a person with an obligation to take out insurance as referred to in Article 1 under d of the Healthcare Insurance Act (Zvw), and these policy conditions form an integral, inseparable part of this insurance agreement.

Go to

www.vgz.nl

for further information
and contact details

D0240-202111

COÖPERATIE VGZ

Voorop in gezondheid en zorg.
Voor iedereen.