# Policy Conditions 2018

## Zorg Zeker Policy

Zorg en Zekerheid
zorgverzekeraar

Compensation Overview

Basic Insurance

Supplementary Insurance


# Policy Conditions 2018

## Compensation overview

Zorg en Zekerheid
zorgverzekeraar

# Reimbursement overview

This overview provides a summary of the reimbursements covered by the Basic and Supplementary insurance policies offered by Zorg en Zekerheid. A list of the services to which you are entitled is presented for each type of care provided with a reference to the corresponding article in the policy conditions. In a number of cases, specific conditions apply to the entitlement to reimbursements and restitutions. Additionally, alternative reimbursements apply to services provided by non-contracted care providers under the Zorg Zeker Policy and supplementary policies. These are listed in the policy conditions. The Zorg Vrij Policy entitles you to 100% reimbursement, provided that the amount claimed is not excessive. For further details see Article 1.7, 'Level of reimbursement', of the policy conditions. A list of care providers with whom we have concluded a contract can be consulted at **zorgenzekerheid.nl/gecontracteerd**.

**Please note!** No rights can be derived from this reimbursement overview. Please consult the policy conditions for a comprehensive overview of all conditions and reimbursements.

This brochure is part of a set of three. The other two are a basic insurance policy and supplementary conditions. Please make sure to consult all three brochures when you need to look something up.

| Reimbursement Overview 2018 | Basic insurance Zorg Zeker Policy Zorg Vrij Policy | Article number | AV-Basis | AV-Sure | AV-Standaard | AV-GeZZin Compact | AV-GeZZin | AV-Top | AV-Plus | AV-Totaal | Article number |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alternative consultations, treatments and medicines (maximum amount applies to all reimbursements together)** | | | | | | | | | | | |
| Including homoeopathy, acupuncture, anthroposophic medicine and chiropractic treatment, halotherapy (collective maximum reimbursement for treatments and medicines) | - | | up to a max. of €250 | up to a max. of €250 | up to a max. of €250 | - | up to a max. of €460 | up to a max. of €460 | up to a max. of €460 | up to a max. of €600 | A1 |
| - treatments | - | | 100%, up to a maximum of €25 per day | 100%, up to a maximum of €25 per day | 100%, up to a maximum of €25 per day | - | 100%, up to a maximum of €40 per day | 100%, up to a maximum of €40 per day | 100%, up to a maximum of €40 per day | 100% up to the maximum amount | |
| - medicines | - | | 50% up to the maximum amount | 50% up to the maximum amount | 50% up to the maximum amount | - | 75% up to the maximum amount | 75% up to the maximum amount | 75% up to the maximum amount | 100% up to the maximum amount | |
| **Glasses, contact lenses and frame** | | | | | | | | | | | |
| Glasses, contact lenses and frame(every two calendar years) | in accordance with the Care Aids Regulations | B20 | 100%, up to a maximum of €40 (from 2.25 dioptres) | 100%, up to a maximum of €40 (from 2.25 dioptres) | 100%, up to a maximum of €40 (from 2.25 dioptres) | - | 100%, up to a maximum of €70 (from 2.25 dioptres) or, for children up to age 12 covered by your policy, one pair of children's glasses per calendar year from0 dioptres, max. €70 | 100%, up to a maximum of €70 (from 2.25 dioptres) | 100%, up to a maximum of €100 (from2.25 dioptres) | 100%, up to a maximum of €150 (from0 dioptres) or, for children up to age 12 covered by your policy, one pair of children's glasses per calendar year from0 dioptres, max. €150 | A2.1 |
| Laser eye treatment (once-only during the term of the insurance) | - | | - | - | - | - | up to a max. of €200 | up to a max. of €200 | up to a max. of €200 | up to a max. of €300 | A2.2 |
| **Care abroad** | | | | | | | | | | | |
| Vaccination due to a stay abroad (contracted) | - | | - | 100% | - | - | 100%, up to a maximum of €80 | 100%, up to a maximum of €80 | 100%, up to a maximum of €80 | 100% | A3.1 |
| Vaccination due to a stay abroad(non-contracted) | - | | - | 100%, up to a maximum of €80 | - | - | 100%, up to a maximum of €80 | 100%, up to a maximum of €80 | 100%, up to a maximum of €80 | 100%, up to a maximum of €150 | |
| **Non-urgent medically necessary care, without permission from Zorg en Zekerheid** | | | | | | | | | | | |
| Medical costs in Europe | max. 80%*, and 100% of the Dutch rate under the Zorg Zeker Polis | B22.2.1 | - | - | - | - | - | - | - | - | |
| Medical costs outside of Europe | | B22.2.2 | - | - | - | - | - | - | - | - | |
| **Urgent, medically necessary care** | | | | | | | | | | | |
| Medical costs in Europe | 100%* Dutch rates | B22.2.1 | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | 100% (supplement to reimbursement under basic insurance) | A3.3.1 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical costs outside of Europe | | B22.2.2 | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of theDutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of theDutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | up to a max. of 200% of the Dutch rate (supplement to reimbursement under basic insurance) | |
| Urgent dental care | - | | - | - | - | - | 100%, up to a maximum of €345 | 100%, up to a maximum of €345 | 100%, up to a maximum of €345 | 100%, up to a maximum of €345 | A3.3.2 |
| Medically necessary repatriation and dispatch of medicines | - | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | A3.3.3 |
| Assistance by ANWB International Assistance for medically necessary assistance | - | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | A3.3.4 |
| Oxygen abroad | - | | 100%, up to a maximum of €600 | 100%, up to a maximum of €600 | 100%, up to a maximum of €600 | - | 100%, up to a maximum of €600 | 100%, up to a maximum of €600 | 100%, up to a maximum of €600 | 100%, up to a maximum of €600 | A3.5 |
| **Pharmaceutical care** | | | | | | | | | | | |
| Medication | in accordance with the PharmaceuticalCare Regulations | B19.2 | - | - | - | - | - | - | - | - | |
| ADHD medication | 100%*, excl. personal contribution | B19.2 | - | - | - | - | 100%, up to a maximum of €250 reimbursement of GVS personal contribution | 100%, up to a maximum of €100 reimbursement of GVS personal contribution | - | 100%, up to a maximum of €250 reimbursement of GVS personal contribution | A4.1 |
| Birth control (pill, intrauterine device, diaphragm) | from age 18 to 21, excluding the compulsory excess for contracted care | A3.7.2 | - | 100% from age 21 (excluding the GVS personal contribution) | 100% from age 21 (excluding the GVS personal contribution) | - | 100% from age 21 (excluding the GVS personal contribution) | 100% from age 21 (excluding the GVS personal contribution) | - | 100% from age 21 (excluding the GVS personal contribution) | A4.2 |
| Antacids | - | | 100%, up to a maximum of €35 | 100%, up to a maximum of €35 | 100%, up to a maximum of €35 | - | 100%, up to a maximum of €35 | 100%, up to a maximum of €35 | 100%, up to a maximum of €35 | 100%, up to a maximum of €35 | A4.3 |
| Diarrhoea vaccinations for infants | - | | - | - | - | - | 100%, up to a maximum of €200 | - | - | 100%, up to a maximum of €200 | A4.4 |
| **Maternity care** | | | | | | | | | | | |
| Maternity package | - | | Standard package | - | Standard package | - | Comprehensive-package | Comprehensive-package | - | Comprehensive-package | A5.1 |
| Home delivery | 100%* | B7.2 | - | - | - | - | - | - | - | - | |
| Delivery in hospital on medical grounds | 100%* | B7.2 | - | - | - | - | - | - | - | - | |
| Delivery in hospital without medical grounds | 100%*, excl. personal contribution€17 p.d./p.p. plus the amount in excess of €245 p.d. | B7.2 | - | - | 100% reimbursement of personal contribution, max. €75 | - | 100% reimbursement of personal contribution, max. €250 | 100% reimbursement of personal contribution, max. €100 | - | 100% reimbursement of personal contribution, max. €250 | A5.2 |
| Maternity care | 110%*, excluding a personal contribution of €4.30/h | B7.3 | - | - | | - | 100% reimbursement of personal contribution, max. €250 | | - | 100% reimbursement of personal contribution, max.€250 | |
| Extended /postponed maternity care | - | | - | - | - | - | up to a max. of 16 hours | up to a max. of 16 hours | - | up to a max. of 16 hours | A5.3.1/ A5.3.2 |
| Electrical breast pump (hire or purchase) | - | | - | - | up to a max. of €40 | - | up to a max. of €40 | up to a max. of €40 | - | up to a max. of €40 | A5.4 |
| Prenatal screening and second trimester ultrasound scan | 100%* | B7.1 | - | - | - | - | - | - | - | - | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prenatal class | - | | 100%, up to a maximum of €100 | - | | 100%, up to a maximum of €100 | - | 100%, up to a maximum of €100 | 100%, up to a maximum of €100 | - | 100%, up to a maximum of €100 | A5.5 |
| Breast feeding course | - | | 100%, up to a maximum of €20 | - | | 100%, up to a maximum of €20 | - | 100%, up to a maximum of €20 | 100%, up to a maximum of €20 | - | 100%, up to a maximum of €20 | A5.6 |
| Combination test (blood test and nuchal translucency test) | - | | - | - | | 100%, up to a maximum of €150 | - | 100%, up to a maximum of €150 | 100%, up to a maximum of €150 | - | 100%, up to a maximum of €150 | A5.7 |
| Non-invasive prenatal test (NIPT) | 100%* in the case of a positive combination test or subject to conditions | B7.1 | - | - | | - | - | - | - | - | - | |
| Lactation expert (supervision and advice for breast feeding) | - | | - | - | | - | - | 100%, up to a maximum of €150 | - | - | 100%, up to a maximum of €150 | A5.8 |
| **Recovery and admission** | | | | | | | | | | | | |
| Convalescent home, care hotel and hospice | - | | max. €35 per day, up to a maximum of €1,050 | - | | max. €35 per day, up to a maximum of €1,050 | - | max. €50 per day, up to a maximum of €1,500 | max. €50 per day, up to a maximum of €1,500 | max. €50 per day, up to a maximum of €1,500 | max. €50 per day, up to a maximum of €1,500 | A6.1 |
| Health trips (every two calendar years) | - | | 100%, up to a maximum of €1,050 | - | | 100%, up to a maximum of €1,050 | - | 100%, up to a maximum of €1,050 | 100%, up to a maximum of €1,050 | 100%, up to a maximum of €1,050 | 100%, up to a maximum of €1,050 | A6.2 |
| Guest house, (i.e. Ronald MacDonald homes) | - | | 100%, up to a maximum of €15 per day | - | | 100%, up to a maximum of €15 per day | - | 100%, up to a maximum of €20 per day | 100%, up to a maximum of €15 per day | 100%, up to a maximum of €15 per day | 100%, up to a maximum of €20 per day | A6.3 |
| Therapeutic youth camp (e.g. KIKA and De Luchtballon) | - | | 50%, up to a maximum of €350 | - | | 50%, up to a maximum of €350 | - | 100%, up to a maximum of €350 | 100%, up to a maximum of €300 | - | 100%, up to a maximum of €350 | A6.4 |
| Substitute informal care | - | | - | - | | - | - | 100%, up to a maximum of6 weeks | 100%, up to a maximum of6 weeks | 100%, up to a maximum of6 weeks | 100%, up to a maximum of6 weeks | A6.5 |
| **Epidermal therapy** | | | | | | | | | | | | |
| Acne treatment | - | | - | 100%, up to a maximum of €150 | | - | - | 100%, up to a maximum of €250 | 100%, up to a maximum of €150 | - | 100%, up to a maximum of €250 | A7.1 |
| Camouflage therapy | - | | 50%, up to a maximum of €115 | 50%, up to a maximum of €115 | | 50%, up to a maximum of €115 | - | 75%, up to a maximum of €115 | 75%, up to a maximum of €115 | 75%, up to a maximum of €115 | 100%, up to a maximum of €150 | A7.2 |
| Dermatography | - | | 50%, up to a maximum of €200 | - | | 50%, up to a maximum of €200 | - | 75%, up to a maximum of €200 | 75%, up to a maximum of €200 | 75%, up to a maximum of €200 | 100%, up to a maximum of €250 | A7.3 |
| Electrical epilation or laser depilation | | | | | | | | | | | | A7.4 |
| - existing users | - | | 50%, up to a maximum of €550 | 50%, up to a maximum of €550 | | 50%, up to a maximum of €550 | - | 75%, up to a maximum of €1,100 | 75%, up to a maximum of €1,100 | 75%, up to a maximum of €1,100 | 100%, up to a maximum of €1,500 | |
| - new users from 2018 | | | 50%, up to a maximum of €550 | 50%, up to a maximum of €550 | | 50%, up to a maximum of €550 | - | 75%, up to a maximum of €600 | 75%, up to a maximum of €600 | 75%, up to a maximum of €600 | 100%, up to a maximum of €800 | |
| Foot care for insured persons with diabetes or rheumatic patients | 100%* for diabetics (Care Profile 2 or higher) | B24.2 | - | - | | - | - | - | - | 100%, up to a maximum of €210 (for diabetics, only Care Profiles 0 and 1) | 100%, up to a maximum of €210 (for diabetics, only Care Profiles 0 and 1) | A7.5 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **General practitioner** | | | | | | | | | | | | |
| Consultations and treatments | 100%* | B5 | - | - | | - | - | - | - | - | - | |
| **Care aids** | | | | | | | | | | | | |
| Medical care aids | in accordance with the Care Aids Regulations | B20 | - | - | | - | - | - | - | - | - | |
| Care aids (mastectomy bra, hearing aid (per ear), support pessary) | yes, excluding personal contribution (for details, see the Care Aids Regulations) | B20 | 100%, up to a maximum of €70 per care aid | - | | 100%, up to a maximum of €70 per care aid | - | 100%, up to a maximum of €140 per care aid | 100%, up to a maximum of €140 per care aid | 100%, up to a maximum of €140 per care aid | 100%, up to a maximum of €200 per care aid | A8.1 |
| Urinary buzzer | - | | 100%, up to a maximum of €85 | - | | 100%, up to a maximum of €85 | - | 100%, up to a maximum of €85 | 100%, up to a maximum of €85 | - | 100%, up to a maximum of €85 | A8.2 |
| Arch supports | - | | 50%, up to a maximum of €35 | - | | 50%, up to a maximum of €35 | - | 100%, up to a maximum of €70 | 100%, up to a maximum of €70 | 100%, up to a maximum of €70 | 100%, up to a maximum of €100 | A8.3 |
| Care aids for home care | - | | 75%, up to a maximum of €40 | - | | 75%, up to a maximum of €40 | - | 75%, up to a maximum of €40 | 75%, up to a maximum of €40 | 75%, up to a maximum of €40 | 75%, up to a maximum of €40 | A8.4 |
| Bandaging for chronic use | in accordance with the Care Aids Regulations | B20 | - | - | | - | - | - | - | - | - | |
| Alarm on social grounds | - | | up to a max. of €3.50 per month | - | | up to a max. of €3.50 per month | - | up to a max. of €4.00 per month | up to a max. of €4.00 per month | up to a max. of €4.00 per month | up to a max. of €5.00 per month | A8.5 |
| Hearing protectors | - | | - | 100%, up to a maximum of €40 | | - | - | 100%, up to a maximum of €40 | - | - | 100%, up to a maximum of €40 | A8.6 |
| **Specialist medical care and hospital admission** | | | | | | | | | | | | |
| Specialist medical care and nursing | 100%*, excl. specifically excluded care | B6.2 | - | - | | - | - | - | - | - | - | |
| Phlebology/proctology | - | | 50%, up to a maximum of €75 | - | | 50%, up to a maximum of €75 | - | 75%, up to a maximum of €100 | 75%, up to a maximum of €100 | 75%, up to a maximum of €100 | 100%, up to a maximum of €150 | A9.1 |
| Protruding ear corrections | - | | - | - | | - | - | 100%, up to a maximum of €500 | 100%, up to a maximum of €500 | - | 100%, up to a maximum of €500 | A9.4 |
| **Circumcision** | | | | | | | | | | | | |
| Without medical grounds up to age 18 | - | | - | - | | - | - | 75%, up to a maximum of €115 | 75%, up to a maximum of €115 | - | 100%, up to a maximum of €150 | A9.2 |
| On medical grounds | 100% | B6.3 | - | - | | - | - | - | - | - | - | |
| **Sterilisation** | | | | | | | | | | | | |
| For men | - | | - | - | | - | - | 100%, max. €150 by GP; 75%, max.€150 by a specialist | 100%, max. €150 by GP; 75%, max.€150 by a specialist | - | 100%, max. €150 by your general practitioner or a specialist | A9.3 |
| For women | - | | - | - | | - | - | 75%, max. €350 by a specialist | 75%, max. €350 by a specialist | - | 100%, max. €700 by a specialist | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Paramedical treatments** | | | | | | | | | | | | |
| **Remedial therapy (maximum number of treatment sessions covered by supplementary insurance applies to chronic and non-chronic treatments together)** | | | | | | | | | | | | |
| **Up to age 18** | | | | | | | | | | | | |
| Physiotherapy | 100%*, if related to a chronic disorder;up to a max. of 9 treatment sessions if related to non-chronic disorders, if result is unsatisfactory a max. of 9 additional sessions | B17.3 | up to a max. of 12 treatment sessions (including max. 9 manual therapy-sessions) | up to a max. of 12 treatment sessions (including max. 9 manual therapy-sessions) | | up to a max. of 12 treatment sessions (including max. 9 manual therapy sessions) | up to a max. of 9 treatment sessions (includingup to a max. of 9 manual therapy sessions) | up to a max. of 25 treatment sessions (including max. 9 manual therapy sessions) | up to a max. of 25 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 25 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 40 treatment sessions (including max. 9 manual therapy sessions) | A10.1 |
| Cesar/Mensendieck remedial therapy | | | up to a max. of 12 treatment sessions | up to a max. of 12 treatment sessions | | up to a max. of 12 treatment sessions | | up to a max. of 25 treatment sessions | up to a max. of 25 treatment sessions | up to a max. of 25 treatment sessions | up to a max. of 40 treatment sessions | A10.2 |
| **From age 18** | | | | | | | | | | | | |
| Physiotherapy | 100%* from the 21st treatment session, if related to chronic disorders | B17.4 | up to a max. of 12 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 12 treatment sessions (including up to a max. of 9 manual therapy sessions) | | up to a max. of 12 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of9 treatment sessions | up to a max. of 25 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 25 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 25 treatment sessions (including up to a max. of 9 manual therapy sessions) | up to a max. of 40 treatment sessions (including up to a max. of 9 manual therapy sessions) | A10.1 |
| Cesar/Mensendieck remedial therapy | | | up to a max. of 12 treatment sessions | up to a max. of 12 treatment sessions | | up to a max. of 12 treatment sessions | | up to a max. of 25 treatment sessions | up to a max. of 25 treatment sessions | up to a max. of 25 treatment sessions | up to a max. of 40 treatment sessions | A10.2 |
| **Other therapies** | | | | | | | | | | | | |
| Movement programmes (including Fitkids and JOGG) | - | | 50%, up to a maximum of €500 every2 calendar years | 50%, up to a maximum of €500 every2 calendar years | | 50%, up to a maximum of €500 every2 calendar years | - | 75%, up to a maximum of €500 every2 calendar years | 75%, up to a maximum of €500 every2 calendar years | 75%, up to a maximum of €500 every2 calendar years | 100%, up to a maximum of €500 every2 calendar years | A10.1.4 |
| Occupational therapy | up to a max. of 10 hours | B17.5 | - | - | | - | - | - | - | up to a max. of 10 hours | up to a max. of 10 hours | A10.4 |
| Speech therapy | 100%* | B17.6 | - | - | | - | - | - | - | - | - | |
| Dietary and/or nutritional advice | max. 3 hours of treatment | B17.7 | - | - | | - | - | 7 x 15 minutes under age 18 | 7 x 15 minutes under age 18 | - | 10 x 15 minutes under age 18 | A10.3 |
| Podology, podo (postural) therapy | - | | 100%, up to a maximum of €50 | - | | 100%, up to a maximum of €50 | - | 100%, up to a maximum of €100 | 100%, up to a maximum of €100 | 100%, up to a maximum of €100 | 100%, up to a maximum of €125 | A10.5 |
| Stutter therapy (Dixhoorn, Del Ferro, Boma or Hausdörfer methods) | - | | - | - | | - | - | 100%, up to a maximum of €400 | 75%, up to a maximum of €350 | - | 100%, up to a maximum of €400 | A10.6 |
| **Preventative courses and information** | | | | | | | | | | | | |
| GeZZondcheck (once every two calendar years) | - | | 100% | 100% | | 100% | - | 100% | 100% | 100% | 100% | A11.1 |
| Preventative courses (e.g. stopping smoking, weight reduction, first aid, medically responsible training programmes, treatment for underweight and overweight individuals, Exercise for Seniors) | - | | 50%, up to a maximum of €115 | 50%, up to a maximum of €115 | | 50%, up to a maximum of €115 | - | 75%, up to a maximum of €150 | 75%, up to a maximum of €150 | 75%, up to a maximum of €150 | 100%, up to a maximum of €175 | A11.2 |
| Stopping smoking | one programme per calendar year | B25 | | | | | | | | | | |
| Menopause consultant | - | | - | - | | - | - | 75%, up to a maximum of €115 | 75%, up to a maximum of €115 | 75%, up to a maximum of €115 | 100%, up to a maximum of €150 | A11.3 |
| Sports Medical Advice (SMA) | - | | - | 100%, up to a maximum of €120 | | - | - | 100%, up to a maximum of €100 | 100%, up to a maximum of €100 | 100%, up to a maximum of €100 | 100%, up to a maximum of €150 | A11.4 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Psychological and psychotherapeutic care** | | | | | | | | | | | | |
| **Generalist basic mental healthcare (GGZ) from age 18** | | | | | | | | | | | | |
| Short-term, medium-term, intensive or chronic treatment, depending on referral | 100%* | B23.1 | - | | | - | - | | | | | |
| **Specialist mental healthcare (GGZ) from age 18** | | | | | | | | | | | | |
| Clinical specialist mental healthcare (GGZ) following authorisation | 100%*, up to a max. of 365 days (may be extended to 1,095 days if required) | B23.2.1 | - | - | | - | - | - | - | - | - | |
| Non-clinical specialist mental healthcare (GGZ) following referral | 100%* | B23.2.2 | - | - | | - | - | - | - | - | - | |
| **Other psychological care** | | | | | | | | | | | | |
| Other care (e.g. Helen Dowling Instituut, Recovery and Balance and alternative psychological care) | - | | - | 75%, up to a maximum of €200 | | - | - | 75%, up to a maximum of €320 | 75%, up to a maximum of € 320 | 75%, up to a maximum of € 320 | 100%, up to a maximum of €500 | B12.1 |
| Psychological care for parents and children (Nanny training, remedial teaching, dyslexia treatment, integrative children's and play therapy) | - | | - | - | | - | - | | - | - | | |
| Light therapy for seasonal depression | - | | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | - | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | max. €7 per day for up to 10 days, or one-off amount of €70 to cover purchase | B12.2 |
| **Rehabilitation** | | | | | | | | | | | | |
| Rehabilitation | 100%* | B8 | - | - | | - | - | - | - | - | - | |
| **Dental care** | | | | | | | | | | | | |
| **Dental care for children under age 18 (supplementary to basic cover)** | | | | | | | | | | | | |
| Basic dental assistance excl. crowns, bridges and orthodontic treatment | 100%*, excl. policy exclusions | B.1B1 8.2 | - | - | | - | - | - | - | - | - | |
| Extra dental assistance (poured fillings, crowns and bridges) | - | | - | 75%, up to a maximum of €150 | | 75%, up to a maximum of €150 | 75%, up to a maximum of €250 | 75%, up to a maximum of €500 | 75%, up to a maximum of €500 | 75%, up to a maximum of €500 | 85%, up to a maximum of €1,000 | A13.1.1 |
| Orthodontic treatment for children up to age 18 | | | | | | | | | | | | A13.1.2 |
| - existing users | | | - | - | | - | 100%, up to a maximum of €1,000 | 100%, up to a maximum of €2,000 | 100%, up to a maximum of €1,750 | - | 100% | |
| - new users from 2018 | - | | - | - | | - | 100%, up to a maximum of €1,000 | 100%, up to a maximum of €1,750 | 100%, up to a maximum of €1,500 | - | 100% | |
| **Dental care for adults from age 18 (maximum amount applies to all reimbursements together)** | | | | | | | | | | | | |
| Total max. reimbursement for dental care | - | | - | max. €150 | | max. €150 | max. €250 | max. €500 | max. €500 | max. €500 | max. €1,000 | A13.2 |
| check-up | - | | - | 100% up to the maximum amount | | 100% up to the maximum amount | 100% up to the maximum amount | 100% up to the maximum amount | 100% up to the maximum amount | 100% up to the maximum amount | 100% up to the maximum amount | A13.2.1 |
| - Other dental care (e.g. prevention, oral hygiene, X-ray diagnostics, poured fillings, crown and bridges, orthodontics, assistance with dentures and personal contribution for full dentures) | - | | - | 75% up to the maximum amount | | 75% up to the maximum amount | 75% up to the maximum amount | 75% up to the maximum amount | 75% up to the maximum amount | 75% up to the maximum amount | 85% up to the maximum amount | A13.2.2 |
| Full dentures | 75%* | B18.3 | - | - | | - | - | - | - | - | - | |
| Dental surgery care | 100%* | B18.3 | - | - | | - | - | - | - | - | - | |
| Dentures: repairs and rebasing | 100%* | B18.3 | - | - | | - | - | - | - | - | - | |
| Accident coverage dental care | - | | - | 100%, up to a maximum of €1,500 | | 100%, up to a maximum of €1,500 | 100%, up to a maximum of €1,500 | 100%, up to a maximum of €1,500 | 100%, up to a maximum of €1,500 | 100%, up to a maximum of €1,500 | 100%, up to a maximum of €2,000 | A13.3 |

| Reimbursement Overview 2018 | Basic insurance Zorg Zeker Policy Zorg Vrij Policy | Article number | AV-Basis | AV-Sure | | AV-Standaard | AV-GeZZin Compact | AV-GeZZin | AV-Top | AV-Plus | AV-Totaal | Article number |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Implants in non-toothless jaw | - | | - | - | | - | - | - | - | 100%, up to a maximum of €750 by a dentist or 100%, up to a maximum of €500 by a dental surgeon | 100%, up to a maximum of €750 by a dentist or 100%, up to a maximum of €500 by a dental surgeon | A13.4 |
| Denture care – special cases | 100%*, excl. personal contribution | B18.4.1 | - | - | | - | - | - | - | - | - | |
| **Shared reimbursement for dental care (* additional premium applies)** | | | | | | | | | | | | |
| Total reimbursement for two paying insured persons | - | | - | max. €300 | | max. €300 | max. €500 | max. €1,000 | max. €1,000 | max. €1,000 | max. €2,000 | A13.2.3 |
| **Other reimbursements** | | | | | | | | | | | | |
| Visiting costs for family member admitted to hospital | - | | 100%, up to a maximum of €250 | - | | 100%, up to a maximum of €250 | - | 100%, up to a maximum of €250 | 100%, up to a maximum of €250 | 100%, up to a maximum of €250 | 100%, up to a maximum of €300 | A14.1 |
| Contribution to patients' association for chronic conditions | - | | max. €20 | - | | max. €20 | - | max. €20 | max. €20 | max. €20 | max. €20 | A14.2 |
| Reimbursement of the personal contribution WLZ/ WMO (home care) | - | | - | - | | - | - | - | - | 100%, up to a maximum of €200 | 100%, up to a maximum of €200 | A14.4 |
| Home care organisation membership | - | | - | - | | - | - | 100%, up to a maximum of €17.50 | - | - | 100%, up to a maximum of €17.50 | A14.5 |
| Sports association membership for children up to age 18 | - | | - | - | | - | - | 100%, up to a maximum of €50 at NOC*NSF and contracted sports associations andinstitutions | - | - | 100%, up to a maximum of €50 at NOC*NSF and contracted sports associations andinstitutions | A14.6 |
| **Nursing and care** | | | | | | | | | | | | |
| Nursing and care (district nursing) | 100%* | B27 | - | - | | - | - | - | - | - | - | |
| Zvw-pgb for nursing and care (district nursing) | 100%* | B27 | - | - | | - | - | - | - | - | - | |
| Stay in primary care institution | 100%* | B27.2 | - | - | | - | - | - | - | - | - | |
| **Transport** | | | | | | | | | | | | |
| Ambulance transport | 100%* max. 200 km | B21.2 | - | - | | - | - | - | - | - | - | |
| **Seated patient transport on specific medical grounds, with prior permission from the 'Vervoerslijn'** | | | | | | | | | | | | |
| By public transportation | 100%*, excl. personal contribution | B21 | - | - | | - | - | 100% reimbursement of personal contribution, up to a max. of €101 | 100% reimbursement of personal contribution, up to a max. of €101 | 100% reimbursement of personal contribution, up to a max. of €101 | 100% reimbursement of personal contribution, up to a max. of €101 | A14.3 |
| By private car | €0.30 per km, excl. personal contribution | B21 | - | - | | - | - | | | | | |
| By taxi | 100%*, excl. personal contribution | B21 | - | - | | - | - | | | | | |
| **Care for persons with a sensory disability** | | | | | | | | | | | | |
| Extramural care for persons with a sensory disability | 100%* | B26 | - | - | | - | - | - | - | - | - | |

* Alternative reimbursements apply to services provided by non-contracted care providers. These are listed in the policy conditions. The Zorg Vrij Policy entitles you to 100% reimbursement, provided that the amount claimed is not excessive. For further details, see Article 1.7 ('Level of reimbursement') of the policy conditions.

# Policy Conditions 2018

## Basic Insurance Zorg Zeker Policy

Zorg en Zekerheid
zorgverzekeraar

# Glossary

### Acupuncturist
An acupuncturist registered as a doctor or dentist in accordance with the conditions stipulated in Section 3 of the Act (Individual Healthcare Professions Act) and who has completed the supplementary training course in acupuncture. This can also be a person who has completed training at higher professional level and satisfied the requirements and quality criteria of the NVA (Netherlands Association for Acupuncture). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Ambulance transport
The medically necessary transport by ambulance of individuals who are ill or wounded.

### Anthroposophic therapist
An anthroposophic therapist must comply with one of the following conditions, namely that he/she must be:
- a physiotherapist who is registered in accordance with the conditions of Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed a supplementary training course in anthroposophy;
- a dietician, speech therapist or remedial therapist who satisfies the requirements of the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who has completed a supplementary training course in anthroposophy;
- a nurse or midwife who is registered in accordance with the conditions of Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed a supplementary training course in anthroposophy;
- a healthcare professional who has completed the training course in artistic therapy or eurhythmics at higher professional education level;
- a healthcare professional who has completed a supplementary training course in anthroposophic (psychosocial) assistance.

All therapists must be registered with a professional association affiliated with the FAG (Federation of Anthroposophic Healthcare). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Pharmacist
A pharmacist who is listed in the register of established pharmacists referred to in Section 61, paragraph 5 of the Medicines Act (*Geneesmiddelenwet*).

### Dispensing general practitioner
A general practitioner (family doctor) who is permitted to dispense medicines by virtue of Section 61, paragraphs 10 and 11 of the Medicines Act.

### Doctor
A doctor registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### Basic insurance
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as the master policy or healthcare insurance.

### Corporate physician
A doctor registered as a corporate physician in the register administered by the RGS (Medical Specialists Registration Committee) of the KNMG (Royal Dutch Medical Association) and who acts on behalf of an employer or the Occupational Health and Safety Service to which that employer is affiliated.

### Pelvic physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a pelvic physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Board of Directors
The Board of Directors of the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### Centre for special dentistry
A university centre or centre deemed to be equivalent by Zorg en Zekerheid established for the provision of dental care in special cases in which treatment requires a team-based approach and/or special expertise.

### Advice centre for heredity issues
An organisation which holds a licence under the Specialist Medical Procedures Act (*Wet op bijzondere medische verrichtingen*) for clinical genetic research and heredity advice.

### Centre for specialist medical care
An institution for specialist medical care that has been accredited as such under or pursuant to the regulations imposed by the Care Institutions (Accreditation) Act (WTZi).

### Chiropractor
A chiropractor who is registered as a professional in the chiropractic profession and who has completed academic training (recognised 'college of chiropractic'). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Chronic disorders requiring physiotherapy and/or remedial therapy
A disorder that is included in Appendix 1 of the Healthcare Insurance Decree on the date on which the treatment was specified on the claim invoice. The list can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Collective
A group of individuals whose interests are promoted by an employer or a legal entity other than the employer by virtue of an agreement between Zorg en Zekerheid and that employer or legal entity.

### Craniosacral therapist
A care provider (who is not the patient's own general practitioner) who is trained in healthcare to at least higher professional education (HBO) standard, and who complies with the educational entry requirements set by the RCN (register for craniosacral therapy in the Netherlands). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Day treatment
Treatment at an institution involving admission and discharge on one and the same day.

### DOT (Diagnosis/Treatment Package towards Transparency) and Diagnosis/Treatment Combination (DTC) care product
DOT is the claim system for hospitals that came into effect on 1 January 2012. The units eligible for reimbursement are called DTC care products. These DTC care products have been defined by the Dutch Healthcare Authority (NZa). A DTC care product commences at the moment an insured person applies for treatment from a medical specialist and is concluded after a fixed number of days. The rates that apply to these care products can be divided into three categories: a fixed category with fixed rates, a regulated category to which maximum rates apply and a non-fixed category in which insurers conclude agreements with hospitals, independent treatment centres and independent extramural specialists about the applicable rates.

### Diagnosis / Treatment Combination for mental healthcare (GGZ), DTC
A DTC describes the defined, validated process involved in specialist medical care and specialist (secondary) mental healthcare, in terms of a DTC code of practice established by the NZa (Netherlands Healthcare Authority). This description includes the patient's care need, the type of care, the diagnosis and the treatment. The DTC process starts at the point at which the policyholder reports a problem to the medical specialist and finishes at the end of treatment, or after 365 days.

### Service structure
An association of general practitioners registered as a legal entity which was established to provide GP care during evenings, nights and weekends and which charges a legally valid rate.

### Dietician
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', in accordance with Section 34 of the BIG (Individual Healthcare Professions) Act.

### Chemist medicine
Medicine that can be obtained at a pharmacy or chemist without a prescription but that is not a homeopathic medicine. This is determined using the KNMP (Royal Dutch Pharmacy Society) list that is applicable at the time of supply. These medicines are also known as 'over-the-counter drugs'.

### DSM IV-TR
Diagnostic Statistical Manual of Mental Disorders: the international classification system for mental healthcare. The DSM lists the criteria that serve as a guideline in the diagnosis of a psychiatric disorder. IV-TR refers to the textual review of the fourth revised version of the DSM.

### Personal contribution
That portion of the costs of care and other services to be borne by the insured person as determined by law. The personal contribution can be a fixed amount per treatment or a percentage of the costs of the care. The personal contribution is not the same as the excess. Excess and personal contribution can be simultaneously applicable to the insured care.

### Occupational therapist
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### EU or EEA state
In addition to the Netherlands, the following countries are part of the European Union: Austria, Belgium, Bulgaria, Croatia, Cyprus (the Greek part), the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Sweden and the United Kingdom. Switzerland has equal status on the basis of treaty provisions. The EEA Member States (signatories to the EEA Agreement) are Liechtenstein, Norway and Iceland.

### Pharmaceutical care
Pharmaceutical care includes advice or supervision for the purpose of assessing medicines and the responsible use of UR medicines (medicines available exclusively on prescription) as referred to in Section 1, paragraph 1 under s of the Medicines Act or the provision of these medicines, or pharmaceutical care to which the Blood Supply Act (*Wet inzake bloedvoorziening*) applies.

### Phlebologist/proctologist
A doctor who complies with the quality criteria used by the Benelux Association for Phlebology, for instance.

### Fraud
Fraud is defined, in any case, as the act of or committing, or an attempt to commit, forgery of documents, deceit, to prejudice entitled parties and/or commit embezzlement with respect to the conclusion and/or performance of a health insurance contract or other insurance contract, and aimed at acquiring a payment or goods or services to which there is no entitlement or acquiring insurance cover under false pretences.

### Physiotherapist
A physiotherapist registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act. A remedial gymnastics masseur as referred to in Section 108 of the aforementioned Act is also deemed to be a physiotherapist.

### Birth centre
A facility that provides delivery and postnatal care under the direction of obstetricians and midwives providing primary obstetrics care. A primary birth centre is typically housed in separate accommodation with a distinctive physiological atmosphere and a direct, covered walkway to the hospital. A primary birth centre serves as an alternative for women who wish to deliver their child at an outpatients' clinic without it being medically necessary to do so.

### Contracted care
Care provided by Zorg en Zekerheid under a health insurance policy on the basis of an agreement concluded between Zorg en Zekerheid and a care provider or care institution.

### Generalist Basic Mental Healthcare (GGZ)
Care offered within the Basic Mental Healthcare (GGZ) framework comprises, in any case, primary psychological healthcare and several components from current specialised mental healthcare. Generalist basic mental healthcare is subdivided into four service types based on the associated patient profiles:

a. Short-term (BK);
b. Basic medium-term mental healthcare (Basis GGZ Middel, BM);
c. Basic intensive mental healthcare (Basis GGZ Intensief, BI);
d. Basic chronic mental healthcare (Basis GGZ Chronisch, BC).

### Geriatric physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a geriatric physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Geriatric rehabilitation
Geriatric rehabilitation includes integral and multi-disciplinary rehabilitation care as provided by specialists in geriatric medicine in connection with physical frailty and complex multimorbidity and a reduced ability to learn and be trained. The aim of geriatric rehabilitation is to improve the insured person's functional limitations and therefore enable a return to the home situation.

### Family
Two married persons or two unmarried persons with or without unmarried children or a single person with one or more unmarried children, who demonstrably cohabit long-term and who run a joint household.

### Family member
Person belonging to the family as referred to in the previous definition.

### Health psychologist
A health psychologist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the BIG (Individual Healthcare Professions) Act.

### GeZZondCheck
The GeZZond Check is a tool used to measure how healthy you are. The results obtained can be used to provide you with personal recommendations regarding your health and lifestyle.

### GGD doctor
A doctor who works for the Municipal Health Services in the field of public health, forensic medicine and medical aid in emergency situations, natural disasters and suchlike.

### Mental healthcare institutions
Institutions that provide medical care in connection with psychiatric disorders and have been accredited as such in accordance with the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, WTZi).

### Haptotherapist
A haptotherapist who has completed a healthcare training course to higher professional education (HBO) standard and who has also completed the supplementary training course in haptotherapy. A haptotherapist must comply with the educational entry requirements and quality criteria used by the VVH (Association of Haptotherapists). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Convalescent home and care hotel
Institutions that offer short-term intensive treatment to people with physical and/or psychosocial problems whose ability to perform daily functions is disrupted and for whom outpatient treatment is not or is not yet sufficient.

### (Classic) homoeopath
A (classic) homoeopathist registered as a doctor or dentist in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in homoeopathic medicine, or a (classic) homoeopathist who has completed a healthcare training course to higher professional education (HBO) standard and a supplementary training course in homoeopathy. A homoeopath or classic homoeopath must comply with the educational entry requirements and quality criteria used by the NVKH (Netherlands Association for Classic Homoeopathy), for instance. A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Treatment coordinator
A care provider who establishes a diagnosis and determines the treatment plan in response to the patient's care need. To that end, the treatment coordinator consults with the patient in a face-to-face meeting at least once. The treatment coordinator is responsible for the effective implementation of the treatment plan by ensuring proper alignment and communication with the fellow care providers, and tests the extent to which the treatment goals are achieved. The treatment coordinator communicates with the patient to evaluate the progress made and adjusts the treatment plan where necessary.

### Master policy
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as ‘basic insurance’ or ‘healthcare insurance’.

### Hospice
An institution specially designed for the temporary care of terminally ill patients in the final phase of their life and for the temporary care of their close family and relatives.

### Skin therapist
A skin therapist who satisfies the requirements stipulated in the Decree on educational requirements and area of expertise for skin therapists, in accordance with Section 34 of the BIG Act.

### General practitioner
A doctor listed as a general practitioner in the register of the KNMG (Royal Dutch Medical Association), established by the RGS (Registration Commission for Medical Specialists).

### Care aids
The care aids as specified in the health insurance policy.

### Care aid provision
The provision of care aids, as well as bandaging, under ministerial regulations, taking into account the Zorg en Zekerheid Care Aids Regulations with respect to requirements for permission, duration of use and volume prescriptions.

### IVF attempt
Care relating to in vitro fertilisation methods, including:
- hormone treatment to stimulate the maturation of ova within the ovaries;
- follicle puncture;
- the fertilisation of ova and cultivation of embryos in a laboratory;
- single or multiple intrauterine implantations of embryos to initiate pregnancy.

### Youth healthcare doctor
A doctor as referred to in the Youth Care Act (*Wet op de jeugdzorg*).

### Dental surgeon
A dental specialist registered as a dental surgeon in the register of specialists in oral diseases and dental surgery of the NMT (Netherlands Dentistry Society).

### Multi-disciplinary care
Multi-disciplinary care, in the event of a specific chronic condition (COPD, CVRM and diabetes mellitus type 2). The care must be provided by a diverse group of care providers in a coordinated manner, and in conformance with the care standards for the condition in question. For an overview of care providers taking part in multi-disciplinary care, please visit our website at zorgenzekerheid.nl/zorgzoeker.

### Child
Unmarried own, adopted or foster child under 18 years old.

### Child physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a child physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Child remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who is registered as a child remedial therapist in the Quality Register for Paramedics.

### Clinical psychologist
A healthcare psychologist registered as such in accordance with the conditions stipulated in Section 14 of the BIG (Individual Healthcare Professions) Act.

### Maternity bureau or maternity centre
An institution accredited in accordance with statutory regulations and acknowledged by Zorg en Zekerheid as such for the provision of maternity care at the home address or other accommodation of the insured party.

### Maternity care
The care of the mother and newborn child at the insured person’s home that is provided by a maternity caregiver affiliated with the maternity bureau, after an intake, by phone or otherwise, by the maternity bureau or maternity centre.

### Laboratory testing
Testing carried out by a laboratory accredited as such in accordance with the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, WTZi).

### Lactation expert
A lactation expert who is affiliated with a professional group of lactation experts and who works in accordance with the guidelines laid down by the NVL (Dutch Association of Lactation Experts).

### Disorders in physical function
Disorders in physical function are defined as handicaps related to movement, vision or mobility. Psychological and social functional disorders arising from a physical defect do not form an indication for reimbursement.

### Speech therapist
A speech therapist who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Manual practitioner
A manual practitioner registered as a doctor in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in manual medicine.

### Manual therapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a manual therapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Informal care
The care of the chronically ill, disabled and people in need of help by close family/relatives, other family, friends, acquaintances and neighbours.

### Market rate
Insofar as the amount charged by the care provider is not unreasonably high in proportion to the amount charged by other care providers for similar procedures.

### Medical adviser
A doctor, dentist, physiotherapist or other expert who advises Zorg en Zekerheid on medical, physiotherapy-related or other matters.

### Medical necessity
An insured person is only entitled to the type and scale of care that is reasonably appropriate to the insured person's needs and insofar as it is covered by this policy, such at the discretion of the medical adviser of Zorg en Zekerheid.

### Medically necessary care abroad
Care that is medically necessary and cannot reasonably be postponed until the insured person has returned to his country of residence.

### Medically necessary repatriation
The medically necessary patient transport from the place of stay abroad to a hospital, rehabilitation institution or nursing home in the Netherlands, in the case of a stay abroad as referred to in Article 3, Care Abroad.

### Medical specialist
A doctor listed as a medical specialist in the register of the KNMG (Royal Dutch Medical Association), established by the RGS (Registration Commission for Specialists).

### Oral hygienist
An independent oral hygienist who satisfies the requirements stipulated in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podotherapists and is authorised under Section 4 of the Decree governing Functional Self-Employment.

### Practitioner of natural medicine
A person registered in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in natural medicine.

### Oedema therapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as an oedema therapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Cesar/Mensendieck remedial therapist
A Cesar/Mensendieck remedial therapist who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Accident
A sudden and direct effect of an external force that causes physical injury the medical nature and location of which can be determined by Zorg en Zekerheid.

### Admission
Admission to an institution, if and insofar as the insured care can only be offered at an institution on medical grounds.

### Orthodontics
A treatment or examination generally acceptable according to medical and dentistry standards and classified as a specialisation practised by an orthodontist.

### Orthodontist
A dental specialist registered in the register of persons specialising in dento-maxillary orthopaedics maintained by the NMT (Netherlands Dentistry Society).

### Orthomolecular practitioner
A doctor registered in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in orthomolecular medicine.

### Educationalist
An educationalist registered as a remedial educationalist with the NVO (Dutch Association of Educators and Educationalists).

### Osteopathist
An osteopathist who has completed a healthcare training course to higher professional education (HBO) standard and who has completed the supplementary course in osteopathy and is registered with the NRO (Dutch Register for Osteopathists). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Menopause consultant
A menopause consultant who has completed a healthcare training course to higher professional education (HBO) standard with the additional qualification of gynaecology and who complies with the quality criteria laid down by the Care for Women association, for instance.

### Partner
The person with whom the insured person cohabits long-term or is married to or with whom the insured person runs a joint household.

### (Medical) pedicure
The pedicure must be registered with the KRP (Quality Register for Pedicures). For treatment to qualify for reimbursement under basic insurance coverage, a pedicure must hold the qualification 'foot care for diabetics'. For treatment to qualify for reimbursement under supplementary insurance coverage, a pedicure must hold an additional qualification 'foot care for diabetics' (DV) and/or 'foot care for rheumatic patients' (RV). In addition to basic foot treatment, he/she specialises in giving foot treatments to diabetics and/or rheumatic patients. A medical pedicure is a specialised pedicure who can treat all forms of clients' complex foot problems.

### Register of personal data
An interlinked collection of personal data relating to various persons that is maintained using IT devices or that is systematically built up to allow for efficient consultation of the data.

### Podopostural therapist
A podopostural therapist who has completed a healthcare training course to intermediate vocational education (MBO) or higher professional education (HBO) standard and who complies with the educational entry requirements and quality criteria used by the Omni Podo Society, for instance.

### Podotherapist
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Podologist
A podologist who has completed a healthcare training course to intermediate vocational education (MBO) or higher professional education (HBO) standard and who complies with the requirements of the Stichting LOOP foundation, for instance.

### Psychosomatic physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a geriatric physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Psychosomatic remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who is registered as a psychosomatic remedial therapist in the Quality Register for Paramedics.

### Psychotherapist
A psychotherapist registered as such in accordance with the conditions stipulated in Section 3 of the BIG Act.

### Psychiatrist/neurologist
A doctor listed as a psychiatrist/neurologist in the register of the KNMG (Royal Dutch Medical Association) established by the RGS (Registration Commission for Specialists). The term ‘psychiatrist’ as used in the terms and conditions is interchangeable with the term ‘neurologist’.

### Reasonable distance
A reasonable distance to a contracted care provider within a fixed radius, in km, from the residence of the insured person. A list of reasonable distances with respect to various types of care is available on request from Zorg en Zekerheid. Please contact Zorg en Zekerheid for this information at (071) 5 825 825 or by visiting one of our shops.

### Pharmaceutical Care Regulations
The Pharmaceutical Care Regulations may be requested from Zorg en Zekerheid and can be viewed at **zorgenzekerheid.nl/brochures**.

### Care Aids Regulations
The Care Aids Regulations may be requested from Zorg en Zekerheid or viewed at **zorgenzekerheid.nl/brochures**.

### Rehabilitation
Examination, advice and treatment of a combined specialist medical, paramedical, behavioural scientific and rehabilitative nature. This care is provided by a team of multi-disciplinary experts under the supervision of a medical specialist affiliated with a rehabilitation institution approved under the regulations imposed by the Care Institutions (Accreditation) Act (*Wet toelating gezondheidsinstellingen*, WTZi).

### Beautician
A beautician who has completed a healthcare training course to higher professional education (HBO) standard and who has also completed the supplementary training courses organised by ANBOS (General Dutch Sector Organisation for Beautician Care), for instance.

### Second opinion
A request made to a second, independent physician for an assessment regarding a diagnosis and/or proposed treatment made by your attending physician. The following requirements apply:
- Both physicians must work within the same field of specialisation;
- You must return to the first physician with the second opinion, thus ensuring that the treatment is carried out under this person’s direction;
- The attending physician must issue a referral for a second opinion.

### Shiatsu therapist
A therapist who has completed a healthcare training course to higher professional education (HBO) standard that complies with the requirements of the VIS (Association for IOKAI Shiatsu), for instance. A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Specialist mental healthcare-
Diagnostics and specialist treatment of complex psychological disorders/conditions. The involvement of a specialist (psychiatrist, clinical psychologist or psychotherapist) is required.

### Specialist care
Care or examinations that in accordance with generally accepted medical standards are part of the specialisation for which the medical specialist is registered and that may be deemed to be the usual treatment or examination.

### Standard maternity package
A maternity package that includes all necessary care aids for the delivery and for the period of recovery following a delivery.

### Dentist
A dentist registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### 'Tandprotheticus' dental technician
A dental technician trained in accordance with the Decree on educational requirements and area of expertise for '*tandprotheticus*' dental technicians.

### 'Tandtechnicus' dental technician
A dental technician who prepares pieces of dental work at a dental laboratory.

### You/the insured person
The person for whom the insurance agreement is entered into and who is registered as an insured person with Zorg en Zekerheid.

### Comprehensive maternity package
A maternity package that along with all necessary care aids for the delivery and period of recovery following delivery also includes a number of useful extras.

### Inpatient care
A stay for at least 24 hours.

### Contracting country
Any state with which the Netherlands has entered into a treaty concerning social security, which includes rules governing the provision of healthcare, other Member States of the European Union, a signatory of the EEA Agreement, or Switzerland.

### Midwife
A midwife registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### Mutilation
Mutilation is defined as a case of serious disfigurement that is directly noticeable in day-to-day life. This mutilation must be the result of a disease, accident or medical procedure.

### Nurse
A nurse as registered in accordance with Section 3 of the BIG (Individual Healthcare Professions) Act.

### Nursing specialist
A nurse as registered in accordance with Section 3 of the BIG (Individual Healthcare Professions) Act who specialises in acute, chronic, preventive or intensive care for somatic conditions or in mental healthcare.

### Insured person
Every person obliged to take out insurance and whose name is specified on the insurance policy, policy endorsement or certificate of registration.

### Insurance
The legal relationship regulated by the insurance agreement.

### Policy period
The length of the total period during which a person has been insured with Zorg en Zekerheid without interruption.

### Policyholder
The person who entered into the insurance agreement with Zorg en Zekerheid.

### Insurance year
The period specified on the policy schedule and each subsequent continuous 12-month period.

### Insurance agreement
The insurance agreement entered into between a policyholder and the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### Welfare organisation
A non-profit organisation dedicated to improving and promoting good health (other than for recreational purposes) by providing care, hosting courses and informative meetings, all in a group context.

### BIG (Individual Healthcare Professions) Act
The Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*, BIG).

### We/us/Zorg en Zekerheid
The Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### District nursing
Nursing and care as provided by nurses.

### WLZ
Long-Term Care Act (*Wet langdurige zorg,* WLZ).

### WMG rates
The rates set under or pursuant to the Healthcare (Market Regulation) Act (*Wet marktordening gezondheidzorg*, WMG).

### Over-the-counter drugs
Medicine that can be obtained at a pharmacy or chemist without a prescription but that is not a homeopathic medicine. This is determined using the KNMP (Royal Dutch Pharmacy Society) list that is applicable at the time of supply. Also known as ‘chemist medicine’.

### Hospital
A centre for specialist medical care that is admitted as a hospital or ZBC (independent treatment centre) in accordance with the rules of the WTZi Act (Care Institutions (Eligibility) Act).

### Persons with sensory disabilities
Persons with a visual or auditive impairment or a communicative impairment resulting from a linguistic developmental disorder.

### Seated patient transport
Transportation by public transport, car or taxi, other than an ambulance, for which the insured person can be reimbursed pursuant to the Healthcare Insurance Act (Zorgverzekeringswet).

### Care hotel and convalescent home
Institutions that offer short-term intensive treatment to people with physical and/or psychosocial problems whose ability to perform daily functions is disrupted and for whom outpatient treatment is not or is not yet sufficient. This does not include a stay at a primary care institution.

### Healthcare insurance policy
The deed concluded between the policyholder and the insurance company in which the health insurance coverage is set down.

### Health Insurer
The insurer who is accredited as such and provides insurance within the meaning of the Healthcare Insurance Act (Zorgverzekeringswet), hereinafter to be referred to as Zorg en Zekerheid.

### Healthcare insurance
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as ‘basic insurance’ or ‘the master policy’.

### Care Intensity Package (ZZP)
A Care Intensity Package (known by its Dutch abbreviation, ZZP) is a care package geared to your personal characteristics and to the care you need. The ZPP comprises the elements of residential services, care, treatment and services, and possibly also day-care activities. There are several types of ZZP, some of which include day-care activities. The level of the ZZP corresponds to the level to which you are entitled. The care must reflect the statutory description of one of the ZZPs defined for this purpose for long-term mental healthcare. A comprehensive description of all the care covered by a ZZP can be found on the website of the Dutch Healthcare Authority NZa.

# Section A
# General Terms and Conditions

## Article 1: General provisions

### 1.1 Basis of the premium

This healthcare insurance agreement is based on:

a. the Healthcare Insurance Act (Zorgverzekeringswet, Zvw);
b. the Healthcare Insurance Decree (Besluit zorgverzekering);
c. the Healthcare Insurance Regulations (Regeling zorgverzekering);
d. the associated explanatory notes to sections a, b and c;
e. the information you supplied to when you took out your insurance.

The healthcare insurance agreement has been laid down in your healthcare insurance policy and in these policy conditions. The insured persons and their healthcare insurance policy or policies are specified on the policy schedule. We will send you your certificate of insurance (which is comprised of the policy schedule and insurance card) as soon as possible after processing your application. In the future you will receive a new policy schedule before the end of each calendar year.

On presentation of your insurance card you will be able to go to a care provider contracted by Zorg en Zekerheid to receive the care to which you are entitled by virtue of this policy (see Article 1.5). In addition, please note that healthcare legislation provides for a duty to provide proof of identify.

This insurance is governed exclusively by Dutch law. The Healthcare Insurance Act, the Healthcare Insurance Decree and the Healthcare Insurance Regulations are of overriding importance in disputes over interpretation with respect to this healthcare insurance agreement.

### 1.2 For whom?

This healthcare insurance is available to all persons obliged to take out insurance who reside in the Netherlands or abroad. Entitlement to care and reimbursement of the costs of care apply to all insured persons who reside in the Netherlands and to insured persons who reside abroad.

### 1.3 Premium type

The Zorg Zeker Policy is a contracted-care policy offered by Zorg en Zekerheid. This means that as a policyholder you are entitled to contracted care by virtue of this healthcare insurance. Contracted care means that you will receive care from a healthcare provider who has a contract with us.

### 1.4 Content and extent of the healthcare insurance

You are entitled to care, or to reimbursement of costs of care, as described in these policy conditions if you reasonably depend on the care in question in terms of its content and extent. Whether you do will be determined in part by the effectiveness and quality of the care or services. The content and extent of the care are also determined by the latest scientific knowledge and practical know-how. If information in this regard is lacking, the content and extent of care are determined according to what are considered to be responsible and adequate care and services within the field of specialisation concerned.

### 1.5 Parties authorised to provide the care

#### 1.5.1 Contracted care provider

Contracted care is provided by a care provider with whom we have concluded an agreement for the relevant type of care: this is known as a contracted care provider.

If you need care as described in Section B you can turn to a healthcare provider contracted by Zorg en Zekerheid. A list of contracted care providers can be found at **zorgenzekerheid.nl./zorgzoeker**. Alternatively, you can contact us by telephone at 071 – 5 825 825 or in person at one of our shops.

The contracted care provider receives the reimbursement for the costs of the care they have provided directly from us.

> As regards the care mentioned in Section B, Zorg en Zekerheid enters into contracts with healthcare providers. Those contracts include agreements on price, quality, efficacy, invoicing methods and the conditions that govern the provision of care.

### 1.5.2 Non-contracted care provider

If you choose to go to a healthcare provider with whom we do not have a contract for the types of care described in Section B (a non-contracted care provider), you may have to pay a portion of the costs of treatment yourself. Section B gives the amount of the reimbursement for each type of care entitlement.

Go to **zorgenzekerheid.nl/zorgzoeker** for a list of our contracted care providers. For the maximum reimbursements for non-contracted care per care type, go to **zorgenzekerheid.nl/vergoedingenzoeker**.

## 1.6 Timely provision of care

If it is expected to be impossible for a contracted care provider to give you the care you need, or to provide such care in time, you are entitled to the mediation services provided by our GeZZond team. In that case we may grant you permission to go to a non-contracted care provider for this care. The costs of this care will then be reimbursed after we have received the invoice, and subject to the relevant policy terms and conditions. We will reimburse the costs of care up to the set maximum rate applicable at that moment in accordance with the Healthcare (Market Regulation) Act (WMG). If no maximum WMG rate has been set, we reimburse the costs up to the maximum reasonable market price current in the Netherlands.

> **GeZZond team**
> Zorg en Zekerheid's GeZZond team will be happy to advise you on a suitable care provider that you can turn to for your needs. Alternatively, the team can provide mediation services in the event you are confronted with unacceptably long waiting times for hospital admission, for example, or for a visit to an outpatients' clinic. For more information about the GeZZond team, go to **zorgenzekerheid.nl/geZZondteam**.

Care which cannot be provided by contracted care provider, or not in time, is also understood to include:
a. the care you need cannot be provided at a reasonable distance from your place of residence; or
b. no high-quality and responsible care can be provided in the vicinity of your place of residence.

In determining the timing of timely provision of care we include medical factors and, if necessary, general, socially acceptable waiting periods based on psychosocial, ethical and societal factors.

## 1.7 Admission to hospital

In the event of admission to a hospital, reimbursement will be based on the rate of accommodation in the lowest class. This will always be sufficient to fund hospital admission in the Netherlands.

> **Example:**
> If a hospital applies two different rates, for example a second-class and a first-class rate, we will only reimburse the lowest (second-class) rate. The difference has to do with the number of patients in a single room, for example. Dutch hospitals rarely apply two different rates, but at hospitals abroad this is far more common.

## 1.8 Start and end of your entitlement to care or reimbursement of the costs of care

If, pursuant to the policy conditions, you are entitled to care or to reimbursement of the costs of care you have incurred, this will only apply if you received the care concerned during the term of this healthcare insurance. The actual date on which the care was provided indicated by the care provider is decisive for the determination of the calendar year to which we will allocate the costs claimed. If a treatment is spread across two calendar years and the care provider claims costs under the Diagnosis Treatment Combination (DBC), the opening date of the DBC will be decisive for the right to reimbursement.

## 1.9 Written permission, referral or prescription

### 1.9.1 Written permission

For some types of care you need our prior written permission before you can claim entitlement to care or to reimbursement of the costs of care. For each type of care, Section B of these terms and conditions specifies whether you need such written permission. This applies both to contracted and non-contracted care (unless this rule is deviated from in these policy conditions).

If you have written permission from a healthcare insurer and you decide to switch to Zorg en Zekerheid, the permission will remain valid until the end date stated on the permission certificate. Reimbursement will then take place in accordance with these policy conditions.

> **Example:**
> You switched to Zorg en Zekerheid with effect from 1 January 2018. You received written permission for plastic surgery from your former healthcare insurer. The end date of that permission is 23 March 2018. If you arrange your treatment before that date, you will not need our permission.

1.9.2 Requesting permission in good time
The insured person/policyholder is obliged to request permission from Zorg en Zekerheid, as is required for a number of care types, sufficiently in advance so as to allow Zorg en Zekerheid an opportunity to obtain all required information and set any additional conditions with respect to the intended treatment or provision.

1.9.3 Failing to comply with obligations
In principle, the insured person will be responsible for the financial or other consequences of failure to comply with his or her obligations as formulated in 1.9.2. This does not alter the fact that, unless the required permission is granted by Zorg en Zekerheid, in principle the insured person has no entitlement to care and Zorg en Zekerheid is under no obligation to reimburse the costs.

1.9.4 Referral or prescription
You may also be required to present a referral or prescription that reflects your dependency on this type of care. For each type of care, Section B of these terms and conditions specifies whether you need a referral or prescription. You do not need a referral for urgent care (i.e., care which cannot be delayed).

1.10 Reimbursement of the costs of other types of care
In some cases you may be entitled to reimbursement of the costs of other types of care than mentioned in these policy conditions. This will apply if the treatment concerned qualifies as a generally accepted treatment method, yields comparable results and is legally permissible. You will however need prior permission for such treatment.

1.11 Repayment
It is possible that the amount you receive from us is higher than the amount to which you are entitled under this agreement. By taking out the healthcare insurance, you automatically authorise us to collect any such excess amount in our name. This authorisation concerns the excess amount that you paid to your healthcare provider.

1.12 When will an invoice expire?
Your right to claim reimbursement of the costs will, in principle, expire three years after the start of the day following the day on which the care concerned was provided. To prevent expiry, you should notify us in writing within this three-year period that you expressly wish to claim the reimbursement.

1.13 Notifications
Notifications sent to your last address and/or email address known to us are deemed to have reached you.

## Article 2: Start, duration and end of the healthcare insurance

2.1 As of what day will you be insured?
In principle, your healthcare insurance comes into effect on the date on which we have received your fully completed application (or application form). The effective date of your healthcare insurance is stated on the policy schedule.

2.1.1 We may not be able to infer from your completed application form whether we are under an obligation to enter into an insurance agreement with you and/or any of the persons stated in your application (or application form). In that case, we will ask you to provide supplementary information that confirms our obligation to enter into an insurance agreement with you and/or the individuals concerned. The healthcare insurance will then become effective on the date on which we have received all supplementary information, unless Article 2.1.2 applies.

2.1.2 If we receive the healthcare insurance application within four months of the person in question becoming subject to the obligation to take out healthcare insurance, the effective date of the insurance is the date on which said obligation arose. In the event of a newborn child, therefore, it is important that you take out insurance for your child with us within four months. Your child will then be insured from the date of his or her birth. If we do not receive your insurance application for a newborn child within four months, the effective date of the insurance is the date of the application and the insurance will have no retroactive effect from the date of birth.

2.1.3 Your healthcare insurance will be effective retroactively up to and including the day on which your previous healthcare insurance ended, provided that no more than one month has lapsed between the end date of your previous healthcare insurance and your new healthcare insurance. This particular retroactive effect shall only apply in the following cases:
a. The previous healthcare insurance was terminated with effect from 1 January;
b. The terms and conditions of the insurance have been amended with negative consequences for the insured person;

c. The premium base has been amended with negative consequences for the insured person.

2.1.4 If you already have another healthcare insurance on the day referred to in 2.1, the healthcare insurance will commence on the date indicated by you, provided it is in the future.

## 2.2 Times at which you may cancel your insurance

As a policyholder, you may terminate your insurance in writing with effect from 1 January of each year. Note that we should have received your notice of termination by 31 December of the preceding year. If we have not, we will extend your healthcare insurance tacitly for a term of one year. If you have given notice of termination by 31 December, the healthcare insurance will end on 1 January of the subsequent year and you will have until 1 February to arrange an alternative healthcare insurance. Your new healthcare insurance will then come into effect retroactively from 1 January.

You can also give notice of termination through the cancellation service of the Dutch healthcare insurers. This means that you authorise your new healthcare insurer to terminate your existing insurance policy or policies and to enter into a new healthcare insurance with you. Again, you will need to have applied for an alternative healthcare insurance by 31 December.

### 2.2.1 Cancelling your insurance early

As a policyholder you can opt for early termination of your healthcare insurance if or when:

a. you have taken out insurance for a person other than yourself and that person has taken out alternative insurance under the Healthcare Insurance Act. This could apply, for instance, when your child turns 18. In this case, notice of termination of the existing healthcare insurance must be given within 30 days.

> **Termination when child turns 18**
> When your child turns 18, you are entitled to terminate his or her insurance early. In that case, your child will have to take healthcare insurance himself or herself.

If you terminate the healthcare insurance and we receive your notice of termination prior to the commencement date of the new healthcare insurance, cancellation will take effect on the commencement date of the new healthcare insurance. If we receive your notice of termination at a later time, cancellation will take effect on the first day of the second calendar month after we have received the notice of termination. You may be requested to present evidence to demonstrate that the insured person has taken out healthcare insurance elsewhere;

b. due to having entered into a new contract of employment, you are no longer able to benefit from a group contract offered by your former employer and have the opportunity to join a new group contract with your new employer. In that case, you will be required to give notice of termination of your healthcare insurance within 30 days of the start of your new employment contract. You may be requested to present evidence to demonstrate that you are switching from one group contract to another;

c. we amend the premium and/or terms and conditions as described in Article 2.8.2;

d. the healthcare authority has notified you that it has issued us with an instruction due to failure to comply with, or has imposed a penalty on us due to violation of, Section 15f of the Processing of Personal Data in Healthcare (Additional Provisions) Act (Wet aanvullende bepalingen verwerking persoonsgegevens in de zorg). Your right to early termination will expire six weeks after you have received a notification as referred to in d. above. Termination will take effect on the first day of the second calendar month following the day on which you gave notice of termination.

### 2.3 Times at which you may not cancel your insurance

If we have sent you a demand for payment in connection with a premium arrears, you will not be able to cancel your healthcare insurance for as long as the premium owed and collection charges remain due. However, you will be able to do so if we have suspended the healthcare insurance cover, or if we have issued a confirmation of termination within two weeks.

### 2.4 Times at which we may cancel your insurance

We can terminate your healthcare insurance only in the following situations:

a. in the case of premium arrears and any collection charges as described in Article 3.6, ‘Payment arrears’;
b. in the case of fraud as described in Article 4.5.

### 2.5 Times at which we may suspend your insurance cover

We may suspend your healthcare insurance cover in the event of premium arrears and any collection charges as described in Article 3.6, ‘Payment arrears’.

## 2.6 When your insurance will end by operation of law

Your healthcare insurance may also end by operation of law. In the situations listed below, the healthcare insurance will end by operation of law on the day following the day on which:

a. we are no longer allowed to offer or execute healthcare insurance policies due to amendment to or revocation of our licence to work in the insurance industry. We will notify you of this no later than two months in advance, stating the reason and the date on which the insurance ends;
b. the insured person dies (you should notify us within 30 days);
c. the obligation to take out insurance ends;
d. you are a member of the military in active service.

As a policyholder, you are obliged to inform us as soon as possible about the death of an insured person, the end of an insured person's obligation to take out insurance or his or her employment as a member of the military in active service. Any overpayment in premiums will be refunded to you or settled with the reimbursement we paid to you without your being entitled to the care concerned. Any amount in healthcare costs unduly reimbursed to you that exceeds the amount in premium payments refunded to you will be charged to you.

## 2.7 Healthcare insurance of uninsured persons

If you are insured with us in accordance with Section 9d(1) of the Healthcare Insurance Act (Uninsured Persons (Detection and Insurance) Act (Wet opsporing en verzekering onverzekerden zorgverzekering)), you are entitled to rescind this healthcare insurance. You must do so within two weeks of the date on which the Central Administration Office (CAK) informed you that you are insured with us. In order to rescind this healthcare insurance, you must demonstrate to us and to the CAK that you were insured over the past period under a different healthcare insurance. This period is the period referred to in Section 9d(1) of the Healthcare Insurance Act.

We are authorised to rescind a healthcare insurance policy taken out by CAK on your behalf on grounds of an error if it can be concluded in retrospect that you were not obliged to take out insurance at that point in time. In this regard we derogate from Section 931, Book 7 of the Dutch Civil Code.

Note that you cannot terminate the healthcare insurance as referred to in Section 9d(1) of the Healthcare Insurance Act during the first 12 months of its term. In this regard we derogate from Section 7 of the Healthcare Insurance Act, except if and when the third paragraph of that section applies: in that case you do have the right to terminate your healthcare insurance.

## 2.8. Change in premium, premium base and conditions

### 2.8.1 Amendment to premium and conditions

We are entitled to amend the terms and conditions and/or premium base relating to the healthcare insurance across the board or for particular groups, at any time of the year. If we do so, we will inform you as a policyholder in this regard in writing. A change in the conditions or premium base will not come into effect until six weeks following the date on which it was made known to you.

### 2.8.2 Right of termination

If we decide to amend the terms and conditions or the premium base to your disadvantage, you will have the right to give notice of termination of your insurance within six weeks of the day on which we informed you about the change. You should give notice of termination in writing, by registered post. The right to terminate your insurance does not apply if the amendment to the terms and conditions or the premium base arises from a change in the official rules as laid down in Sections 11 to 14 inclusive of the Healthcare Insurance Act.

If we have not received your written notice of termination before the day on which the new terms and conditions or premium base come into effect, we will continue the healthcare insurance subject to the new terms and conditions.

## 2.9 Unlawful registration

a. If an insurance agreement is concluded for your benefit under the terms of the Healthcare Insurance Act and it subsequently emerges that you did not have an obligation to obtain insurance or did not have such an obligation after a certain point in time, the insurance agreement will lapse with retrospective effect to such time as such obligation to be covered by health insurance did not exist (or did no longer exist).
b. We will set off all premiums paid after the date on which there was no more obligation to take out insurance against the costs of any healthcare services used from that date at Zorg en Zekerheid's expense and pay or charge the balance to you.

## Article 3: Premium and excess

### 3.1 Premium base

The premium base is the premium without premium discount for a voluntary excess and/or a discount in a group contract. Your premium discount, if applicable, is stated on your policy schedule.

### 3.1.1 Calculation of the premium

| | | |
|---|---|---|
| Premium base | € | |
| Discount on voluntary excess | € | - |
| Group discount (% of the premium base) | € | - |
| Subtotal | | |
| | | |
| Instalment discount (% of the interim result) | € | - |
| Premium to be paid | € | - |

### 3.2 Who pays the premium

The policyholder is under an obligation to pay the premium. No premium is owed for insured persons who have not yet reached the age of 18. The premium will not be owed until the first day of the calendar month following the insured person's 18th birthday. In the case of the insured person's death, premium is owed up to and including the date of death.

> **Example:**
> A person who turns 18 on 2 February will owe premium from 1 March.

The policyholder is obliged to pay the premium in advance and to pay any contributions arising from domestic or foreign statutory provisions or regulations, for all insured persons. The policyholder can choose to pay the premium on a monthly basis, a quarterly basis, a half-yearly basis or a yearly basis. If you opt to pay the premium on a half-yearly or yearly basis, you are entitled to a 1% or 2% discount, respectively, over the premium due.

### 3.3 Premium discount by virtue of a group contract

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

From the date that you are no longer able to participate in the group contract, the premium discount and any amended terms and conditions as agreed in the group contract will lapse.

### 3.4 Participation in a single group contract at a time

When you join a group contract, your choice for a voluntary excess may be limited or excluded. When you join a group contract mid-term, this may result in adjustment to your previously selected voluntary excess.

### 3.5 Settlement of premium with reimbursement due

You are not permitted to settle any payable premium with any reimbursements still owed from us.

In the event of an amendment to your insurance policy during the course of the month, we are entitled calculate, recalculate or refund the premium as of the first day of the following month.

In the event of the death of the insured person, settlement and/or a refund of the premium will take place as of the day following the date of death.

### 3.6 Payment arrears

If you fail to pay or refund the premium, compulsory or voluntary excess, personal contributions, unduly paid reimbursements or statutory contributions in time, we will send you a reminder. You will then have 30 days from the date of receipt of the reminder to pay the amount or amounts due. If you then fail to pay within the set deadline, you will no longer be entitled to (reimbursement of the costs for) any medical treatments that took place after the first day following the payment deadline.

### 3.6.1

If you have incurred payment arrears amounting to two monthly premium payments, we will offer you a payment arrangement. We will do so within ten working days of the day on which we determined your payment arrears.

### 3.6.2

If you have incurred payment arrears amounting to four monthly premium payments, we will notify you as soon as possible of our intention to report the matter to the CAK, as referred to in Section 18c of the Healthcare Insurance Act. Once your premium arrears amounts to six monthly premiums, we will actually report the matter unless you inform us within four weeks of this announcement that you contest the premium arrears or the amount of the arrears.

3.6.3 If we decide to maintain our standpoint despite your objection, you may, within four weeks after receiving this announcement, submit the dispute to the Stichting Klachten en Geschillen Zorgverzekeringen (Health Insurances Complaints and Disputes Foundation, SKGZ) or to a civil court. If a payment arrangement as referred to in Section 18a of the Healthcare Insurance Act is taken into effect at a point in time when the arrears in payment amount to a sum equal to four monthly premium payments, the healthcare insurer will not issue a notification as referred to in Section 18b(1) as long as the new payment instalment terms are met (see Section 18b(3) of the Healthcare Insurance Act).

3.6.4 If you have incurred payment arrears amounting to six or more monthly premium payments, we will report you to the CAK. This report will include your (i.e. the policyholder's) personal data and the personal data of any insured persons involved as required for levying the administrative premium and for implementing Section 34a of the Healthcare Insurance Act. We will not report the matter if:

a. you have contested the premium payment arrears in due time and we have not yet notified you of our standpoint on the matter;
b. the term mentioned in Section 18b(2) of the Healthcare Insurance Act has not yet expired;
c. you have submitted the dispute in due time to the SKGZ or to a civil court and as long as no irrevocable decision has been made with respect to the dispute;
d. you have registered with an accredited debt assistance organisation and are able to show us a written agreement concluded with this organisation for the stabilisation of your debts.

3.6.5 We will instantly inform the CAK of the date on which:

a. the debts arising from the healthcare insurance will be or have been paid or annulled in full;
b. the debt restructuring scheme for natural persons, as referred to in the Bankruptcy Act (Faillissementswet), becomes applicable to the policyholder;
c. an agreement has been concluded as referred to in Section 18c(2)(d) of the Healthcare Insurance Act (i.e. a written agreement for the stabilisation of the policyholder's debts). This agreement must have been concluded through the intervention of a debt restructuring organisation as referred to in Section 48 of the Consumer Credit Act (Wet op het consumentenkrediet). Alternatively, we may inform you (i.e., the policyholder) and the CAK of the date on which a payment arrangement was effected. The parties to the payment arrangement must at least include you, in your capacity as the policyholder, and us, in our capacity as the healthcare insurer.

3.6.6 If we decide to engage a collection agency to ensure recovery of our claim, all the collection costs will be for your account. This includes both judicial and extra-judicial costs. With effect from 1 July 2012, the extra-judicial costs amount to a minimum of €40. You will owe extra-judicial costs from the moment you are in default.

3.6.7 Entitlement to care and reimbursement of the associated costs will resume on the day following the day on which we have received the amount due and any costs owed.

## 3.7 Compulsory excess

### 3.7.1 Amount of the compulsory excess

If you are aged 18 or older, a compulsory excess of €385 per calendar year applies. The amount of the compulsory excess is set by the government every year and applies to every individual insured person.

Compulsory excess means that the costs of insured care up to that amount are for your own account. This concerns costs that you may incur under your basic insurance policy in the course of the year.

> **Example:**
> This may involve situations like a hospital admission, in which we will reimburse the admission costs. You will then receive an invoice from us for the payment of your compulsory excess and any voluntary excess.

### 3.7.2 The types of care to which the compulsory excess applies

The compulsory excess applies to all the types of care referred to in these policy conditions, with the exception of:

a. general practitioner care; please be aware that, for example, medicines prescribed by a general practitioner are not covered by general practitioner care. The same applies to laboratory tests (for blood analysis, for example) in connection with general practitioner care. If, at the general practitioner's request, the laboratory tests are performed by a different healthcare provider, the compulsory excess applied. The consultation costs incurred within the context of the NEXT project by a psychiatrist however are not covered by the excess;
b. the direct costs for maternity and obstetric care. However, the costs of any associated care do come under the excess. This could be the costs of any ambulance transport, or of tests performed elsewhere and charged separately;

c. the costs of contracted multi-disciplinary care for chronic conditions (multi-disciplinary care), with the exception of care outside of multi-disciplinary care;
d. contraceptives for insured persons between 18 and 20 years of age;
e. nursing and care (district nursing) as described in Section B, Articles 27 and 27.1;
f. donor transport, if the donor has healthcare insurance and the costs can be charged to that insurance. In that case, we will reimburse the costs of public transport at the lowest fare available in the Netherlands. If there is a medical need to travel by car, we will reimburse the costs of transport by car;
g. follow-up examinations for donors after the period referred to in Article 9 fourth indent has expired;
h. the medication check by a pharmacist;
i. treatment on the basis of a knee or hip surgery diagnosis in a hospital selected by us. You will find our list of selected hospitals at **zorgenzekerheid.nl/vergoedingenzoeker**.

### 3.7.3 Effective date of the compulsory excess

If you turn 18 in the course of a calendar year, the compulsory excess will apply from the first day of the calendar month following your eighteenth birthday. The amount of the compulsory excess will in that case be calculated as described in Article 3.7.4.

### 3.7.4 Calculating the amount of the compulsory excess

Unless the insurance starts or ends on 1 January due to the insured person's turning 18 or for any other reason, we will calculate the excess for the calendar year concerned as follows:

$$\text{Excess} \times \frac{\text{the number of days of insurance coverage in the calendar year concerned}}{\text{the number of days in the calendar year concerned}}$$

The resulting amount will be rounded off in whole euros.

> **Example:**
> The insurance commences on 1 November of a calendar year due to the insured person's reaching the age of 18. We will then calculate the amount of the excess for the period up until 1 January of the following calendar year. This period includes 61 days. A calendar year (other than a leap year) has 365 days. The excess is therefore: €385.00 x 61 divided by 365 = €64.34, which is rounded to €64.00.

### 3.7.5 Compulsory excess for Diagnosis-Treatment Combination (DTC)

The costs of a treatment claimed within the context of DTC, integrated delivery care, basic mental healthcare or a ZZP mental health care product are deducted from the compulsory excess for the calendar year in which the DTC, integrated delivery care, basic mental healthcare or ZZP mental healthcare product was opened.

### 3.7.6 Payment of the compulsory excess

If we pay the costs of your treatment directly to your care provider, we will charge or recover any available compulsory excess. In the event of recovery, you will receive a written request to that effect from us asking you to effect payment within 14 days.

We will only reimburse costs exceeding the amount of compulsory excess and any voluntary excess. Compulsory excess also applies to components of insurance packages specifying a maximum amount unless determined otherwise in the relevant terms and conditions.

## 3.8 Voluntary excess

### 3.8.1 What is voluntary excess?

When taking out healthcare insurance, as a policyholder you may opt for voluntary excess provided that the insured person is at least 18 years old. You can opt for voluntary excess in the amount of €0, €100, €200, €300, €400 or €500 per calendar year. Your chosen voluntary excess is stated on the policy schedule.

A voluntary excess means that the costs of care up to that amount are for your own account. Note that this amount will be charged on top of your compulsory excess from Article 3.7.1. For the payment of the costs of care to which an excess applies, the compulsory excess is used first and the voluntary excess is applied over the remaining amount.

You will qualify for a premium discount depending on the level of the voluntary excess you have chosen. For information on the premium discount regarding the voluntary excess, please refer to the quote module on **zorgenzekerheid.nl**.

### 3.8.2 The types of care to which the voluntary excess applies

The voluntary excess applies to the care that is subject to the compulsory excess (see Article 3.7.2).

One exception is given in Article 3.7.2, under i. (treatment on the basis of a knee or hip surgery diagnosis in a hospital selected by us): in this case, the compulsory excess does not apply, but your voluntary excess does.

### 3.8.3 Moments when you can change your voluntary excess

You can only change your voluntary excess with effect of 1 January of the new calendar year. This means you cannot change your voluntary excess retroactively, from €500 to €100 for example.

For the new voluntary excess to be effective as of 1 January of the new calendar year, we need to have received your change by 31 December of the preceding calendar year. You can submit your change via **MijnZZ.nl**, by telephone at 071 – 5 825 825 or in person at one of our shops.

### 3.8.4 Calculating the amount of the voluntary excess

If the healthcare insurance commences or ends in the course of a year, we will calculate the voluntary excess for that calendar year as follows:

$$\text{Voluntary excess} \times \frac{\text{the number of days of insurance coverage in the calendar year concerned}}{\text{the number of days in the calendar year concerned}}$$

The resulting amount will be rounded off in whole euros.

> Example for 18-year-old
> You have chosen a voluntary excess of €100. The healthcare insurance commences on 1 November due to the insured person's reaching the age of 18.
>
> In that case we will not claim the full voluntary excess amount of €100. This is because we will also take account of the period covered by the voluntary excess, which, in this particular case, is 61 days (= the number of days left until 1 January of the subsequent calendar year).
>
> A normal calendar year (i.e., not a leap year) has 365 days. The voluntary excess is therefore:
>
> €100 x (61 / 365) = €17 (rounded off in whole euros).

If the applicable voluntary excess is changed during a calendar year and you had already taken out healthcare insurance with us before the change, we will calculate the voluntary excess as follows:

First we will add up the following amounts:

(Annual voluntary excess for period 1 x no. of days to which this applies) = amount 1
+
(Annual voluntary excess for period 2 x no. of days to which this applies) = amount 2

Etcetera.

We will then divide the sum of these amounts by the number of days the calendar year concerned. The result is then rounded off to whole euros.

### 3.8.5 Voluntary excess for Diagnosis-Treatment Combination (DTC)

Amounts claimed under a so-called DTC, integrated delivery care, basic mental healthcare or a ZZP mental healthcare product are deducted from the voluntary excess for the calendar year in which the DTC, integrated delivery care, basic mental healthcare or ZZP mental healthcare product was opened.

### 3.8.6 Payment of the voluntary excess

If we pay the costs of your treatment directly to your care provider, we will charge or recover any available voluntary excess. In the event of recovery, you will receive a written request to that effect from us asking you to effect payment within 14 days.

If you submit your healthcare expense claims directly to us, we will deduct any available voluntary excess from the reimbursements due.

Voluntary excess also applies to components of insurance packages specifying a maximum amount, unless determined otherwise in the relevant terms and conditions.

3.8.9 Voluntary excess after 18th birthday

We will contact you at least four weeks before the first day of the month following your 18th birthday. We will do so by sending you a letter in which you are asked to indicate, by a set deadline, your choice of voluntary excess. If you fail to indicate your choice in writing by the set deadline, your premium will be calculated on the basis of the voluntary excess of the policyholder.

## Article 4: Other provisions

4.1 Obligations

4.1.1 Your obligations

a. to ask the attending doctor or medical specialist to inform the medical advisor of Zorg en Zekerheid of the reason for the admission if the medical advisor requests this;
b. to cooperate with the medical adviser or others at Zorg en Zekerheid charged with verification with respect to obtaining all required information, with due observance of the privacy regulations. This is understood to include, at the instruction of Zorg en Zekerheid, the granting of cooperation with respect to obtaining a second opinion from an independent specialist. The costs of such a second opinion will be borne by Zorg en Zekerheid;
c. to inform Zorg en Zekerheid of facts that could result in the costs being recovered from (possible) liable third parties, in which case Zorg en Zekerheid will be provided with all necessary information and/or cooperation free of charge; the insured person/policyholder is not permitted, without a written statement of approval from Zorg en Zekerheid, to come to any arrangements with the liable third party or that third party's insurer concerning the costs that have been or will be reimbursed by Zorg en Zekerheid;
d. to report to Zorg en Zekerheid within 30 days that the insured person has been remanded in custody or that his or her detention has ended, in connection with the statutory provision regarding the suspension of coverage and the obligation to pay premiums during the term of detention;
e. to submit the original and clearly specified invoices to Zorg en Zekerheid before 31 December of the third year following the year in which the treatment took place. What is decisive in this respect is the date of treatment and/or that on which care was provided, and not the date of the invoice concerned. Where the invoice relates to a DOT and/or a DTC, all costs that are associated with this DOT and/or DTC will be deemed to have been incurred in the year in which it was opened. If these invoices are submitted later, you will no longer be entitled to compensation for the costs of this care. Only original invoices, or digital invoices that have been authenticated by the care provider, will be processed. When claiming costs incurred abroad or the costs of seated patient transport, a claim form from Zorg en Zekerheid for care provided abroad/seated patient transport must be used; for more information, also see **zorgenzekerheid.nl**;
f. to the extent that the policy requires a referral in order for care to be sought, to submit to Zorg en Zekerheid at its request the referral from the care provider concerned;
g. the policyholder is obliged to ensure that any change that could influence the rights and obligations arising from the insurance agreement is communicated in writing to Zorg en Zekerheid as soon as possible, but no later than 30 days after the change concerned occurred. Such changes include:

lapsing of the statutory obligation to be insured;
divorce, end of a long-term cohabitation or end of a registered partnership;
death;
birth;
change of bank account number;
change of address;
change of email address;
commencement of imprisonment and its ending.

If the change is not communicated to Zorg en Zekerheid within 30 days, the change will only take effect as of the date it is actually reported and not retroactively from the date of the change. Exceptions to this rule are birth (see Article 2.1.1), death and commencement of a period of imprisonment (the healthcare insurance will be suspended as of the date of placement in a penitentiary institution).

4.2 Not covered by the insurance

4.2.1 Exclusions

You are not entitled to reimbursement for the costs of:

a. personal contributions / payments owed under the Healthcare Insurance Act, WLZ, WMO, Youth Act and/or in connection with population screenings;
b. medical examinations for employment or other purposes (e.g. for a driving licence or pilot's licence), certifications or vaccinations, unless provided otherwise in the applicable ministerial regulations;
c. flu vaccination;
d. alternative medicines;
e. medicines to prevent illness in connection with a journey;
f. maternity package, surgical dressings and sterile hydrophilic gauze for obstetric care;

g. treatments that require a referral and for which the referral was not requested/issued in advance;
h. claims resulting from failure to attend an appointment with a care provider;
i. treatments against snoring involving uvuloplasty;
j. treatments aimed at sterilisation;
k. treatments aimed at reversing sterilisation;
l. treatment aimed at circumcision of male insured persons, unless the treatment is medically necessary;
m. plagiocephaly and brachycephaly (skull deformations in infants) treatment without craniosynostosis with a redression helmet;
n. care provided outside the Netherlands with the exception of costs as referred to in Article 22, 'Abroad';
o. examinations for treatments which are not generally accepted scientifically or are unusual in the context of the practice of the profession or specialism, or which are not included in the legal description of what the profession entails;
p. continued hospital admission, if our medical advisor is of the opinion that such continued admission is not necessary;
q. pre-natal screening for genetic defects other than by SEO (routine ultrasonography) in the second trimester of pregnancy, where there are no medical grounds;
r. if the costs are the result of damage caused by or arising from armed conflict, civil war, insurrection, internal civil commotion, riots and mutiny as provided in Section 3.38 of the Financial Supervision Act (Wet op het financieel toezicht, Wft);
s. if the costs are the result of or are connected with an armed conflict, active participation in civil wars, civil commotion either domestically or internationally, riots, revolts and mutiny.

#### 4.2.2. Double cover

You are not entitled to care nor to reimbursement of the costs of care if the costs arise from illnesses or accidents and the insured person can claim for the resulting costs under statutory insurance cover, government-imposed insurance, any type of subsidy scheme or – if this insurance agreement had not been concluded – an agreement other than this one.

#### 4.2.3 Liability

a. We cannot be held liable for damage incurred by you as a result of any action or omission on the part of your healthcare provider.
b. Our liability, if any, for damage resulting from our own shortcomings shall be limited to the amount of the costs we would have had to reimburse if the healthcare insurance had been executed properly, unless in the case of wilful misconduct or gross negligence.

### 4.3 Entitlement to care as a result of terrorism

Should you need care as a result of an act of terrorism, then you may qualify for a part of such care. The following rule applies in this regard: If the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT) expects that the total damage caused by acts of terrorism that is claimed from life, non-life or benefits in kind funeral insurance companies (including healthcare insurers) subject to the Financial Supervision Act (WFT) in a particular calendar year exceeds the amount for which NHT has taken out reinsurance, you will only be entitled to a certain percentage of the costs or value of the care or other services. This percentage is determined by NHT and is the same for all insured persons.

The exact definitions and provisions for the care entitlement referred to above are set out in the NHT's Clausuleblad terrorismedekking (Terrorism Cover Clauses Sheet). It is possible that following an act of terrorism we receive a supplementary payment pursuant to Section 33 of the Healthcare Insurance Act or Section 2.3 of the Healthcare Insurance Decree. In that case, you will be entitled to a supplementary reimbursement as referred to in Section 33 of the Healthcare Insurance Act.

The NHT's Terrorism Cover Clauses Sheet applies to this policy. The clauses sheet was filed at the Amsterdam District Court under number 6/2005 on 6 January 2005 and at the Amsterdam Chamber of Commerce under number 27178761 on 17 January 2005. The clauses sheet can be consulted at **terrorismeverzekerd.nl** and **zorgenzekerheid.nl**. You can also request this information by contacting Zorg en Zekerheid at telephone number (071) 5 825 825 or by visiting one of our shops.

### 4.4 How we deal with your personal data

In order to take out health insurance or to change or terminate your health insurance, you will need to provide personal data to us. We will collect and process your personal data in order to effect and implement the health insurance agreement and any supplementary insurance cover. We will store your personal data in our registry of persons. This registration is subject to the applicable privacy regulations and the codes of conduct that we are required to comply with.

What else will we do with your personal data? We will:

a. make your personal data available to the care provider for the purpose of verifying your insurance status;
b. use your personal data for the purpose of statistical analysis;

c. use your personal data inspections and/or investigations among insured persons and care providers for the purpose of establishing whether the care was actually provided and/or has proved effective;
d. have the right to share your personal data with third parties for the purpose of executing the healthcare insurance, with due regard for the applicable privacy regulations. If you wish, we will not disclose your address to such third parties. Please inform us of your wishes in this regard in writing;
e. maintain, within the framework of a responsible acceptance, risk and fraud policy, an Events Register subject to the Code of Conduct for the Processing of Personal Data by Health Insurers. An Incidents Register will be maintained in accordance with the Incident Warning Protocol for Financial Institutions and we are authorised to view and/or enter your personal data in the External Reference Register maintained by Stichting Centraal Information Systeem (CIS) (the Netherlands Central Information System Foundation) in The Hague.

## 4.5 How we deal with fraud

If you commit fraud or if another person commits fraud on your behalf, your right to care and reimbursement of care will lapse. We will recover any and all reimbursements made as of the date the fraud was first committed. In addition, we will charge you for the costs of investigating the fraud.

We will also have the right to terminate any existing insurance agreements you may have with Zorg en Zekerheid (that is, healthcare insurance policies and/or supplementary healthcare policies) as of the date the fraud was first committed.

In the case of fraud we will enter your name or the name of the insured person in the External Reference Register. Fraud investigations are conducted in accordance with the Protocol for Insurers and Criminality. In the case of fraud, or strong suspicions of fraud, we may also decide to report the case to the police.

## 4.6 Complaints and disputes

### 4.6.1 You have a complaint

If you are dissatisfied with a decision that we have made or with our service, you are free to submit a complaint within eight weeks. You may simply lodge your complaint with us by completing the online complaints form on our website: **zorgenzekerheid.nl/klacht**. Alternatively, you can submit your complaint to our Complaints Committee:

**Zorg en Zekerheid**
**Attn.: de Klachtencommissie**
**Postbus 428**
**2300 AK LEIDEN**

If you are dissatisfied with our response to your complaint or if you have not received a response from us within our target response period of ten weeks, you can submit your complaint or the dispute to Stichting Klachten en Geschillen Zorgverzekeringen (Health Insurances Complaints and Disputes Foundation, SKGZ), Postbus 291, 3700 AG Zeist. You may also submit the dispute to the competent civil court.

### 4.6.2 Complaints about our forms

If you consider our forms to be superfluous or unnecessarily complicated, you may submit a complaint about this to the Dutch Healthcare Authority (NZa). The NZa will then pronounce judgement in the form of a binding opinion. Please submit your complaint in writing to the following address: NZa Postbus 3017 3502 GA Utrecht.

## 4.7. Concluding provision

Matters not covered by these policy terms and conditions will be decided on by the Board of Zorg en Zekerheid. Adopted by the Members' Council on 09 November 2017 and to take effect on 01 January 2018.

# Section B Extent of the cover Medical care

## Article 5: General practitioner care

*What am I entitled to?*
You are entitled to:
- medical care provided by a general practitioner or another doctor/care provider working under the authority of a general practitioner (for example, a nurse attached to a general practitioner's surgery);
- medical care provided by the services structure (the after-hours clinic) to which the general practitioner is affiliated;
- relevant testing, including laboratory testing prescribed by the general practitioner, which is charged for by the general practitioner, a hospital or a laboratory.

*What are the conditions?*
The extent of this assistance is limited to the care generally provided by general practitioners.

*What am I not entitled to?*
You are not entitled to:
- influenza vaccinations;
- medical examinations.

For the full list of exclusions, see Section A, Article 4.2 of these policy conditions.

*What is reimbursed if I go to a non-contracted care provider or institution?*
Costs of general practitioner care provided by a non-contracted care provider or care institution are reimbursed up to the maximum rate determined by the NZa for non-contracted general practitioner care.

If the NZa has not determined a maximum rate specifically for non-contracted general practitioner care and the care may be given by non-contracted providers, the amount charged will be reimbursed up to 80% of the maximum market rate.

## Article 6: Specialist medical care (excl. mental healthcare)

### 6.1. General
Reimbursement of the costs of the types of care referred to in Articles 6 through 16 (with the exception of acute care) requires a prior referral from your general practitioner, company doctor, school doctor, medical specialist or physician assistant, Municipal Health Service (GGD) doctor, infectious diseases specialist, geriatric doctor, geriatric disease specialist or, in the event of obstetric care, a referral from a midwife or, in the event of dental or orthodontic care, from a dental surgeon, dentist or orthodontist. Such a referral will remain valid for one year, unless the party issuing it has specified a different term.

The extent of this assistance is limited to the care provided by medical specialists. With respect to oral care provided by a dental surgeon, reimbursement is possible with due observance of Article 18. Care provided by a sports physician will only qualify for reimbursement if it concerns medical specialist care aimed at recovery, cure or prevention of (a deterioration of) a condition. This care may comprise:
- exercise physiology examination and guidance as part of a rehabilitation programme, and/or;
- diagnostics and treatment of injuries of the musculoskeletal system resulting from movement and/or strain.

### 6.1.1 Conditionally qualifying treatments
Some treatments have been conditionally included in the basic insurance in accordance with Section 2.1(5) of the Healthcare Insurance Decree (Bz) and Article 2.2 of the Healthcare Insurance Regulations (Rz). This concerns treatments whose efficacy has not yet been sufficiently demonstrated. However, they do qualify for temporary reimbursement under the basic insurance. The Minister of Health, Welfare and Sport may conditionally admit new treatments in the course of the calendar year. The document 'Conditionally qualifying treatments' lists all the treatments referred to in this section; for the latest version check **zorgenzekerheid.nl/brochures**.

## 6.2 In-patient care (hospital admission)
*What am I entitled to?*
You are entitled to:
- a stay in a centre for medical specialist care, at the lowest available rate, during an uninterrupted period of up to 1,095 days. An interruption in the stay of at most thirty days will not be regarded as an interruption. Consequently,

these days during which the stay is interrupted will not be included in the calculation of the 1,095 days. On the other hand, interruptions due to weekend and holiday leave do count towards the calculation of the 1,095 days;
- medical specialist treatments and the stay, whether in combination with nursing and care or otherwise;
- the paramedical care and medicines associated (with the exception of medicines excluded under Article 2.1 of the Healthcare Insurance Regulations), care aids and bandaging aids, during the period of admission.

*What are the conditions?*
- The care provided must be in accordance with the care as generally offered by medical specialists.
- The stay must be medically necessary and must be provided in connection with medical specialist care.
- Zorg en Zekerheid must be informed as soon as there are no longer any grounds for medical specialist assistance in combination with a stay in a centre for specialist medical care.

*Does Zorg en Zekerheid need to approve this beforehand?*
You must have the prior permission of Zorg en Zekerheid for in-patient asthma treatment (e.g. in the Netherlands Asthma Centre in Davos or in Heideheuvel).

*What is reimbursed if I go to a non-contracted care provider or institution?*
- The costs of care provided by a non-contracted centre for specialist medical care are reimbursed up to a maximum 80% of the or WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.
- If this concerns urgent care, you will be reimbursed up to a max. of 100% of the prevailing Dutch market rate or WMG rate.

### 6.3 Non-clinical medical specialist care
*What am I entitled to?*
You are entitled to:
- specialist medical treatment provided at or by a centre for specialist medical care contracted by Zorg en Zekerheid;
- specialist medical treatment provided by an extramural medical specialist contracted by Zorg en Zekerheid;
- the day care associated with the treatment, as well as the medicines, care aids and bandaging aids associated with the treatment.

*What are the conditions?*
The care provided must be in accordance with the care generally offered by medical specialists.

*Does Zorg en Zekerheid need to approve this beforehand?*
The prior written permission from Zorg en Zekerheid is required for reimbursement for oral care provided by a dental surgeon if the treatment included periodontal surgery, extraction under anaesthesia, osteotomy or the placement of a dental implant.

*What is reimbursed if I go to a non-contracted care provider or institution?*
The costs of care provided by a non-contracted centre for specialist medical care or by a non-contracted care provider are reimbursed up to a maximum 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 6.4 Treatments of a plastic surgical nature
*What am I entitled to?*
You are entitled to:
plastic surgery treatments, with due observance of the previous paragraphs, if necessary to correct:
- defects in appearance accompanied by demonstrable disorders in physical function;
- mutilation as a result of a disease, accident or medical procedure;
- paretic or drooping upper eyelids if resulting in a seriously limited field of vision or the result of a congenital defect or a chronic disorder present at birth;
- the following congenital deformities: cleft lips, jaws and palates, facial bone deformities, benign deformity of blood vessels, lymphatic vessels or connecting tissue, birthmarks or defects of the urinary tract and genital organs;
- primary sex characteristics in the case of established transsexualism;
- electrical epilation in transsexuals as referred to in Article 17.8 of these policy conditions.

*Does Zorg en Zekerheid need to approve this beforehand?*
You must have the prior written permission of Zorg en Zekerheid for a limited number of procedures. These procedures are included in the list of DTC care products which require permission. You can consult this list on **zorgenzekerheid.nl**. The granting of permission may be subject to further medical conditions.

*What am I not entitled to?*
- stomach liposuction;
- the surgical placement of a breast prosthesis other than after a complete or partial mastectomy or agenesia/aplasia of the breast if you are a woman and a comparable situation if you are a transgender woman;

- the surgical replacement of a breast prosthesis other than after a complete or partial mastectomy;
- the surgical removal of a breast prosthesis if doing so is not medically necessary;
- abdominal wall surgery, unless, for example, in the case of a mutilation the seriousness of which can be compared to a third-degree burn, untreatable blemishes in the skin creases or a very serious restriction in the freedom of movement.

Some medical specialist treatments are not covered by the basic insurance. For a few treatments, Zorg en Zekerheid has included reimbursement in a number of its supplementary insurance policies. For more information, consult **zorgenzekerheid.nl/brochures** for the policy conditions of the supplementary insurance policies under Medical Specialist Assistance.

In addition, Zorg en Zekerheid has concluded discount agreements with a number of medical specialist centres for those with supplementary insurance. For more information, go to **zorgenzekerheid.nl/zorgzoeker**.

*What is reimbursed if I go to a non-contracted care provider?*
The costs of care provided by a non-contracted centre for specialist medical care or by a non-contracted care provider are reimbursed up to a maximum 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 6.5 Primary diagnostics

Primary diagnostics consists of laboratory examinations (e.g. blood and urine tests), clarifying diagnostics (e.g. X-rays) and functional examinations (e.g. ECGs). Primary diagnostics are requested by a primary care provider, in which case the results of the tests are communicated to the primary care provider in question.

*What am I entitled to?*
You are entitled to first-line diagnostics examination provided it is carried out by:
- a general practitioner practice;
- a primary diagnostics centre (EDC);
- a hospital or ZBC;
- a midwife or obstetrician (see Article 7 for the applicable conditions).

*What are the conditions?*
The general practitioner must have issued a request for all primary diagnostics.

Additionally, the request may be issued by:
- the obstetrician/midwife for prenatal screening (see Article 7);
- the company doctor for diagnostics in the event of work-related conditions;
- the Municipal Health Service doctor for individual care in the case of tuberculosis and infectious diseases.

*What is reimbursed if I go to a non-contracted care provider?*
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 7: Obstetric care and maternity care

### 7.1 Prenatal screening

Prenatal screening comes under the Population Screening Act (Wet op het bevolkingsonderzoek, WBO). For the specific components of prenatal screening referred to below, the care provider concerned must have signed an agreement with one of the Regional Centres for Prenatal Screening, unless there are medical grounds. These centres have a WBO licence and meet the quality requirements to which the care provider concerned is subject.

*What am I entitled to?*
You are entitled to prenatal screening (this reimbursement applies only to female insured persons). The screening covers the following components:
- counselling by the obstetrician, the general practitioner actively involved in obstetrics or a medical specialist attending the insured person throughout the pregnancy. This is understood to mean: obtaining information that allows a well-considered decision to be made with respect to whether prenatal screening should be performed;
- structural ultrasound screening, also known as the '20-week ultrasound';
- all pregnant insured persons who have had a combination test (comprising a nuchal translucency and blood test) or a Non-Invasive Prenatal Test (NIPT) with a 'positive' have an indication for follow-up examination, including invasive diagnostics. The costs of the combination test are for the account of the woman concerned (with the exception of women who have a 'medical indication').

Some of our supplementary insurance policies include a reimbursement for a combination test for women. For the applicable reimbursements, check **zorgenzekerheid.nl/vergoedingenzoeker** for the policy conditions for the supplementary insurance policies under delivery-related care.

*What is reimbursed if I go to a non-contracted care provider or institution?*
Costs of prenatal screening provided by a non-contracted care provider or care institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 7.2 Delivery and obstetric care

Female insured persons and their children are entitled to obstetric care as provided by obstetricians and general practitioners active in obstetrics. With regard to this care, the following situations may occur:

#### Delivery and/or post-natal care on medical grounds in a hospital

*What am I entitled to?*
You are entitled to:
- medical specialist (obstetric) care, as referred to in Article 6, in combination with treatment and nursing as well as a stay in the hospital or otherwise. This applies to the mother and (commencing on the day of the delivery) her child;
- hospital accommodation, if the hospitalised mother is nursing her healthy infant (breast feeding), for as long as Zorg en Zekerheid is liable to reimburse the mother for the hospitalisation and treatment costs.

*What are the conditions?*
There must be a medical necessity for the stay in the hospital in the opinion of the obstetrician, the general practitioner or the medical specialist.

*Do I need a referral?*
A specific referral by an obstetrician or general practitioner is required.

*What else do I need to know?*
If mother and child leave the hospital together before the post-natal period (the period of ten days from the day of delivery) has expired, they will retain an entitlement to the remaining days of post-natal care with due observance of the provisions in Article 7.3.

*What is reimbursed if I go to a non-contracted care provider or institution?*
Costs of care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

#### Delivery and/or post-natal care without medical grounds in a hospital or birth centre

*What am I entitled to?*
Commencing on the date of delivery, you are entitled to:
- obstetric care (including pre and after care) by an obstetrician or a general practitioner active in obstetrics;
- the use of the hospital's delivery room or birth centre during the delivery.

*Do I need to pay a personal contribution?*
For delivery and/or post-natal care without medical grounds in a hospital or birth centre, both mother and child are subject to a personal contribution of €34 per day in the hospital (€17 for the mother and €17 for the child). The personal contribution is increased by the amount that exceeds the hospital fee (€245: €122.50 for the mother and €122.50 for the child) per day. The number of days in the hospital is determined based on specifications from the hospital or from the birth centre and/or maternity bureau that will be providing any additional maternity care following discharge from the hospital or birth centre. If the baby is ultimately delivered by a medical specialist (transfer to a gynaecologist during delivery), the personal contribution will cease to apply.

*Does the personal contribution count towards the excess?*
This personal contribution does not count towards the excess applicable in the policy.

Most of our supplementary insurance policies include a reimbursement for this personal contribution. Consult **zorgenzekerheid.nl/vergoedingenzoeker** for the policy conditions of the supplementary insurance policies under Delivery-related care.

*What else do I need to know?*
If mother and child leave the hospital or birth centre together before the post-natal period (the period of ten days from the day of delivery) has expired, they will retain an entitlement to the remaining days of post-natal care.

*What is reimbursed if I go to a non-contracted care provider or institution?*
Costs of care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### Delivery and/or post-natal care at home

*What am I entitled to?*
You are entitled to obstetric care (including pre and after care) charged by the midwife or the general practitioner active in obstetrics.

*What is reimbursed if I am helped by a non-contracted care provider?*
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 7.3 Maternity care

*What am I entitled to?*
We reimburse the costs (incurred by female policyholders and their newborn children) of maternity care as provided by maternity carers, provided by a qualified maternity carer or an O&G nurse. The maternity care consists of the registration and intake by the maternity centre, midwife assistance in the event of delivery at home and the maternity care in accordance with the Landelijk Indicatieprotocol Kraamzorg (National Indication Protocol for Maternity Care).

The degree of maternity care to be provided depends on your personal situation following the delivery. The number of hours of maternity care that you will receive will be determined, in consultation with you, by the obstetrician or gynaecologist based on the National Indication Protocol for Maternity Care.

*What are the conditions?*
- Maternity care registrations must be submitted via the 'Zorg en Zekerheid Maternity Line' (telephone number: (071) 5 825 555) of via **zorgenzekerheid.nl** zoek op kraamzorg, uiterlijk in de 20e week van de zwangerschap;
- In the event of a stay in hospital: if mother and child leave the hospital together before the post-natal period (the period of ten days from the day of delivery) has expired, they will retain an entitlement to the remaining days of post-natal care in accordance with the National Indication Protocol for Maternity Care. The day of discharge is not counted as a day in hospital.
- The maternity care must be provided under the auspices of a maternity centre on the instruction of the 'Zorg en Zekerheid Maternity Line'.
- The maternity care must be provided by a maternity carer who is affiliated with a maternity centre.

Zorg en Zekerheid offers reimbursement for supplementary maternity care in most of its supplementary insurance policies. For the applicable reimbursements, check **zorgenzekerheid.nl/vergoedingenzoeker** for the policy conditions for the supplementary insurance policies under delivery-related care.

*Do I need to pay a personal contribution?*
Policyholders pay a personal contribution of €4.30 per hour towards the costs of maternity care.

*Does the personal contribution count towards the excess?*
This personal contribution does not count towards the excess applicable in the policy.

Most of our supplementary insurance policies include a reimbursement for this personal contribution. Consult **zorgenzekerheid.nl/vergoedingenzoeker** for the policy conditions of the supplementary insurance policies under Delivery-related care.

*What is reimbursed if I go to a non-contracted care provider or institution?*
Costs of maternity care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 8: Rehabilitation

### 8.1 Rehabilitation

*What am I entitled to?*
We reimburse the costs of revalidation in a clinical (admission) or non-clinical (part time or day treatment) situation.

*What are the conditions?*
- This care must be designated for the insured person as the most effective type to prevent, reduce or resolve a disability that is the result of disorders or limitations in the ability to move or a disability that is the result of a disorder of the central nervous system that causes limitations in communication, cognition and behaviour.

- The care must enable the policyholder to attain or retain a certain degree of independence which is reasonably possible in the light of the insured person's limitations.
- For eligibility to clinical rehabilitation, there must be an expectation that better results will be achieved in the short term with clinical rehabilitation rather than with non-clinical rehabilitation.

### 8.2 Geriatric rehabilitation

*What am I entitled to?*
You are entitled to geriatric rehabilitation that originates in:
- admission to hospital, possibly followed by part-time or day treatment at home (ambulant geriatric rehabilitation); or:
- the situation at home (within a week following the geriatric assessment).

*What are the conditions?*
- The care comprises integral and multidisciplinary rehabilitation care as generally provided by geriatric care specialists in connection with vulnerability, complex multi-morbidity and reduced learning and training ability.
- The aim of geriatric rehabilitation is to reduce functional impairments so as to enable the patient to return to the home situation.
- An indication of geriatric rehabilitation is deemed to be present if the insured person suffers from an acute condition that results in equally acute mobility disorders and/or a deterioration in the patient's ability to care for themselves. This is to be determined by the geriatric internist and/or the clinical specialist in geriatric medicine following a written referral from the hospital's medical specialist.
- The care follows (either immediately or within a week after discharge from hospital of a patient with an indication for rehabilitation) and is initially accompanied by a stay in connection with medical care such as provided by medical specialists (a hospital admission).
- You are not entitled to geriatric rehabilitation if prior to your hospitalisation you were admitted to a Wlz institution where you received treatment under the Exceptional Medical Expenses Act (AWBZ) or the Long-Term Care Act (Wlz).
- The total duration of the treatment should not exceed six months. In exceptional cases, Zorg en Zekerheid may permit an extended period.

*Does Zorg en Zekerheid need to approve this beforehand?*
Continuation of treatment of an indication which takes, or is expected to take, longer than 120 days from the 121th day requires prior written approval (which must be applied for at least four weeks before the end of the first 120 days) from Zorg en Zekerheid.

### 8.3 Non-contracted rehabilitation

*What is reimbursed if I go to a non-contracted institution?*
Costs of care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

*Do I need prior permission from Zorg en Zekerheid if I go to a non-contracted care institution?*
In order for Zorg en Zekerheid to determine whether you are eligible for care, you should apply for prior permission in writing if you intend to go to a non-contracted rehabilitation institution. This does not apply to geriatric rehabilitation.

## Article 9: Organ transplants

*What am I entitled to?*
You are entitled to:
- transplants of issue and organs if the transplant is carried out in an EU or EEA country or in another country if the donor resides in that country and is your spouse, registered partner or blood relative in the first, second or third degree;
- any medical specialist care provided in relation to the selection of a donor and in connection with the operative removal of the transplant parts from the selected donor;
- the examination, preservation, removal and transport of the post-mortem transplant material in connection with the intended transplant;
- medical care to which the donor is entitled under this policy for no more than thirteen weeks, or six months in the case of a liver transplant following the date of discharge from the hospital where the donor was admitted for the purposes of selection or removal of the transplant part. The care must be connected with an organ transplant covered by this insurance;
- transport in the Netherlands by means of public transport at the lowest available fare, or, if and to the extent medically necessary, transport by car, in connection with the selection, admission to and discharge from the hospital and with the care referred to in the previous full sentence. If the donor has a medical insurance, the costs of this type of transport will be payable by the donor's medical insurance;
- Travel to and from the Netherlands by a donor resident abroad in connection with a kidney, bone marrow or liver transplant carried out for an insured person in the Netherlands as well as other costs incurred due to the transplant

and connected with the donor's residence abroad. If the donor has a medical insurance, the costs of this type of transport will be payable by the donor's medical insurance.

*Which costs do not qualify for reimbursement?*
Accommodation costs in the Netherlands incurred by the donor residing abroad are not reimbursed and neither is any loss of earnings incurred by the donor.

*What is reimbursed if I go to a non-contracted institution?*
Costs of care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 10: Dialysis

*What am I entitled to?*
In the event of non-clinical haemodialysis and peritoneal dialysis as well as the associated medical specialist care provided in a dialysis centre, you are entitled to:
- the accompanying examinations, treatment, nursing and pharmaceutical care;
- psychosocial care provided by the dialysis centre as well as assistance provided by persons who assist with administering dialysis treatment in any other place than a dialysis centre.

In the event of home dialysis and in addition to the entitlements referred to above, you are entitled to:
- alterations made in and to the home and restoring it to its original condition insofar as we deem these expenses to be reasonable and no provision is made for them in any other statutory regulation;
- any other costs which are directly related to home dialysis treatment insofar as we deem such costs to be reasonable and no provision is made for them in any other statutory regulation.

In the event of home dialysis and in addition to the entitlements referred to above (covered by the DTC), you are also entitled to:
- training provided by the dialysis centre of persons performing or assisting with the dialysis;
- the reimbursement of costs associated with lending out dialysis equipment and accessories, or regularly monitoring and maintaining it (including replacement), and the chemicals and fluids required for the performance of the dialysis treatment;
- the required professional assistance provided by the dialysis centre during a dialysis;
- other items that are reasonably required to perform home dialysis.

*Does Zorg en Zekerheid need to approve this beforehand?*
You require the advance written permission of Zorg en Zekerheid to be reimbursed for non-medical costs associated with home dialysis, to which further (administrative) conditions may apply.

*What is reimbursed if I go to a non-contracted institution?*
Costs of care provided by a non-contracted institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 11: Mechanical respiration

*What am I entitled to?*
You are entitled to the necessary mechanical respiration and the associated medical specialist and pharmaceutical care, accommodation, nursing and care in a recognised respiration centre.

In the event of necessary mechanical respiration at home, you are entitled to:
- the supply by the respiration centre of the equipment necessary, ready to use, for each treatment provided to the insured person;
- the medical specialist and pharmaceutical care to be provided by a respiration centre in connection with the mechanical respiration.

*What are the conditions?*
Respiration treatment at the home of the policyholder must be carried out under the supervision of a respiration centre.

*What am I not entitled to?*
Nursing that is necessary in connection with artificial respiration at home, within this article.

*What is reimbursed if I go to a non-contracted institution?*
The costs of care provided by a non-contracted centre for mechanical respiration are reimbursed up to a maximum

80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 12: Oncological disorders in children

*What am I entitled to?*
You are entitled to centralised (referential) diagnosis, coordination and registration of submitted blood and bone marrow products, declared by SKION (Stichting Kinderoncologie Nederland or the Dutch Child Oncology Group).

*Do I need a referral?*
You require a written referral from the general practitioner or medical specialist.

## Article 13: Thrombosis service

*What am I entitled to?*
You are entitled to the following services provided by the thrombosis service:
- regular blood samples;
- necessary laboratory tests to ascertain the coagulation time of the blood, carried out or arranged by the thrombosis service;
- provision of equipment and accessories for measuring the coagulation time of your blood;
- training you in the use of the equipment referred to in the point above as well as supervising for measurements;
- giving you advice on the use of coagulants or anti-coagulants.

*Do I need a referral?*
A referral by a general practitioner or medical specialist is required.

What is reimbursed if I go to a non-contracted institution?
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 14: Advice for hereditary issues

*What am I entitled to?*
You are entitled to:
- centralised (referential) diagnosis, coordination and registration of submitted blood and bone marrow products, declared by a centre for heredity testing. The care comprises tests to establish and determine the extent of genetic disorders by means of family trees, chromosome tests, biochemical diagnostics, ultrasound and DNA tests;
- advice on genetic issues and psychosocial assistance associated with this type of care;
- advice from and tests conducted on other persons if required in the context of providing advice to the insured party.

*What are the conditions?*
The treatment must be performed at a centre for advice on hereditary issues that holds a licence for the application of clinical genetic testing and advice on hereditary issues under the Specialist Medical Practice Act (WBMV).

*Do I need a referral?*
A referral from your general practitioner or medical specialist is required.

*What is reimbursed if I go to a non-contracted institution?*
The costs of care provided by a non-contracted centre for mechanical respiration are reimbursed up to a maximum 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 15: Audiological care

*What am I entitled to?*
You are entitled to care provided by an audiological centre consisting of:
- an examination of auditory function;
- advice about hearing aids to be purchased;
- information about the use of hearing aids;
- psychosocial care if necessary in connection with problems associated with impaired hearing;
- assistance in diagnosing speech and language disorders in children.

*Do I need a referral?*
You must be referred by a general practitioner, company doctor, paediatrician, school doctor or an ear, nose and throat (ENT) specialist.

*What is reimbursed if I go to a non-contracted institution?*
The costs of care provided by a non-contracted audiology centre are reimbursed up to a maximum 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 16: Fertility-related care

### 16.1 IVF

*What am I entitled to?*
We reimburse the costs of the first three IVF attempts to become pregnant per treated female policyholder (including the medicine).

*What are the conditions?*
- There must be medical grounds.
- The female insured person must be less than 43 years old when the attempt is initiated.
- An insured person who is over 43 years old and who made the IVF attempt before she reached the age of 43 is entitled to have the attempt completed.
- If the female insured person is younger than 38 a maximum of one embryo will be returned in a first or second attempt.
- If the female insured person is between 38 and 42 years of age, two embryos will be returned in a first or second attempt, if this is justified on medical grounds.
- The treatment must be performed in an IVF centre licensed to apply IVF treatments under the Special Medical Procedures Act (Wbmv).

*Do I need a referral?*
You must be referred by your general practitioner.

*What am I not entitled to?*
The costs of a fourth and subsequent IVF attempt(s) per potential pregnancy after three attempts have been made between a successful follicle puncture and the time when a pregnancy has been continuous for ten weeks, counting from the time of the follicle puncture, and if the implantation of cryopreserved embryos did not result in a continuous pregnancy of nine weeks and three days, counting from the implantation, are not compensated.

*What else do I need to know?*
- If the IVF attempt results in the creation of multiple viable embryos, these may be deep-frozen and returned at a later time. These returned embryos will then be viewed as a part of the IVF attempt that led to their creation.
- An achieved pregnancy is understood to mean:
  a. a continuous pregnancy of at least twelve weeks, calculated from the first day of the final menstruation before a spontaneous (physiological) pregnancy;
  b. a continuous pregnancy of at least ten weeks after the follicle puncture in the event of IVF (with respect to cryo-embryos, the ten-week period does not start with the puncture, but with the time of the implantation and the term ‘continuous pregnancy’ first applies after nine weeks and three days).

### 16.2 Other fertility-related care

*What am I entitled to?*
You are entitled to receive fertility-related care other than IVF attempts.

*What are the conditions?*
- There must be medical grounds.
- The female insured person must be less than 43 years old.

*Do I need a referral?*
You must be referred by your general practitioner.

### 16.3 Non-contracted fertility-related care

*What is reimbursed if I go to a non-contracted institution?*
Costs of care provided by a non-contracted licensed institution are reimbursed up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 17: Paramedical care

### 17.1. General

Entitlement to paramedical care includes physiotherapy, remedial therapy, dietary advice, occupational therapy and speech therapy. Paramedical care also comprises specialised treatments within these types of care. The scope of this care is limited to the usual paramedical care generally provided by physiotherapists, remedial therapists, dieticians, occupational therapists and speech therapists. Appendix 1 to the Healthcare Insurance Decree forms part of these insurance conditions: we will send it to you at your request; alternatively, you can consult it on **zorgenzekerheid.nl/brochures**.

### 17.2 General terms and conditions for physiotherapy and/or remedial therapy (also apply to 17.3 and 17.4)

- The physiotherapy treatment must be performed by a physiotherapist.
- The remedial therapy treatment must be performed by a remedial therapist.
- In case of oedema and/or scar therapy, the treatment may also be performed by a skin therapist.
- The physiotherapist, remedial therapist and skin therapist must be registered in the Central Quality Register for Physiotherapy, the Physiotherapy Quality Mark or the Quality Register for Paramedics (quality registered status).
- In the event of a manual therapy, child physiotherapy, pelvic physiotherapy, oedema therapy or geriatric physiotherapy session, the treatment must be performed by a physiotherapist who is registered for the relevant specialty in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark.
- In the event of a child remedial therapy session, the treatment must be performed by a remedial therapist who is registered in the Quality Register for Paramedics (quality registered status).
- A chronic disorder should be listed in Appendix 1 to the Healthcare Insurance Decree. Reimbursement for treatments for a number of disorders is limited to the duration of the treatment or by age, as indicated in Appendix 1 to the Healthcare Insurance Decree.
- In the case of a chronic condition, the physiotherapy or remedial therapy must be medically necessary and prescribed by an attending physician. A referral is required; for details see 17.3 and 17.4.
- The physiotherapeutic or remedial therapeutic care consists of ‘deliverables’. Each deliverable counts as one treatment. This means that, for example, a ‘screening’ and an ‘intake and examination following screening’ also qualify as one treatment each.
- Every treatment programme starts with a ‘screening’ and an ‘intake and examination following screening’ or with ‘screening, intake and examination’ or ‘intake and examination following referral’.
- Reimbursement may be claimed for a maximum of one physiotherapy or remedial therapy session per day, unless:
  a. there is a medical necessity to schedule multiple sessions on one day (as determined by a doctor), those sessions are suitably spread over time and Zorg en Zekerheid has given the therapist its prior written approval; the treatment session concerns ‘screening’, ‘screening and intake and examination’, ‘intake and examination following screening’ or ‘intake and examination following referral’. Combined with specific deliverables, these deliverables can be provided on one and the same day. Your therapist will know which deliverables qualify;
- If your treatment consists of group sessions you will not be entitled to reimbursement for individual sessions that apply to the same condition, whether or not given by a different physiotherapist and/or remedial therapist. This does not apply if individual sessions are included in the group treatment and used as a baseline measurement, interim evaluation and/or final measurement.
- In special cases you will need prior written approval from Zorg en Zekerheid for physiotherapy and/or remedial therapy. This concerns the following indications (Appendix 1 to the Healthcare Insurance Decree):
  a. Div D5 Rehabilitation (day) treatment, 12 months following discharge;
  b. Div D5 Admission to nursing home, 12 months following discharge;
  c. Div D5 Admission to hospital, 12 months following discharge;
  The request for permission from Zorg en Zekerheid must be submitted by your attending physiotherapist or remedial therapist.
- Treatments provided during the session, such as shockwave and dry needling, are part of the standard treatment and may not be separately invoiced by the physiotherapist and/or remedial therapist.
- The costs of auxiliary materials and bandages provided during the session are part of the treatment and may not be separately invoiced by the physiotherapist and/or remedial therapist.
- In the case of treatment for intermittent claudication, your physiotherapist or remedial therapist must be affiliated with ClaudicatioNet.
- As regards treatment for Parkinson’s disease and Parkinsonisms, your physiotherapist or remedial therapist must be affiliated with ParkinsonNet.
- In the case of child physiotherapy treatment, the condition must fall within the Child Physiotherapy Domain Description published by the Netherlands Association for Child Physiotherapy (NVFK). The child physiotherapist will be familiar with this list.
- In the case of manual therapy treatment, the condition must fall within the Manual Therapy Domain Description published by the Netherlands Association for Manual Therapy (NVMT). The physiotherapist will be familiar with this list.
- In the case of pelvic physiotherapy treatment, the condition must be consistent with the guidelines laid down by the Dutch Association for Physical Therapy for Pelvic Floor Disorders (NVFB).
- In the case of geriatric physiotherapy treatment, the condition must be included in the list of criteria drawn up by the Dutch Association for Physiotherapy in Geriatrics (NVFG).

## 17.3 Physiotherapy and/or remedial therapy for insured persons under age 18

### Chronic disorders

*What am I entitled to?*
You are entitled to treatments that are medically necessary per insured person per calendar year as indicated in Appendix 1 to the Healthcare Insurance Decree, physical therapy and/or remedial therapy.

*Do I need a referral?*
You require a written referral from a doctor if you need treatment for a disorder that is included on the List of Chronic Disorders.

### Non-chronic disorders

*What am I entitled to?*
You are entitled to:
- a maximum of nine (child) physiotherapy and/or remedial therapy treatments per disorder per calendar year;
- in the event of an unsatisfactory result at the end of these treatments, each insured person is entitled to an additional nine (child) physiotherapy and/or remedial therapy treatments per referral per calendar year.

*Do I need a referral?*
No, the physiotherapist can be consulted directly.

*What are the conditions?*
All primary physiotherapy sessions, also if provided by a skin or remedial therapist, count towards he maximum numbers mentioned above. This also applies to primary care sessions that were provided in a hospital or institution.

Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement that you receive on account of your basic insurance. For more information, please refer to the policy conditions for the supplementary insurance policies under Paramedical Treatments.

### Non-contracted physiotherapy and/or remedial therapy

What is reimbursed if I go to a non-contracted physiotherapist, remedial therapist or skin therapist?
Costs of care provided by a non-contracted physiotherapist, remedial therapist or skin therapist (oedema or scar therapy) are reimbursed up to 80% of the prevailing Dutch market rate.

## 17.4 Physiotherapy and/or remedial therapy for insured persons from age 18

### Chronic disorders

*What am I entitled to?*
You are entitled to:
- the medically necessary treatments for physiotherapy and/or remedial therapy in the event of conditions included in Appendix 1 to the Health Insurance Decree (the List of Chronic Disorders), to the extent the specified term has not been exceeded; the treatment of 'skin scar tissue following a trauma or otherwise', carried out by either a physiotherapist or skin therapist;
- reimbursement for a maximum of 37 supervised ambulatory training sessions per year in the case of stage 2 peripheral artery disease (intermittent claudication);
- reimbursement for a maximum of 12 supervised remedial therapy sessions in the case of abrasion of the hip or knee joint over a period of no more than 12 months.

*What are the conditions?*
All primary physiotherapy sessions, also if provided by a skin therapist or remedial therapist, count towards the maximum numbers mentioned above. This also applies to primary care sessions that were provided in a hospital or institution.

*Do I need a referral?*
If your condition is on the List of Chronic Disorders, you will need a written referral from a physician before you can start the treatment.

*What am I not entitled to?*
the first 20 physiotherapy and/or remedial therapy treatments in the event of an initial series of treatment sessions on chronic medical grounds. This does not apply to treatment for intermittent claudication and abrasion of the hip or knee joint;
reimbursement for the first 20 physiotherapy and/or remedial therapy treatments in the event of an existing series of treatment sessions for a chronic condition in patients who turn 18. This does not apply to treatment for intermittent claudication and abrasion of the hip or knee joint.

### Non-chronic disorders

What am I entitled to?
You are entitled to the first nine sessions of pelvic physiotherapy for urine incontinence, provided this therapy is part of a 'stepped care' programme.

*What are the conditions?*
All primary physiotherapy sessions count towards the maximum numbers mentioned above. This also applies to primary care sessions that were provided in a hospital or institution.

*Do I need a referral?*
No, the physiotherapist can be consulted directly.

> Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement that you receive on account of your basic insurance. For more information, please refer to the policy conditions for the supplementary insurance policies under Paramedical Treatments.

*What is reimbursed if I go to a non-contracted physiotherapist, remedial therapist or skin therapist?*
Costs of care provided by a non-contracted physiotherapist, remedial therapist or skin therapist (oedema or scar therapy) are reimbursed up to 80% of the prevailing Dutch market rate.

## 17.5 Occupational therapy

*What am I entitled to?*
You are entitled to occupational therapy for a maximum of ten treatment hours per insured person per calendar year.

> A number of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement that you receive on account of your basic insurance. For more information, refer to the policy conditions for the supplementary insurance policies under Occupational Therapy.

*What are the conditions?*
- The treatment must be performed by an occupational therapist.
- The occupational therapist must be registered in the Quality Register for Paramedics (quality registered status).
- The objective of the occupational therapy is to promote and restore the insured person's ability to care for themselves and to do things independently.
- All primary occupational therapy treatments count towards the specified maximum number of treatment hours, including primary treatment sessions in a hospital or institution.
- Every treatment programme starts with a 'screening' and an 'intake and examination following screening' or with a 'screening, intake and examination' or 'intake and examination following referral'.
- Reimbursement may be claimed for a maximum of one remedial therapy session per day, unless:
  a. There is a medical necessity to schedule multiple sessions on one day (as determined by a doctor), those sessions are suitably spread over time and Zorg en Zekerheid has given the therapist its prior written approval.
  b. The treatment session concerns 'screening', 'screening and intake and examination', 'intake and examination following screening' or 'intake and examination following referral'. Combined with specific deliverables, these deliverables can be provided on one and the same day. Your therapist will know which deliverables qualify.
- The treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your occupational therapist is affiliated with ParkinsonNet.

*Do I need a referral?*
No, remedial therapists can be consulted directly.

*What is reimbursed if I go to a non-contracted occupational therapist?*
The costs of care provided by a non-contracted occupational therapist are reimbursed up to a maximum of 80% of the prevailing Dutch market rate.

## 17.6 Speech therapy

*What am I entitled to?*
You are entitled to speech therapist treatment.

*What are the conditions?*
- The treatment must be performed by a speech therapist.
- The treatment must serve a medical purpose.
- The treatment can be expected to restore or improve the speech function or the ability to speak.
- The occupational therapist must be registered in the Quality Register for Paramedics (quality registered status).
- Every treatment programme starts with a 'screening' and an 'intake and examination following screening' or with 'screening, intake and examination' or 'intake and examination following referral'.

- In the case of aphasia, preverbal speech therapy or stuttering the treatment must be provided by a speech therapist registered in the quality register maintained by the Dutch Association for Speech Therapy and Phoniatrics (quality registered status).
- Reimbursement may be claimed for a maximum of one speech therapy session per day, unless:
  a. there is a medical necessity to schedule multiple sessions on one day (as determined by a doctor), those sessions suitably spread over time and Zorg en Zekerheid has given the therapist its prior written approval;
  b. the treatment session concerns 'screening', 'screening and intake and examination', 'intake and examination following screening' or 'intake and examination following referral'. Combined with specific deliverables, these deliverables can be provided on one and the same day. Your therapist will know which deliverables qualify;
  c. the treatment is in accordance with the Hänen programme for parents. In addition to this programme, simultaneous treatment for another indication may be started for the same insured person.
- All primary speech therapy treatments count towards the specified maximum number of treatment hours, including primary treatment sessions in a hospital or institution.
- The treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your speech therapist is affiliated with ParkinsonNet.

*Do I need a referral?*
No, speech therapists can be consulted directly.

*What am I not entitled to?*
- Speech therapy treatment does not include the treatment of dyslexia and language development problems (due to dialect or having a different first language). If only your command of Dutch is substandard and Dutch is your second language, there is no development problem but an issue concerning the learning of a second language, which does not qualify for reimbursement by Zorg en Zekerheid.
- Speech therapy treatments provided at school are not eligible for reimbursement.
- If your treatment consists of group sessions you will not be entitled to reimbursement for individual sessions that apply to the same condition, whether or not given by a different speech therapist. This does not apply if individual sessions are included in the group treatment and used as a baseline measurement, interim evaluation and/or final measurement.

*What is reimbursed if I go to a non-contracted speech therapist?*
Costs of care provided by a non-contracted speech therapist are reimbursed up to a maximum of 80% of the prevailing Dutch market rate.

### 17.7 Dietary advice
*What am I entitled to?*
You are entitled to receive dietary advice provided with a medical objective, to a maximum of three treatment hours per calendar year.

A number of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement received on account of basic insurance to persons who are overweight or underweight. For the applicable reimbursements, check **zorgenzekerheid.nl/vergoedingenzoeker** for the policy conditions for supplementary insurance policies under preventative training courses.

*What are the conditions?*
- The treatment must be performed by a dietician.
- The dietician must be registered in the Quality Register for Paramedics (quality registered status).
- All primary dietary advice sessions count towards the specified maximum number of treatment hours, including primary treatment sessions in a hospital.
- The treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your dietician is affiliated with ParkinsonNet.
- Every treatment programme starts with a 'screening' and, possibly, an 'intake and examination following screening' or with a 'screening, intake and examination' or 'intake and examination following referral'.

*Do I need a referral?*
No, the dietician can be consulted directly.

*What am I not entitled to?*
Dietary advice for the indications diabetes, COPD or CVRM may be part of coordinated multidisciplinary care procured from a care group. If you receive your dietary advice via coordinated multidisciplinary care, you are not entitled to the afore-mentioned three hours of dietary advice treatment for the same indication or for a related issue.

*What is reimbursed if I go to a non-contracted dietician?*
Costs of care provided by a non-contracted dietician are reimbursed up to a maximum of 80% of the prevailing Dutch market rate.

### 17.8 Electrical epilation or laser treatment for transsexuals

*What am I entitled to?*
You are entitled to electrical epilation and/or laser treatment of the beard (face and neck).

*What am I not entitled to?*
You are not entitled to epilation of body and limbs.

*What are the conditions?*
- The treatment must be performed by a qualified skin therapist.
- The skin therapist must be registered in the Quality Register for Paramedics (quality registered status).

*Do I need a referral?*
No, the skin therapist can be consulted directly.

*Does Zorg en Zekerheid need to approve this beforehand?*
Reimbursement of more than ten electrical epilation and or laser treatment sessions for transsexuals requires prior written approval (requested by the therapist) from Zorg en Zekerheid.

*What is reimbursed if I go to a non-contracted skin therapist?*
Costs of care provided by a non-contracted skin therapist are reimbursed up to a maximum of 80% of the prevailing Dutch market rate.

## Article 18: Oral care

### 18.1 General provisions

*What am I entitled to?*
- Oral care comprises care as generally provided by dentists, on the understanding that it may only relate to dental care that is necessary.
- The oral care may only be provided by a legally authorised care provider such as a dentist, dental surgeon, orthodontist, dental technician and oral hygienist.

What am I not entitled to?
- The covered oral care does not include treatments that are unnecessarily expensive, unnecessarily complicated or not effective from a dental care perspective.
- Prosthetics produced and declared by a dental technician are not eligible for reimbursement.

### Oral care provided by another dental surgery

Written notification from the general practitioner or specialist is required for entitlement to reimbursement for the costs of oral care performed where the insured person is staying (i.e., somewhere other than the location where the care provider ordinarily conducts his or her practice).

*What is reimbursed if I go to a non-contracted care provider?*
The costs of full dentures, supported by implants or otherwise, provided by a non-contracted care provider are reimbursed up to a maximum of 80% of the prevailing Dutch market rates.

For a complete overview of contracted care providers, please consult **zorgenzekerheid.nl/zorgzoeker**.

### 18.2 Oral care under age 18

*What am I entitled to?*
If you visit an independent oral hygienist, you are entitled to:
a. periodic, preventative dental checks once a year, unless the insured person requires that particular dental care more than once a year;
b. incidental dental consultations;
c. removal of tartar;
d. application of fluoride to insured persons from the onset of the permanent teeth, no more than twice per year, unless the insured person requires that particular dental care more than twice per year;
e. fissure sealing;
f. periodontal assistance.

For details on treatments and the associated performance codes that qualify for reimbursement, consult the document entitled Reimbursements for treatment by independent oral hygienists - supplementary insurance, at **zorgenzekerheid.nl/brochures**.

If you visit the remaining care providers as listed in Article 18.1 you are entitled to:
a. periodic, preventative dental checks once a year, unless the insured person requires that particular dental care more than once a year;
b. incidental dental consultations;
c. removal of tartar;
d. application of fluoride to insured persons from the onset of the permanent teeth, no more than twice per year, unless the insured person requires that particular dental care more than twice per year;
e. fissure sealing;
f. periodontal assistance;
g. anaesthesia;
h. endodontic assistance, with the exception of external whitening;
i. restoration of tooth sections with plastic materials;
j. treatment for complaints of the jaw joint (gnathological aid);
l. dental surgery performed by a dentist or a dental surgeon with the exception of the fitting of a dental implant;
m. X-rays, except for orthodontic purposes;
n. removable prosthetics, not on implants, for the upper and/or lower jaw (including repairs and rebasing);
o. oral care in special cases as referred to in Article 18.4;
d. medically required stay as referred to in Article 18.5.

*What am I not entitled to?*
- crowns and bridges;
- orthodontic care with the exception of Article 18.4.

Most of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement for oral care that you receive on account of your basic insurance. For more information, refer to the policy conditions for the supplementary insurance policies under 'Oral care'.

*What reimbursement is there for oral care performed outside regular surgery hours?*
Insured persons under age 18 are only entitled to reimbursement for oral care conducted outside of regular surgery hours if the provision of such care cannot be reasonably delayed until another day.

*Does Zorg en Zekerheid need to approve this beforehand?*
- Insured persons require prior written permission from Zorg en Zekerheid for entitlement to reimbursement for the costs of care as referred to in Article 18.2(k) if it concerns an extraction under anaesthesia or osteotomy.
- Written permission is also required for a general X-ray of the jaw.
- Written permission is also required for oral care in special cases as referred to in Article 18.4.
- Written permission is also required if the full dentures (with the exception of an immediate denture) is replaced within five years of its purchase.

A written application to obtain permission from Zorg en Zekerheid must include a supporting letter from the dentist, dental surgeon or centre for special dentistry, as well as a written treatment plan and an estimate of the costs involved.

Permission may be revoked if:
- the oral care is no longer necessary;
- the insured person does not follow the care provider's instructions;
- the insured person seriously neglects his or her dental hygiene;
- another care provider takes over the treatment;
- treatment other than that for which permission was granted is performed.

### 18.3 Oral care from age 18
*What am I entitled to?*
You are entitled to:
a. oral care in special cases as referred to in Article 18.4;
b. surgical dental assistance of a specialist nature and the accompanying X-ray examination, with the exception of periodontal surgery, placement of a dental implant and simple extractions, unless in the case of oral care in special cases as referred to in Article 18.4;
c. removable full dentures for the upper and/or lower jaw, whether or not supported on dental implants (this includes the fitting of the fixed part of the suprastructure), unless in the case of oral care in special cases as referred to in Article 18.4;
d. a medically required stay as referred to in Article 18.5.

Most of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement for oral care that you receive on account of your basic insurance. For more information, refer to the policy conditions for the supplementary insurance policies under 'Oral care'.

*Do I need to pay a personal contribution?*
The following personal contributions apply to prosthetics:
- Reimbursement for a full dental prosthesis supported by an implant as referred to in Article 18.3(b) amounts to 75% of the amount for contracted care for insured persons from age 18. The remaining 25% is your personal contribution. For an implant-supported prosthesis this applies to the prosthetic part including the fixed part of the suprastructure:
  · when supported by implants in the lower jaw, the maximum reimbursement amounts to 90% of the contracted rate; the remaining 10% is he personal contribution.
  · When supported by implants in the upper jaw, the maximum reimbursement amounts to 92% of the contracted rate; the remaining 8% is he personal contribution.
- In the case of repair or rebasing of a supported dental prosthesis, the personal contribution amounts to 10% of the amount claimed.
- Insured persons from age 18 are liable to pay a personal contribution for care as stipulated in Article 18.4.1 under a), b) and c). Insofar as this concerns care that is not directly related to a disorder requiring special dental care, insured persons are liable to pay a personal contribution equal to the amount that the relevant insured person would be charged if Section 2.7, paragraph 1 of the Healthcare Insurance Decree would not be applicable.

*Does Zorg en Zekerheid need to approve this beforehand?*
Insured persons from age 18 require the advance written permission of Zorg en Zekerheid for:
- entitlement to care as referred to in Article 18.3(a), if it concerns an extraction under anaesthesia or osteotomy;
- entitlement to care as referred to in Article 18.3(b), if the full dentures not supported by implants (with the exception of immediate dentures) are replaced within five years after purchase;
- entitlement to care as referred to in Article 18.3(b), if the insured person receives treatment from a non-contracted care provider whose rate is higher than the rate agreed with contracted care providers. For a complete overview of contracted dentists, dental technicians and the agreed rates, please consult **zorgenzekerheid.nl**.
- oral care in special cases as referred to in Article 18.4;
- dentures supported by implants;
- all care related to implants provided by a non-contracted care provider.

A written application to obtain permission from Zorg en Zekerheid must be accompanied by a supporting letter from the dentist, dental surgeon (see 6.2 and 6.3) or centre for special dentistry, as well as a written treatment plan and an estimate of the costs involved.
Permission may be revoked if:
- the oral care is no longer necessary;
- the insured person does not follow the care provider's instructions;
- the insured person seriously neglects his or her dental hygiene;
- another care provider takes over the treatment;
- treatment other than that for which permission was granted is performed.

### 18.4 Oral care in special cases
*Does Zorg en Zekerheid need to approve this beforehand?*
Prior written permission from Zorg en Zekerheid is required for oral care as referred to in paragraphs 18.4.1 to 18.4.3 inclusive.

*Do I need to pay a personal contribution?*
In the case of oral care as referred to in paragraphs 18.4.1 to 18.4.3 inclusive, insured persons are liable to pay a personal contribution as provided for in Article 18.3.

### 18.4.1 Oral care in special cases
*What am I entitled to?*
You are entitled to the necessary dental care and dental surgery of a specialist nature and the associated medically necessary accommodation as referred to in Article 18.5 in the following cases:
a. if the insured person has a developmental disorder, growth disorder or acquired defect in the tooth, jaw and mouth system of such severity that, without such care, he or she would not be able to retain or acquire a dental function equal to the one he or she would have had if the disorder had not occurred;
b. if the insured person has a non-dental physical or mental disorder and, without such care, he or she would not be able to retain or acquire a dental function equal to the one he or she would have had if the disorder had not occurred;
c. if medical treatment without such care would have a demonstrably insufficient outcome and, without such additional care, the insured person would not be able to retain or acquire a dental function equal to the one he or she would have had if the disorder had not occurred.

### 18.4.2 Implants in a toothless jaw
*What am I entitled to?*
You are entitled to the placement of a dental implant if you have a seriously shrunken toothless jaw and the implant serves to attach a removable denture.

*Does Zorg en Zekerheid need to approve this beforehand?*
Written permission from Zorg en Zekerheid is required for all care related to implants.

### 18.4.3 Orthodontics in special cases

*What am I entitled to?*
You are entitled to orthodontic assistance only in the case of a severe developmental or growth disorder of the tooth, jaw and mouth system that necessitates additional diagnostics or treatment by disciplines other than the dental discipline.

*What are the conditions?*
The treatment must be performed by an orthodontist.

*Does Zorg en Zekerheid need to approve this beforehand?*
Written permission from Zorg en Zekerheid is required for all orthodontic treatments in special cases. An application to obtain permission from Zorg en Zekerheid must include a supporting letter from orthodontist or centre for special dentistry, as well as a written treatment plan and an estimate of the costs involved.

*Do I need to pay a personal contribution?*
You will not be liable to pay a personal contribution for orthodontic treatment in special cases.

In a number of its supplementary insurance policies, Zorg en Zekerheid offers reimbursement for orthodontics in general until the age of 18. For more information, refer to the policy conditions for the supplementary insurance policies under Oral Care.

### 18.5 A medically necessary stay

A stay in the lowest-class accommodation in a hospital during an uninterrupted period of up to 1,095 days, which stay is medically necessary in connection with dental surgery of a specialist nature as described in Article 18 and which may or may not include nursing care, paramedical care or other care:

a. An interruption of a maximum of 30 days is not regarded as an interruption as such, but it will not be included in the 1,095 days referred to above.
b. In deviation from what is stated under a, interruptions owing to weekends or holiday leave are included in the calculation of the 1,095 days.

### 18.6 Dental implants for patients under age 23

*What am I entitled to?*
You are entitled to tooth replacement assistance with non-plastic materials (crowns and bridges) and dental implants for the replacement of:

- one or more permanent incisors or canines that have not developed at all; or
- if the absence of such a tooth or teeth is the direct consequence of an accident.

*What are the conditions?*

- The insured person must be less than 23 years old.
- The need for the care was established before the insured person turned 18.
- The insured person does not require oral care in special cases as referred to in Article 18.4.

*Does Zorg en Zekerheid need to approve this beforehand?*
Prior written permission from Zorg en Zekerheid is required for care involving implants. A written application to obtain permission from Zorg en Zekerheid must include a supporting letter from the treatment provider, as well as a written treatment plan and an estimate of the costs involved.

*Do I need to pay a personal contribution?*
You will not be liable to pay a personal contribution for the treatment.

## Article 19: Pharmaceutical care

### 19.1 General provisions

*What am I entitled to?*
You are entitled to pharmaceutical care as determined by the insurance agreement and the applicable Zorg en Zekerheid Pharmaceutical Care Regulations. Prior written permission for the provision of medicine is required where Zorg en Zekerheid specifies such in the policy conditions or Regulations. You can consult the Regulations on **zorgenzekerheid.nl/brochures**. You can also request a copy by calling (071) 5 825 825 or visit one of our shops.

> Contracted pharmacies and other contracted pharmaceutical care providers will charge the prices for medicines and rates for care as agreed with Zorg en Zekerheid.

*What is reimbursed if I go to a non-contracted care provider?*
As regards the provision of pharmaceutical care and medicines by a non-contracted pharmacist, dispensing general practitioner or medically specialised pharmaceutical supplier, a maximum of 80% of the WMG (maximum) rate is reimbursed with respect to reimbursements and supplements associated with the delivery of the pharmaceutical products. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

This concerns the reimbursement for medicines and the (partial) deliverable provision of a prescription medicine (prescription medicine only) and/or the instruction for prescription medicine-related aids, medication assessment, chronic use of prescription medicines, pharmaceutical supervision for hospitalisation, pharmaceutical supervision for discharge from hospital and pharmaceutical supervision for day care / outpatient care, as described in the applicable NZa policy rule, 'Descriptions of pharmaceutical care deliverables'.

A list of contracted care providers is available on **zorgenzekerheid.nl/zorgzoeker** and will be sent to you on request by Zorg en Zekerheid. You may also contact Zorg en Zekerheid for this information by calling (071) 5 825 825 or by visiting one of our shops.

### 19.2 Medicines

*What am I entitled to?*
You are entitled to medicines or advice and supervision as provided by pharmacists, dispensing general practitioners and other medically specialised suppliers ('pharmacist' below), for the purpose of assessing medicines and the responsible use of:

a. registered medicines designated in the Healthcare Insurance Regulations to the extent that they are designated by Zorg en Zekerheid;
b. medicines that are prepared by or on the instruction of a pharmacist in his or her pharmacy on a small scale to the extent that they form part of rational pharmacotherapy. In this connection, we use the definition of rational pharmacotherapy as issued by the National Health Care Institute (Zorginstituut Nederland). Rational pharmacotherapy is the treatment of a condition with a medicine in a form suitable for the patient, the working and effectiveness of which has been confirmed in the scientific literature. Furthermore, the medicine forms the best economic option for both the healthcare insurer and the patient. These medicines, which are prepared on prescription, only qualify for reimbursement if there is no equivalent, or virtually equivalent, registered medicine that is reimbursed under the basic insurance. Since 1 January 2016, all healthcare insurers use a national reimbursements list specifying the medicines that meet the above conditions. This approach is the result of consultation among patients' associations, healthcare insurers, pharmacists and physicians' associations. Additional conditions are attached to a number of pharmacy preparations. For the full list, go to **zorgenzekerheid.nl/brochures**. This web page also offers an overview of the medicines concerned;
c. medicines as referred to in Section 40(3)(f) of the Medicines Act (Geneesmiddelenwet), to the extent that they form part of rational pharmacotherapy, which medicines, at the request of a doctor, as referred to in the said Section, have been prepared in the Netherlands by a licensed manufacturer in accordance with the Medicines Act;
d. medicines as referred to in Section 40(3)(c) of the Medicines Act, to the extent that they from part of rational pharmacotherapy, which medicines are commercially available in a Member State or in a third country and which, at the request of a doctor, as referred to in the said Section, have been imported into the Netherlands and are intended for the insured person who suffers from an illness that does not occur in the Netherlands more frequently than in 1 in 150,000 inhabitants;
e. medicines that are added to Appendix 2 to the Regulations (for the most recent list of all medicines in Appendix 2 to the Regulations, go to **wetten.overheid.nl**) over the course of the year and other newly introduced medicines are subject to permission and possibly to additional conditions. If no permission is required we will announce that on our website, **www.zorgenzekerheid.nl**. Any additional conditions will also be published there.

Provided that the care is insured, you are entitled to the following pharmaceutical care deliverables as described in the applicable policy rule, 'Descriptions of pharmaceutical care deliverables', published by the NZa:

- provision of a medicine and a supervisory interview for a new medicine;
- patient instruction for prescription medicine-related aid, maximum of one instruction per aid, except in the case of identified erroneous use;
- medication assessment for the chronic use of prescription medicines, maximum of one assessment per year;
- pharmaceutical guidance in connection with day care / outpatient care;
- pharmaceutical guidance in connection with hospitalisation, maximum of one session per hospital admission;
- pharmaceutical guidance in connection with discharge, maximum of one session upon discharge from hospital.

*What are the conditions?*

- The medicines are designated in the Healthcare Insurance Regulations and designated as such by Zorg en Zekerheid. The Zorg en Zekerheid Pharmaceutical Care Regulations elucidate a number of issues.
- If the prescriber does not consider it medically responsible to provide the insured person with the designated medicine and indicates this by including the phrase 'medical need' on the prescription, the insured person retains

an entitlement to another registered medicine with the same active ingredient. If the pharmacist has doubts about the medical need, he or she will consult the prescriber of the medicine. The prescriber is only allowed to state 'medical need' on the prescription if it is not medically responsible for you to undergo treatment with the designated medicine. The prescriber must substantiate his decision.
- Unless Zorg en Zekerheid has made additional agreements (see**zorgenzekerheid.nl**) with a pharmacist/ dispensing general practitioner, the medicines must be prescribed by a general practitioner, medical specialist, dentist, dental specialist or midwife and must be provided under the supervision of the pharmacist/dispensing general practitioner.
- The prescription regulations (see the Zorg en Zekerheid Regulations) apply to pharmaceutical care.
- The Medicine Reimbursement System (GVS) adopted by the government applies to the reimbursement of the costs of medicines. This means that a reimbursement limit has been determined for a number of medicines (or their ingredients). If the price of a medicine is higher than the determined reimbursement limit, you will remain liable to pay the additional costs (the GVS personal contribution); this also applies to pharmacy preparations. This personal contribution does not count towards the excess applicable in the policy.
- Claims to a number of medicines are subject to the additional conditions as included in Appendix 2 of the Healthcare Insurance Regulations. The Healthcare Insurance Regulations can be viewed on **www.wetten.nl**.
- Zorg en Zekerheid may set additional conditions in its Pharmaceutical Care Regulations with respect to the effectiveness of medicine provision and the provision of pharmaceutical care (to supplement the Dutch Healthcare Authority (NZa) policy rule, 'Descriptions of pharmaceutical care deliverables').
- Total parenteral nutrition (TPN) only qualifies for reimbursement if provided by a medically specialised supplier.
- Reimbursement of total parenteral nutrition (TPN) requires prior written approval from Zorg en Zekerheid.

What am I not entitled to?
- care that does not fall under pharmaceutical care as referred to in the Decree and/or the Healthcare Insurance Regulations;
- pharmaceutical care services to which no entitlement exists (deliverables provided in relation to the Provision of information regarding pharmaceutical self-management for patient groups, Advice relating to pharmaceutical self-care, Advice relating to the use of prescription medicines while travelling abroad and Advice relating to the risk of falling ill while travelling abroad, as specified in the Dutch Healthcare Authority (NZa) policy rule, 'Descriptions of pharmaceutical care deliverables');
- medicines in the case of a risk of contracting an illness when travelling;
- medicines for study purposes as referred to in Section 40(3)(b) of the Medicines Act;
- medicines that are the equivalent of, or virtually the equivalent of, any non-designated, registered medicine;
- medicines as referred to in Section 40(3)(f) of the Medicines Act, with the exception of medicines as referred to in Article 19.2(d).

A number of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement that you receive on account of your basic insurance. For more information, refer to the policy conditions for the supplementary insurance policies under Pharmaceutical Care.

### 19.3 Diet preparations

*What am I entitled to?*

You are entitled to polymer, oligomer, monomer and modular diet preparations and the associated advice and guidance by the provider of those preparations to insured persons for whom an adjusted normal diet and other special diet products do not work and who:
- suffer from a metabolic disorder, food allergy or resorption disorder;
- suffer from illness-related malnutrition or are at risk of suffering from such malnutrition as established by a validated screening instrument;
- depend on the diet preparation in accordance with the guidelines issued by the respective professional associations in the Netherlands.

*What are the conditions?*
- Drip-feed preparations must be supplied by a medically specialised supplier.
- The 'Diet Preparations Statement of Zorg en Zekerheid' must be filled in, in addition to the national ZN form for diet preparations (ZN website), by a dietician or medical specialist and the supplier of the preparation has established that the conditions have been met.
- The first prescription concerns the use of diet preparations over a period of no more than one month.

*Supplementary conditions relating to diet preparations for infants:*
- Reimbursement of special diet preparations for infants with CMA is subject to the elimination-provocation test.
- Special diet preparations for infants only qualify for reimbursement if the 'Diet Preparations Statement of Zorg en Zekerheid' has been completed and the supplier of the preparation has established that the conditions have been met.

*Does Zorg en Zekerheid need to approve this beforehand?*
- To qualify for reimbursement of diet preparations after one month you will need prior written approval from Zorg en Zekerheid.

- To qualify for reimbursement of diet preparations for infants after one month you will need prior written approval from Zorg en Zekerheid.

## Article 20: Care aids

The extent of the entitlement to reimbursement is determined by the insurance agreement and the Zorg en Zekerheid Care Aids Regulations. Prior permission for the provision, replacement, correction or repair of the medical aid in question is required where Zorg en Zekerheid specifies such in the Care Aids Regulations. This permission may be subject to additional conditions that are included in the Care Aids Regulations. You can consult the Care Aids Regulations on **zorgenzekerheid.nl/brochures**. You may also contact Zorg en Zekerheid for this information by calling (071) 5 825 825 or by visiting one of our shops.

*What am I entitled to?*
You are entitled to the provision of operational care aids and bandaging aids.

*What are the conditions?*
- The care aid must be, in the opinion of Zorg en Zekerheid, necessary, effective, not unnecessarily expensive or unnecessarily complicated.
- A claim may only be made for the provision of bandaging aids if there is a serious condition that requires long-term medical treatment that involves these aids.
- The care aid must be prescribed by the attending doctor.
- With respect to bandaging aids, a declaration of medical necessity from a general practitioner or medical specialist must be submitted together with the first invoice.

*What am I not entitled to?*
- The costs of normal use are to be borne by the insured person, unless the ministerial regulation and/or the Care Aids Regulations specify otherwise. The costs of normal use are understood to include the costs of energy consumption and batteries.
- Care aids and bandaging aids that are prescribed to an insured person undergoing inpatient treatment in a long-term care (Wlz) institution and that are considered necessary for the care provided by this institution.

*What is reimbursed if I go to a non-contracted care provider?*
Costs of delivery of care and bandaging aids by a non-contracted supplier are reimbursed at 80% of the WGM (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 21: Patient transport

### 21.1 General provisions
A distinction is made in patient transport between:
- transport by ambulance, which refers to medically necessary transport by ambulance;
- seated patient transport, which refers to transport by public means of transport, taxi or by the patient's own car.

### 21.2 Ambulance transport
*What am I entitled to?*
You are entitled to medically necessary ambulance transport over a distance of no more than 200 kilometres unless Zorg en Zekerheid grants written permission for transport over a longer distance.

*What are the conditions?*
The costs must relate to patient transport:
a. to a care provider or an institution where the insured person will receive care the costs of which are to be covered either entirely or partially by this insurance policy;
b. to an institution where the costs of your stay will be covered in full or in part under the Wlz;
c. to a care provider or institution where an insured person under age 18 will receive mental healthcare the costs of which are payable in part or in their entirety by the municipal executive responsible under the Youth Act (Jeugdwet);
d. from an institution for long-term care to a care provider or institution:
    - where you will undergo examination or treatment the costs of which are covered in full or in part under the Wlz;
    - for the measuring and fitting of a prosthesis whose costs are covered in full or in part under the Wlz;
e. to your own home (or to a different residence if you cannot reasonably receive the care in your own home) if you arrive from a healthcare provider / healthcare institution as referred to under a through d.

*What else do I need to know?*
The patient transport also includes the transport of a companion if necessary, or if the patient is a child under age 16. In exceptional cases, Zorg en Zekerheid may permit the transport of two companions.

*What is reimbursed if I go to a non-contracted care provider?*
Ambulance transport by a non-contracted transport provider is reimbursed at 80% of the WGM (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 21.3 Seated patient transport on medical grounds

*What am I entitled to?*
You are entitled to medically necessary seated patient transport (public transport at the lowest available fare, transport by (the insured person's own) car or taxi) to and from healthcare provider or healthcare institution over a one-way distance of no more than 200 kilometres unless Zorg en Zekerheid grants permission for transport over a longer distance.

*What are the conditions?*
- This relates to patient transport in the following circumstances:
  a. You must undergo kidney dialysis.
  b. You must undergo oncological treatment involving chemotherapy or radiotherapy.
  c. You can only move using a wheelchair.
  d. Your eyesight is limited to such an extent that you are unable to move without assistance.
  e. You are less than 18 years old and due to complex somatic issues or a physical disability you rely on nursing and care, involving a need for permanent supervision or the availability of 24/7 care assistance nearby.

- The transport must qualify as patient transport:
  a. to a person or institution where you will receive care the costs of which are covered in full or in part under your healthcare insurance;
  b. to an institution where the costs of your stay will be covered in full or in part under the insurance as referred to in the Long-Term Care Act (Wlz);
  c. from an institution for long-term care to:
     1. a person or institution where the costs of examination or treatment will be covered in full or in part under the insurance as referred to in the Wlz;
     2. a person or institution for the measuring and fitting of a prosthesis whose costs are covered in full or in part under the insurance as referred to in the Wlz;
  d. to your home (or to a different residence if you cannot reasonably receive the required care in your own home) when arriving from one of the persons or institutions referred to in a. through c. above.

*Does Zorg en Zekerheid need to approve this beforehand?*
- Reimbursement of transport by public transportation or taxi requires prior written approval from Zorg en Zekerheid. For this purpose you must request the seated patient transport as described in Article 21.4.
- If the seated patient transport is not possible by public transport, taxi or privately owned car, you may request Zorg en Zekerheid in advance for transport by an alternative means.

*What else do I need to know?*
- Reimbursement of the costs of transport by (private) car amounts to €0.30 per kilometre. The reimbursement is calculated on the basis of the shortest usual single-journey distance. The single-journey distance is calculated using the 'optimum route' quoted by the Routenet route planner (**www.routenet.nl**).
- Costs of public transport or use of a car (your own car or otherwise) are reimbursed on the basis of the shortest distance.
- The patient transport also includes the transport of a companion if necessary, or if the patient is a child under age 16. In exceptional cases, Zorg en Zekerheid may permit the transport of two companions.
- Other than in the situations specified above, the insured person may invoke the hardship clause if, owing to the treatment of a long-term illness or condition, he is dependent on long-term seated patient transport several times a week over a specific distance or with a specific travel time, the refusal of which transport would result, overall, in an unfair situation for the insured person. To invoke the hardship clause, the insured person may submit an application which includes a supporting letter from the attending physician. The hardship clause applies in any case if you depend on ambulant geriatric rehabilitation care (GRZ) and insofar as the transport is to and from the GRZ institution and your own home (or a different residence if you cannot reasonably receive the care you need in your own home).

*What is reimbursed if I go to a non-contracted care provider?*
Transport by a non-contracted transport provider is reimbursed at 80% of the WGM (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

### 21.4 Requesting seated patient transport

*How can I apply for seated patient transport?*
- If there are medical grounds as referred to above, the insured party must contact the Transport Line (Vervoerslijn), telephone number (071) 5 825 700 in order to report the medical grounds concerned.
- The Transport Line will determine the type of transport to which the insured party is entitled.
- If the Transport Line indicates that transport by taxi is required, the insured person must contact the Netherlands Healthcare Transport Switchboard (Zorgvervoercentrale Nederland), telephone number 010 280 81 88 to order the transport by taxi (for wheelchair users or otherwise).

### 21.5 Personal contribution towards seated patient transport

*Do I need to pay a personal contribution?*
The costs of seated patient transport are subject to a personal contribution of €101 per insured person per calendar year.

- The personal contribution is not payable for transport from an institution: where the insured person was admitted for long-term care covered under healthcare insurance or compulsory insurance for long-term care to a different institution where the insured person is admitted to undergo specialist examinations or treatment covered under healthcare insurance or compulsory long-term healthcare insurance, which specialist examinations or treatment cannot be carried out at the first-mentioned institution;
- as referred to in a. to a person or institution to undergo specialist examinations or treatment covered under healthcare insurance which cannot be carried out at the first-mentioned institution, and for the return journey to that institution;
- where the insured person was admitted for care covered under exceptional medical expenses insurance to a person or institution for dental care covered under exceptional medical expenses insurance which cannot be provided at the first-mentioned institution, and for the return journey to that institution.

*Does the personal contribution count towards the excess?*
This personal contribution does not count towards the excess applicable in the policy.

> A number of Zorg en Zekerheid's supplementary insurance policies offer reimbursement of the personal contribution towards seated patient transport. For more information, refer to the policy conditions for the supplementary insurance policies under Other.

### 21.6 Claiming costs of seated patient transport

*How can I claim the costs incurred?*
To claim transport costs in the event you use your own transport, you must complete the seated patient transport declaration form and submit this together with your invoices and appointment card to Zorg en Zekerheid. For the submission deadlines, consult Article 4.1.1(e).

## Article 22: Abroad

### 22.1 General provisions

For the purposes of the reimbursement of costs of treatment abroad, a distinction is made between:
a. insured persons who live in the Netherlands (Article 22.2);
b. insured persons who live in an EU/EEA country or treaty country other than the Netherlands (Articles 22.2 and 22.3);
c. insured persons who live in a non-EU/EEA country or non-treaty country (Articles 22.2 and 22.4).

If an insured person is abroad and calls in the care of a care provider or care institution not contracted by Zorg en Zekerheid reimbursement will take place in accordance with the provisions listed elsewhere in this policy that apply specifically to that type of care provided by a non-contracted care provider or institution within the Netherlands.

If the reimbursement amount is not indicated specifically under the type of care in question, if provided by a non-contracted care provider or care institution, the costs will be reimbursed in full in accordance with the prevailing Dutch market rate or WMG rate.

You will be liable to pay any costs that exceed the prevailing Dutch market rate or WMG rate.

> More information about healthcare insurance abroad can be found on the website of the National Health Care Institute (Zorginstituut Nederland) at **zorginstituutnederland.nl**.

*What are the conditions?*
If the insured person wishes to submit an invoice prepared in a language other than Dutch, French, German or English, he must append a certified translation. Original invoices in other languages must be drawn up and/or translated such that without the need for further queries Zorg en Zekerheid can determine the reimbursement due.

*Do I need permission?*
Permission from Zorg en Zekerheid is required for intramural care outside the Netherlands (i.e., admission or a stay in an institution for at least one night). If Zorg en Zekerheid grants prior written permission for calling upon care in a country other than the Netherlands, reimbursement of the costs will be up to a maximum of 100% of the prevailing Dutch WGM rate. In the event of care in another EU or EEA Member State, you are entitled to care in accordance with the statutory regulations of that country based on the provisions of the EU Regulation on social security or the

relevant treaty. Reimbursement of the costs of this care, or entitlement to treatment, will be provided with due observance of the conditions that apply under the relevant social security regulation or treaty.

### 22.2 Resident in the Netherlands

#### 22.2.1 Temporary residence in another EU/EEA country or treaty country

This article also applies to an insured person who lives in another country and who is staying temporarily in the Netherlands or another EU/EEA country or treaty country.

*What am I entitled to?*

You may choose from the following entitlements:

- care in accordance with the statutory regulations of the country concerned, based on the provisions of the EU Regulation on social security or the relevant treaty. Reimbursement of the costs of this care, or entitlement to treatment, will be provided with due observance of the conditions that apply under the relevant social security regulation or treaty;
- care provided by a care provider or care institution contracted by Zorg en Zekerheid in the relevant country;
- reimbursement of the costs of care provided by a non-contracted care provider or care institution subject to the provisions of Article 22.1;
- if Zorg en Zekerheid has issued prior permission to call in care in a country other than your country of residence, you are entitled to reimbursement of the costs subject to the provisions of Article 22.1.
- medically necessary care and reimbursement of care (administered within 24 hours after the complaint has started and that cannot be reasonably delayed until the insured person's return to his or her country of residence) up to 100% of the Dutch market rate or WMG rate. In all cases, you will be liable to pay any costs that exceed the prevailing Dutch market rate or WMG rate.

*What are the conditions?*

- Only your own attending physician or medical specialist in your own country of residence may refer you to an institution in another country.
- Care according to the statutory regulations of a country other than the insured person's country of residence only applies if it concerns, in the case of treaty countries, medically necessary care (which care cannot reasonably be delayed until the insured person's return to his or her own country of residence) and, in the case of EU/EEA countries, treatments that become medically necessary during the stay in the country concerned, with due observance of the nature of the treatments and the expected duration of the stay.
- Care according to the statutory regulations of the country concerned must be called for according to the prescribed treaty system (European insurance card). Payments made in the foreign country by the insured person will count towards the excess.

#### 22.2.2 Temporary stay in a non-EU/EEA country or non-treaty country

This article also applies to an insured person who lives in another country and who is staying temporarily in a country that is neither an EU/EEA country nor a treaty country.

*What am I entitled to?*

You may choose from the following entitlements:

- care provided by a care provider or care institution contracted by Zorg en Zekerheid in the relevant country;
- reimbursement of the costs of care provided by a non-contracted care provider or care institution subject to the provisions of Article 22.1;
- if Zorg en Zekerheid has issued prior permission to call in care in a country other than your country of residence, you are entitled to reimbursement of the costs subject to the provisions of Article 22.1;
- medically necessary care and reimbursement of care (administered within 24 hours after the complaint has started and that cannot be reasonably delayed until the insured person's return to his or her country of residence) up to 100% of the prevailing Dutch market rate or WMG rate. In all cases, you will be liable to pay any costs that exceed the prevailing Dutch market rate or WMG rate.

*What are the conditions?*

Only your own attending physician or medical specialist in your own country of residence may refer you to an institution in another country.

### 22.3 Resident in an EU/EEA country or treaty country other than the Netherlands

*What am I entitled to?*

Insured persons who live in a EU/EEA country or treaty country other than the Netherlands may choose, in their country of residence, reimbursement of:

- care in accordance with the statutory regulations of the country concerned, based on the provisions of the EU Regulation on social security or the relevant treaty. The costs of this care will be reimbursed with due observance of the conditions that apply under the relevant social security regulation or treaty;
- care provided by a care provider or care institution contracted by Zorg en Zekerheid in the relevant country;
- reimbursement of the costs of care provided by a non-contracted care provider or care institution subject to the provisions of Article 22.1;

- medically necessary care and reimbursement of care (received in a country other than the country of residence and which cannot be reasonably delayed until the insured person's return to his or her country of residence) up to 100% of the Dutch market rate or WMG rate. In all cases, you will be liable to pay any costs that exceed the prevailing Dutch market rate or WMG rate.

### 22.4 Resident in a non-EU/EEA country or non-treaty country

*What am I entitled to?*
- Insured persons who live in a country that is not a EU/EEA country or treaty country may choose , in their country of residence, reimbursement of:
- care provided by a care provider or care institution contracted by Zorg en Zekerheid in the relevant country;
- reimbursement of the costs of care provided by a non-contracted care provider or care institution subject to the provisions of Article 22.1;
- medically necessary care and reimbursement of care (received in a country other than the country of residence and which cannot be reasonably delayed until the insured person's return to his or her country of residence) up to 100% of the Dutch market rate or WMG rate. In all cases, you will be liable to pay any costs that exceed the prevailing Dutch market rate or WMG rate.

*What are the conditions?*
Only your own attending physician or medical specialist in your own country of residence may refer you to an institution in another country.

### 22.5 Authorised care provider or institution

Care abroad must be provided by a care provider or care institution that is authorised to provide that care in the country concerned.

## Article 23: Mental healthcare

### 23.1 Generalist basic mental healthcare (GGZ) from age 18

What am I entitled to?
You are entitled to generalist basic mental healthcare (GGZ) such as generally provided by clinical psychologists and psychiatrists. This care is available to insured persons from age 18 and consists of five deliverables: a short, medium-term, intensive, chronic and incomplete treatment programme.

You are entitled to generalist basic mental healthcare (GGZ) delivered by the following coordinating care providers in an independent practice:
a. a healthcare psychologist;
b. a psychotherapist;
c. a clinical (neuro)psychologist;
d. insured persons who turn 18 during treatment (under the Youth Act) are also permitted to receive the care from the following coordinating care providers:
   - a child and youth psychologist;
   - a remedial educationalist-generalist.

If you receive generalist basic mental healthcare at a specialist mental healthcare institution, the following can be added to the above list of coordinating care providers:
- the nursing specialist of the mental healthcare institution;
- the geriatric care specialist or clinical geriatrician (if dementia is the primary diagnosis);
- the substance abuse specialist in the KNMG Profile Register (if substance abuse and/or gambling addiction are the primary diagnosis).

*What are the conditions?*
- The responsibilities of a coordinating care provider in direct contact (activities performed in direct contact with you):
  a. making and co-assessing a diagnosis and preparing the patient's medical record during the diagnostics phase. The diagnosis should be substantiated;
  b. preparing a treatment plan aimed at a responsible treatment in accordance with the current scientific standards and the guideline;
  c. evaluating the treatment and, if required, adjusting the treatment plan.
- The healthcare provider has a Mental Healthcare Quality Charter in place that is registered with **ggzkwaliteitsstatuut.nl**;

*What am I not entitled to?*
The care does not include:
- specialist care as referred to in Article 23.2;
- intelligence tests;
- psychological testing at school;
- counselling in the form of training and other courses;

- remedial education;
- treatment for adjustment disorders;
- help for problems related to the patient's professional life and relationships, unless the problem arises from the above-mentioned disorder according to DSM-5;
- help in the event of stress and burn-out, unless the problem arises from the above-mentioned disorder according to DSM-5;
- help for psychological complaints in the absence of a mental disorder;
- interventions that do not meet the current scientific and practical standards. Interventions not assessed by the National Health Care Institute (Zorginstituut Nederland) will be assessed by Zorg en Zekerheid against the current scientific and practical standards, based on the 'GGZ Therapies' recommendation of Zorgverzekeraars Nederland or any subsequent additional recommendations. To view this recommendation, go to **zorgenzekerheid.nl/brochures**.

*Do I need a referral?*
A referral from a general practitioner, company doctor or medical specialist is required for generalist basic mental healthcare.

The referral letter must include the following information:
- personal details of the client who is being referred;
- the reason for the referral (the diagnostic details need not be visible);
- the type of care referred to (generalist basic mental healthcare);
- name, position and AGB code of the referrer;
- signature of the referrer;
- date (prior to the start of treatment).

A referral remains valid for no more than one year. However, after that year no new referral is required for follow-up treatment under the same diagnosis. If the treatment is interrupted for more than one year, a new referral will be required to qualify for follow-up treatment.

We adhere to the 'GGZ Referrals Decision' issued by the Ministry of Health, Welfare and Sport, dated 21 April 2017. To view this document, go to **zorgenzekerheid.nl/brochures**.

*What is reimbursed if I go to a non-contracted care provider?*
Costs of visits to a non-contracted care provider are reimbursed up to 80% of the prevailing market rate.

### 23.2 Specialist mental healthcare (GGZ) from age 18

*What am I entitled to?*
You are entitled to specialist mental healthcare as generally provided by psychiatrists or clinical psychologists. Specialist mental healthcare is available to insured persons from age 18. The care does not include the generalist basic mental healthcare (GGZ) referred to in Article 23.1.

*What are the conditions?*
- There must be a coordinating care provider.
- The responsibilities of a coordinating care provider in direct contact (activities performed in direct contact with you):
  a. making and co-assessing a diagnosis and preparing the medical record during the diagnostics phase. The diagnosis should be substantiated;
  b. preparing a treatment plan aimed at a responsible treatment in accordance with the current scientific standards and the guideline;
  c. evaluating the treatment and, if required, adjusting the treatment plan.
  - In addition, the coordinating care provider is responsible for:
  a. the authorities and competencies of fellow care providers in connection with the independent performance of that part of the treatment for which auxiliary staff are responsible;
  b. preparing the patient's medical record in accordance with the relevant requirements. Fellow care providers also have their own responsibility in this context;
  c. being informed by fellow care providers and other professionals involved in the treatment, to the extent required to ensure responsible patient treatment. The coordinating care provider tests whether the activities contribute to and are consistent with the established treatment plan;
  d. ensuring that he or she meets up with fellow care providers individually and as a team as frequently as required by the patient's condition;
  e. effective communication with the patient and his or her friends and relatives (if applicable and with the patient's consent) on the progress of the treatment relative to the treatment plan;
  f. concluding the treatment in accordance with the DTC rules.
- Auxiliary staff are available for patients at an institution for specialist mental healthcare. Auxiliary staff are authorised to carry out part of the treatment under the coordinating care provider's supervision.
- Only care providers included in the in de DTC-GGZ table of professions, as incorporated in Appendix 3 to the applicable NZa Specialist Mental Healthcare Regulations, are permitted to perform auxiliary staff tasks. To view these Regulations, go to**zorgenzekerheid.nl/brochures**;

- The care is provided in the care provider's practice or clinic, unless there is a medical need to provide the treatment at home.
- The healthcare provider has a Mental Healthcare Quality Charter in place that is registered with **ggzkwaliteitsstatuut.nl**;

*Do I need a referral?*
A referral from a general practitioner, company doctor or medical specialist is required for specialist mental healthcare. This does not apply to acute care / care in crisis situations.

*The referral letter must include the following information:*
- personal details of the client who is being referred;
- the reason for the referral (the diagnostic details need not be visible);
- the type of care referred to (specialist mental healthcare);
- name, position and AGB code of the referrer;
- signature of the referrer;
- date (prior to the start of treatment).

With respect to the period for which the referral has been granted, you must hold a valid referral that was issued less than one year before commencement of the care. No new referral is required for follow-up treatment under the same diagnosis, provided that the follow-up treatment commences within a year after the end of the prior treatment. If the treatment is interrupted for more than one year, a new referral will be required to qualify for follow-up treatment.

We adhere to the 'GGZ Referrals Decision' issued by the Ministry of Health, Welfare and Sport, dated 21 April 2017. To view this document, go to **zorgenzekerheid.nl/brochures**.

### 23.2.1 Clinical specialist mental healthcare (GGZ) from age 18

*What am I entitled to?*
You are entitled to:
- admission to a specialist mental healthcare institution, an institution for specialist addiction treatment or the psychiatric ward of a hospital for at most three years (1,095 days). An interruption of a maximum of 30 days is not regarded as an interruption as such, but it will not be included in the three years (1,095 days) referred to above. On the other hand, interruptions due to weekend and holiday leave do count towards the calculation of the three years (1,095 days);
- normal medical specialist treatments and the stay, whether in combination with nursing and care or otherwise;
- the paramedical care, medicines, care aids and bandaging aids associated with the treatment during the period of admission.

*What are the conditions?*
- The admission is medically necessary as part of the treatment.
- There must be a coordinating care provider. In specialist mental healthcare, these are:
  a. in all cases, the psychiatrist;
  b. in all cases, the psychologist;
  c. the nursing specialist in the event of patients/clients undergoing treatment whose primary focus is not (or no longer) on biological and psychological factors, but rather on the consequences of the psychiatric disorder and/or the limitations to which it gives rise in the patient/client's personal and interpersonal faculties;
  d. the psychotherapist in types of psychotherapy within various therapeutic frameworks;
  e. the mental health psychologist for patients undergoing treatment whose primary focus is not on biological factors or the consequences of the psychiatric disorder and the limitations to which it gives rise, but rather on the psychological factors;
  f. the substance abuse specialist in the KNMG Profile Register for the prevention, diagnostics and treatment of substance abuse and addiction, including alcohol and tobacco, illicit substances and medicines, and so-called behavioural addictions; if there is no co-morbidity with serious and complex psychiatric disorders;
  g. the clinical neuropsychologist for care issues involving specific neuropsychological components;
  h. the clinical geriatrician, a specialist in geriatric care for (biologically) elderly patients in whose complaints multi-morbidity (of both a psychiatric and somatic nature) plays a prominent role.
  i. Insured persons who turn 18 during treatment (under the Youth Act) are also permitted to receive the care from the following coordinating care providers:
- a child and youth psychologist;
- a remedial educationalist-generalist.

What am I not entitled to?
- neurofeedback;
- psychoanalysis;
- treatment for adjustment disorders;
- help for problems related to the patient's professional life and relationships, unless the problem arises from the above-mentioned diagnosis according to DSM-5;
- help in the event of stress and burn-out which are not expressed in a diagnosis according to DSM-5, which does qualify for reimbursement;

- intelligence tests;
- psychological testing at school;
- counselling in the form of training and other courses;
- remedial education;
- help for psychological complaints in the absence of a mental disorder;
- interventions that do not meet the current scientific and practical standards. Interventions not assessed by the National Health Care Institute (Zorginstituut Nederland) will be assessed by Zorg en Zekerheid against the current scientific and practical standards, based on the 'GGZ Circular Therapies' recommendation of Zorgverzekeraars Nederland or any subsequent additional recommendations. To view this recommendation, go to **zorgenzekerheid.nl/brochures**;
- specialised care or addiction treatment care primarily aimed at resocialisation;
- admission on the basis of a social indication (such as the lack of proper housing).

*Does Zorg en Zekerheid need to approve this beforehand?*
Continuation of a stay that takes or is expected to take longer than one year (second and third years of stay) requires prior written approval (which must be applied for at least two months before the end of the first year) from Zorg en Zekerheid.

The application should state the reasons why the stay is necessary, the care intensity package and an indication of the expected duration of the continued stay. In individual cases, the medical advisor may request access to the treatment plan. A long-term mental healthcare (LGGZ) checklist must be available that reflects the long-term mental healthcare indication. A list of approved organisations can be found at **www.zorgenzekerheid.nl./brochures**.

*What is reimbursed if I go to a non-contracted mental healthcare institution?*
Costs of care provided by a non-contracted specialist mental healthcare institution are reimbursed up to 80% of the prevailing Dutch market rate.

*Do I need prior permission from Zorg en Zekerheid if I go to a non-contracted care institution?*
You will have to apply for prior permission in writing if you decide to stay in a non-contracted care institution for specialist mental healthcare. To apply for this permission, the care provider must send to Zorg en Zekerheid on your behalf:
a. a letter of referral from your general practitioner, medical specialist or company doctor;
b. the grounds for clinical admission, in accordance with the guidelines set down by the profession;
c. the proposed treatment plan, including the number of treatment sessions (in minutes) and the activities and operations to be carried out;
d. the names of the care providers, including the coordinating care provider (stating the BIG registration number), who are involved in the provision of the care;
e. an itemisation of the service component to be reimbursed, including the deployment of nursing, care-providing and social-pedagogical staff in relation to the disorder;
f. the DTC reimbursement code and the care category.

The 'medically necessary stay at the mental healthcare institution' of the Zorginstituut is the main criterion in this assessment.

> To continue a treatment that will take or is expected to take longer than one year, you will need to apply for approval again. For additional conditions in this regard, see Article 23.2.1, *Does Zorg en Zekerheid need to approve this beforehand?*

### 23.2.2 Outpatient specialist mental healthcare (GGZ) from age 18

*What am I entitled to?*
You are entitled to specialist mental healthcare:
- by one of the following coordinating care providers in an independent practice:
  a. a psychotherapist;
  b. a clinical (neuro-)psychologist;
  c. a psychiatrist.
- at a mental healthcare institution by one of the following coordinating care providers:
  a. in all cases, the psychiatrist;
  b. in all cases, the psychologist;
  c. the nursing specialist in the event of patients/clients undergoing treatment whose primary focus is not (or no longer) on biological and psychological factors, but rather on the consequences of the psychiatric disorder and/or the limitations to which it gives rise in the patient/client's personal and interpersonal faculties;
  d. the psychotherapist in types of psychotherapy within various therapeutic frameworks;
  e. the mental health psychologist for patients undergoing treatment whose primary focus is not on biological factors or the consequences of the psychiatric disorder and the limitations to which it gives rise, but rather on the psychological factors;
  f. the substance abuse specialist in the KNMG Profile Register for the prevention, diagnostics and treatment of substance abuse and addiction, including alcohol and tobacco, illicit substances and medicines, and so-

called behavioural addictions; if there is no co-morbidity with serious and complex psychiatric disorders;
g. the clinical neuropsychologist for care issues involving specific neuropsychological components;
h. the clinical geriatrician, a specialist in geriatric care for (biologically) elderly patients in whose complaints multi-morbidity (of both a psychiatric and somatic nature) plays a prominent role.
i. Insured persons who turn 18 during treatment (under the Youth Act) are also permitted to receive the care from the following coordinating care providers:

- a child and youth psychologist;
- a remedial educationalist-generalist.

*What are the conditions?*
The healthcare provider has a Mental Healthcare Quality Charter in place that is registered with **ggzkwaliteitsstatuut.nl**;

*What am I not entitled to?*
- neurofeedback;
- psychoanalysis;
- treatment for adjustment disorders;
- help for problems related to the patient's professional life and relationships, unless the problem arises from the above-mentioned disorder according to DSM-IV;
- assistance with stress and burn-out;
- intelligence tests;
- psychological testing at school;
- counselling in the form of training and other courses;
- remedial education;
- help for psychological complaints in the absence of a mental disorder;
- interventions that do not meet the current scientific and practical standards. Interventions not assessed by the National Health Care Institute (Zorginstituut Nederland) will be assessed by Zorg en Zekerheid against the current scientific and practical standards, based on the 'GGZ Circular Therapies' recommendation of Zorgverzekeraars Nederland or any subsequent additional recommendations. To view these recommendations, go to **zorgenzekerheid.nl/brochures**;

*What is reimbursed if I go to a non-contracted care provider?*
Costs of care provided by a non-contracted care provider are reimbursed up to 80% of the prevailing Dutch market rate.

## Article 24: Multi-disciplinary care

### 24.1 Multi-disciplinary care

*What am I entitled to?*
You are entitled to multi-disciplinary coordinated care (also known as chain care) if you are suffering from a specific chronic disorder. We refer you to the Glossary for an explanation of the term 'multi-disciplinary care'.

*What am I not entitled to?*
Self-management courses (not provided by a general practitioner or medical practice assistant) are expressly excluded from the chain. This type of care is covered however by some of our supplementary insurance policies.

*What are the conditions?*
Multi-disciplinary care, in the event of a specific chronic condition (COPD, CVRM and diabetes mellitus type 2). The care must be provided by a diverse group of care providers in a coordinated manner, and in conformance with the care standards for the condition in question. For an overview of care providers participating in the multi-disciplinary care, go to our website **zorgenzekerheid.nl**. You will find the overview in the 'Chain care' section under the heading 'Care and health'.

*What is reimbursed if I go to a non-contracted care provider or institution?*
The costs of chain care provided by a non-contracted care provider are reimbursed up to a maximum of 80% of the maximum rate for non-contracted multi-disciplinary care as determined by the NZa. 80%

### 24.2 Foot care not provided by multi-disciplinary care

What am I entitled to?
You are entitled to foot care as generally provided by general practitioners to insured persons with diabetes mellitus type 1 or 2. This care can be provided by podotherapists and/or by a pedicure commissioned by a podotherapist. This care can be provided both as part of multi-disciplinary care (Article 24.1) and outside of multi-disciplinary care.

*What are the conditions?*
- The care provided must be medically necessary.
- You must at least qualify for Care Profile 2. An exception is the annual foot check, for which Care Profile 1 is the minimum.

- The care must be provided by a podotherapist or by a pedicure contracted by a podotherapist. For more information, go to **www.zorgenzekerheid.nl**.
- The podotherapist must submit the claim directly to Zorg en Zekerheid in digital format.
- The pedicure cannot submit his or her claim directly to Zorg en Zekerheid but should do so via the podotherapist.
- The podotherapist must be registered in the Quality Register for Paramedics (quality registered status).

*Do I need a referral?*
You require a written referral from the general practitioner or medical specialist if the care is not provided by either the general practitioner or medical specialist.

*What is reimbursed if I go to a non-contracted care provider?*
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 25: Stop-smoking programme

*What am I entitled to?*
This is medical care administered with the purpose of changing behaviour so as to help the client to stop smoking. You are entitled to medicines prescribed as part of the programme. You can attend the programme as part of a group or on an individual basis.

*What are the conditions?*
You are entitled to only one stop-smoking programme per calendar year.

*What is reimbursed if I go to a non-contracted care provider?*
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 26: Care for persons with sensory disabilities

*What am I entitled to?*
You are entitled to extramural care for persons with a sensory disability. This care covers multidisciplinary care for persons with a visual or auditive impairment or a communicative impairment resulting from a linguistic developmental disorder.

The care should be aimed at coping with, eliminating or compensating the impairment so as to enable the insured person to live as independently as possible. The care comprises:
- diagnostic screening;
- interventions aimed at helping patients to cope with the disability psychologically;
- interventions that remove or compensate the disabilities, thus increasing the patients' ability to care for themselves.

Besides the treatment of the person with a sensory disability, this also includes the indirect and systematic co-treatment of parents or carers, children and adults in the environment of the person with a sensory disability, teaching them skills that are in the latter's person's interest.

*What am I not entitled to?*
You are not entitled to:
- support in connection with the insured person's social functioning (such as the costs of an interpreter for the deaf in care contexts);
- complex, long-term and comprehensive support to deaf-blind adults and pre-lingually deaf adults.

*Do I need a referral?*
You will need a written referral prior to the start of:
- care for sensory disabilities for insured persons with an auditive impairment or a communicative impairment resulting from a linguistic developmental disorder. You must have a referral from a medical specialist or a clinical physician-audiologist associated with an audiology centre. That referral must be based on the guidelines issued by the Confederation of Dutch Audiology Centres (FENAC). In the event of new care needs, a referral may also be issued by a general practitioner or paediatrician provided that the disorder has not changed in the meantime;
- care for sensory disabilities for insured persons with a visual impairment. You must have a referral from a medical specialist under the Guideline for Visual Disorders, Rehabilitation and Referral issued by the Dutch Association for Opthalmology (NOG). In the event of new care needs, a referral may also be issued by a general practitioner or paediatrician provided that the disorder has not changed in the meantime.

*Does Zorg en Zekerheid need to approve this beforehand?*
If you need to stay in an institution on medical grounds combined with extramural care for sensory disabilities, you should apply for written permission from us prior to the start of your stay. The application must include / be accompanied by the following information:
- the letter of referral;
- the reasons why your stay at the institution is a medical necessity;
- the expected duration;
- the treatment plan.

*What is reimbursed if I go to a non-contracted care provider?*
Costs for care provided by a non-contracted care provider are reimbursed at 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse the costs up to 80% of the prevailing market rate.

## Article 27: Nursing and care

### 27.1: District nursing

*What am I entitled to?*
You are entitled to nursing and care (district care) as provided by nurses.

### Reimbursement in the form of a Personal Budget (Zvw-pgb)

You may qualify for reimbursement for the costs of nursing and care in the form of a Personal Budget. You will need prior written permission from Zorg en Zekerheid for the care concerned. This budget will enable you to purchase district nursing services yourself, subject to the Personal Budget for Nursing and Care Regulations. These regulations state the conditions you will have to meet in order to qualify for a Personal Budget (Zvw-pgb). To view the Regulations, go to**zorgenzekerheid.nl/brochures**;

*What are the conditions?*
- Your care needs must be assessed in advance by a nurse trained at higher professional education (HBO) level.
- If the insured person is less than 18 years old, his or her care needs must be assessed by a paediatric nurse trained at higher professional education (HBO) level.
- The care relates to the need for the medical care referred to in Section 2.4 of the Healthcare Insurance Decree or a high risk of such a need.
- The care is not associated with a stay as referred to in Articles 6.2, 18.5 and 27.2.
- The care is provided by a specialist nurse, nurse, level-3 care-giver or care-giver within the meaning of the Individual Healthcare Professions Act. To qualify for the Personal Budget additional conditions apply as listed in the Personal Budget for Nursing and Care Regulations.
- The care is of a type other than maternity care as referred to in Article 7.

*What am I not entitled to?*
You are not entitled to:
- care which is aimed at eliminating your inability to care for yourself in your daily activities;
- nursing and care under the Healthcare Insurance Act if the nursing and care are covered by an indication under the Long-Term Care Act (Wlz) or such an indication could be applied for.
-

*Do I need a referral?*
- You need a referral from a paediatrician for nursing and care for insured persons under age 18.
- Palliative terminal care requires a statement from the attending physician. That statement should reflect an estimated life expectancy of less than three months.

*Does Zorg en Zekerheid need to approve this beforehand?*
You will have to apply for prior written permission if you need more than 12 hours of care a day. This does not apply however to palliative terminal care. You can find the authorisation form at **zorgenzekerheid.nl/wijkverpleging**, under ‘Downloads’.

*What is reimbursed if I go to a non-contracted care provider?*
The costs of care at a non-contracted care provider are reimbursed up to a maximum of 75% of the prevailing Dutch market rate.

In your refund claim you should state the care needs assessment (name of assessor and number of hours of care) and the name of the care provider. The diagnostic details need not be visible.

### 27.2 Stay in primary care institution

*What am I entitled to?*
You are entitled to a medically necessary stay in an institution for in-patient primary care in connection with medical

care as generally provided by general practitioners. The institution should offer 24-hour supervision. The care comprises:
- a stay including the nursing and care inextricably linked with the facility;
- generalist medical care (care as provided by general practitioners);
- paramedical care to the extent it is inextricably linked with the reason for admission;
- medicines, care aids and bandaging materials to the extent they are inextricably linked with the reason for admission.

*What are the conditions?*
- The general practitioner or medical specialist has established the medical grounds and issued a referral for a stay in an institution for in-patient primary care.
- The care is provided by a care-giver within the meaning of the Individual Healthcare Professions Act, at level 3 or higher, and under the supervision of a nurse trained at higher professional education (HBO) level.
- Upon admission in the institution for in-patient primary care, the patient can be expected to eventually recover and return home, unless in the case of palliative care.
- The institution has formulated a Care Plan specifying the estimated duration of the stay.
- The duration of the stay at an institution for in-patient primary care is at least 24 hours and will not generally exceed 91 days. The right to stay at the institution for in-patient primary care lapses after 1,095 days; the institution for in-patient primary care is authorised under the Care Institutions (Accreditation) Act (WTZi).

*What am I not entitled to?*
You are not entitled to reimbursement of the costs of a stay at an institution for in-patient primary care if:
- respite care (Wmo/Wlz), care in crisis situations (Wmo/Wlz) or geriatric rehabilitation care are the designated types of care;
- you have an indication for specialist medical care (e.g. hospital admission) or specialist mental healthcare.

*Does Zorg en Zekerheid need to approve this beforehand?*
You need prior written approval from Zorg en Zekerheid to continue a treatment that will take or is expected to take longer than 91 days. The application must be submitted to Zorg en Zekerheid no later than two weeks before the end of the 91-week period.

*What is reimbursed if I go to a non-contracted care provider?*
The costs of care provided by a non-contracted institution are reimbursed up to a maximum of 75% of the prevailing Dutch market rate.

In your refund claim you should include the referral issued by the general practitioner or medical specialist. The diagnostic details on the referral need not be visible.

# Section C Information

Please call our staff at our Contact Centre if you have any questions. They can be reached by telephone on working days from 8 a.m. to 6 p.m. CET at: (071) 5 825 825. You can also visit one of our shops. For more information, please visit **zorgenzekerheid.nl**.

### MyZZ

Persons insured with Zorg en Zekerheid can access MyZZ. MyZZ allows you to view and, if applicable, change claims you have submitted, your excess, your personal details and the policy data. In addition, MyZZ allows you to submit your invoices online. You can also do so via the Zorg en Zekerheid app. You can log in to MyZZ using your DigiD account at **zorgenzekerheid.nl/mijnzz**.

### How do I get my invoice reimbursed?

Zorg en Zekerheid requires the original invoices (i.e. no PIN slips or receipts) or computer invoices authenticated by the care provider in order for it to be able to reimburse any costs.

You can submit invoices as follows:
- Write your personal customer number on your original invoice and submit the invoice online via MyZZ **zorgenzekerheid.nl/mijnzz** or the Zorg en Zekerheid app. You are obliged to keep the original invoice for three years after uploading. We may request that you send us the invoice during this period for the purpose of verification.
- Submit your invoice using the Zorg en Zekerheid app (free download from the App Store or Google Play Store).

or:
- Write your personal customer number on the original invoice(s) and send your original invoice(s) in an envelope postage paid to:

**Zorg en Zekerheid**
**Attn.: Afdeling Declaraties**
**Postbus 428**
**2300 AK LEIDEN**

- As all original invoices remain the property of Zorg en Zekerheid we recommend that you make a copy for your own records.
- The deadline for submitting invoices is 31 December of the third year after the year in which the treatment was carried out.
- There are a number of medical treatments for which you will need to ask for approval beforehand; a list of these can be found in these policy conditions in Section B: Extent of the cover.

### How do I get my invoice for my foreign stay reimbursed?

To claim medical costs incurred abroad you must submit both the original invoice and a claim form (declaratieformulier). You can download this form via **zorgenzekerheid.nl** or request it from Zorg en Zekerheid. You can send the original invoice with the claim form postage paid to:

**Zorg en Zekerheid**
**Attn.: Afdeling declaraties Buitenland**
**Postbus 428**
**2300 AK Leiden**

### A single IBAN

You do not need to state your IBAN when making a claim. When paying out your claims, Zorg en Zekerheid will use the IBAN it also uses for the collection or payment of premiums (if possible). This IBAN is stated on your policy schedule.

# Policy Conditions 2018

## Supplementary Insurance

Zorg en Zekerheid
zorgverzekeraar

# Glossary

### Acupuncturist
An acupuncturist registered as a doctor or dentist in accordance with the conditions stipulated in Section 3 of the Act (Individual Healthcare Professions Act) and who has completed the supplementary training course in acupuncture. This can also be a person who has completed training at higher professional level and satisfied the requirements and quality criteria of the NVA (Netherlands Association for Acupuncture). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Ambulance transport
The medically necessary transport by ambulance of individuals who are ill or wounded.

### Anthroposophic therapist
An anthroposophic therapist must comply with one of the following conditions, namely that he/she must be:
- a physiotherapist who is registered in accordance with the conditions of Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed a supplementary training course in anthroposophy;
- a dietician, speech therapist or remedial therapist who satisfies the requirements of the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who has completed a supplementary training course in anthroposophy;
- a nurse or midwife who is registered in accordance with the conditions of Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed a supplementary training course in anthroposophy;
- a healthcare professional who has completed the training course in artistic therapy or eurhythmics at higher professional education level;
- a healthcare professional who has completed a supplementary training course in anthroposophic (psychosocial) assistance.

All therapists must be registered with a professional association affiliated with the FAG (Federation of Anthroposophic Healthcare). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Pharmacist
A pharmacist who is listed in the register of established pharmacists referred to in Section 61, paragraph 5 of the Medicines Act (*Geneesmiddelenwet*).

### Dispensing general practitioner
A general practitioner (family doctor) who is permitted to dispense medicines by virtue of Section 61, paragraphs 10 and 11 of the Medicines Act.

### Doctor
A doctor registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### Basic insurance
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as the master policy or healthcare insurance.

### Corporate physician
A doctor registered as a corporate physician in the register administered by the RGS (Medical Specialists Registration Committee) of the KNMG (Royal Dutch Medical Association) and who acts on behalf of an employer or the Occupational Health and Safety Service to which that employer is affiliated.

### Pelvic physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a pelvic physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Board of Directors
The Board of Directors of the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### Centre for special dentistry
A university centre or centre deemed to be equivalent by Zorg en Zekerheid established for the provision of dental care in special cases in which treatment requires a team-based approach and/or special expertise.

### Advice centre for heredity issues
An organisation which holds a licence under the Specialist Medical Procedures Act (*Wet op bijzondere medische verrichtingen*) for clinical genetic research and heredity advice.

### Centre for specialist medical care
An institution for specialist medical care that has been accredited as such under or pursuant to the regulations imposed by the Care Institutions (Accreditation) Act (WTZi).

### Chiropractor
A chiropractor who is registered as a professional in the chiropractic profession and who has completed academic training (recognised 'college of chiropractic'). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Chronic disorders requiring physiotherapy and/or remedial therapy
A disorder that is included in Appendix 1 of the Healthcare Insurance Decree on the date on which the treatment was specified on the claim invoice. The list can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Collective
A group of individuals whose interests are promoted by an employer or a legal entity other than the employer by virtue of an agreement between Zorg en Zekerheid and that employer or legal entity.

### Craniosacral therapist
A care provider (who is not the patient's own general practitioner) who is trained in healthcare to at least higher professional education (HBO) standard, and who complies with the educational entry requirements set by the RCN (register for craniosacral therapy in the Netherlands). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Day treatment
Treatment at an institution involving admission and discharge on one and the same day.

### DOT (Diagnosis/Treatment Package towards Transparency) and Diagnosis/Treatment Combination (DTC) care product
DOT is the claim system for hospitals that came into effect on 1 January 2012. The units eligible for reimbursement are called DTC care products. These DTC care products have been defined by the Dutch Healthcare Authority (NZa). A DTC care product commences at the moment an insured person applies for treatment from a medical specialist and is concluded after a fixed number of days. The rates that apply to these care products can be divided into three categories: a fixed category with fixed rates, a regulated category to which maximum rates apply and a non-fixed category in which insurers conclude agreements with hospitals, independent treatment centres and independent extramural specialists about the applicable rates.

### Diagnosis / Treatment Combination for mental healthcare (GGZ), DTC
A DTC describes the defined, validated process involved in specialist medical care and specialist (secondary) mental healthcare, in terms of a DTC code of practice established by the NZa (Netherlands Healthcare Authority). This description includes the patient's care need, the type of care, the diagnosis and the treatment. The DTC process starts at the point at which the policyholder reports a problem to the medical specialist and finishes at the end of treatment, or after 365 days.

### Service structure
An association of general practitioners registered as a legal entity which was established to provide GP care during evenings, nights and weekends and which charges a legally valid rate.

### Dietician
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', in accordance with Section 34 of the BIG (Individual Healthcare Professions) Act.

### Chemist medicine
Medicine that can be obtained at a pharmacy or chemist without a prescription but that is not a homeopathic medicine. This is determined using the KNMP (Royal Dutch Pharmacy Society) list that is applicable at the time of supply. These medicines are also known as 'over-the-counter drugs'.

### DSM IV-TR
Diagnostic Statistical Manual of Mental Disorders: the international classification system for mental healthcare. The DSM lists the criteria that serve as a guideline in the diagnosis of a psychiatric disorder. IV-TR refers to the textual review of the fourth revised version of the DSM.

### Personal contribution
That portion of the costs of care and other services to be borne by the insured person as determined by law. The personal contribution can be a fixed amount per treatment or a percentage of the costs of the care. The personal contribution is not the same as the excess. Excess and personal contribution can be simultaneously applicable to the insured care.

### Occupational therapist
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### EU or EEA state
In addition to the Netherlands, the following countries are part of the European Union: Austria, Belgium, Bulgaria, Croatia, Cyprus (the Greek part), the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Sweden and the United Kingdom. Switzerland has equal status on the basis of treaty provisions. The EEA Member States (signatories to the EEA Agreement) are Liechtenstein, Norway and Iceland.

### Pharmaceutical care
Pharmaceutical care includes advice or supervision for the purpose of assessing medicines and the responsible use of UR medicines (medicines available exclusively on prescription) as referred to in Section 1, paragraph 1 under s of the Medicines Act or the provision of these medicines, or pharmaceutical care to which the Blood Supply Act (*Wet inzake bloedvoorziening*) applies.

### Phlebologist/proctologist
A doctor who complies with the quality criteria used by the Benelux Association for Phlebology, for instance.

### Fraud
Fraud is defined, in any case, as the act of or committing, or an attempt to commit, forgery of documents, deceit, to prejudice entitled parties and/or commit embezzlement with respect to the conclusion and/or performance of a health insurance contract or other insurance contract, and aimed at acquiring a payment or goods or services to which there is no entitlement or acquiring insurance cover under false pretences.

### Physiotherapist
A physiotherapist registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act. A remedial gymnastics masseur as referred to in Section 108 of the aforementioned Act is also deemed to be a physiotherapist.

### Birth centre
A facility that provides delivery and postnatal care under the direction of obstetricians and midwives providing primary obstetrics care. A primary birth centre is typically housed in separate accommodation with a distinctive physiological atmosphere and a direct, covered walkway to the hospital. A primary birth centre serves as an alternative for women who wish to deliver their child at an outpatients' clinic without it being medically necessary to do so.

### Contracted care
Care provided by Zorg en Zekerheid under a health insurance policy on the basis of an agreement concluded between Zorg en Zekerheid and a care provider or care institution.

### Generalist Basic Mental Healthcare (GGZ)
Care offered within the Basic Mental Healthcare (GGZ) framework comprises, in any case, primary psychological healthcare and several components from current specialised mental healthcare. Generalist basic mental healthcare is subdivided into four service types based on the associated patient profiles:
a. Short-term (BK);
b. Basic medium-term mental healthcare (Basis GGZ Middel, BM);
c. Basic intensive mental healthcare (Basis GGZ Intensief, BI);
d. Basic chronic mental healthcare (Basis GGZ Chronisch, BC).

### Geriatric physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a geriatric physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Geriatric rehabilitation
Geriatric rehabilitation includes integral and multi-disciplinary rehabilitation care as provided by specialists in geriatric medicine in connection with physical frailty and complex multimorbidity and a reduced ability to learn and be trained. The aim of geriatric rehabilitation is to improve the insured person's functional limitations and therefore enable a return to the home situation.

### Family
Two married persons or two unmarried persons with or without unmarried children or a single person with one or more unmarried children, who demonstrably cohabit long-term and who run a joint household.

### Family member
Person belonging to the family as referred to in the previous definition.

### Health psychologist
A health psychologist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the BIG (Individual Healthcare Professions) Act.

### GeZZondCheck
The GeZZond Check is a tool used to measure how healthy you are. The results obtained can be used to provide you with personal recommendations regarding your health and lifestyle.

### GGD doctor
A doctor who works for the Municipal Health Services in the field of public health, forensic medicine and medical aid in emergency situations, natural disasters and suchlike.

### Mental healthcare institutions
Institutions that provide medical care in connection with psychiatric disorders and have been accredited as such in accordance with the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, WTZi).

### Haptotherapist
A haptotherapist who has completed a healthcare training course to higher professional education (HBO) standard and who has also completed the supplementary training course in haptotherapy. A haptotherapist must comply with the educational entry requirements and quality criteria used by the VVH (Association of Haptotherapists). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Convalescent home and care hotel
Institutions that offer short-term intensive treatment to people with physical and/or psychosocial problems whose ability to perform daily functions is disrupted and for whom outpatient treatment is not or is not yet sufficient.

### (Classic) homoeopath
A (classic) homoeopathist registered as a doctor or dentist in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in homoeopathic medicine, or a (classic) homoeopathist who has completed a healthcare training course to higher professional education (HBO) standard and a supplementary training course in homoeopathy. A homoeopath or classic homoeopath must comply with the educational entry requirements and quality criteria used by the NVKH (Netherlands Association for Classic Homoeopathy), for instance. A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Treatment coordinator
A care provider who establishes a diagnosis and determines the treatment plan in response to the patient's care need. To that end, the treatment coordinator consults with the patient in a face-to-face meeting at least once. The treatment coordinator is responsible for the effective implementation of the treatment plan by ensuring proper alignment and communication with the fellow care providers, and tests the extent to which the treatment goals are achieved. The treatment coordinator communicates with the patient to evaluate the progress made and adjusts the treatment plan where necessary.

### Master policy
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as ‘basic insurance’ or ‘healthcare insurance’.

### Hospice
An institution specially designed for the temporary care of terminally ill patients in the final phase of their life and for the temporary care of their close family and relatives.

### Skin therapist
A skin therapist who satisfies the requirements stipulated in the Decree on educational requirements and area of expertise for skin therapists, in accordance with Section 34 of the BIG Act.

### General practitioner
A doctor listed as a general practitioner in the register of the KNMG (Royal Dutch Medical Association), established by the RGS (Registration Commission for Medical Specialists).

### Care aids
The care aids as specified in the health insurance policy.

### Care aid provision
The provision of care aids, as well as bandaging, under ministerial regulations, taking into account the Zorg en Zekerheid Care Aids Regulations with respect to requirements for permission, duration of use and volume prescriptions.

### IVF attempt
Care relating to in vitro fertilisation methods, including:
- hormone treatment to stimulate the maturation of ova within the ovaries;
- follicle puncture;
- the fertilisation of ova and cultivation of embryos in a laboratory;
- single or multiple intrauterine implantations of embryos to initiate pregnancy.

### Youth healthcare doctor
A doctor as referred to in the Youth Care Act (*Wet op de jeugdzorg*).

### Dental surgeon
A dental specialist registered as a dental surgeon in the register of specialists in oral diseases and dental surgery of the NMT (Netherlands Dentistry Society).

### Multi-disciplinary care
Multi-disciplinary care, in the event of a specific chronic condition (COPD, CVRM and diabetes mellitus type 2). The care must be provided by a diverse group of care providers in a coordinated manner, and in conformance with the care standards for the condition in question. For an overview of care providers taking part in multi-disciplinary care, please visit our website at zorgenzekerheid.nl/zorgzoeker.

### Child
Unmarried own, adopted or foster child under 18 years old.

### Child physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a child physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Child remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who is registered as a child remedial therapist in the Quality Register for Paramedics.

### Clinical psychologist
A healthcare psychologist registered as such in accordance with the conditions stipulated in Section 14 of the BIG (Individual Healthcare Professions) Act.

### Maternity bureau or maternity centre
An institution accredited in accordance with statutory regulations and acknowledged by Zorg en Zekerheid as such for the provision of maternity care at the home address or other accommodation of the insured party.

### Maternity care
The care of the mother and newborn child at the insured person’s home that is provided by a maternity caregiver affiliated with the maternity bureau, after an intake, by phone or otherwise, by the maternity bureau or maternity centre.

### Laboratory testing
Testing carried out by a laboratory accredited as such in accordance with the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, WTZi).

### Lactation expert
A lactation expert who is affiliated with a professional group of lactation experts and who works in accordance with the guidelines laid down by the NVL (Dutch Association of Lactation Experts).

### Disorders in physical function
Disorders in physical function are defined as handicaps related to movement, vision or mobility. Psychological and social functional disorders arising from a physical defect do not form an indication for reimbursement.

### Speech therapist
A speech therapist who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Manual practitioner
A manual practitioner registered as a doctor in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in manual medicine.

### Manual therapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a manual therapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Informal care
The care of the chronically ill, disabled and people in need of help by close family/relatives, other family, friends, acquaintances and neighbours.

### Market rate
Insofar as the amount charged by the care provider is not unreasonably high in proportion to the amount charged by other care providers for similar procedures.

### Medical adviser
A doctor, dentist, physiotherapist or other expert who advises Zorg en Zekerheid on medical, physiotherapy-related or other matters.

### Medical necessity
An insured person is only entitled to the type and scale of care that is reasonably appropriate to the insured person's needs and insofar as it is covered by this policy, such at the discretion of the medical adviser of Zorg en Zekerheid.

### Medically necessary care abroad
Care that is medically necessary and cannot reasonably be postponed until the insured person has returned to his country of residence.

### Medically necessary repatriation
The medically necessary patient transport from the place of stay abroad to a hospital, rehabilitation institution or nursing home in the Netherlands, in the case of a stay abroad as referred to in Article 3, Care Abroad.

### Medical specialist
A doctor listed as a medical specialist in the register of the KNMG (Royal Dutch Medical Association), established by the RGS (Registration Commission for Specialists).

### Oral hygienist
An independent oral hygienist who satisfies the requirements stipulated in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podotherapists and is authorised under Section 4 of the Decree governing Functional Self-Employment.

### Practitioner of natural medicine
A person registered in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in natural medicine.

### Oedema therapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as an oedema therapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Cesar/Mensendieck remedial therapist
A Cesar/Mensendieck remedial therapist who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Accident
A sudden and direct effect of an external force that causes physical injury the medical nature and location of which can be determined by Zorg en Zekerheid.

### Admission
Admission to an institution, if and insofar as the insured care can only be offered at an institution on medical grounds.

### Orthodontics
A treatment or examination generally acceptable according to medical and dentistry standards and classified as a specialisation practised by an orthodontist.

### Orthodontist
A dental specialist registered in the register of persons specialising in dento-maxillary orthopaedics maintained by the NMT (Netherlands Dentistry Society).

### Orthomolecular practitioner
A doctor registered in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act and who has completed the supplementary training course in orthomolecular medicine.

### Educationalist
An educationalist registered as a remedial educationalist with the NVO (Dutch Association of Educators and Educationalists).

### Osteopathist
An osteopathist who has completed a healthcare training course to higher professional education (HBO) standard and who has completed the supplementary course in osteopathy and is registered with the NRO (Dutch Register for Osteopathists). A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Menopause consultant
A menopause consultant who has completed a healthcare training course to higher professional education (HBO) standard with the additional qualification of gynaecology and who complies with the quality criteria laid down by the Care for Women association, for instance.

### Partner
The person with whom the insured person cohabits long-term or is married to or with whom the insured person runs a joint household.

### (Medical) pedicure
The pedicure must be registered with the KRP (Quality Register for Pedicures). For treatment to qualify for reimbursement under basic insurance coverage, a pedicure must hold the qualification 'foot care for diabetics'. For treatment to qualify for reimbursement under supplementary insurance coverage, a pedicure must hold an additional qualification 'foot care for diabetics' (DV) and/or 'foot care for rheumatic patients' (RV). In addition to basic foot treatment, he/she specialises in giving foot treatments to diabetics and/or rheumatic patients. A medical pedicure is a specialised pedicure who can treat all forms of clients' complex foot problems.

### Register of personal data
An interlinked collection of personal data relating to various persons that is maintained using IT devices or that is systematically built up to allow for efficient consultation of the data.

### Podopostural therapist
A podopostural therapist who has completed a healthcare training course to intermediate vocational education (MBO) or higher professional education (HBO) standard and who complies with the educational entry requirements and quality criteria used by the Omni Podo Society, for instance.

### Podotherapist
A dietician who complies with the requirements set down in the 'Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists', as referred to in Section 34 of the BIG (Individual Healthcare Professions) Act.

### Podologist
A podologist who has completed a healthcare training course to intermediate vocational education (MBO) or higher professional education (HBO) standard and who complies with the requirements of the Stichting LOOP foundation, for instance.

### Psychosomatic physiotherapist
A physiotherapist registered in accordance with the regulations referred to in Section 3 of the BIG (Individual Healthcare Professions) Act and registered as a geriatric physiotherapist in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy) or the Physiotherapy Quality Mark.

### Psychosomatic remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Decree governing Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthopaedists and Podotherapists and who is registered as a psychosomatic remedial therapist in the Quality Register for Paramedics.

### Psychotherapist
A psychotherapist registered as such in accordance with the conditions stipulated in Section 3 of the BIG Act.

### Psychiatrist/neurologist
A doctor listed as a psychiatrist/neurologist in the register of the KNMG (Royal Dutch Medical Association) established by the RGS (Registration Commission for Specialists). The term ‘psychiatrist’ as used in the terms and conditions is interchangeable with the term ‘neurologist’.

### Reasonable distance
A reasonable distance to a contracted care provider within a fixed radius, in km, from the residence of the insured person. A list of reasonable distances with respect to various types of care is available on request from Zorg en Zekerheid. Please contact Zorg en Zekerheid for this information at (071) 5 825 825 or by visiting one of our shops.

### Pharmaceutical Care Regulations
The Pharmaceutical Care Regulations may be requested from Zorg en Zekerheid and can be viewed at **zorgenzekerheid.nl/brochures**.

### Care Aids Regulations
The Care Aids Regulations may be requested from Zorg en Zekerheid or viewed at **zorgenzekerheid.nl/brochures**.

### Rehabilitation
Examination, advice and treatment of a combined specialist medical, paramedical, behavioural scientific and rehabilitative nature. This care is provided by a team of multi-disciplinary experts under the supervision of a medical specialist affiliated with a rehabilitation institution approved under the regulations imposed by the Care Institutions (Accreditation) Act (*Wet toelating gezondheidsinstellingen*, WTZi).

### Beautician
A beautician who has completed a healthcare training course to higher professional education (HBO) standard and who has also completed the supplementary training courses organised by ANBOS (General Dutch Sector Organisation for Beautician Care), for instance.

### Second opinion
A request made to a second, independent physician for an assessment regarding a diagnosis and/or proposed treatment made by your attending physician. The following requirements apply:
- Both physicians must work within the same field of specialisation;
- You must return to the first physician with the second opinion, thus ensuring that the treatment is carried out under this person’s direction;
- The attending physician must issue a referral for a second opinion.

### Shiatsu therapist
A therapist who has completed a healthcare training course to higher professional education (HBO) standard that complies with the requirements of the VIS (Association for IOKAI Shiatsu), for instance. A list of registers and approved professional associations can be found at **zorgenzekerheid.nl/zorgzoeker**.

### Specialist mental healthcare-
Diagnostics and specialist treatment of complex psychological disorders/conditions. The involvement of a specialist (psychiatrist, clinical psychologist or psychotherapist) is required.

### Specialist care
Care or examinations that in accordance with generally accepted medical standards are part of the specialisation for which the medical specialist is registered and that may be deemed to be the usual treatment or examination.

### Standard maternity package
A maternity package that includes all necessary care aids for the delivery and for the period of recovery following a delivery.

### Dentist
A dentist registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### 'Tandprotheticus' dental technician
A dental technician trained in accordance with the Decree on educational requirements and area of expertise for '*tandprotheticus*' dental technicians.

### ‘Tandtechnicus’ dental technician
A dental technician who prepares pieces of dental work at a dental laboratory.

### You/the insured person
The person for whom the insurance agreement is entered into and who is registered as an insured person with Zorg en Zekerheid.

### Comprehensive maternity package
A maternity package that along with all necessary care aids for the delivery and period of recovery following delivery also includes a number of useful extras.

### Inpatient care
A stay for at least 24 hours.

### Contracting country
Any state with which the Netherlands has entered into a treaty concerning social security, which includes rules governing the provision of healthcare, other Member States of the European Union, a signatory of the EEA Agreement, or Switzerland.

### Midwife
A midwife registered as such in accordance with the conditions stipulated in Section 3 of the BIG (Individual Healthcare Professions) Act.

### Mutilation
Mutilation is defined as a case of serious disfigurement that is directly noticeable in day-to-day life. This mutilation must be the result of a disease, accident or medical procedure.

### Nurse
A nurse as registered in accordance with Section 3 of the BIG (Individual Healthcare Professions) Act.

### Nursing specialist
A nurse as registered in accordance with Section 3 of the BIG (Individual Healthcare Professions) Act who specialises in acute, chronic, preventive or intensive care for somatic conditions or in mental healthcare.

### Insured person
Every person obliged to take out insurance and whose name is specified on the insurance policy, policy endorsement or certificate of registration.

### Insurance
The legal relationship regulated by the insurance agreement.

### Policy period
The length of the total period during which a person has been insured with Zorg en Zekerheid without interruption.

### Policyholder
The person who entered into the insurance agreement with Zorg en Zekerheid.

### Insurance year
The period specified on the policy schedule and each subsequent continuous 12-month period.

### Insurance agreement
The insurance agreement entered into between a policyholder and the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### Welfare organisation
A non-profit organisation dedicated to improving and promoting good health (other than for recreational purposes) by providing care, hosting courses and informative meetings, all in a group context.

### BIG (Individual Healthcare Professions) Act
The Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*, BIG).

### We/us/Zorg en Zekerheid
The Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

### District nursing
Nursing and care as provided by nurses.

### WLZ
Long-Term Care Act (*Wet langdurige zorg,* WLZ).

### WMG rates
The rates set under or pursuant to the Healthcare (Market Regulation) Act (*Wet marktordening gezondheidzorg*, WMG).

### Over-the-counter drugs
Medicine that can be obtained at a pharmacy or chemist without a prescription but that is not a homeopathic medicine. This is determined using the KNMP (Royal Dutch Pharmacy Society) list that is applicable at the time of supply. Also known as ‘chemist medicine’.

### Hospital
A centre for specialist medical care that is admitted as a hospital or ZBC (independent treatment centre) in accordance with the rules of the WTZi Act (Care Institutions (Eligibility) Act).

### Persons with sensory disabilities
Persons with a visual or auditive impairment or a communicative impairment resulting from a linguistic developmental disorder.

### Seated patient transport
Transportation by public transport, car or taxi, other than an ambulance, for which the insured person can be reimbursed pursuant to the Healthcare Insurance Act (Zorgverzekeringswet).

### Care hotel and convalescent home
Institutions that offer short-term intensive treatment to people with physical and/or psychosocial problems whose ability to perform daily functions is disrupted and for whom outpatient treatment is not or is not yet sufficient. This does not include a stay at a primary care institution.

### Healthcare insurance policy
The deed concluded between the policyholder and the insurance company in which the health insurance coverage is set down.

### Health Insurer
The insurer who is accredited as such and provides insurance within the meaning of the Healthcare Insurance Act (Zorgverzekeringswet), hereinafter to be referred to as Zorg en Zekerheid.

### Healthcare insurance
The healthcare insurance in accordance with the ZVW Act (Healthcare Insurance Act) taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as ‘basic insurance’ or ‘the master policy’.

### Care Intensity Package (ZZP)
A Care Intensity Package (known by its Dutch abbreviation, ZZP) is a care package geared to your personal characteristics and to the care you need. The ZPP comprises the elements of residential services, care, treatment and services, and possibly also day-care activities. There are several types of ZZP, some of which include day-care activities. The level of the ZZP corresponds to the level to which you are entitled. The care must reflect the statutory description of one of the ZZPs defined for this purpose for long-term mental healthcare. A comprehensive description of all the care covered by a ZZP can be found on the website of the Dutch Healthcare Authority NZa.

# Section A Extent of cover

This section sets out the entitlements and/or reimbursements that you are entitled to as an insured person. These Articles set out the conditions under which you are entitled to reimbursement, along with the (maximum) reimbursement, as adopted by the Members' Council on 09 November 2017. The reimbursement for medical costs under the Zorg en Zekerheid supplementary insurance policies is based on the rates agreed with the care providers by us or on our behalf. If no rates have been agreed, we will reimburse the medical costs in accordance with the rates set under the Healthcare (Market Regulation) Act (WMG). If no WMG rate has been agreed, we will reimburse the medical costs in accordance with the rates published on **zorgenzekerheid.nl/vergoedingenzoeker**. As an insured person, you are only entitled to care if you reasonably depend on the type of care in question in terms of its content and extent. Whether you do will be determined in part by the effectiveness and quality of the care or services. Together, the insurance terms and conditions and this section constitute the General Terms and Conditions for your supplementary insurance with Zorg en Zekerheid.

## Article 1: Alternative consultations, treatments and medicines

*What is reimbursed?*
Costs are defined as the costs of consultations, treatments and medicines. Each calendar year, the following costs are eligible for reimbursement for each insured person:
- homoeopathic/anthroposophical medicines, and
- the following alternative treatments:
  - acupuncture;
  - anthroposophy;
  - chiropractic;
  - craniosacral therapy;
  - halotherapy;
  - haptotherapy;
  - (classic) homoeopathy;
  - manual medicine;
  - natural medicine;
  - orthomolecular medicine;
  - osteopathy;
  - (medical) Shiatsu.

*What are the conditions for reimbursement?*
Medicines:
- The medicines must be prescribed by your attending doctor.
- The medicines must be supplied by a pharmacist or dispensing general practitioner.
- The medicines must be registered in the database maintained by the CBG (Medicines Evaluation Board). The list of registered medicines can be found at **cbg-meb.nl** or alternatively the medicines are produced by one of the following manufacturers: Wala®, Weleda®, Heel®, Vogel®, Biohorma®, Vsm®, Reckeweg®, Dolyssos® or Steigerwald®.

Treatment methods:
- In the case of manual medicine, orthomolecular medicine or natural medicine, the treatment must be provided by a doctor who is not your own general practitioner.
- In the case of halotherapy, you must be referred by a doctor, general practitioner or physiotherapist.
- For all other alternative treatment methods named above, the person treating you must comply with the conditions set out in the Glossary.

*How much reimbursement will I receive under my supplementary insurance?*
The percentage of reimbursement and maximum amounts apply for all alternative consultations, treatments and medicines together.

| | **AV-GeZZin Compact** | **AV-Basis AV-Sure AV-Standaard** | **AV-Top AV-GeZZin AV-Plus** | **AV-Totaal** |
|---|---|---|---|---|
| Maximum | No reimbursement | €250 | €460 | €600 |
| Treatment/ Consulations | No reimbursement | 100% up to €25 per day | 100% up to €40 per day | 100% |
| Medication | No reimbursement | 50% | 75% | 100% |

## Article 2: Optic care

### 2.1 Lenses, contact or premium lenses and frames

*What is reimbursed?*
Every insured person is entitled to reimbursement every two calendar years for the purchase of lenses, contact or premium lenses and frames.

*What are the conditions for reimbursement?*
- To be eligible for reimbursement, lenses must have a strength of at least 2.25 dioptres (also if only the frame is to be reimbursed).
- Please note that if this concerns lenses with a strength starting at 0 dioptres, this must concern prescription glasses.

*How much reimbursement will I receive under my supplementary insurance?*
The maximum reimbursement applies for the costs of glasses, lenses and spectacle frames together.

| **AV-GeZZin Compact** | **AV-Basis AV-Sure AV-Standaard** | **AV-Top** | **AV-GeZZin** | **AV-Plus** | **AV-Totaal** |
|---|---|---|---|---|---|
| No reimbursement | Maximum of €40 once every two calendar years | Maximum of €70 once every two calendar years | Maximum of €70 once every two calendar years, orone pair of children's glasses per calendar year for children up to age 12 starting at 0 dioptres up to a maximum €70 | Maximum of €100 every two calendar years | Maximum of €150 once every two calendar years, starting at 0 dioptres,or one pair of children's glasses per calendar year for children up to age 12 starting at 0 dioptres up to a maximum €150 |

### 2.2 Laser eye treatment

*What is reimbursed?*
The costs of laser eye treatment on a once-only basis, regardless of whether this concerns one or both eyes.

*What are the conditions for reimbursement?*
The reimbursement set out in the table below applies once only during the entire term of the insurance. 'Once only' means that if we have reimbursed the costs of eye-laser treatment at any moment (also if we did so in a previous calendar year), we will not reimburse them again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis AV-Sure AV-Standaard AV-GeZZin Compact** | **AV-Top AV-GeZZin AV-Plus** | **AV-Totaal** |
|---|---|---|
| No reimbursement | A maximum of €200 (once-only) | A maximum of €300 (once-only) |

## Article 3: Abroad

### 3.1 Vaccination in the case of planned stay abroad

*What is reimbursed?*
The costs of the tablets/injection(s)/consultations and the vaccination booklet qualify for reimbursement. The reimbursement applies for each insured person per calendar year.

*What are the conditions for reimbursement?*
- The costs must have been incurred as the result of a planned stay abroad or during an actual stay abroad.
- Reimbursement covers the costs of tablets/injection(s)/consultations and the vaccination booklet in accordance with the applicable GGD list and the website of the National Coordination Centre for Travel Advice (Landelijk Coördinatiecentrum Reizigersadvisering, LCR). See **lcr.nl** for more information.
- The Pharmaceutical Care Regulations apply; see **zorgenzekerheid.nl/brochures**.

*Which costs do not qualify for reimbursement?*
Laboratory tests, gnat cream and gnat oil are excluded from reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*
The maximum reimbursement applies for the costs of the tablets/injection(s)/consultations and the vaccination booklet together.

| | **AV-Basis<br>AV-Standaard<br>AV-GeZZin<br>Compact** | **AV-Sure** | **AV-Top<br>AV-GeZZin<br>AV-Plus** | **AV-Totaal** |
|---|---|---|---|---|
| Contracted care provider* | No reimbursement | 100% | A maximum of €80 | 100% |
| Nonc-ontracted care provider | No reimbursement | A maximum of €80 | A maximum of €80 | A maximum of €150 |

* For a list of contracted care providers, see **zorgenzekerheid.nl/zorgzoeker**

### 3.2 General terms and conditions for reimbursement of the costs of urgent, medically necessary care abroad

*What are the conditions for reimbursement?*
The costs of urgent, medically necessary medical care and/or dental care and/or of assistance abroad will be reimbursed if the following conditions are met:
- When leaving to travel abroad it could not be foreseen that the medical and/or dental care would be needed.
- Obtaining medical and/or dental care was not the sole reason or one of the reasons for the stay abroad.
- It would not be medically justifiable to delay the treatment until the person returns to the Netherlands.
- In the case of hospital admission, long-term medical treatment or more than two treatments at the outpatients' clinic, ANWB International Assistance (ANWB Alarmcentrale) is contacted promptly. This service should preferably be contacted by calling (+31 71 5 825 444), by email (**alarmcentrale@anwb.nl**) or by fax
- (+31 70 3 147 040).
- When claiming medicines and bandaging aids, a copy of the prescription or proof of the consultation with a general practitioner/medical specialist is included.
- This reimbursement can only be applied for once per calendar year.

### 3.3 Urgent, medically necessary care during a stay abroad

*What are the conditions for reimbursement?*
The costs must have been incurred during a holiday or business trip (including downhill and cross-country skiing trips), work placement or period of study.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis, AV-Sure, AV-Standaard, AV-GeZZin Compact, AV-Top, AV-GeZZin, AV-Plus, AV-Totaal** |
|---|
| - Cost price in Europe;<br>- Outside Europe, a maximum of 200% of the prevailing market rates or WMG rates in the Netherlands*. |

* The reimbursement of a maximum of 200% of the prevailing market rates or WMG rates in the Netherlands will be determined inclusive of the reimbursement awarded under a basic insurance.

In the case of countries outside Europe (such as the United States), we recommend taking out travel insurance that covers medical expenses.

### 3.3.1 Medical costs

*What is reimbursed?*

The following medical costs are eligible for reimbursement:

- medical care by a doctor or medical specialist;
- hospital nursing in the lowest category;
- (local) medically necessary ambulance transportation from the patient's location abroad to the nearest hospital, doctor or specialist and back again to the original location abroad;
- medically necessary transportation by taxi, own transport or public transport. If you use your own transport, Zorg en Zekerheid will reimburse a sum of €0.30 per kilometre. The reimbursement will in all cases be limited to a maximum of €115 per holiday and/or business trip;
- physiotherapeutic treatments of a chronic condition that have already started in the Netherlands;
- medicines or bandaging aids on prescription from a doctor or medical specialist abroad.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis, AV-Sure, AV-Standaard, AV-GeZZin Compact, AV-Top, AV-GeZZin, AV-Plus, AV-Totaal** |
|---|
| - Cost price in Europe;<br>- Outside Europe, a maximum of 200% of the prevailing market rates or WMG rates in the Netherlands*. |

* The reimbursement of a maximum of 200% of the prevailing market rates or WMG rates in the Netherlands will be determined inclusive of the reimbursement awarded under a basic insurance.

### 3.3.2 Dental costs

*What is reimbursed?*

The costs of emergency dental care based on the cost price are eligible for reimbursement.

*What are the conditions for reimbursement?*

The costs concerned must relate to emergency dental care.

*Which costs do not qualify for reimbursement?*

The costs of crowns, bridges and implants are excluded.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | A maximum of €345 |

### 3.3.3 Medically necessary repatriation to the Netherlands and dispatch of medicines

*What is reimbursed?*

The costs of medically necessary repatriation and of sending the medically necessary medicines are eligible for reimbursement.

*What are the conditions for reimbursement?*

The costs must relate to:

- medically necessary repatriation to the Netherlands of the ill or injured insured person or the transfer of the insured party's mortal remains to the Netherlands;
- medically necessary assistance with the above-mentioned repatriation;
- the dispatch of medicines insofar as permitted by customs regulations. There must be an urgent medical need for the medicines, which must not be available in the country where the insured person is staying and must be prescribed by a doctor.

In addition, the repatriation, assistance and dispatch of medicines must be carried out by or on the instructions of ANWB International Assistance (ANWB Alarmcentrale), once approved.

*Which costs do not qualify for reimbursement?*

The costs of repatriation on social (non-medical) grounds do not qualify for reimbursement, other than in the case of transportation of mortal remains.

*How much reimbursement will I receive under my supplementary insurance?*

**AV-Basis, AV-Sure, AV-Standaard, AV-GeZZin Compact, AV-Top, AV-GeZZin, AV-Plus, AV-Totaal**

100%

### 3.3.4 The costs of support from ANWB International Assistance

*What is reimbursed?*
The costs of support from ANWB International Assistance (ANWB Alarmcentrale) are eligible for reimbursement.

*What are the conditions for reimbursement?*
- The costs of organisation and mediation by ANWB International Assistance in connection with the following events:
- illness, accident and death;
- hospital admission;
- long-term medical treatment and more than two treatments at an outpatients' clinic by a doctor or specialist;
- medically necessary repatriation of the insured person to the Netherlands;
- dispatch of medicines.

*How much reimbursement will I receive under my supplementary insurance?*

**AV-Basis, AV-Sure, AV-Standaard, AV-GeZZin Compact, AV-Top, AV-GeZZin, AV-Plus, AV-Totaal**

100%

### 3.4. Exclusions

*Which costs do not qualify for reimbursement?*
There is no entitlement to reimbursement of medicinal and/or dental costs and/or costs from your supplementary insurance for assistance provided abroad in relation to:

a. a stay in a country for which a travel warning has been issued by the Netherlands Ministry of Foreign Affairs (see **minbuza.nl**) or the ANVR (Dutch Association of Travel Agents and Tour Operators);
b. costs relating to ski jumping, ski flying, skijoring, ski mountaineering, ski touring, glacier skiing, glacier rekking, bobsleighing, competitive tobogganing, skeleton, ice hockey, paraskiing, heliskiing, the figure jumping section of freestyle skiing, and the preparation for and participation in winter sport competitions (not including 'Gästerennen' (hotel guest races)); If you practise a sport that is not listed above, please phone our specialist team Buitenland at (071) 5 825 266 or else e-mail **declaraties@zorgenzekerheid.nl**;
c. costs arising from high-risk sports such as hang-gliding, parachute jumping and fighting sports, bicycle racing competitions, rugby, wild water sports, horse racing, competitive ocean sailing and mountain trips other than on marked paths and trails, diving (without a licence or professional supervision);
d. if you practise a sport that is not listed above, please phone our specialist team Buitenland at (071) 5 825 266 or else e-mail **declaraties@zorgenzekerheid.nl**;
e. costs relating to pregnancy or delivery after the 31st week;
f. costs relating to dental work for insured persons with AV-Basis, AV-Standaard, AV-Sure or AV-GeZZin Compact insurance;
g. Costs relating to alternative care with respect to treatment as well as medication;
h. costs relating to paramedical care, with the exception of treatment for which prior authorisation was obtained;
i. costs included on invoices prepared in a language other than Dutch, French, German or English. Original invoices in other languages must be drawn up and/or translated such that without the need for further queries Zorg en Zekerheid can determine the reimbursement due.

### 3.5 Oxygen abroad

*What is reimbursed?*
The costs of oxygen on holiday per calendar year are eligible for reimbursement.

*What are the conditions for reimbursement?*
You already need oxygen on medical grounds.

*How much reimbursement will I receive under my supplementary insurance?*

**AV-Basis, AV-Sure, AV-Standaard, AV-GeZZin Compact, AV-Top, AV-GeZZin, AV-Plus, AV-Totaal**

100%

## Article 4: Pharmaceutical care

### 4.1 Reimbursement of GVS personal contribution

*What is reimbursed?*
The costs of the GVS personal contribution for the medicines Concerta®, Strattera®, Equasym® and Medikinet®.

*What are the conditions for reimbursement?*
- The medicines must be prescribed by your attending physician or general practitioner and provided by a contracted pharmacist.
- The Pharmaceutical Care Regulations apply. You can consult the Regulations on **zorgenzekerheid.nl/brochures**.

*What is the GVS personal contribution?*
The Medicine Reimbursement System (GVS) implemented by the government applies. Under this system, a maximum amount is set for Concerta®, Strattera®, Equasym® and Medikinet®. If the price of the medicine is higher than the maximum amount, the additional costs will be charged to the policyholder/insured person (this is known as the 'GVS personal contribution').

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|
| No reimbursement | 100%, up to a maximum of €100 | 100%, up to a maximum of €250 |

### 4.2 Birth control

*What is reimbursed?*
The costs of birth control (oral medicines, care aids). These costs also include the costs of the work/operation carried out by the obstetrician / general practitioner.

*What are the conditions for reimbursement?*
- The costs are reimbursed excluding the GVS personal contribution, if applicable.
- The contraceptives must be prescribed by your attending physician or general practitioner and provided by a contracted pharmacist.
- Costs of care at a non-contracted care provider are reimbursed up to a maximum of 100% of the invoice amount, in accordance with the prevailing Dutch market rate.
- The Pharmaceutical Care Regulations apply. You can consult the Regulations on **zorgenzekerheid.nl/brochures**.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Sure**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100% from age 21 jaar (excluding the GVS personal contribution) |

### 4.3 Antacids

*What is reimbursed?*
Antacids are no longer reimbursed under the Healthcare Insurance Act.

*What are the conditions for reimbursement?*
- The antacids must be prescribed by your attending physician or general practitioner and provided by a contracted pharmacist.
- Antacids will only be reimbursed under your AV policy in the event of non-chronic use or, in the case of chronic use, after the first 15 days of such use.
- This only concerns antacids officially registered as such.
- Costs of care at a non-contracted care provider are reimbursed up to a maximum of 100% of the invoice amount, in accordance with the prevailing Dutch market rate.
- The Pharmaceutical Care Regulations apply. You can consult the Regulations on **zorgenzekerheid.nl/brochures**.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €35 |

### 4.4 Vaccinations

*What is reimbursed?*
The costs of diarrhoea vaccinations for infants. This includes the costs of administering the vaccination.

*What are the conditions for reimbursement?*
- The vaccinations are not part of the government's general vaccination programme.
- The vaccination must be given by a doctor in consultation with your general practitioner.
- The Pharmaceutical Care Regulations apply. You can consult the Regulations on **zorgenzekerheid.nl/brochures**.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-Plus** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €200 |

## Article 5: Delivery-related care

Note that only female insured persons can make claims for the reimbursements or entitlements set out in this section.

### 5.1 Maternity package

*What is reimbursed?*
Insured persons who are pregnant or who are adopting a baby can apply to Zorg en Zekerheid for a maternity package. If both parents are insured with Zorg en Zekerheid, they are eligible for only one maternity package.

*What are the conditions for reimbursement?*
You must apply for your maternity package in the 20th week of your pregnancy at the latest by phoning the Zorg en Zekerheid Maternity Hotline ('Kraamlijn') on (071) 5 825 555 or via the website **zorgenzekerheid.nl**, search term 'maternity care'. If you are adopting, you can also apply for the maternity package if the child is less than six months old.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|
| No maternity package | Standard maternity package | Comprehensive maternity package |

### 5.2 Reimbursement of the personal contribution for obstetric assistance and maternity care

*What is reimbursed?*
The personal contribution that you must pay per delivery under the basic insurance is eligible for reimbursement.

*What are the conditions for reimbursement?*
The personal contribution must relate to the costs of delivery at an outpatients' clinic without medical grounds or to the costs of maternity care.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Standaard** | **AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|---|
| No reimbursement | 100%, up to a maximum of €75 | 100%, up to a maximum of €100 | 100%, up to a maximum of €250 for maternity care and 100%, up to a maximum of €250, for delivery at an outpatients' clinic without medical necessity |

### 5.3 Reimbursement of extended or postponed maternity care

#### 5.3.1 Reimbursement for extended maternity care

*What is reimbursed?*

Extended maternity care after the tenth day after delivery.

*What are the conditions for reimbursement?*

- The maternity bureau will provide the medical grounds in consultation with the midwife.
- The care must be provided by a maternity centre that is engaged via the Maternity Hotline (phone number: 071 - 5 825 555).
- The extended maternity care must follow the conventional post-natal period (the ten-day period calculated from the day of delivery) or release from hospital (a maximum of ten days after delivery) without interruption.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | Maximum of 16 hours |

#### 5.3.2 Reimbursement for postponed maternity care

*What is reimbursed?*

If you are no longer entitled to regular and/or extended maternity care, you may still be eligible for postponed maternity care. This may be the case, for example, if you need to stay longer in hospital after a Caesarean or in the case of a multiple birth or incubation care. The medical necessity of the situation must be confirmed by the maternity centre in consultation with the attending obstetrician or midwife.

*What are the conditions for reimbursement?*

- The maternity bureau will provide the medical grounds in consultation with the midwife.
- The care must be provided by a maternity centre that is engaged via the Maternity Hotline (phone number: 071 - 5 825 555).
- You can claim reimbursement for postponed maternity care for a period of up to six weeks after the delivery or after the adoption of children less than six months old. The six-week period does not apply to incubated children.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | Maximum of 16 hours |

### 5.4 Breast pump

*What is reimbursed?*
Each insured party will be eligible once per calendar year for reimbursement of the costs of hiring a breast pump or only once during the entire term of the insurance for reimbursement of the costs of purchasing a breast pump.

*What are the conditions for reimbursement?*
In order to be eligible for reimbursement, you must provide a proof of purchase or hiring.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | Maximum of €40 |

### 5.5 Prenatal/antenatal course

*What is reimbursed?*
The costs of a female insured person taking one prenatal or antenatal course per calendar year.

*What are the conditions for reimbursement?*
- The course must take place during the pregnancy and must prepare you for the delivery.

or:
- The course must promote your physical recovery and must be attended within six months after the delivery.

The course must be organised by:
- a home care organisation;
- a qualified care provider who is affiliated with and complies with the quality requirements of the 'Samen Bevallen' association;
- a physiotherapist;
- a Cesar remedial therapist;
- a Mensendieck remedial therapist.

In order to be eligible for reimbursement, you must provide proof of participation (photocopied or original document, which must also state the costs of participation).

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin**<br>**AV-Top**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €100,00 |

### 5.6 Breastfeeding course

*What is reimbursed?*
The costs of an insured person taking the 'Zorg en Zekerheid breastfeeding course' per calendar year. You can apply by phoning the Zorg en Zekerheid Maternity Hotline ('Kraamlijn') on (071) 5 825 555 or via the website **zorgenzekerheid.nl**(search term: 'maternity care').

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin**<br>**AV-Top**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €20,00 |

### 5.7 Combination test

*What is reimbursed?*
The costs of one combination test taken by a female insured person per calendar year. The combination test consists of a nuchal translucency measurement (also known as a NT measurement) and a probability blood test.

*What are the conditions for reimbursement?*
The combination test must be carried out by a general practitioner, midwife or medical specialist who holds a WBO (Population Screening Act) permit for prenatal screening.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Standaard**<br>**AV-GeZZin**<br>**AV-Top**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €150 |

### 5.8 Lactation expert

*What is reimbursed?*
The costs of one lactation expert consulted by an insured person per calendar year.

*What are the conditions for reimbursement?*
The lactation expert must be affiliated with a professional group of lactation experts and must work in accordance with the guidelines laid down by the NVL (Dutch Association of Lactation Experts).

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus**<br>**AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €150 |

## Article 6: Recovery and stay

### 6.1 Convalescent home, care hotel and hospice

*What is reimbursed?*
The costs of the stay in a convalescent home, care hotel or hospice in the Netherlands are eligible for reimbursement. The costs of a home care consultation from a hospice are also reimbursed. The reimbursement applies for each insured person per calendar year.

*What are the conditions for reimbursement?*
A referral from the attending doctor is required for a stay in a convalescent home or care hotel.

*Does Zorg en Zekerheid need to approve this beforehand?*
The convalescent home or care hotel must have obtained prior permission from Zorg en Zekerheid. A list of Zorg en Zekerheid-approved convalescent homes and care hotels can be found at **www.zorgenzekerheid.nl/vergoedingenzoeker**.

Which costs do not qualify for reimbursement?
The costs of a stay in a care home / residential care centre not included on the list of approved convalescent homes and care hotels.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|---|
| No reimbursement | A maximum of €35 per day, up to a total of €1,050 | A maximum of €50 per day, up to a total of €1,500 |

### 6.2 Health trips

If you have rheumatoid arthritis, Bechterew's disease or psoriatic arthritis you may qualify for reimbursement of the costs of a health trip.

*What is reimbursed?*
Each insured person may qualify for reimbursement of the travel, accommodation and treatment costs of at least a single two-week health trip to a foreign destination once every two calendar years.

*What are the conditions for reimbursement?*
The health trip must be organised by an organisation that Zorg en Zekerheid has made arrangements with.

*Does Zorg en Zekerheid need to approve this beforehand?*
You must have submitted an application to and obtained approval from Zorg en Zekerheid beforehand; the application must include supporting information from the attending doctor. A list of Zorg en Zekerheid approved organisations can be consulted at **zorgenzekerheid.nl/vergoedingenzoeker**.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €1,050 |

### 6.3 Guesthouse

*What is reimbursed?*
Each insured person qualifies for reimbursement of the costs of the personal contribution upon admission of a family member to a hospital in the Netherlands. The reimbursement applies to each day or night spent at a guesthouse associated with a hospital.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Plus**<br>**AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|
| No reimbursement | A maximum of €15 per day | A maximum of €20 per day |

### 6.4 Therapeutic camp for youngsters

*What is reimbursed?*
Insured persons who are under 18 with conditions such as CARA (chronic aspecific respiratory disorder), diabetes mellitus, cystic fibrosis, cancer or obesity may apply once per calendar year for reimbursement of the costs of a stay and treatment at a therapeutic camp.

*What are the conditions for reimbursement?*
- The therapeutic camp must be located in the Netherlands.
- The organisation must be in the hands of a recognised patients' interest group/association. A list of Zorg en Zekerheid approved organisations can be found at **zorgenzekerheid.nl/vergoedingenzoeker**.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Basis**<br>**AV-Standaard** | **AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €350 | 100%, up to a maximum of €350 | 100%, up to a maximum of €350 |

### 6.5 Substitute informal care

*What is reimbursed?*
The costs of substitute informal care during the holiday of the regular informal care provider(s) for an insured person per calendar year are eligible for reimbursement.

*What are the conditions for reimbursement?*
The substitute informal care must be arranged and charged for by the Stichting Mantelzorgvervanging Nederland (Handen in Huis) foundation.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | Up to a maximum of six weeks |

## Article 7: Epidermal therapy

### 7.1 Acne treatment

*What is reimbursed?*
The costs of acne treatment for an insured person per calendar year are eligible for reimbursement.

*What are the conditions for reimbursement?*
- The treatment must be carried out by a skin therapist or beautician certified to provide this treatment.
- You are required to send to Zorg en Zekerheid when requested a statement of medical necessity from the person administering the treatment.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Sure**<br>**AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|
| No reimbursement | 100%, up to a maximum of €150 | 100%, up to a maximum of €250 |

### 7.2 Camouflage therapy

*What is reimbursed?*
In the case of camouflage therapy, the costs of the treatment, instructive lessons and cosmetic products for an insured person per calendar year will be eligible for reimbursement.

*What are the conditions for reimbursement?*
- The skin abnormality must be located on the face or neck.
- The treatment must be carried out by a skin therapist or beautician certified to provide this treatment.
- You are required to send to Zorg en Zekerheid when requested a statement of medical necessity from the person administering the treatment.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €115 | 75%, up to a maximum of €115 | 100%, up to a maximum of €115 |

### 7.3 Dermatography (medical tattoo)

*What is reimbursed?*

The costs of dermatography following a medical treatment for an insured person per calendar year are eligible for reimbursement.

*What are the conditions for reimbursement?*

- The treatment must be carried out by a skin therapist or dermatologist.
- You are required to send to Zorg en Zekerheid when requested a statement of medical necessity from the person administering the treatment.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €200 | 75%, up to a maximum of €200 | 100%, up to a maximum of €200 |

### 7.4 Electrical epilation or laser depilation

*What is reimbursed?*

Female insured persons are eligible once only during the entire term of the insurance for the reimbursement of the costs of electrical epilation or laser depilation. 'Once only' means that if we have reimbursed the costs of electrical epilation or laser depilation at any moment (also if we did so in a previous calendar year), we will not reimburse them again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.

*What are the conditions for reimbursement?*

- The hair must be present in places on the face considered unusual by common opinion.
- The treatment must be carried out by a skin therapist or beautician certified to provide this treatment.
- You are required to enclose a statement of medical necessity from the person administering the treatment with the first invoice.

*How much reimbursement will I receive under my supplementary insurance?*

| | **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|---|
| Existing users | No reimbursement | 50%, up to a maximum of €550 | 75%, up to a maximum of €1,100 | 100%, up to a maximum of €1,500 |
| New users from 2018 | No reimbursement | 50%, up to a maximum of €550 | 75%, up to a maximum of €600 | 100%, up to a maximum of €800 |

### 7.5 Foot care for insured persons with diabetes or rheumatic patients

Insured persons with diabetes or rheumatoid arthritis are eligible for reimbursement of the costs of foot care.

*What is reimbursed?*

The costs of foot care for an insured person per calendar year are eligible for reimbursement. An insured person with diabetes type 1 or type 2 only qualifies for reimbursement of foot care in the case of Care Profiles 0 and 1 (with the exception of the annual foot check, the costs of which are reimbursed under the basic insurance).

*What is not reimbursed?*

- the medical indication 'abrasion of the joints';
- the annual foot check charged by a medically qualified pedicure;
- cosmetic care.

*What are the conditions for reimbursement?*

The treatment must be performed by a medical pedicure or a pedicure holding an additional qualification 'foot care for diabetics' (DV) and/or 'foot care for rheumatic patients' (RV). The pedicure must be registered with the KRP (Quality Register for Pedicures).

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-GeZZin** | **AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €210 |

## Article 8: Care aids

### 8.1 Additional reimbursement of care aids

*What is reimbursed?*

- Each calendar year, the following costs are eligible for reimbursement for each insured person:
- a mastectomy bra and adhesive strips for a breast prosthesis;
- the personal contribution for a wig;
- the personal contribution for a hearing aid from a contracted care provider (the maximum contribution applies per ear);
- a support pessary.

*Which costs do not qualify for reimbursement?*

- the costs of the voluntary and compulsory excess and the amount that remains as your personal contribution if you went to a non-contracted care provider within the framework of contracted care;
- costs to which the principle of medical necessity does not apply;
- the costs of your personal contribution for a hearing aid from a non-contracted care provider;
- the costs of the after-sales contract, the maintenance devices, the cleaning set or the replacement guarantee for hearing aids.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 100%, up to a maximum of €70 per care aid | 100%, up to a maximum of €140 per care aid | 100%, up to a maximum of €200 per care aid |

### 8.2 Urinary buzzer

*What is reimbursed?*

Each insured party will be eligible once per calendar year for reimbursement of the costs of hiring a urinary buzzer or only once during the entire term of the insurance for reimbursement of the costs of purchasing a urinary buzzer.

'Once only during the entire term of the insurance means' that if we have reimbursed these costs at any moment (also if we did so in a previous calendar year), we will not reimburse them again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.

*What are the conditions for reimbursement?*

The urinary buzzer must be prescribed by the attending physician.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €85 |

### 8.3 Arch supports

*What is reimbursed?*
Each calendar year, the following costs for arch supports and/or podotherapeutic soles are eligible for reimbursement for each insured person:

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €35 | 100%, up to a maximum of €70 | 100%, up to a maximum of €100 |

### 8.4 Care aids for home care

*What is reimbursed?*
The insured parties will be eligible once only during the entire term of the insurance for the reimbursement of the costs of purchasing:
- a hip support belt;
- a dressing stick;
- a 'helping hand';
- a hip protector;
- a three-legged or four-legged walking aid;
- a Zimmer frame;
- crutches.

'Once only during the entire term of the insurance means' that if we have reimbursed these costs at any moment (also if we did so in a previous calendar year), we will not reimburse them again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.

*What are the conditions for reimbursement?*
The care aid must be prescribed by the attending doctor or midwife. This prescription must be included with the invoice.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 75%, up to a maximum of €40 |

### 8.5 Warning on social grounds

*What is reimbursed?*
We reimburse the costs of renting a personal alarm device.

*What are the conditions for reimbursement?*
- There must be social grounds (i.e., a social need) for a personal alarm that Zorg & Zekerheid can establish.
- The personal alarm device must be supplied by the municipality, SWO foundation for the welfare of the elderly, a contracted care provider or by a home care organisation or a contracted institution.

*Which costs do not qualify for reimbursement?*
Alarm centre connection and subscription costs are not reimbursed.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | A maximum of €3.50 per month | A maximum of €4.00 per month | A maximum of €5.00 per month |

### 8.6 Hearing protectors

*What is reimbursed?*
The costs of hearing protectors is reimbursed once per calendar year.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-Plus** | **AV-Sure**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €40,00 |

## Article 9: Specialist medical care

### 9.1 Phlebology/proctology

*What is reimbursed?*
The costs of consultations, bandaging aids and injections for phlebological and proctological treatments for an insured person per calendar year. Only the costs of treatment of venous disorders (such as varicose veins, 'venous ulcers' and haemorrhoids) will be reimbursed.

*What are the conditions for reimbursement?*
- You will need a referral from a general practitioner or specialist.
- The treatment must be carried out by a phelobologist doctor, dermatologist or phlebologist-proctologist doctor.
- Treatment individually or in group sessions, in a polyclinic or in a centre for phlebology.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €75 | 75%, up to a maximum of €100 | 100%, up to a maximum of €150 |

### 9.2 Circumcision of youngsters without medical grounds

*What is reimbursed?*
Male insured persons under age 18 are eligible once only during the entire term of the insurance for reimbursement of the costs of a circumcision without medical grounds.

*What are the conditions for reimbursement?*
The circumcision must be carried out by a doctor, general practitioner or contracted institution in the Netherlands.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 75%, up to a maximum of €115 | 100%, up to a maximum of €150 |

### 9.3 Sterilisation

*What is reimbursed?*
The costs of sterilisation for an insured person per calendar year are eligible for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

#### Sterilisation of men

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin** | **AV-Totaal** |
|---|---|---|
| No reimbursement | - 100%, up to a maximum of €150, if the treatment is carried out by the general practitioner;<br>- 75%, up to a maximum of €150, if the treatment is carried out by a medical specialist in a hospital. | 100%, up to a maximum of €150, if the treatment is carried out by a medical specialist in a hospital or by a general practitioner. |

#### Sterilisation of women

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 75%, up to a maximum of €350, if the treatment is carried out by a medical specialist in a hospital. | 100%, up to a maximum of €700, if the treatment is carried out by a medical specialist in a hospital. |

### 9.4 Protruding ear corrections

*What is reimbursed?*
The costs of protruding ear corrections for insured persons under 15 years of age are eligible for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €500 |

## Article 10: Paramedical treatments

### 10.1 General terms and conditions for physiotherapy and/or remedial therapy

- The physiotherapy treatment must be performed by a physiotherapist.
- The treatment must be carried out by a Mensendieck or Cesar remedial therapist respectively.
- In case of oedema and/or scar therapy, the treatment can also be performed by a contracted skin therapist.
- The physiotherapist, remedial therapist and skin therapist must be registered in the Central Quality Register for Physiotherapy of the KNGF (Royal Dutch Association for Physiotherapy), the Physiotherapy Quality Mark or the Quality Register for Paramedics (quality registered status).
- In the event of a manual therapy, child physiotherapy, pelvic physiotherapy, oedema therapy, psychosomatic physiotherapy or geriatric physiotherapy session, the treatment must be performed by a physiotherapist who is registered for the relevant specialty in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark.
- In the event of a child remedial therapy session, the treatment must be performed by a remedial therapist who is registered in the Quality Register for Paramedics (quality registered status); a chronic disorder should be listed in Appendix 1 to the Healthcare Insurance Decree. Whether a condition may be deemed chronic can also depend on the insured person's age. In addition, reimbursement for treatments for a number of disorders is limited to the maximum duration of the treatment, as indicated in Appendix 1 to the Healthcare Insurance Decree;
- In the case of a chronic condition, the therapy must be medically necessary and prescribed by an attending physician.
- The physiotherapeutic or remedial therapeutic care consists of 'deliverables'. Each deliverable counts as one treatment. This means that, for example, a 'screening' and an 'intake and examination following screening' also qualify as one treatment each.
- Every treatment programme starts with a 'screening' and an 'intake and examination following screening' or 'screening, intake and examination' or 'intake and examination following referral'.
- Physiotherapy or remedial therapy for non-chronic complaints is directly accessible (no referral necessary). This Direct Accessibility Physiotherapy (DTF) comprises the 'screening', 'intake and examination following screening' and 'screening and intake and examination'.
- Reimbursement may be claimed for a maximum of one physiotherapy or remedial therapy session per day, unless:
  a. there is a medical necessity to schedule multiple sessions on one day (as determined by a doctor), those sessions suitably spread over time and Zorg en Zekerheid has given the therapist its prior approval;
  b. the treatment session concerns 'screening', 'screening and intake and examination', 'intake and examination following screening' or 'intake and examination following referral'. Combined with specific deliverables, these deliverables can be provided on one and the same day. Your therapist will know which deliverables qualify.
- If your treatment consists of group sessions you will not be entitled to reimbursement for individual sessions that apply to one and the same condition, whether or not given by another physiotherapist and/or remedial therapist. This does not apply if individual sessions are included in the group treatment and used as a baseline measurement, interim evaluation and/or final measurement.
- In special cases you will need prior written approval from Zorg en Zekerheid for physiotherapy or remedial therapy. This concerns the following indications (Appendix 1 to the Healthcare Insurance Decree):
  a. Div D5 Rehabilitation (day) treatment, 12 months following discharge;
  b. Div D5 Admission to nursing home, 12 months following discharge;
  c. Div D5 Admission to hospital, 12 months following discharge.
- The request for permission from Zorg en Zekerheid must be submitted by your attending physiotherapist or remedial therapist.
- The stipulated maximum number of treatments per supplementary package relates to all the physiotherapeutic treatments defined in 10.1.1, 10.1.2 and 10.1.3 together.
- Treatments provided during the session, such as shockwave and dry needling, are part of the standard treatment and may not be separately invoiced by the physiotherapist or remedial therapist.
- The costs of materials provided during the session, such as bandages and auxiliary bandaging, are part of the treatment and may not be separately invoiced by the physiotherapist or remedial therapist.
- The medical indication 'abrasion of the hip and knee joints' does not qualify for reimbursement.
- In the case of treatment for intermittent claudication, your physiotherapist or remedial therapist must be affiliated with ClaudicatioNet. You will find the details of the contracted ClaudicatioNet physiotherapists at **zorgenzekerheid.nl/zorgzoeker** or you can request them by phoning our Contact Centre at (071) 5 825 825 or at one of our insurance shops.
- Zorg en Zekerheid only reimburses supervised ambulatory training after 37 sessions for intermittent claudication from the basic insurance by a physiotherapist or remedial therapist affiliated with ClaudicatioNet. As regards treatment for Parkinson's disease and Parkinsonisms, your physiotherapist or remedial therapist must be affiliated with ParkinsonNet.

### 10.1.1 Physiotherapy by a contracted physiotherapist

*What is reimbursed?*
Provided that there is no entitlement to reimbursement under the basic insurance, an insured person's costs of physiotherapy - for both chronic and non-chronic conditions - per calendar year qualify for reimbursement.

*What specialised physiotherapy treatments are reimbursed?*
Specialised physiotherapy treatments eligible to reimbursement are manual therapy, child physiotherapy, pelvic physiotherapy, oedema therapy, psychosomatic physiotherapy and geriatric physiotherapy treatments.

*What are the conditions for reimbursement?*
- The treatment must be performed by a contracted physiotherapist. You will find the details of these contracted physiotherapists at **zorgenzekerheid.nl/zorgzoeker** or you can request them by phoning our Contact Centre at: (071) 5 825 825 or by contacting one of our insurance shops.
- These specialised physiotherapy treatments are subject to the supplementary conditions as set out in Article 10.1.3.
- All sessions for primary physiotherapy, also when provided by a skin therapist, and remedial therapy count towards the above-mentioned maximum numbers, including primary care sessions that took place at a hospital or institution.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| A maximum of 9 treatment sessions<br>* reimbursement in conjunction with remedial therapy | A maximum of 12 treatment sessions | A maximum of 25 treatment sessions | A maximum of 40 treatment sessions |

### 10.1.2 Physiotherapy by a non-contracted physiotherapist

*What is reimbursed?*
Provided that there is no entitlement to reimbursement under the basic insurance, an insured person's costs of physiotherapy - for chronic and non-chronic conditions - per calendar year qualify for reimbursement. This includes manual therapy, child physiotherapy, pelvic therapy, oedema and epidermal therapy, psychosomatic and geriatric physiotherapy treatments. Reimbursement of the costs of specialised physiotherapy treatment is subject to the supplementary conditions listed in Article 10.1.3.

Costs of care provided by a non-contracted physiotherapist, remedial therapist or skin therapist (oedema or scar therapy) are reimbursed up to 75% of the prevailing Dutch market rate. The reimbursement for a specialised care session (e.g. manual therapy) by a non-contracted physiotherapist, remedial therapist or skin therapist equals the reimbursement for a regular session at a non-contracted physiotherapist, remedial therapist or skin therapist (no surcharge is awarded).

*What is not reimbursed?*
- the 'screening', 'intake and examination following screening' and 'screening and intake and examination' (Direct Accessibility Physiotherapy) deliverables by a non-contracted care provider;
- the 'surcharge for home treatment', the 'surcharge for institutional treatment' and the 'surcharge for treatment in the workplace' by a non-contracted care provider.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| A maximum of 9 treatment sessions<br>* reimbursement in conjunction with remedial therapy | A maximum of 12 treatment sessions | A maximum of 25 treatment sessions | A maximum of 40 treatment sessions |

### 10.1.3 Specialised physiotherapy

#### Manual therapy
As part of the number of treatment sessions per supplementary insurance indicated in Articles 10.1.1 and 10.1.2, a maximum of nine manual therapy treatment sessions will be reimbursed where necessary. Both the treatment sessions under the basic insurance and the treatment sessions under the supplementary insurance count toward this maximum of nine.

*What are the conditions for reimbursement?*
- The treatment must be performed by a physiotherapist who is registered as a manual therapist in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark (quality registered status).
- Manual therapy treatment is reimbursed if the condition falls within the Manual Therapy Domain Description published by the Netherlands Association for Manual Therapy (NVMT). Please consult your physiotherapy about the list of qualifying conditions.

#### Child physiotherapy
*What are the conditions for reimbursement?*
- The treatment must be performed by a physiotherapist who is registered as a child physiotherapist in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark (quality registered status).
- Child physiotherapy treatment is reimbursed if the condition falls within the Child Physiotherapy Domain Description published by the Netherlands Association for Child Physiotherapy (NVFK). Please consult your physiotherapy about the list of qualifying conditions.

#### Pelvic physiotherapy
If the insured person is suffering from complaints in the area of the pelvis, stomach and pelvic floor, such as urine incontinence, pregnancy-related pelvic or pelvic floor complaints, there may be grounds for pelvic physiotherapy.

*What are the conditions for reimbursement?*
- The treatment must be performed by a physiotherapist who is registered as a pelvic physiotherapist in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark (quality registered status).
- Pelvic physiotherapy treatment qualifies if the condition is consistent with the guidelines laid down by the Dutch Association for Physical Therapy for Pelvic Floor Disorders (NVFB). Please consult your physiotherapy about the list of qualifying conditions.

#### Oedema therapy
If there are disorders of the lymphatic or venous system, there may be grounds for oedema therapy.

*What are the conditions for reimbursement?*
- The treatment must be carried out by a physiotherapist who is registered in the Oedema Therapy subregister maintained by the Central Quality Register for Physiotherapy (quality registered status) or by a skin therapist contracted by Zorg en Zekerheid.
- A valid referral is required for treatment of a chronic indication by a skin therapist.

#### Psychosomatic physiotherapy
If there are physical problems that are clearly linked to physical dysfunctionality, there may be grounds for treatment for psychosomatic physiotherapy.

*What are the conditions for reimbursement?*
- The treatment must be performed by a physiotherapist who is registered as a psychosomatic physiotherapist in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark (quality registered status). Please consult your physiotherapy about the list of qualifying conditions.
- There must be moderate to seriously complicated psychological factors hindering recovery as assessed by Zorg en Zekerheid's medical adviser, with due observance of the NFP (Dutch Association for Psychosomatic Physiotherapy)'s guidelines.
- The insured person is at least 18 years old.

#### Geriatric physiotherapy
If there are physical complaints that are clearly linked to geriatric problems, there may be grounds for geriatric physiotherapy treatment.

*What are the conditions for reimbursement?*
- The treatment must be performed by a physiotherapist who is registered as a geriatric physiotherapist in the Central Quality Register for Physiotherapy or the Physiotherapy Quality Mark (quality registered status). Please consult your physiotherapy about the list of qualifying conditions.
- The disorders must have been established based on the list of criteria drawn up by the NVFG (Dutch Association for Physiotherapy in Geriatrics).

### 10.1.4 KNGF (Royal Dutch Association for Physiotherapy) movement programme

*What is reimbursed?*

A fully completed movement programme that meets the KNGF Movement Interventions standards and is provided in physiotherapy practices that hold a 2 or 3-star quality care label. On **zorgenzekerheid.nl/zorgzoeker** you will find an overview per condition of contracted physiotherapists offering a KNGF movement programme in 2 or 3-star practices.

*What is not reimbursed?*

Indications for which you are also attending an individual programme with the physiotherapist do not quality for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| AV-GeZZin Compact | AV-Basis<br>AV-Sure<br>AV-Standaard | AV-Top<br>AV-GeZZin<br>AV-Plus | AV-Totaal |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €500 every two calendar years | 75%, up to a maximum of €500 every two calendar years | 100%, up to a maximum of €500 every two calendar years |

### 10.1.5 Fitkids movement programme or JOGG lifestyle intervention programme

*What is reimbursed?*

A fully completed Fitkids movement programme provided by a contracted physiotherapist affiliated with Fitkids. Or a fully completed lifestyle intervention programme within the framework of JOGG (Healthy Weight for Youth) by a contracted physiotherapy practice with a 3 or 2-star Quality Care label. You will find the details of the contracted physiotherapists with a quality label at **zorgenzekerheid.nl/zorgzoeker** or you can request them by phoning our Contact Centre at (071) 5 825 825 or at one of our insurance shops.

*How much reimbursement will I receive under my supplementary insurance?*

| AV-GeZZin Compact | AV-Basis<br>AV-Sure<br>AV-Standaard | AV-Top<br>AV-GeZZin<br>AV-Plus | AV-Totaal |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €500 every two calendar years | 75%, up to a maximum of €500 every two calendar years | 100%, up to a maximum of €500 every two calendar years |

### 10.2 Mensendieck and/or Cesar remedial therapy

*What is reimbursed?*

Provided that there is no entitlement to reimbursement under the basic insurance, the costs of Mensendieck or Cesar Remedial Therapy, given by a contracted care provider, for both chronic and non-chronic conditions for each insured person per calendar year qualify for reimbursement.

*What are the conditions for reimbursement?*

- The treatment must be carried out by a Mensendieck or Cesar remedial therapist respectively.
- The remedial therapist must be registered in the Quality Register for Paramedics (quality registered status).
- In the event of a child remedial therapy session or psychosomatic remedial therapy session, the treatment must be performed by a remedial therapist who is registered for the therapy concerned in the Quality Register for Paramedics (quality registered status).
- A chronic disorder should be listed in Appendix 1 to the Healthcare Insurance Decree. Whether a condition may be deemed chronic can also depend on the insured person's age. In addition, reimbursement for treatments for a number of disorders is limited to the maximum period indicated in Appendix 1.
- In the case of a chronic condition, the therapy must be medically necessary and prescribed by an attending physician.
- The remedial therapy care consists of 'deliverables'. Each deliverable counts as one treatment. This means that, for example, a 'screening' and an 'intake and examination following screening' also qualify as one treatment each; every treatment programme starts with a 'screening' and an 'intake and examination following screening' or 'screening, intake and examination' or 'intake and examination following referral'.
- Physiotherapy for non-chronic complaints is directly accessible (no referral necessary). This direct accessibility comprises the 'screening', 'intake and examination following screening' or 'screening and intake and examination'.
- Reimbursement may be claimed for a maximum of one physiotherapy session per day, unless:
  a. there is a medical necessity to schedule multiple sessions on one day (as determined by a doctor), those sessions suitably spread over time and Zorg en Zekerheid has given the therapist its prior approval;
  b. the treatment session concerns 'screening', 'screening and intake and examination', 'intake and examination following screening' or 'intake and examination following referral'. Combined with specific deliverables, these

deliverables can be provided on one and the same day. Your therapist will know which deliverables qualify.
- If your treatment consists of group sessions you will not be entitled to reimbursement for individual sessions, whether or not given by another remedial therapist. This does not apply if individual sessions are included in the group treatment and used as a baseline measurement, interim evaluation and/or final measurement.
- In special cases you will need prior written approval from Zorg en Zekerheid for physiotherapy. This concerns the following indications (Appendix 1 to the Healthcare Insurance Decree):
  a. Div D5 Rehabilitation (day) treatment, 12 months following discharge;
  b. Div D5 Admission to nursing home, 12 months following discharge;
  c. Div D5 Admission to hospital, 12 months following discharge.
  The request for permission from Zorg en Zekerheid must be submitted by your attending remedial therapist;
- Treatments provided during the session are part of the standard treatment and may not be separately invoiced by the remedial therapist.
- Materials provided during the session, such as bandages and auxiliary bandaging, are part of the treatment and may not be separately invoiced by the remedial therapist.
- Zorg en Zekerheid only reimburses supervised ambulatory training after 37 sessions for intermittent claudication from the basic insurance by a remedial therapist affiliated with ClaudicatioNet. You will find the details of the contracted ClaudicatioNet physiotherapists at **zorgenzekerheid.nl/zorgzoeker** or you can request them by phoning our Contact Centre at (071) 5 825 825 or at one of our insurance shops.
- In the case of treatment for intermittent claudication, your remedial therapist must be affiliated with ClaudicatioNet.
- As regards treatment for Parkinson's disease and Parkinsonisms, your remedial therapist must be affiliated with ParkinsonNet.

*What is reimbursed if I go to a non-contracted remedial therapist?*
- Costs of care by a non-contracted remedial therapist are reimbursed up to 75% of the prevailing contracted rate. The reimbursement for a specialised care session (e.g. child remedial therapy) by a non-contracted remedial therapist equals the reimbursement for a regular session at a non-contracted remedial therapist (no surcharge is awarded).
- the 'screening', 'intake and examination following screening' and 'screening and intake and examination' deliverables (direct accessibility) by a non-contracted care provider are not reimbursed;
- The 'surcharge for home treatment', the 'surcharge for institutional treatment' and the 'surcharge for one-off treatment in the workplace' by a non-contracted care provider will not be reimbursed.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| A maximum of 9 treatment sessions<br>* reimbursement in conjunction with physical therapy | A maximum of 12 treatment sessions | A maximum of 25 treatment sessions | A maximum of 40 treatment sessions |

### 10.3 Dietary advice
*What is reimbursed?*
The costs of dietary advice by a dietician for an insured person under age 18 per calendar year, as a supplement to the reimbursement paid under the master policy. The maximum reimbursement for treatment by a non-contacted dietician is 75% of the prevailing market rate.

*What are the conditions for reimbursement?*
- The treatment must be performed by a dietician.
- The dietary advice must serve a medical purpose; the dietician must be registered in the Quality Register for Paramedics (quality registered status).
- The treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your dietician is affiliated with ParkinsonNet.
- All primary dietary advice treatments count towards the maximum number of 15-minute sessions mentioned, including primary treatment sessions in a hospital or institution.
- Every treatment programme starts with a 'screening' and, possibly, an 'intake and examination following screening' or 'screening, intake and examination' or 'intake and examination following referral'.

*What is not reimbursed?*
- the 'screening', 'intake and examination following screening' and 'screening and intake and examination' (Direct Accessibility) deliverables by a non-contracted care provider;
- the 'surcharge for final treatment' by a non-contracted care provider.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top**<br>**AV-GeZZin** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 7 x 15 minutes | 10 x 15 minutes |

### 10.4 Occupational therapy

*What is reimbursed?*

In addition to the reimbursement covered by basic insurance, an insured person's costs of advice, instructions, training or treatment by an occupational therapist per calendar year. Costs of visits to a non-contracted occupational therapist are reimbursed up to 75% of the prevailing market rate.

*What are the conditions for reimbursement?*
- The occupational therapy must take place in a treatment location or at the home address of the insured person with the aim of promoting or restoring the insured person's ability to care for themselves and to perform tasks independently.
- Zorg en Zekerheid only reimburses treatment for Parkinson's disease and Parkinsonisms if your occupational therapist is affiliated with ParkinsonNet.
- Every treatment programme starts with a 'screening' and an 'intake and examination following screening' or with a 'screening, intake and examination' or 'intake and examination following referral'.
- All primary occupational therapy treatments count towards the specified maximum number of treatment hours, including primary treatment sessions in a hospital or institution.

*What is not reimbursed?*
- the 'screening', 'intake and examination following screening' and 'screening and intake and examination' (Direct Accessibility) deliverables by a non-contracted care provider;
- the 'surcharge for home treatment', the 'surcharge for institutional treatment' and the 'surcharge for treatment in the workplace' by a non-contracted care provider.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-GeZZin** | **AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | A maximum of 10 hours |

### 10.5 Podology / podo (postural) therapy

*What is reimbursed?*

The costs of treatments/consultations by a registered podologist, podopostural therapist, podotherapist or orthopaedic shoemaker, for an insured person per calendar year.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 100% up to a maxium of €50 | 100% up to a maxium of €100 | 100% up to a maxium of €125 |

### 10.6 Stutter therapy

*What is reimbursed?*
The costs of stutter therapy for an insured person per calendar year qualify for reimbursement.

*What are the conditions for reimbursement?*
The treatment must follow the Del-Ferro, Boma, Hausdörfer or Dixhoorn treatment methods.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Plus** | **AV-Top** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|---|
| No reimbursement | 75%, up to a maximum of €350 | 100%, up to a maximum of €400 |

## Article 11: Prevention

### 11.1 GeZZondCheck check-up

*What is reimbursed?*
The costs of the GeZZondCheck check-up once every two calendar years qualify for reimbursement.

*What are the conditions for reimbursement?*
- The GeZZond Check must be carried out by a home care organisation or general practitioner contracted by Zorg en Zekerheid. A list of contracted organisations can be found at **zorgenzekerheid.nl./zorgzoeker**.
- The invoice must state the precise dates on which the examinations, courses, information or advice was/were held/given and the precise courses taken.
- You do not participate in the Multi-Disciplinary Care Programme.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, once every two calendar years |

### 11.2 Preventative courses

*What is reimbursed?*
The costs of one or more preventative courses for an insured person per calendar year qualify for reimbursement if provided by an approved organisation.

Reimbursement may be available for the following courses:
- Weight loss when overweight
- Stopping smoking
- Learning how to cope with…
- Alcohol training
- Self-management for a lymph oedema
- Self-management for …
- First aid course (EHBO) or AED training
- First aid for kids
- More Physical Exercise for the Elderly (MBvO)
- Medically approved training programmes.

For a complete list of addresses of the institutions that offer courses eligible for reimbursement and/or have concluded an agreement with us, go to **zorgenzekerheid.nl/zorgzoeker**.

*What are the conditions for reimbursement?*
The invoice must state the precise dates on which the examinations, courses, information or advice was/were held/given and the precise courses taken.

*Which costs do not qualify for reimbursement?*
The costs of medicines, dietary supplements and course materials do not qualify for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*
The reimbursement applies for one or more courses together.

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 50%, up to a maximum of €115 | 75%, up to a maximum of €150 | 100%, up to a maximum of €175 |

### 11.3 Menopause consultant
*What is reimbursed?*
The costs of treatment administered by a menopause consultant for female insured persons per calendar year qualify for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 75% up to a maximum of €115 | 100% up to a maximum of €150 |

### 11.4 Sports Medical Advice
*What is reimbursed?*
The costs of consultations and/or medical tests for an insured person per calendar year qualify for reimbursement.

*What are the conditions for reimbursement?*
The consultations and/or tests must be carried out by a registered sports physician in a specialised medical sports centre (sports medical advice centres, sports medical departments).

How much reimbursement will I receive under my supplementary insurance?

| **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Sure** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 100%, up to a maximum of €120 | 100%, up to a maximum of €100 | 100%, up to a maximum of €150 |

## Article 12: Psychological care

### 12.1 Other psychological care
*What is reimbursed?*
- The costs of treatments for an insured person per calendar year by:
- the Helen Dowling Institute;
- a Simonton therapist;
- therapists affiliated with the SBLP (sections of the NVPIT and NVBT), NVAGT and NVPO;
- therapist members of the NVVS.

and psychological care per insured person per calendar year comprising:
- 'Kanjer' training;
- Keiko Kidz training;
- integrative child therapy for insured persons under age 18 with an AV-GeZZin or AV-Totaal policy;
- nanny training for insured persons with an AV-GeZZin or AV-Totaal policy;
- remedial teaching for insured persons with an AV-GeZZin or AV-Totaal policy;
- the treatment of dyslexia for insured persons with an AV-GeZZin or AV-Totaal policy.

*What are the conditions for reimbursement?*
- You should engage one of our approved therapists and professional associations as can be found on **zorgenzekerheid.nl.**
- The integrative child therapy treatment must be carried out by a therapist who satisfies the conditions stated by the VIT or who is affiliated with the VVvK or NVPMKT and must be multi-disciplinary.
- The nanny course, remedial teaching or dyslexia treatment must be carried out by a remedial educationalist associated with the NVO (Dutch Association of Remedial Educationalists) or a practitioner working in accordance with the conditions stated by the LBRT (National Remedial Teachers' Union).

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Sure** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|
| No reimbursement | 75%, up to a maximum of €200 | 75%, up to a maximum of €320 | 100%, up to a maximum of €500 |

### 12.2 Light therapy

*What is reimbursed?*
Once only per calendar year, the cost of hiring a Bright Light (light therapy for seasonal depression) for a maximum period of ten days are eligible for reimbursement. You may also opt to claim the one-off purchasing costs of a Bright Light. 'One-off' means that if we have reimbursed those costs at any moment (also if we did so in a previous calendar year), we will not reimburse the purchasing costs of a Bright Light again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.

*What are the conditions for reimbursement?*
In order to be eligible for reimbursement, you must provide a proof of purchase or hiring.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-GeZZin Compact** | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | For a maximum period of ten days up to a maximum of €7 per day, or as a one-off reimbursement of the purchase costs up to a maximum of €70 |

## Article 13: Dental assistance

*What are the general terms and conditions for reimbursement?*
The costs of dental treatment are only reimbursed if, in Zorg en Zekerheid's opinion, that treatment is effective and in line with unusual professional practice and the treatment is not unnecessarily expensive or complicated. As care provided under the supplementary insurance is in supplement to the basic insurance, care provided under the basic insurance can never come under the supplementary insurance. The only costs eligible for reimbursement are those not covered by the healthcare insurance or otherwise; also see Section B, Articles 8(f) and 9. The treatment must be carried out by a dentist or orthodontist, unless stated otherwise.

Treatments aimed at prevention and oral hygiene, dental check-ups and gum treatments can also be performed and invoiced by independent oral hygienists. The associated treatments are described in Articles 13.2.1 and 13.2.2. You will find the reimbursements that apply to the correspondingt care categories at **zorgenzekerheid.nl/vergoedingenzoeker**.

The treatments are reimbursed in accordance with the NZa's ruling on rates.

The amounts set out in the reimbursement tables are for an insured person per calendar year, unless otherwise stated.

*Which costs do not qualify for reimbursement?*
- statements of good dental health;
- appointments not cancelled in time;

- replacement or repair of equipment as the result of careless use;
- taking and assessing multi-dimensional jaw X-rays;
- comprehensive jaw X-rays up to age 18;
- medical procedures or treatments by a dental technician;
- the fitting of a dental implant, with the exception of the provisions of Article 13.4;
- bleaching of elements (with the exception of internal bleaching under the AV-Totaal policy);
- in orthodontics, the use of an electronic chip and selection of the data of the electronic chip in removable equipment, including the relevant technician's costs;
- vacuum-shaped covers used in orthodontic treatment, e.g. Invisalign®;
- the costs for which you will be invoiced if you go to a non-contracted care provider for full dentures.

### 13.1.1 Dental care for insured persons under age 18

*What is reimbursed?*

The costs of dental care. Orthodontic treatment for insured persons under the age of 18 are not covered by dental care as referred to in this article; for further details see Article 13.1.2.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis** | **AV-Sure**<br>**AV-Standaard** | **AV-GeZZin**<br>**Compact** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|---|---|
| No reimbursement | 75%, up to a maximum of €150 | 75%, up to a maximum of €250 | 75%, up to a maximum of €500 | 85%, up to a maximum of €1000 |

### 13.1.2 Orthodontics to insured persons under age 18

*What is reimbursed?*

The costs of orthodontic treatment.

*What are the conditions for reimbursement?*

- The treatment must be carried out by an orthodontist or dentist.
- This reimbursement applies once only during the entire term of the insurance. 'Once only' means that if we have reimbursed the costs of orthodontic treatment at any moment (also if we did so in a previous calendar year), we will not reimburse them again (in the current nor in any future calendar year). If you switch to a different care provider and decide to return to Zorg en Zekerheid afterwards in any calendar year, you will not requalify for reimbursement.
- If you take out supplementary insurance with us in a subsequent calendar year that offers a higher reimbursement, we will include the amount of reimbursement that you already received under your previous insurance with us to calculate the maximum reimbursement to which you are entitled under your supplementary insurance.

*How much reimbursement will I receive under my supplementary insurance?*

| | **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-Plus** | **AV-GeZZin**<br>**Compact** | **AV-Top** | **AV-GeZZin** | **AV-Totaal** |
|---|---|---|---|---|---|
| Exicting users | No reimbursement | 100% up to a maximum of €1.000 | 100% up to a maximum of €1.750 | 100% up to a maximum of €2.000 | 100% |
| New users from 2018 | No reimbursement | 100% up to a maximum of €1.000 | 100% up to a maximum of €1.500 | 100% up to a maximum of €1.750 | 100% |

## 13.2 Dental care for insured persons from age 18

### 13.2.1 Check-up

*What is reimbursed?*

The full costs of dental treatments relating to check-ups if the treatments are carried out and invoiced by a dentist or oral hygienist are eligible for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| AV-Basis | AV-Sure<br>AV-Standaard | AV-GeZZin<br>Compact | AV-Top<br>AV-GeZZin<br>AV-Plus | AV-Totaal |
|---|---|---|---|---|
| No reimbursement | 100%, up to a maximum of €150 | 100%, up to a maximum of €250 | 100%, up to a maximum of €500 | 100%, up to a maximum of €1000 |

The maximum amount per supplementary insurance also applies for the dental treatments referred to under 13.2.1 and 13.2.2 together.

### 13.2.2 Other dental treatments

*What is reimbursed?*

- the necessary dental treatments, invoiced by a dentist or oral hygienist;
- treatments including prevention, X-ray diagnostics, oral hygiene, anaesthetic and inlays;
- orthodontic treatment, invoiced by an orthodontist or dentist;
- the personal contribution towards the costs of full dentures in the upper and/or lower jaw, invoiced by a dentist or dental technician;
- the personal contribution towards the costs of implant-supported full dentures in the upper and/or lower jaw, invoiced by a dentist or dental technician;
- partial dentures in the upper and/or lower jaw invoiced by a dentist or dental technician;
- mouth protectors made and invoiced by a dentist;
- small X-rays for a root canal treatment or gum treatment performed by a dentist.

*How much reimbursement will I receive under my supplementary insurance?*

| AV-Basis | AV-Sure<br>AV-Standaard | AV-GeZZin<br>Compact | AV-Top<br>AV-GeZZin<br>AV-Plus | AV-Totaal |
|---|---|---|---|---|
| No reimbursement | 75%, up to a maximum of €150 | 75%, up to a maximum of €250 | 75%, up to a maximum of €500 | 85%, up to a maximum of €1000 |

The maximum amount applies for the dental treatments referred to under 13.2.1 and 13.2.2 together.

### 13.2.3 Sharing

*What is reimbursed?*

Twice the maximum reimbursement per type of supplementary insurance for the care referred to in Article 13.2 per calendar year, provided that you are both covered under an AV-Delen policy.

*What are the conditions for reimbursement?*

The payment conditions stated in Article 13.2 continue to apply.

*Which costs do not qualify for reimbursement?*

- implants in a non-toothless jaw;
- accident cover.

How much reimbursement will I receive under my supplementary insurance?

| AV-Delen €150 in combination with AV-Sure, AV-Standaard | AV-Delen €250 in combination with AV-GeZZin Compact | AV-Delen €500 in combination with AV-Top, AV-GeZZin, AV-Plus | AV-Delen €1,000 in combination with AV-Totaal |
|---|---|---|---|
| Up to a maximum of €300 per 2 participants | Up to a maximum of €500 per 2 participants | Up to a maximum of €1,000 per 2 participants | Up to a maximum of €2,000 per 2 participants |

### 13.3 Accident-related dental care coverage

*What is reimbursed?*

The costs of dental assistance needed as the result of an accident are eligible for reimbursement. The treatment of the injury must be appropriate and usual and must not be unnecessarily expensive or complicated.

*What are the conditions for reimbursement?*
- The dental injury must have arisen from an accident during the term of the insurance.
- The accident must be reported to Zorg en Zekerheid within 60 days.
- The costs must have been incurred as a direct result of the accident.
- The care provider must draw up a treatment plan (with a budget) that shows the connection between the treatment and the injury resulting from the accident.
- The treatment must be carried out by an authorised care provider.

*Which costs do not qualify for reimbursement?*
- the costs of accident-related dental assistance, once a period of two years has elapsed since the accident;
- the costs of accident-related dental assistance that have arisen as the result of an accident abroad. Please see Article 3.3.2 of these policy conditions for more information on dental care when abroad.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis** | **AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 100%, up to a maximum of €1,500 per occurrence | 100%, up to a maximum of €2,000 per occurrence |

### 13.4 Implants in a non-toothless jaw
*What is reimbursed?*
The following costs are eligible for reimbursement:
- examination, diagnostics and preparation of a treatment plan;
- the bone structure required for fitting the implant;
- fitting the implant;
- the costs of the implant.

*What are the conditions for reimbursement?*
- The treatment must be performed by a dentist or dental surgeon.
- The dentist must invoice the treatment using the performance codes from the Implantology chapter (J codes) of the NZa's ruling on rates.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-GeZZin** | **AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €750,00 by a dentist or<br>100%, up to a maximum of €500,00 by a dental surgeon |

## Article 14: Other

### 14.1 Visiting costs for family member admitted to hospital
*What is reimbursed?*
Eligible for reimbursement are the costs per calendar year, per insured person, for the transportation of the insured person from the home address to the institution and back, should a family member be admitted to a hospital or rehabilitation institution in the Netherlands or to the asthma centre in Davos.

*What are the conditions for reimbursement?*
- The family member admitted must also have supplementary insurance with Zorg en Zekerheid.
- The claim must state:
  - the name of the insured person admitted and that of the insured person who is visiting;
  - the name of the hospital;
  - the period during which the visited insured person was admitted.

*What else do I need to know?*
- The reimbursement is calculated on the basis of the shortest usual single-journey distance. The single-journey distance is calculated using the 'optimum route' quoted by the Routenet route planner (**www.routenet.nl**).
- If you travel using your own vehicle, the maximum reimbursement is €0.30 per kilometre. In addition, the single-journey distance is reduced by 20 kilometres (and again by 20 kilometres for the return journey), the costs of which remain for your own account.
- If you use a (wheelchair) taxi or public transport, the reimbursement will be granted on the basis of the lowest class.
- The reimbursement only covers the kilometre allowance.
- The reimbursement will be awarded for a maximum of one visit per day.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus** | **AV-Totaal** |
|---|---|---|
| No reimbursement | 100%, up to a maximum of €250 | 100%, up to a maximum of €300 |

### 14.2 Subscription fee for patients' associations

*What is reimbursed?*
The costs of membership of a patients' association for an insured person per calendar year will be eligible for reimbursement.

*What are the conditions for reimbursement?*
It must be a patients' association for insured persons with a chronic disorder.

*Which costs do not qualify for reimbursement?*
The subscription fee for associations are for your own account.
Donations and supportive membership.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Sure**<br>**AV-GeZZin Compact** | **AV-Basis**<br>**AV-Standaard**<br>**AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €20 |

### 14.3 Reimbursement of personal contribution for seated patient transport

*What is reimbursed?*
If you are entitled to seated patient transport under the basic insurance, you owe a maximum personal contribution of €101 per calendar year. Each calendar year, the costs of your personal contribution are eligible for reimbursement.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact** | **AV-Top**<br>**AV-GeZZin**<br>**AV-Plus**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €101 |

### 14.4 Reimbursement of the personal contribution Wlz/WMO

*What is reimbursed?*
In some cases, a personal contribution will apply to care provided within the context of the Long-Term Care Act (Wlz) and Social Support Act (WMO). Each calendar year, the costs of your personal contribution are eligible for reimbursement.

*What are the conditions for reimbursement?*
- You need home care on medical grounds.
- The invoice must be from the Central Administrative Office (CAK) or the municipality.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-Plus** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €200 |

### 14.5 Home care organisation membership

*What is reimbursed?*
The membership fee for a home care organisation.

*What are the conditions for reimbursement?*
The home care organisation must be associated with an acknowledged member service organisation.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-Plus** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €17.50 |

### 14.6 Sports association membership

*What is reimbursed?*
The membership fee for a sports association or contracted sports organisation for every child insured (free of charge) under age 18, per calendar year.

*What are the conditions for reimbursement?*
The sports association or sports organisation must belong to an association affiliated with the NOC*NSF or have a contract with Zorg en Zekerheid.

*What else do I need to know?*
Sports associations tend to base their membership fees on seasons rather than calendar years. In practice, this means that a claim for a sports association membership fee for 2017-2018 will be reimbursed to the 2017 calendar year.

*How much reimbursement will I receive under my supplementary insurance?*

| **AV-Basis**<br>**AV-Sure**<br>**AV-Standaard**<br>**AV-GeZZin Compact**<br>**AV-Top**<br>**AV-Plus** | **AV-GeZZin**<br>**AV-Totaal** |
|---|---|
| No reimbursement | 100%, up to a maximum of €50 |

# Section B
# Insurance Terms and Conditions of the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid U.A.

## 1. General

Arrangements that Zorg en Zekerheid proposes separately and that relate to the subjects referred to in these insurance terms and conditions will be deemed to be part of these insurance terms and conditions once the insured persons have been informed about them.

## 2. Registration

### 2.1 The application

The insurance application must be made in writing, by telephone or online. The applicant will fully cooperate with Zorg en Zekerheid in efforts to obtain information and assist with any enquiries that Zorg en Zekerheid deems necessary for the assessment of the application.

### 2.2 Conditions for registration

Registration for supplementary insurance offered by Zorg en Zekerheid is open to:

1. persons residing in the Netherlands or another EU/EEA country who are registered as an insured person with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. based in Leiden;
2. insured persons residing in the Netherlands that have a healthcare insurance policy with a healthcare insurer to the extent that this insurer offers and implements healthcare insurance policies;
3. those persons have been accepted by virtue of a decision of the Management Board of Zorg en Zekerheid.
   a. With respect to the supplementary insurance policy AV-Plus, registration is only open to persons aged 18 and older who meet one of the conditions as referred to in subsection a. under 1, 2 or 3.

With respect to AV-Delen policies, the following conditions apply:

1. The only persons eligible to be insured persons for the AV-Delen policy are those persons who are both insured with Zorg en Zekerheid under a supplementary insurance policy that includes dental insurance. Additionally, both of them must have the same AV-Pakket (Supplementary Insurance Package);
2. The AV-Delen policy may only be taken out by two paying insured persons of Zorg en Zekerheid who are registered on a single policy and have the same supplementary insurance policy.
3. AV-Delen insurance only relates to dental assistance as referred to in Article 13.2 of the policy conditions.

### 2.3 Rejection of application

Zorg en Zekerheid may reject the application if an insurance was previously terminated because the premium owed was not paid. Zorg en Zekerheid may also reject the application if the insurance has already ended in connection with the provisions set out in Article 3.3b, first indent under 1, 2 and 3 or if the policyholder or insured person is registered in the incident warning system for financial institutions (external reference register).

### 2.4 Acceptance of supplementary insurance

By accepting supplementary insurance, the policyholder takes on the full responsibility for and guarantees the accuracy and completeness of all information provided to Zorg en Zekerheid.

### 2.5 Concealment

Zorg en Zekerheid will not be obliged to reimburse any costs and is authorised to terminate the insurance without notice at a time of its choosing if the information on the application form or provided otherwise (in writing) to Zorg en Zekerheid is incomplete or inconsistent with the truth. This also applies if circumstances are concealed that are of such a nature that the insurance agreement would not have been entered into or not under the same conditions if Zorg en Zekerheid had known about them. This is without prejudice to Zorg en Zekerheid's right to invoke invalidity of the insurance in accordance with the applicable provisions of Title 7:17 of the Dutch Civil Code. If Zorg en Zekerheid incurs costs in respect of its concealment enquiries, these costs will be recouped from the policyholder.

### 2.6 Register of personal data

a. The personal information provided with respect to the application for or amendment or termination of the insurance policy and any other personal information to be submitted will be included in the registry of persons maintained by Zorg en Zekerheid. This registration is subject to the WBP (Personal Data Protection Act) and the Code of Conduct for the Processing of Personal Data by Health Insurers.
b. With respect to the performance of this agreement, Zorg en Zekerheid will provide information to care providers

or care institutions regarding your insurance status. With respect to the fulfilment of the healthcare insurance policy, Zorg en Zekerheid reserves the right to provide personal data to third parties with due observance of the Personal Data Protection Act. You must inform Zorg en Zekerheid in writing if you do not wish your address to be made available to third parties.

c. Within the framework of a responsible acceptance, risk and fraud policy, Zorg en Zekerheid will maintain an Events Register subject to the Code of Conduct for the Processing of Personal Data by Health Insurers. An Incidents Register will be maintained in accordance with the Incident Warning Protocol for Financial Institutions and we are authorised to view and/or enter your personal data in the External Reference Register maintained by the Netherlands Central Information System Foundation (Stichting Centraal Information Systeem, CIS) in The Hague.

## 3. Commencement and termination of the insurance

### 3.1 Inception of the insurance

a. The insurance commences on the first day of the month following the month in which Zorg en Zekerheid received the insurance application; this applies to the registration of children, amendments for insured persons reaching the age of 18 and insured persons originating from a group with a supplementary policy that could not be maintained in view of the conditions applicable to the group.
b. Newborn infants are registered as at their date of birth if reported within four months after their birth. If the infant is registered after this 4-month term, registration will be effective from the date on which the insurance application is received.
c. If Zorg en Zekerheid has requested further information to help it to process the insurance application, the insurance policy will commence on the first day of the month following the month in which Zorg and Zekerheid received the necessary information.
d. Subject to the exceptions referred to under 3.1a, if you do not have supplementary insurance and/or wish to move to a higher or lower level of supplementary insurance, that insurance will not commence until 1 January of the next calendar year.
e. You can only opt for AV-GeZZin during the course of the year in connection with pregnancy on condition that you are already registered for supplementary insurance with Zorg en Zekerheid. However, it is not possible to opt for AV-GeZZin during the course of a year if you are insured under an AV-Gemak policy.

### 3.2 Term

a. The insurance policy commences on the date specified on the original/amended policy schedule. As the policyholder, you may terminate your healthcare insurance no later than 31 December of each year. If you terminate in time, your insurance policy will be terminated as of the following 1 January. If you do not terminate the supplementary insurance, we will extend it tacitly each year for a term of one year. Termination can be effected:
   - by yourself (as the policyholder). In this case, you must cancel in writing, by telephone or by email by 31 December at the latest;
   - by utilising our cancellation service. Insurers have set up a transfer service. This means that if at any time up to 31 December you enter into a healthcare insurance for the next calendar year, the new healthcare insurer will cancel your healthcare insurance with us on your behalf;
   - If you do not wish to use this service, you must make this known on the application form you fill in for your new healthcare insurer.
b. If the insurance commences on a date other than 1 January, the insurance will be entered into for the remaining part of the current calendar year.

### 3.3 Termination

a. The insurance ends:
   - on the expiration of the agreed term if the policyholder terminates the insurance before 1 January of any year in writing, by telephone or by email;
   - at the moment at which the insured person no longer has his or her permanent residence in the Netherlands or another EU/EEA country;
   - upon the death of the policyholder or insured person;
   - through cancellation by the insured person due to an amendment to the insurance conditions, insurance package and/or the premium, as referred to in 7.1 and in the manner stipulated in 7.3.

b .Zorg en Zekerheid may terminate the insurance:
   - by means of a written cancellation effective from a time of Zorg en Zekerheid's choosing in the case of:
     1. inaccurate representation or concealment as referred to in 2.5;
     2. late payment as referred to in 6.1(g) under 1;
     3. (actual or attempted) fraud, deception, intentional misinformation and/or other serious misconduct by the insured person;
     a. if the conditions for registration referred to in 2.2 are no longer complied with;
     b. by cancellation or disqualification from membership by the Zorg en Zekerheid Board, effective from the day that the membership ends for this reason.

### 3.4 Untruthful representation of facts

The loss of right to payment and termination of the current insurance agreement with Zorg en Zekerheid (healthcare insurance and/or supplementary insurance):

a. Any claim to the reimbursement of the costs of care and/or the provision of care will be cancelled if an incorrect representation of events is provided, forged or misleading documents are submitted or any incorrect statement is made intentionally by the policyholder or on the policyholder's behalf, or if the policyholder commits fraud.
b. Zorg en Zekerheid will claim back from the policyholder all costs already paid as per the date of any of the actions specified under a.
c. In the event of any of the actions specified under a., Zorg en Zekerheid is entitled to terminate the insurance contract.
d. Any investigation costs incurred by Zorg en Zekerheid in establishing the actions as referred to under a. will be recovered from the policyholder.
e. Investigations to establish fraud are conducted in accordance with the Protocol for Insurers and Criminality and the relevant provisions under and by virtue of the Healthcare Insurance Act. In the event that fraud is discovered, Zorg en Zekerheid will register the policyholder and/or insured person in question with the External Reference Register. In the event of established fraud or a strong suspicion of fraud, the case can be reported to the police.

## 4. Obligations of the policyholder/insured person

### 4.1 Obligations

a. The insured person/policyholder is obliged to ensure that any change that could influence the rights and obligations arising from the insurance agreement is communicated in writing, by telephone or by email to Zorg en Zekerheid as soon as possible, but no later than 30 days after the change concerned occurred. Such changes include:
   - change of address;
   - email address;
   - marriage or the entering into of a cohabitation arrangement;
   - birth (within four months) and death;
   - commencement of imprisonment and its ending;
   - change of bank account number;
   - divorce.
b. The policyholder/insured person must ensure that the necessary changes are made to the policy schedule.
c. The policyholder/insured person is obliged to inform Zorg en Zekerheid of any facts that could lead to costs being recouped from (actually or potentially) liable third parties, and will provide Zorg en Zekerheid with all necessary information and/or cooperation free of charge in this context.
d. Unless he has the written consent of Zorg en Zekerheid, the policyholder/insured party is not permitted to make an arrangement (or to cause this to be done) with the liable third party or with the latter's insurer in respect of the costs that have been or will be reimbursed by Zorg en Zekerheid.
e. The policyholder/insured person is obliged to submit original and clearly itemised invoices to Zorg en Zekerheid by 31 December of the third year following the year in which the treatment was carried out. Only original invoices, or computerised invoices that have been authenticated by the care provider, will be processed.
f. All consequences arising from failure to fulfil the above obligations or to do so in time will be for the risk of the policyholder/insured person.
g. The policyholder/insured person is obliged to refrain from acts that could harm Zorg en Zekerheid's interests. If Zorg en Zekerheid's interests are harmed by a failure to fulfil the above-mentioned obligations, Zorg en Zekerheid will not be required to reimburse any costs and may reclaim any reimbursements that have already taken place.
h. Notifications sent by Zorg en Zekerheid to the policyholder's last known address will be deemed to have reached him/her.
i. Your legal claim vis-à-vis Zorg en Zekerheid with respect to the right to reimbursement of costs will in principle expire three years after the start of the day following the day on which the care concerned was provided.
j. If Zorg en Zekerheid refuses your request for the reimbursement of the costs of care either entirely or partially, it will inform you of the refusal in writing. In the case of rejection, your legal claim vis-à-vis Zorg en Zekerheid will lapse six months after the date of the written rejection.
k. To prevent your legal claim vis-à-vis Zorg en Zekerheid from expiring through lapse of time, you must inform Zorg en Zekerheid in writing within the expiry term that you are explicitly claiming payment. Instituting a legal claim against the rejection is another way to prevent your claim against Zorg en Zekerheid from lapsing.
l. In the case of imprisonment, the cover under supplementary insurance for the insured person in question will be suspended as of the first day of imprisonment, unless you inform us that you do not wish this. In the case of the above-mentioned suspension, you will not owe any premiums. No cover will be granted either for costs incurred during this suspension period. You supplementary insurance will resume as of the last day of imprisonment, provided that we are informed about this within 30 days of that date. If you fail to inform us about the last day of imprisonment within 30 days of that date, cover under your supplementary insurance will not resume until we have been notified and will not be resumed retroactively from the last day of imprisonment.
m. If, as the policyholder or insured person, you have expressly consented to the policy and announcements and other communications being sent to you by Zorg en Zekerheid electronically, communications between you and Zorg en Zekerheid will be in electronic form as much as possible to the extent permitted by the law.

### 4.2 Freedom of choice

The insured person is free to choose the care provider/care-providing institution or body, unless the conditions stipulate otherwise.

## 5. Cover

### 5.1 Cover during the term

a. There is only a right to entitlements or reimbursement of costs incurred during the term of the insurance agreement. The date of the treatment or delivery is the determining factor when establishing the right to reimbursement, with due observance of the provisions of Article 2.5 and Article 6.1(g) under 1.
b. The cover is limited to the amounts and numbers set out in the policy conditions.
c. The content, extent, duration and method of receiving the entitlement and/or reimbursements will be determined by the Board after hearing the Members' Council. The entitlements and/or reimbursements will be made known to the policyholder/insured person via the policy conditions in a way to be determined by the Board.

### 5.2 The desired package

a. The policyholder/insured person may choose from various supplementary insurances. It is not possible to be insured through more than one package at a time, except in the case of AV-Delen.
b. Children will take most comprehensive package of the parent(s) on whose policy their names have been printed if and in so far as the latter have an insurance from the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.
c. With due observance of the provisions under b, and given the age limit specified in Article 2.2 (b), children both of whose parents have a supplementary AV-Plus insurance are insured in accordance with the AV-Top.
d. If the policyholder/insured person wishes to transfer to a package with more limited cover, the policyholder/insured person must inform Zorg en Zekerheid accordingly in writing, by telephone or by email before 1 January of any year. The insurance will then be amended as at the following 1 January.
e. If the policyholder/insured person wishes to transfer to a package with more extensive cover, the policyholder/insured person must inform Zorg en Zekerheid accordingly in writing, by telephone or by email before 1 January of any year. The insurance will then be amended as at the following 1 January.
f. Children under age 18 with their own policy, and whose parents are not insured with Zorg en Zekerheid (or are not permitted to be so), do not owe a premium and are insured under the AV-Sure policy.

## 6. The premium

### 6.1. Payment of the premium

a. The premium is owed for each insured person. The amount will be set by the Board, after hearing the Members' Council.
b. Insured persons under age 18 will not owe any premium if one of their parents has also taken out supplementary insurance with Zorg en Zekerheid. If neither of the parents has entered into a supplementary insurance, an insured person under age 18 will be liable to pay the premium in accordance with Article 6.1 under a.
c. The premium is owed as an advance payment for the period to be determined by the Board and must be paid in the manner to be stipulated by the Board.
d. The policyholder/insured person is not permitted to off-set the premium with any payments to be granted by Zorg en Zekerheid;
e. The policyholder/insured person is obliged to make timely payment of the premium and may never invoke the fact that the premium was not collected in time, for example if a notice of default is issued because the premium was not paid by the due date.
f. The obligation to pay premiums commences on the inception date and ends on the date on which the insurance ends.
g. Overdue payment:
    1. If the policyholder/insured person fails to fulfil the obligation to pay the premium, statutory contributions, excess and costs in time, Zorg en Zekerheid is entitled to terminate the insurance policy, after the policyholder has been sent a written demand to pay within a period set specified in the reminder of at least 14 days, which reminder has been to no avail.
    2. In the event of termination of the insurance contract, insurance can again be applied for after payment of the amount and any costs owed. The insurance will then commence on 1 January of the next calendar year;
    3. If a policyholder has already received a demand due to late payment of premium, statutory contributions, excess, personal contributions or costs, in the event of a failure to pay a subsequent invoice on time Zorg en Zekerheid will not be required to send the policyholder a separate written demand for payment.
h. If Zorg en Zekerheid takes measures to collect its claim, the resulting costs (both judicial and extrajudicial) will be charged to the person owing the premium. The extrajudicial costs will be set to a minimum amount of €15. The extrajudicial costs become payable from the moment the person who is liable to pay the premium is in default.

### 6.2 Tax on premiums

If Zorg en Zekerheid is liable to pay tax on the insurance premiums for insured persons abroad, it will charge you for this. You are obliged to pay these taxes by the deadlines set by Zorg en Zekerheid. Should you fail to fully fulfil

this obligation to pay in time, this will lead to the suspension of the cover and to the termination of the supplementary insurance as stipulated in Article 6.1 paragraph g, subparagraph 1 of these policy conditions.

### 6.3. Calculation of the premium

Premium base
Group discount (% of the premium base)
Internet discount (% of the premium base) -
Interim result (premium to be paid)

Instalment discount (% of the interim result) -
Premium to be paid

### 6.4 Internet discount

You may apply for an Internet discount on your supplementary insurance if you use MyZZ and authorise us to deduct the premiums owed by direct debit. If you are already registered as a policyholder with Zorg en Zekerheid, the Internet discount will commence as of 1 January of the new insurance year.

## 7. Change in premium and/or conditions

### 7.1 Changes

Zorg en Zekerheid is entitled to change the conditions and/or premium for a current insurance with Zorg en Zekerheid either en bloc or per group. The changes will be carried out as at a date to be set by Zorg en Zekerheid. Zorg en Zekerheid will inform you of these changes on the premium invoice or via another method.

### 7.2 Notification of changes

Prior to the date on which the conditions and/or premium are due to change, Zorg en Zekerheid will inform the policyholder/insured person of these changes, unless the changes are of minor importance and augment the insured person's rights.

### 7.3 Right of cancellation

Policyholders/insured persons who refuse to accept the changed conditions and/or premium can end the insurance by cancelling it. The policyholder/insured person must submit such a cancellation request in writing or by email to Zorg en Zekerheid no later than 30 days after the latter informed him of the change. Zorg en Zekerheid will then end the insurance effective from the date of the change and will refund the premium already paid.

### 7.4 Continuation of the insurance

If by the 31st day after notification of the change Zorg en Zekerheid has not received a request, either in writing or by email, from the policyholder/insured person to end the insurance, the insurance will be continued with under the new conditions and/or at the new premium.

### 7.5 No right of cancellation

The option to cancel the insurance will not apply:

a. If the conditions and/or premium is/are revised due to statutory regulations or provisions, this to include a change in the extent of the care to which a party is entitled by virtue of the Healthcare Insurance Act or AWBZ Act;
b. In the event the premium is lowered and/or the cover is extended.

## 8. Exclusions

You are not entitled to reimbursement of the costs:

a. if they are the result of or are related to intent or gross negligence on the part of the insured person or if they are the result of or related to any crime in which the insured person intentionally participated;
b. that are the result of or are connected with an armed conflict, active participation in civil wars, civil commotion either domestically or internationally, riots, revolts and mutiny;
c. if they are the result of or related to terrorism, insofar as not determined otherwise in the Schedule governing Terrorism Cover published by the Dutch Terrorism Risk Reinsurance Company. The clauses sheet was filed with the Amsterdam District Court on 6 January 2005 under number 6/2005 and with the Amsterdam Chamber of Commerce on 17 January 2005 under number 27178761. The clauses sheet can also be consulted on **terrorismeverzekerd.nl** and **zorgenzekerheid.nl/brochures**. You can also obtain this information by contacting our Contact Centre at telephone number (071) 5825 825 or by visiting one of our shops;
d. that are related to damage caused by, related to or resulting from an atomic nuclear reaction, regardless of how this arose;
e. the exclusion set out in 8(d) does not apply to loss/damage caused by radioactive nuclides located outside the nuclear plant and that are used or intended to be used for industrial, commercial, agricultural, medical, scientific or security purposes, provided that a permit issued by the central government is in force for the preparation,

use, storage and disposal of radioactive materials. A nuclear power plant ('kerninstallatie') is deemed to be a nuclear power plant within the meaning of the Nuclear Incidents (Third Party Liability) Act (WAK) (Bulletin of Acts and Decrees 1979225);

f. insofar as a third party is liable, by virtue of Dutch or foreign law, for the loss/damage suffered, the provisions of 8(e) will not apply;
g. if and insofar as you are entitled to this reimbursement by virtue of your healthcare insurance policy conditions or under the Wlz;
h. if the costs were incurred outside the Netherlands, with the exception of the costs referred to in Section A 3;
i. costs incurred for treatments for which prior referral or authorisation had to be requested and which referral or authorisation was not requested in advance nor issued.

## 9. Double cover

a. You are not entitled to reimbursement or entitlements if the costs arose due to illness and/or accidents and the insured person can assert his or her rights to the resulting costs by virtue of an insurance provided by law, a government arrangement, any subsidy scheme or, if the insurance agreement in question had not been entered into, an agreement other than this one.
b. This insurance will only apply for the excess of loss exceeding the cover granted under the insurances and arrangements referred to in paragraph a. or that would have been granted if the insurance in question had not existed.

## 10. Disputes

This insurance is governed exclusively by Dutch law. If you do not agree with a decision made in relation to the implementation of this insurance, you may submit a complaint in writing no later than 12 weeks after having been informed of the decision, to:

**Zorg en Zekerheid**
**Attn.: de Klachtencommissie**
**Postbus 428**
**2300 AK LEIDEN**

If you do not agree with a decision that Zorg en Zekerheid has made about your complaint or if you have not received a response within one month of submitting the complaint, you may turn to the following body:

**Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ)**
**Attn.: de Ombudsman Zorgverzekeringen**
**Postbus 291**
**3700 AG ZEIST**

## 11. Concluding provision

The Board will rule on any cases not regulated by these insurance terms and conditions. Adopted by the Members' Council on 09 November 2017 and to take effect on 01 January 2018.

# Section C Information

Please call our staff at our Contact Centre if you have any questions. They can be reached by telephone on working days from 8 a.m. to 6 p.m. CET at: (071) 5 825 825. You can also visit one of our shops. For more information, please visit **zorgenzekerheid.nl**.

### Discounts

Zorg en Zekerheid offers a number of discount options for glasses, specialist medical care and care aids. For more information, go to **zorgenzekerheid.nl/klantvoordeel**.

### MyZZ

Persons insured with Zorg en Zekerheid can access MyZZ. MyZZ allows you to view and, if applicable, change claims you have submitted, your excess, your personal data and the policy data. In addition, MyZZ allows you to submit your invoices online. You can log in to MyZZ using your DigiD account at **zorgenzekerheid.nl/mijnzz**.

### How do I get my invoice reimbursed?

Zorg en Zekerheid requires the original invoices (i.e. no PIN slips or receipts) or computer invoices authenticated by the care provider in order for it to be able to reimburse any costs.

- Write your personal customer number on your original invoice(s) and submit your invoice(s) online via MyZZ **zorgenzekerheid.nl/mijnzz**. You are obliged to keep the original invoice for three years after uploading. We may request that you send us the invoice during this period for the purpose of verification.
- Submit your invoice using the Zorg en Zekerheid app (free download from the App Store or Google Play Store). or:
- Write your personal customer number on the original invoice(s) and send your original invoice(s) in an envelope (no stamp required) to:
  **Zorg en Zekerheid**
  **Attn.: Afdeling Declaraties**
  **Postbus 428**
  **2300 AK LEIDEN**
- As all original invoices remain the property of Zorg en Zekerheid we recommend that you make a copy for your own administrative records.
- The deadline for submitting invoices is 31 December of the third year after the year in which the treatment was carried out.

There are a number of medical treatments for which you will need to ask for approval beforehand; a list of these can be found in these policy conditions in Section A: Extent of the cover.

### How do I get my invoice for my foreign stay reimbursed?

When it comes to claiming costs incurred abroad, you must submit both the original invoice and a claim form (*declaratieformulier*). You can download this form via **zorgenzekerheid.nl** or request it from Zorg en Zekerheid. You can send the original invoice with the claim form postage paid to:
**Zorg en Zekerheid**
**Attn.: Afdeling declaraties Buitenland**
**Postbus 428**
**2300 AK Leiden**
The original invoices must be itemised such that without further queries Zorg en Zekerheid can deduce the reimbursement it is obliged to pay. Computerised invoices must be authenticated by the care provider.

- Invoices should preferably be drawn up in French, German or English. Original invoices in other languages must be drawn up and/or translated such that without the need for further queries Zorg en Zekerheid can deduce the reimbursement it is obliged to pay.
- If Zorg en Zekerheid deems it necessary for the submitted invoice(s) to be translated, then Zorg en Zekerheid can require the insured person to have the invoice(s) translated by a sworn translator.
- The translation costs referred to in the previous subsection will not be eligible for reimbursement.
- he reimbursement of the costs incurred will be made in the Netherlands in EUR, based on the exchange rate in accordance with the guidelines published by the European Central Bank (ECB). Should no such rate be available, then the conversion rate on the day of treatment will be used, unless there is a clear deviation from the parallel rate or else no rate is available.

### A single IBAN

You do not need to state your IBAN when making a claim. When paying out your claims, Zorg en Zekerheid will use the IBAN it also uses for the collection or payment of premiums (if possible). This IBAN is stated on your policy schedule.

Zorg en Zekerheid
zorgverzekeraar

Postbus 400, 2300 AK Leiden
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