Policy Conditions 2021

Zorg Zeker Policy

Zorg en Zekerheid
zorgverzekeraar

Reimbursement Overview

Basic Insurance

Supplementary Insurance

Policy Conditions 2021
Reimbursement overview

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zorgverzekeraar

Reimbursement Overview

Basic Insurance

Supplementary Insurance

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 1.5.2, '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**.

Note: No rights may 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, which also includes basic insurance and supplementary insurance.
Note: Please make sure to consult all three brochures when you need to look something up.

Reimbursement Overview 2021	Basic insurance Zorg Zeker Polis and Zorg Vrij Polis	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 (collective maximum reimbursement for treatments and medicines)	-		max. €250	max. €250	max. €250	-	max. €460	max. €460	max. €460	max. €600	A1
- treatments	-		100% max. €25 per day	100% max. €25 per day	100% max. €25 per day	-	100% max. €40 per day	100% max. €40 per day	100% max. €40 per day	100% up to maximum amount	
- medicines	-		50% up to maximum amount	50% up to maximum amount	50% up to maximum amount	-	75% up to maximum amount	75% up to maximum amount	75% up to maximum amount	100% up to maximum amount	
Glasses, contact lenses and frame											
Glasses, contact lenses and frames (per 2 calendar years)	in accordance with the Care Aids Regulations	B20	100% max. €40 (from 2.25 dioptres)	100% max. €40 (from 2.25 dioptres)	100% max. €40 (from 2.25 dioptres)	-	100% max. €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 from 0 dioptres, max. €70	100% max. €70 (from 2.25 dioptres)	100% max. €100 (from 2.25 dioptres)	100% max. €150 (from 0 dioptres) or for children up to age 12 covered by your policy one pair of children's glasses per calendar year from 0 dioptres, max. €150	A2.1
Laser eye treatment (once only during the term of the insurance)	-		-	-	-	-	max. €200	max. €200	max. €200	max. €300	A2.2
Care abroad											
Vaccination due to a stay abroad (contracted)	-		-	100%	-	-	100% max. €80	100% max. €80	100% max. €80	100%	A3.1
Vaccination due to a stay abroad (non-contracted)	-		-	100% max. €80	-	-				100% max. €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%* of 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
Medical costs outside of Europe	100%* of Dutch rates	B22.2.2	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	max. 200% of the Dutch rate (supplement to reimbursement under basic insurance)	
Urgent dental care	-		-	-	-	-	100% max. €345	100% max. €345	100% max. €345	100% max. €345	A3.3.2

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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% max. €600	100% max. €600	100% max. €600	-	100% max. €600	100% max. €600	100% max. €600	100% max. €600	A3.5
Pharmaceutical care											
Medicines	100%*, excl. personal contribution of €250	B19.2	-	-	-	-	-	-	-	-	
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)	A4.1
Antacids	-		100% max. €35	100% max. €35	100% max. €35	-	100% max. €35	100% max. €35	100% max. €35	100% max. €35	A4.2
Diarrhoea vaccinations for infants	-		-	-	-	-	100% max. €200	-	-	100% max. 200.00	A4.3
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%*, excluding a personal contribution of €18.50 p.d./p.p. and the amount in excess of €262 p.d.	B7.2	-	-	100% reimbursement of personal contribution, max. €75	-	100% reimbursement of personal contribution, max. €262	100% reimbursement of personal contribution, max. €100	-	100% reimbursement of personal contribution, max. €262	A5.2
Maternity care	100%*, excluding a personal contribution of €4.60/h	B7.3	-	-		-	100% reimbursement of personal contribution, max. €262		-	100% reimbursement of personal contribution, max. €262	
Extended/postponed maternity care	-		-	-	-	-	max. 16 hours	max. 16 hours	-	max. 16 hours	A5.3
Electrical breast pump (hire or purchase)	-		-	-	max. €40	-	max. €75	max. €40	-	max. €75	A5.4
Prenatal screening and second trimester ultrasound scan	100%*	B7.1	-	-	-	-	-	-	-	-	
Prenatal class	-		100% max. €100	-	100% max. €100	-	100% max. €100	100% max. €100	-	100% max. €100	A5.5
Breast feeding course	-		100% max. €20	-	100% max. €20	-	100% max. €20	100% max. €20	-	100% max. €20	A5.6
Non-invasive prenatal test (NIPT)	100%*, subject to conditions	B7.1	-	-	-	-	-	-	-	-	
Lactation expert (supervision and advice for breast feeding)	-		-	-	-	-	100% max. €150	-	-	100% max. €150	A5.7
Combined Lifestyle Intervention											
Combined Lifestyle Intervention programme	100%*	B28	-	-	-	-	-	-	-	-	
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, max. €1,500	max. €50 per day, max. €1,500	max. €50 per day, max. €1,500	max. €50 per day, max. €1,500	A6.1
Health trips (per 2 calendar years)	-		-	-	-	-	100% max. €1,050	100% max. €1,050	100% max. €1,050	100% max. €1,050	A6.2
Guest house (i.e. Ronald MacDonald homes)	-		100% max. €15 per day	-	100% max. €15 per day	-	100% max. €20 per day	100% max. €15 per day	100% max. €15 per day	100% max. €20 per day	A6.3
Therapeutic youth camp (e.g. KIKA and De Luchtballon)	-		50% max. €350	-	50% max. €350	-	100% max. €350	100% max. €300	-	100% max. €350	A6.4
Substitute informal care	-		-	-	-	-	100% max. 3 weeks	100% max. 3 weeks	100% max. 3 weeks	100% max. 3 weeks	A6.5.1
Broker for informal care			-	-	-	-	100%, max. €250	100%, max. €250	100%, max. €250	100%, max. €250	A6.5.2

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Epidermal therapy											
Acne treatment	-		-	100% max. €150	-	-	100% max. €250	100% max. €150	-	100% max. €250	A7.1
Camouflage therapy	-		50% max. €115	50% max. €115	50% max. €115	-	75% max. €115	75% max. €115	75% max. €115	100% max. €150	A7.2
Dermatography	-		50% max. €200	-	50% max. €200	-	75% max. €200	75% max. €200	75% max. €200	100% max. €250	A7.3
Electrical epilation or laser depilation											A7.4
- existing users	-		50% max. €550	50% max. €550	50% max. €550	-	75% max. €1,100	75% max. €1,100	75% max. €1,100	100% max. €1,500	
- new users from 2018	-		50% max. €550	50% max. €550	50% max. €550	-	75% max. €600	75% max. €600	75% max. €600	100% max. €800	
Foot care for insured persons with diabetes or rheumatic patients	100%* for diabetics (Care Profile 2 or higher)	B24.2	-	-	-	-	-	-	100% max. €210 (for diabetics, only Care Profile 1)	100% max. €210 (for diabetics, only Care Profile 1)	A7.5
General practitioner											
Consultations and treatments	100%*	B5	-	-	-	-	-	-	-	-	
Care aids											
Medical care aids	in accordance with the Care Aids Regulations	B20	-	-	-	-	-	-	-	-	
Care aids (mastectomy bra, wigs, hearing aid (per ear), support pessary)	yes, excluding personal contribution (for details, see the Care Aids Regulations)	B20	100% max. €70 per care aid	-	100% max. €70 per care aid	-	100% max. €140 per care aid	100% max. €140 per care aid	100% max. €140 per care aid	100% max. €200 per care aid	A8.1
Urinary buzzer	-		100% max. €85	-	100% max. €85	-	100% max. €85	100% max. €85	-	100% max. €85	A8.2
Arch supports	-		50% max. €35	-	50% max. €35	-	100% max. €70	100% max. €70	100% max. €70	100% max. €100	A8.3
Care aids for home care	-		75% max. €40	-	75% max. €40	-	75% max. €40	75% max. €40	75% max. €40	75% max. €40	A8.4
Bandaging for chronic use	in accordance with the Care Aids Regulations	B20	-	-	-	-	-	-	-	-	
Alarm on social grounds	-		max. €3.50 per month	-	max. €3.50 per month	-	max. €4.00 per month	max. €4.00 per month	max. €4.00 per month	max. €5.00 per month	A8.5
Hearing protectors	-		-	100% max. €40	-	-	100% max. €40	-	-	100% max. €40	A8.6
Specialist medical care and hospital admission											
Specialist medical care and nursing	100%*, excl. specifically excluded care	B6.2	-	-	-	-	-	-	-	-	
Phlebology/proctology	-		50% max. €75	-	50% max. €75	-	75% max. €100	75% max. €100	75% max. €100	100% max. €150	A9.1
Protruding ear corrections	-		-	-	-	-	100% max. €500	100% max. €500	-	100% max. €500	A9.3
Sterilisation											
For men	-		-	-	-	-	100% max. €300 when performed by your GP, or 75% max. €300 when performed by a specialist	100% max. €300 when performed by your GP, or 75% max. €300 when performed by a specialist	-	100% max. €300 when performed by your GP or a specialist in hospital	A9.2
For women	-		-	-	-	-	75% max. €1,200 when performed by a specialist	75% max. €1,200 when performed by a specialist	-	100% max. €1,200 when performed by a specialist	

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Paramedical treatments **Remedial therapy (maximum number of treatments covered by supplementary insurance applies to chronic and non-chronic treatments together)**											
Up to age 18											
Physiotherapy	100%* if this relates to a chronic disorder, max. 9 treatment sessions if related to non-chronic disorders, if result is unsatisfactory a max. of 9 additional sessions	B17.1	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 9 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 40 treatment sessions (including max. 9 treatment sessions of manual therapy)	A10.1
Cesar/Mensendieck remedial therapy			max. 12 treatment sessions	max. 12 treatment sessions	max. 12 treatment sessions		max. 25 treatment sessions	max. 25 treatment sessions	max. 25 treatment sessions	max. 40 treatment sessions	
From age 18											
Physiotherapy	100%* from the 21st treatment session, if related to chronic disorders	B17.1	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 12 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 9 treatment sessions	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 25 treatment sessions (including max. 9 treatment sessions of manual therapy)	max. 40 treatment sessions (including max. 9 treatment sessions of manual therapy)	A10.1
Cesar/Mensendieck remedial therapy			max. 12 treatment sessions	max. 12 treatment sessions	max. 12 treatment sessions		max. 25 treatment sessions	max. 25 treatment sessions	max. 25 treatment sessions	max. 40 treatment sessions	
Other therapies											
Exercise programmes (including Fitkids and JOGG)	-		50% max. €500 per 2 calendar years	50% max. €500 per 2 calendar years	50% max. €500 per 2 calendar years	-	75% max. €500 per 2 calendar years	75% max. €500 per 2 calendar years	75% max. €500 per 2 calendar years	75% max. €500 per 2 calendar years	A10.1.1/ A10.1.2
Occupational therapy	max. 10 hours	B17.2	-	-	-	-	-	-	max. 10 hours	max. 10 hours	A10.3
Speech therapy	100%*	B17.3	-	-	-	-	-	-	-	-	
Dietary and/or nutritional advice	max. 3 hours of treatment	B17.4	-	-	-	-	7 x 15 minutes under age 18	7 x 15 minutes under age 18	-	10 x 15 minutes under age 18	A10.2
Dietary and/or nutritional advice for malnutrition, unintended weight loss or oncology			-	-	-	-	-	8 x 15 minutes	8 x 15 minutes	8 x 15 minutes	
Podology, podiatry, podopostural therapy	-		100% max. €50	-	100% max. €50	-	100% max. €100	100% max. €100	100% max. €100	100% max. €125	A10.4
Stutter therapy (Del-Ferro, Boma or Hausdörfer) methods	-		-	-	-	-	100% max. €400	75% max. €350	-	100% max. €400	A10.5
Preventative courses and information											
GeZZondcheck (once per 2 calendar years)	-		100%	100%	100%	-	100%	100%	100%	100%	A11.1
Preventative courses (first aid, Exercise for Seniors, coping with an illness or disorder, informal care, sleep therapy course)	-		50% max. €115	50% max. €115	50% max. €115	-	75% max. €150	75% max. €150	75% max. €150	100% max. €175	A11.2
Quit Smoking	one programme per calendar year	B25									
Menopause consultant	-		-	-	-	-	75% max. €115	75% max. €115	75% max. €115	100% max. €150	A11.3
Sports Medical Advice (SMA)	-		-	100% max. €120	-	-	100% max. €100	100% max. €100	100% max. €100	100% max. €150	A11.4
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	-	-	-	-	-	-	-	-	

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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 (including psychosocial counselling in connection with cancer, body-oriented therapy)	-		-	75% max. €200	-	-	75% max. €320	75% max. €320	75% max. €320	100% max. €500	A12.1
Psychological care for parents and children (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 €70 once-only purchasing costs	max. €7 per day for up to 10 days or €70 once-only purchasing costs	max. €7 per day for up to 10 days or €70 once-only purchasing costs	-	max. €7 per day for up to 10 days or €70 once-only purchasing costs	max. €7 per day for up to 10 days or €70 once-only purchasing costs	max. €7 per day for up to 10 days or €70 once-only purchasing costs	max. €7 per day for up to 10 days or €70 once-only purchasing costs	A12.2
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	B18.1 / B18.2	-	-	-	-	-	-	-	-	
Extra dental assistance (poured fillings, crowns and bridges)	-		-	75% max. €150	75% max. €150	75% max. €250	75% max. €500	75% max. €500	75% max. €500	85% max. €1,000	A13.1.1
Orthodontic treatment for children under the age of 18											A13.1.2
- existing users			-	-	-	100% max. €1,000	100% max. €2,000	100% max. €1,750	-	100%	
- new users from 2018	-		-	-	-	100% max. €1,000 (waiting period: 12 months)	100% max. €1,750 (waiting period: 12 months)	100% max. €1,500 (waiting period: 12 months)	-	100%	
Dental care for adults from age 18 (maximum amount applies to all reimbursements together)											
Total maximum 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 maximum amount	100% up to maximum amount	100% up to maximum amount	100% up to maximum amount	100% up to maximum amount	100% up to maximum amount	100% up to maximum amount	A13.2.1
Other dental care (e.g. prevention, oral hygiene, X-ray diagnostics, poured fillings, crowns and bridges, orthodontics and assistance with dentures)	-		-	75% up to maximum amount	75% up to maximum amount	75% up to maximum amount	75% up to maximum amount	75% up to maximum amount	75% up to maximum amount	85% up to maximum amount	A13.2.2
Full dentures	75%*	B18.3	-	75% (personal contribution) up to maximum amount	75% (personal contribution) up to maximum amount	75% (personal contribution) up to maximum amount	75% (personal contribution) up to maximum amount	75% (personal contribution) up to maximum amount	75% (personal contribution) up to maximum amount	85% (personal contribution) up to maximum amount	A13.2.2
Dentures: repairs and rebasing	100%*, excl. personal contribution		-	-	-	-	-	-	-	-	
Dental surgery care	100%*, excl. personal contribution		-	-	-	-	-	-	-	-	
Accident coverage dental care	-		-	100% max. €10,000	100% max. €10,000	100% max. €10,000	100% max. €10,000	100% max. €10,000	100% max. €10,000	100% max. €10,000	A13.3
Implants in non-toothless jaw	-		-	-	-	-	-	-	100% max. €750 when performed by a dentist or 100%, max. €500 when performed by a dental surgeon	100% max. €750 when performed by a dentist or 100%, max. €500 when performed 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

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Other reimbursements											
Visiting costs for family member admitted to hospital	-		100% max. €250	-	100% max. €250	-	100% max. €250	100% max. €250	100% max. €250	100% max. €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 under the Wlz/WMO (home care)	-		-	-	-	-	-	-	100% max. €200	100% max. €200	A14.4
Home care organisation membership	-		-	-	-	-	100% max. €17.50	-	-	100% max. €17.50	A14.5
Sports association membership fee for children up to age 18	-		-	-	-	-	100% max. €50 fee for membership of a sports association affiliated with the NOC*NSF	-	-	100% max. €50 fee for membership of a sports association affiliated with the NOC*NSF	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, max. €108	100% reimbursement of personal contribution, max. €108	100% reimbursement of personal contribution, max. €108	100% reimbursement of personal contribution, max. €108	A14.3
By private car	€0.32 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 1.5.2 ('Level of reimbursement') of the policy conditions.

Policy Conditions 2021

Basic Insurance

Zorg Zeker Policy

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Definitions

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
Institutional admission, if and insofar as the insured care can only be offered at an institution on medical grounds.

Basic insurance
The health insurance in accordance with the Healthcare Insurance Act taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another health insurer.

Beautician
A beautician who is affiliated with the General Dutch Sector Organisation for Beauticians (ANBOS).

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

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 physical 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.

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.

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 ZZP 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 health care. A comprehensive description of all the care covered by a ZZP can be found on the website of the Dutch Healthcare Authority.

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.

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.

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

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.

Centre for genetic counselling
An institution which holds a licence under the terms of the Special Medical Procedures Act (*Wet op de bijzondere medische verrichtingen)* for clinical genetic testing and the provision of genetic counselling.

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 (*Wet toelating zorginstellingen*, Wtz).

Cesar/Mensendieck remedial therapist
A Cesar/Mensendieck remedial therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

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

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

Coordinating care provider
A care provider who establishes a diagnosis and determines the treatment plan in response to the patient's care need. To that end, the coordinating care provider consults with the patient in a face-to-face meeting at least once. The coordinating care provider 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 coordinating care provider communicates with the patient to evaluate the progress made and adjusts the treatment plan where necessary.

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

Dental surgeon
A dental specialist registered as a dental surgeon in the register of specialists in oral diseases and dental surgery of the Royal Dutch Dental Association (KNMT).

Dentist
A dentist registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Diagnosis/Treatment Package (DTP)
A DTP describes the defined, validated process involved in specialist medical care and specialist (secondary) mental health care, in terms of a DTP code of practice established by the Dutch Healthcare Authority under the Healthcare (Market Regulation) Act. This description includes the patient's care need, the type of care, the diagnosis and the treatment. The DTP process starts at the point at which the insured person reports a problem to the medical specialist and finishes at the end of treatment, or after 120 days in the case of specialist medical care and after 365 days in the case of specialist mental healthcare.

Dietician
A dietician who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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.

District nursing
Nursing and care as provided by nurses.

Doctor
A doctor registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Educationalist
An educationalist registered as a remedial educationalist with the Association of Educationalists in the Netherlands (NVO).

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 countries (the states that are party to the Agreement on the European Economic Area) are Liechtenstein, Norway and Iceland.

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.

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.

Generalist Basic Mental Health Care (GGZ)
Diagnostics and treatment for minor to moderate, non-complex mental or stable chronic problems.

General practitioner
A doctor registered as a general practitioner in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association (KNMG).

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

Geriatric remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and who is registered as a geriatric remedial therapist in the Quality Register for Paramedics.

GeZZondcheck
The GeZZondcheck 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.

GVS personal contribution
The Medicine Reimbursement System (GVS) is part of the entitlement schemes provided under the Healthcare Insurance Act. Medicines that are registered in the GVS are covered by health insurers under the basic insurance. A personal contribution applies to specific medicines.

Hand therapist
An occupational therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a hand therapist in the Quality Register for Paramedics.

Health insurance
The health insurance in accordance with the Healthcare Insurance Act taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another health insurer. Also known as 'basic insurance' or 'the master policy'.

Health insurance policy
The (digital) deed concluded between the policyholder and the insurance company in which the health insurance coverage is set out.

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

Health psychologist
A health psychologist registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

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.

Hospital
A centre for specialist medical care that is admitted as a hospital or independent treatment centre (ZBC) in accordance with the rules of the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, Wtz).

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

Inpatient care
A stay for at least 24 hours.

Insurance
The legal relationship regulated by the insurance agreement.

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

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 laboratory cultivation of embryos;
- single or multiple intrauterine implantations of embryos to initiate pregnancy.

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

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 Dutch Association of Lactation Experts (NVL).

Lifestyle coach
A lifestyle coach is a professional who guides people to take control over their own health and welfare, explicitly based on the definition of positive health. The aim is to enable people to feel good about the life they lead, taking account of all their abilities and limitations. A lifestyle coach is registered as a lifestyle coach in the register of the Professional Association of Dutch Lifestyle Coaches (BLCN) or the relevant section of the register for paramedics.

Long-Term Care Act
The Dutch Long-Term Care Act (*Wet langdurige zorg,* Wlz).

Manual practitioner
A manual practitioner registered as a doctor in accordance with the conditions set out in Section 3 of the BIG Act and who has completed the supplementary training course in manual medicine.

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

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.

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 care provider, after an intake, by phone or otherwise, by the maternity care provider or maternity centre.

Maternity care agency 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 person.

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

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 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, and as deemed necessary by the medical adviser of Zorg en Zekerheid.

Medical specialist
A doctor registered as a medical specialist in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association (KNMG).

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

Mental health care 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*, Wtz).

Midwife
A midwife registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Multidisciplinary care
Multidisciplinary care is provided 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 multidisciplinary care, go to our website **zorgenzekerheid.nl**.

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 Act.

Nursing specialist
A nurse as registered in accordance with Section 3 of the BIG Act who specialises in acute, chronic, preventive or intensive care for somatic conditions or in mental health care.

Occupational therapist
An occupational therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

Optometrist
A paramedic who carries out checks, measurements and various supplementary medical examinations on eyes, either autonomously or under the supervision of an ophthalmologist.

Oral hygienist
An independent oral hygienist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and is authorised under Section 4 of the Healthcare (Unsupervised Activities) Decree and under the Independent Authorisation for Registered Oral Therapists (Temporary Measures) Decree.

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 Royal Dutch Dental Association (KNMT).

Orthoptist
A paramedic who diagnoses and treats disorders regarding the joint functioning and development of the eyes.

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.

Paediatrician
A physician registered as a KNMG youth healthcare physician in the Youth Healthcare Profiles Register administered by the Medical Specialisms Board of the Royal Dutch Medical Association.

Paediatric occupational therapist
An occupational therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a paediatric occupational therapist in the Quality Register for Paramedics.

Paediatric physiotherapist
A physiotherapist registered as such in accordance with the regulations referred to in Section 3 of the BIG Act and registered as a paediatric physiotherapist in the Quality Register for Physiotherapy NL of the KNGF (Royal Dutch Association for Physiotherapy) or as a paediatric physiotherapist with the Physiotherapy Quality Mark.

Paediatric remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and who is registered as a paediatric remedial therapist in the Quality Register for Paramedics.

(Medical) pedicurist
The pedicurist must be registered with the Quality Register for Pedicurists (KRP), the Paramedical Foot Care Register (RPV) or the Quality Register for Medical Foot Care Providers (KMV). For treatment to qualify for reimbursement under basic insurance coverage, a pedicurist must hold the qualification 'foot care for diabetics'. For treatment to qualify for reimbursement under supplementary insurance coverage, a pedicurist 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 pedicurist or paramedical chiropodist is a specialised pedicurist who can treat all forms of clients' complex foot problems.

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.

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

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(1)(s) of the Medicines Act (*Geneesmiddelenwet*) or the provision of these medicines, or pharmaceutical care to which the Blood Supply Act (*Wet inzake bloedvoorziening*) applies.

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

Physician's assistant (PA)
A physician's assistant registered as such in accordance with the conditions set out in Section 3 of the BIG Act. A PA may take over and interdependently carry out a physician's tasks such as taking a case history and drawing up a treatment plan, as well as perform activities such as operations, pacemaker implantations, endoscopies, nerve blocks and central venous catheter (CVC) placements.

Physiotherapist
A physiotherapist registered as such in accordance with the conditions set out in Section 3 of the BIG Act. A remedial gymnastics masseur as referred to in Section 108 of the aforementioned Act is also deemed to be a physiotherapist.

Podiatrist
A podiatrist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

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

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

Psychiatrist
A doctor listed as a psychiatrist in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association.

Psychosomatic physiotherapist
A physiotherapist registered as such in accordance with the regulations referred to in Section 3 of the BIG Act and registered as a psychosomatic physiotherapist in the Quality Register for Physiotherapy NL of the KNGF (Royal Dutch Association for Physiotherapy) or as a psychosomatic physiotherapist with the Physiotherapy Quality Mark.

Psychosomatic remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree 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 set out in Section 3 of the BIG Act.

Quality statute model (GGZ)
The mental health care (GGZ) quality statute model describes the quality and accountability measures mental health care providers must have in place for curative mental health care. This model has been in effect since 1 January 2017 and governs all providers of generalist basic mental health care and specialist mental health care under the Healthcare Insurance Act.

Rational pharmacotherapy
Rational pharmacotherapy is a type of treatment with a medicine in a form suitable for you, the working and effectiveness of which has been confirmed in the scientific literature. Furthermore, the medicine forms the best economic option for both the health insurer and the patient.

Reasonable distance
A reasonable distance to a contracted care provider within a fixed radius, in km, from the residence of the insured person. You can obtain this information by phoning Zorg en Zekerheid on (071) 5825 825 or by visiting one of our shops.

Registered oral hygienist
Registered oral hygienists satisfy the following conditions:
- have successfully completed the current 4-year oral care training programme, obtaining their diploma in 2006 or later;
- have entered into a written consultant-on-call agreement with a dentist (concerning such issues as after-care and pain relief);
- are included in the temporary BIG register , experimentation clause 36a;
- hold the radiation protection supervisory staff certificate.

Registered podologist
A podologist who has successfully completed a registered podologist training programme and is included in the quality register of Quality Registration and Accreditation for Healthcare Professionals (KABIZ).

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.

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 zorginstellingen*, Wtz).

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.

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.

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

Specialised Mental Health Care (GGZ)
Diagnostics and treatment of moderately/severely complex psychological ailments. The coordinating care provider has a significant share in the substantive treatment.

Specialised physiotherapist
A physiotherapist who, through supplementary training, has acquired supplementary knowledge of a specific discipline within the field of physiotherapy.

Specialised remedial therapist
A remedial therapist who, through supplementary training, has acquired supplementary knowledge of a specific discipline within the field of remedial therapy.

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.

Speech therapist
A speech therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

'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.

User

- An existing user has either:
  a. received the reimbursement previously AND not changed the supplementary insurance; or
  b. received the reimbursement previously, has not been covered by basic or supplementary insurance for a period of time and has now taken out the same supplementary insurance as before.
- A new user has either:
  a. not received the reimbursement before; or
  b. received the reimbursement previously, but changed the supplementary insurance; or
  c. received the reimbursement previously, has not been covered by basic or supplementary insurance for a period of time and has now taken out supplementary insurance that is different from the one before.

Waiting period for orthodontic treatment

Insured persons who are receiving orthodontic treatment must have taken out supplementary insurance for orthodontic treatment with us at least twelve months prior to the start of the treatment in order to claim reimbursement.

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.

We/us/Zorg en Zekerheid

The Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

WMG rates

The rates set under or pursuant to the Healthcare (Market Regulation) Act (*Wet marktordening gezondheidszorg*, Wmg).

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.

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 identity.

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 applies 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.

Costs for care provided by a non-contracted care provider are reimbursed at up to a maximum of 80% of the WMG (maximum) rate. If there is no WMG (maximum) rate, Zorg en Zekerheid will reimburse up to 80% of the prevailing market rate. If you receive nursing and care (Articles 27.1 and 27.3) from a non-contracted care provider, the costs are reimbursed up to a maximum of 75% of the prevailing Dutch market rate.

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

1.5.3 Turnover ceilings

With a number of care providers, Zorg en Zekerheid has agreed on a maximum amount that they are permitted to claim in any given calendar year (the turnover ceiling). This helps us keep healthcare affordable. Most care providers are under a contractual obligation to continue to provide the care even if the turnover ceiling has been reached. We call this the 'continued care obligation'.

We have no continued care obligation agreement with a small number of care providers. Go to **zorgenzekerheid.nl/zorgzoeker** for a list of these providers, or consult your care provider. It may be the case that you can no longer receive care from this care provider during the year in question. If so, please call or email our Care Advice & Mediation Team at telephone number (071) 5 825 828 or zorgadvies@zorgenzekerheid.nl. One of our consultants will then help you find a care provider that you can turn to. If you are already under the care of a provider who reaches his turnover ceiling, this will not affect your care in any way; you will be able to complete your treatment with that care provider.

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 Care Advice & Mediation 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 will reimburse the costs up to the maximum reasonable market price current in the Netherlands.

Care Advice & Mediation Team
Zorg en Zekerheid's Care Advice & Mediation 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. You will find more information about the Care Advice & Mediation Team at **zorgenzekerheid.nl/zorgadvies**.

Care which cannot be provided, or cannot be provided in time, by a contracted care provider is also understood to include:
a. care that cannot be provided within a reasonable distance from your place of residence;
or:
b. the absence of high-quality and responsible care 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 hospital admission, 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 as 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 submits one claim, then the date on which treatment started 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 the care or to reimbursement of its costs. 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 these policy conditions provide otherwise).

If you have written permission from your previous 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 2021. You received written permission for plastic surgery from your former healthcare insurer. The end date of that permission is 23 March 2021. If you receive 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 treatments, entitlements and institutions, 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 any financial or other consequences of failure to comply with their 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 those 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 of undue reimbursement

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 of care will, in principle, expire on 31 December of the third year following the year in which the treatment took place. To prevent expiry, you should notify us in

writing within the period mentioned in the previous sentence 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 and that of any co-insured persons 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 from 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 and you satisfy the switching conditions.

2.2 Times at which you may cancel your insurance

As a policyholder, you may terminate your healthcare 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 received it, 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 out 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 3.4, ‘Payment arrears’;
b. in the case of fraud as described in Article 4.5, 'How we deal with fraud';
c. if there are important reasons for us to take the healthcare insurance off the market.

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 3.4, ‘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, and of the end of an insured person’s obligation to take out insurance or of 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 the 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 twelve 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 seven 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 seven 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 from such time as such obligation to be covered by health insurance did not exist (or ceased to 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 under age 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, quarterly, half-yearly or yearly basis. If you opt to pay the premium on a half-yearly or yearly basis, you are entitled to a discount over the premium due. When you join a group contract, your choice may be limited to a monthly payment plan. Consequently, you will not be entitled to a discount for half-yearly or yearly payment.

3.2.1 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.

3.2.2 Voluntary excess on participation in single group contact

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.

3.3 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 to 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.

3.4 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 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.

3.4.1 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.

3.4.2 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 amount 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.

3.4.3 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 takes 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).

3.4.4 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 details and the personal details 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.

3.4.5 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.

3.4.6 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 extrajudicial costs. With effect from 1 July 2012, the extrajudicial costs amount to a minimum of
€40. You will owe extrajudicial costs from the moment you are in default.

3.4.7 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.

3.5 Compulsory excess

3.5.1 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 case 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.

3.5.2 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 applies. The consultation costs incurred by a psychiatrist within the context of Transparent Next 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, such as the costs of any ambulance transport, medicines or tests performed elsewhere and charged separately. Having an IUD implanted by an obstetrician will however count towards your excess;
c. contraceptives for insured persons from 18 to 20 years of age;
d. nursing and care (district nursing) as described in Section B, Articles 21 and 27.1;
e. 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. If there is a medical need to travel by car, we will reimburse the costs of transport by car;
f. costs of care of donors related to the donation that are incurred after 13 weeks or, in the case of a liver transplant, after 26 weeks following the donation when the donor is still alive;
g. medicines listed by us as Preferred in the *Reglement Farmaceutische Zorg* (Pharmaceutical Care Regulations). Please note that pharmacy services, such as the cost of dispensing medicine, the counselling interview in the case of a new medicine or inhalation instructions are not exempt from this excess. Also see Section B, Article 19;
h. the medication check by a contracted pharmacist;
i. the costs of contracted multidisciplinary care for chronic conditions (multidisciplinary care), with the exception of care outside of multidisciplinary care;
j. the ZZ-approved Quit Smoking programmes (including medication), which you will find on **zorgenzekerheid.nl/vergoedingenzoeker**;
k. the Combined Lifestyle Intervention (CLI);
l. care aids on loan.

3.5.3 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 18th birthday. The amount of the compulsory excess will in that case be calculated as described in Article 3.5.4.

3.5.4 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:

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

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.

3.5.5 Compulsory excess for Diagnosis-Treatment Package (DTP)

The costs of a treatment claimed within the context of a DTP, 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 DTP, integrated delivery care, basic mental healthcare or ZZP mental healthcare product was opened.

3.5.6 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 we decide to recover the amount, you will receive a written request from us asking you to effect payment within 14 days, or a notice informing you that we will deduct the amount to be recovered by direct debit 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.

3.6 Voluntary excess

3.6 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. It is not possible to opt for voluntary excess in some group insurance contracts.

A voluntary excess means that the costs or reimbursement 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 3.5.1. 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**.

3.6.2 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 3.5.2).

3.6.3 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 on (071) 5 825 825 or in person at one of our shops.

3.6.4 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:

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

The resulting amount will be rounded off in whole euros.

Example for 18-year-old:
You have chosen a voluntary excess of €100.00. 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 in the calendar year concerned. The result is then rounded off to whole euros.

3.6.5 Voluntary excess for Diagnosis-Treatment Package (DTP)

Amounts claimed under a so-called DTP, 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 product concerned was opened.

3.6.6 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 we decide to recover the amount, you will receive a written request from us asking you to effect payment within 14 days, or a notice informing you that we will deduct the amount to be recovered by direct debit within 14 days.

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

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

3.6.7 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 Zorg en Zekerheid's medical advisor of the reason for the admission if the latter so requests;
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, 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 any liable third parties, in which case Zorg en Zekerheid must 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 itemised 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 the date on which care was provided, and not the date of the invoice concerned. Where the invoice relates to a DTP, all costs that are associated with this DTP 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. to ensure, as the policyholder, 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;
   - start and end of a jail term.

   If the change is not communicated to Zorg en Zekerheid within 30 days, it will only take effect as of the date it is actually reported and not retroactively from the date of the change. The following exceptions apply: lapsing of the statutory obligation to be insured, birth (see Article 2.1.1), death, and start of a jail term (the healthcare insurance will be suspended as of the date of placement in a penitentiary institution) and its ending (the healthcare insurance will recommence on the date that the imprisonment ends).

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 (unless you belong to a risk group);
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. treatments 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 concerned, 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 war, 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 in connection with an illness or accident if the insured person can claim compensation 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 the 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. You can consult the Clauses Sheet via www.terrorismeverzekerd.nl.

4.4 How we deal with your personal data

In order to take out health insurance or to change or terminate your policy, 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. When processing your personal details, we adhere to the applicable laws and regulations, such as the General Data Protection Regulation. For details on how we do this, please consult our Privacy Statement, which is published on our website.

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 for 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. In accordance with the Incident Warning Protocol for Financial Institutions, we will maintain an Incidents Register and are authorised to view and/or enter your personal data in the External Reference Register maintained by Stichting Centraal Informatie 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 the costs 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 can 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 400
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 within one year 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 29 October 2020 and to take effect on 1 January 2021.

B: Extent of cover

Medical care

Article 5: General practitioner care

5.1. General

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:
- flu vaccinations;
- medical examinations.

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

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

5.2 Medical care for members of specific patient categories

What am I entitled to?
The medical care provided by general practitioners to specific patient groups (GZSP) is a set of types of care for vulnerable people who are (still) living at home and have (highly) complex issues, such as elderly people with multiple health issues, people with progressive degenerative neurological disorders, people with non-congenital brain injuries or people with an intellectual disability. More specifically, this concerns:
- care as generally provided by geriatric care specialists;
- care as provided by doctors for the mentally disabled;
- care as provided by behavioural scientists and paramedics.

The care need is diverse and may concern issues in the somatic, psychological and/or behavioural fields; the care is mostly multidisciplinary in nature. This type of care can encompass both individual and group treatment.

What am I not entitled to?
You are not entitled to this type of care if you have an indication from the Care Assessment Centre for care under the Long-Term Care Act.

Do I need a referral?
You will need to have a referral from your general practitioner. In the case of people with an intellectual disability, a referral from a paediatrician will also be accepted.

Does Zorg en Zekerheid need to approve this beforehand?
Continuation of group day treatment which takes longer than six months requires prior written approval from Zorg en Zekerheid. The request for extension of the treatment must be applied for at least three weeks before the end of the first six months of group day treatment.

Medical Care for Specific Patient Groups (GZSP) - Transitional Scheme for 2021
Please note: if you have an indication from the Care Assessment Centre but your GZSP treatment has not yet started, your Care Assessment Centre indication will qualify as a referral for GZSP during the first three months of 2021. This care will then be paid for by your health insurer. If you do not use your Care Assessment Centre indication as a referral for commencement of a treatment programme in the first three months of 2021, you will need a new referral for this care from 1 April 2021, provided by an issuer covered by GZSP.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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, youth healthcare physician, medical specialist (including a sports physician) or physician assistant, emergency assistance physician, nursing specialist, Municipal Health Service (GGD) doctor, infectious diseases specialist, geriatric care specialist, doctor for the mentally disabled, optometrist and orthoptist (can only issue a referral to an ophthalmologist), audiological clinical physicist or, in the event of obstetric care or congenital defects in a newborn child, a referral from a midwife. 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 is 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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. To view the 'Conditionally qualifying treatments', go to www.zorginstituutnederland.nl.

6.2 Inpatient 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 prior written permission from Zorg en Zekerheid for the treatment of complex pulmonary rehabilitation.

In the event that you wish to engage a care provider with whom we have not concluded a contract, you may have to pay a portion of the costs of treatment yourself. please see Article 1.5 of these policy conditions.

6.3 Non-clinical medical specialist care

What am I entitled to?
You are entitled to:
- medical specialist treatments in or by a centre for medical specialist care;
- medical specialist treatment provided by an extramural medical specialist;
- 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 provided 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 17.5 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 DTP 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 implantation and surgical replacement of a breast prosthesis other than following a full or partial mastectomy or in the event of aganesis or aplasia of the breast in women, or to address a comparable situation in diagnosed transsexuality;
- the surgical removal of a breast prosthesis without medical grounds;
- 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/polisvoorwaarden** 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**.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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, geriatric care specialist or doctor for the mentally disabled 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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. 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’;
- combined first-trimester screening test or non-invasive prenatal test (NIPT) exclusively on medical grounds;
- all pregnant insured persons who have had a combination test (comprising a nuchal translucency and blood test) or a NIPT with a 'positive' result have an indication for follow-up examination, including invasive diagnostics.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

7.2 Delivery and obstetric care

You and your child are entitled to medical care as generally provided by obstetricians. This includes the care provided before, during and after delivery. In the context of delivery, 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, if required. This applies both to you and (commencing on the day of the delivery) to your child;
- hospital accommodation, if you are nursing your healthy infant (breast feeding), for as long as Zorg en Zekerheid is liable to reimburse you for the hospitalisation and treatment costs.

What are the conditions?
There must be a medical necessity for the hospital delivery and/or stay 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 you and your child leave the hospital together before the post-natal period (the period of ten days from the day of delivery) has expired, you will retain an entitlement to the remaining days of post-natal care with due observance of the provisions in Article 7.3.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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, including childbirth assistance at the hospital or birth centre.

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 you and your child are subject to a personal contribution of €37 per day in the hospital (€18.50 for you and €18.50 for your child). The personal contribution is increased by the amount that exceeds the hospital fee (€262: €131 for you and €131 for your 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.

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 you and your 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, you will retain an entitlement to the remaining days of post-natal care.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

7.3 Maternity care

What am I entitled to?
You are entitled to maternity care as provided by maternity carers to mother and child in the context of delivery, provided by a qualified maternity carer or an O&G nurse. The maternity care consists of the registration and intake by the maternity centre, childbirth 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 scope of the maternity care to be provided depends on your personal situation following the delivery. The obstetrician or gynaecologist will consult with you to determine the number of hours of maternity care that you will receive, based on the National Indication Protocol for Maternity Care.

What are the conditions?
- you must apply for maternity care no later than in the 20th week of your pregnancy via **zorgenzekerheid.nl/aanvragenkraamzorg** or by phoning the Zorg en Zekerheid Maternity Line (**'Kraamlijn'**) on telephone number: (071) 5 825 555);
- in the event of a stay in hospital: if you and your child leave the hospital together before the post-natal period (the period of ten days from the day of delivery) has expired, you 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** or refer to 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 €4.60 per hour towards the costs of maternity care.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 8: Rehabilitation

8.1 Rehabilitation
What am I entitled to?
We reimburse the costs of rehabilitation 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.

Does Zorg en Zekerheid need to approve this beforehand?
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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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). The care must follow (either immediately or within a week after discharge from hospital of a patient with an indication for rehabilitation) and initially be accompanied by a stay in connection with medical care such as provided by medical specialists (a hospital admission);

or:
- the home situation in the event of an acute mobility disorder or decline in the patient's ability to care for themselves, as based on a 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 for geriatric rehabilitation must be determined by the geriatric internist, the clinical geriatrician or geriatric care specialist following a written referral from the hospital's medical specialist;
- if you enter ambulant geriatric rehabilitation care (GRZ) from a home or inpatient primary care (ELV) situation in which you received no prior specialist medical care, the geriatric care specialist may, under specific circumstances, perform a geriatric assessment. In such a case, the indication for access to geriatric rehabilitation is conditional, among other things, upon an assessment of your medical stability. In the event of an acute condition, the geriatric care specialist will always contact the attending medical specialist; in the case of doubt, a medical specialist will be consulted to assess your medical stability;
- 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 material. The care must be connected with an organ transplant covered by this insurance;
- transport by means of public transport at the lowest available fare within the Netherlands, or, if medically necessary, transport by car within the Netherlands, in connection with the selection, admission to and discharge from the hospital and with the care referred to in the previous bullet; 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 DTP specialist medical care), you are also entitled to:
- training provided by the dialysis centre of persons performing or assisting with the dialysis;
- reimbursement of the 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 at 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;
- reimbursement of electricity costs for the use of oxygen equipment.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 15: Audiological care

What am I entitled to?
You are entitled to care provided by an audiological centre consisting of:
- an examination of your 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 insured person (including the medicine and the required storage of the embryos).

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 can be returned in a first or second attempt, if this is justified on medical grounds;
- the treatment must be performed at an IVF centre licensed to apply IVF treatments under the Special Medical Procedures Act (WBMV);
- the costs of embryo storage are reimbursed only if the individual insured person is entitled to reimbursement for IVF or ICSI treatment under her healthcare insurance.

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 any 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 point in 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).

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 17: Paramedical care

17.1 Physiotherapy and remedial therapy

What am I entitled to?

You are entitled to physiotherapy and remedial therapy as generally provided by physiotherapists and remedial therapists, to the extent there are medical or paramedical grounds to justify such care.

For persons under age 18

You are only entitled to:

- treatment of a condition included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders), from the first treatment session. Please bear in mind that the duration of treatment of a number of chronic disorders is limited as set out in the above list.
- up to nine treatment sessions per referral per calendar year for conditions not included in Appendix 1 to the Health insurance Decree (List of Chronic Disorders). In the event of an unsatisfactory result, you are entitled to an additional nine treatment sessions, at most, per referral per calendar year.

Note: As soon as you turn 18, your entitlement is that of persons aged 18 and over and the treatment of any condition included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) will not be eligible for reimbursement until the 21nd treatment session after your 18th birthday.

For persons aged 18 and over:

Your entitlement to care is limited to the following cases / the following disorders:

- conditions in the List of Chronic Disorders:
  treatment of a condition included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders), from the 21st treatment session. Please bear in mind that the duration of treatment of a number of chronic disorders is limited as set out in the above list.
- pelvic physiotherapy to treat urine incontinence:
  the first nine sessions of pelvic physiotherapy for urine incontinence as part of a 'stepped care' programme;
- intermittent claudication:
  a maximum of 37 supervised training sessions over a 12-month period in the case of Fontaine stage 2 peripheral artery disease (intermittent claudication);
- arthrosis:
  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 consecutive months;
- COPD:
  reimbursement for supervised remedial therapy for COPD sessions, in the case of stage II (moderate COPDS) or higher of the GOLD Classification for spirometry. The number of treatment sessions is as follows:

Severity category for symptoms and risk of worsening	First 12 months	For every subsequent 12-month period
A	5	0
B1	27	3
B2	70	52
C or D	70	52

Appendix 1 to the Health Insurance Decree
A number of conditions are listed in Appendix 1 to the Healthcare Insurance Decree in what is known as the 'List of Chronic Disorders'. Disorders in this list include specific disorders of the nervous system or the musculoskeletal system, specific lung and vascular disorders, lymph oedema, weak sections of tumours and skin scar tissue. Your physiotherapist will be able to tell you whether your disorder appears on the list. You can find the list on **zorgenzekerheid.nl/polisvoorwaarden** or apply for a copy from us.

Procedures and materials
In some cases the therapist will perform procedures such as shockwave, dry needling or ultrasound imaging. Such procedures are part of the standard treatment and may not be separately invoiced to you by the physiotherapist and/or remedial therapist.

The costs of materials provided during a session, such as bandages and auxiliary bandaging, are part of the treatment and may not be separately invoiced to you by the physiotherapist or remedial therapist.

Additional reimbursement under a supplementary insurance policy
If the first 20 physiotherapy or remedial therapy treatment sessions are not reimbursed, you may qualify for partial reimbursement of those sessions under our supplementary insurance policies. For more information, go to**zorgenzekerheid.nl/zorgverzekeringen**.

What are the conditions?
a. The care must be provided by the following care providers:

	Physiotherapy	Specialised physiotherapy excl. oedema and scar therapy	Oedema and scar therapy	Remedial therapy	Specialised remedial therapy
Physiotherapist	Yes	No	No	No	No
Specialised physiotherapist	Yes	Yes	No	No	No
Remedial therapist	No	No	No	Yes	No
Specialised remedial therapist	No	No	No	Yes	Yes
Oedema therapist or skin therapist	No	No	Yes	No	No

- the physiotherapist or specialised physiotherapist must be registered for the specialisation concerned in the Kwaliteitsregister Fysiotherapie NL or with the Physiotherapy Quality Mark (Keurmerk Fysiotherapie);
- the remedial therapist or specialised remedial therapist must be registered for the specialisation concerned in the Quality Register for Paramedics (KP) (quality registered status);
- do you qualify for supervised ambulatory training sessions in the case of stage 2 peripheral artery disease (intermittent claudication)? In that case, your physiotherapist or remedial therapist must be registered for intermittent claudication with Chronisch ZorgNet and be known as such with Zorg en Zekerheid through registration in the Vektis AGB register;
- if you are being treated for Parkinson's disease and Parkinsonisms, your physiotherapist or remedial therapist must be registered with ParkinsonNet and be known as such with Zorg en Zekerheid through registration in the Vektis AGB register.

b. The number of treatment sessions is determined as follows:
- have you commenced a new treatment programme with a physiotherapist? In that case, the physiotherapist will first examine you to exactly determine your condition and identify the right treatment for you. This counts as one treatment. If the physiotherapist then proceeds to providing the treatment, this counts as another treatment. This means that the costs of two treatments can be claimed for your first visit to the physiotherapist;
- all physiotherapy and remedial therapy treatments count towards the total. This also applies to outpatient treatments that were provided in a hospital or institution.

c. Group treatment:
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 treatment sessions serve as a baseline measurement, interim evaluation and/or final measurement.

Do I need a referral?
Is your condition included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) or will you be treated for hip or knee joint arthrosis, Fontaine II intermittent claudication or COPD Gold class II or higher? In that case you will need a written referral from your attending physician, the nursing specialist or the physician assistant before you can start the treatment. Alternatively, you can produce a diagnosis statement including the following details: your name, the name of the doctor who gave the diagnosis and a clear description of the diagnosis.

Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.

Is your condition not included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) and are you not being treated for hip or knee joint arthrosis, Fontaine II intermittent claudication or COPD Gold class II or higher? In that case, you do not need a referral for treatment by a physiotherapist or remedial therapist. We call this 'direct accessibility'.

Does Zorg en Zekerheid need to approve this beforehand?
If you are going to receive care following a period you spent in a hospital, nursing home or rehabilitation institution (day treatment) and that care does not concern a condition included in Appendix 1 to the Healthcare Insurance Decree (List of Chronic Disorders) but is aimed to expedite your recovery following discharge or termination of the day treatment programme, you will need prior written permission for that care from Zorg en Zekerheid. Your physiotherapist will have to apply for that permission on your behalf.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

17.2 Occupational therapy

What am I entitled to?
You are entitled to occupational therapy as generally provided by occupational therapists 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 or the specialised occupational therapist, such as an occupational therapist for hand issues or a paediatric occupational therapist, must be included 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. This also applies to outpatient treatments that were provided in a hospital or institution;
- 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?
- Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.
- In other situations you will have direct access to the occupational therapist.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

17.3 Speech therapy

What am I entitled to?
You are entitled to speech therapy as generally provided by speech therapists.

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 speech therapist must be registered in the Quality Register for Paramedics (quality registered status);
- 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;
- 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?
- Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.
- In other situations you will have direct access to the speech therapist.

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 sessions provided by way of speech therapy support in education do not qualify 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 treatment sessions serve as a baseline measurement, interim evaluation and/or final measurement.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

17.4 Dietary advice

What am I entitled to?
You are entitled to receive dietary advice with a medical objective as typically provided by dieticians, 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 for persons who are overweight or underweight. For the applicable reimbursements, check **zorgenzekerheid.nl/vergoedingenzoeker** or 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 dietary advice treatments count towards the specified maximum number of treatment hours. This also applies to outpatient treatments that were provided in a hospital or institution;
- the treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your dietician is affiliated with ParkinsonNet.

Do I need a referral?
- Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.
- In other situations you will have direct access to the dietician.

What am I not entitled to?
Dietary advice for the indications diabetes, asthma, COPD or CVRM (Cardiovascular Risk Management) may be part of coordinated multidisciplinary care procured from a care group. If you receive dietary and/or nutritional advice through coordinated multidisciplinary care for one of these indications, this will be covered by your multidisciplinary care entitlement of Article 24. In that case, you will not be entitled to the three treatment hours for dietary and/or nutritional advice mentioned above for the same indication or for issues associated with that indication.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

17.5 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 properly qualified skin therapist;
- the skin therapist must be registered in the Quality Register for Paramedics (quality registered status).

Do I need a referral?
Yes, you will need a referral from your attending medical specialist for this type of care.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 18: Oral care

18.1 General provisions

What am I entitled to?
You are entitled to:
- 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 and competent care provider such as a dentist, dental surgeon, orthodontist, dental technician, registered oral hygienist 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).

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

18.2 Oral care under age 18

What am I entitled to?
You are entitled to:
a. one periodic check (periodic preventive dental check) a year, unless there are dental-medical grounds for more than one check a year;
b. incidental dental consultations;
c. removal of tartar;
d. a maximum of two fluoride treatments a year (unless more treatments in any one year are necessary), commencing from the appearance of the first element of a permanent set of teeth;
e. the sealing of milk teeth using fissure sealant;
f. periodontal assistance (for tissue that attaches a tooth or molar to the jaw);
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);
k. dental surgery performed by a dentist or a dental surgeon, with the exception of the fitting of a dental implant;
l. X-rays, except for orthodontic purposes;
m. removable dentures (frame prostheses, partial prostheses (plate) or full dentures).

For details on treatments and the associated performance codes that qualify for reimbursement at an independent oral hygienist or registered oral hygienist, consult the document entitled Reimbursements for treatment by independent oral hygienists or registered oral hygienists at **zorgenzekerheid.nl/vergoedingenzoeker**.

Do I need to pay a personal contribution?
No, no personal contribution is required for persons under age 18.

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

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 reasonably be delayed until another day.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written approval from Zorg en Zekerheid for:
- the sealing of milk teeth with fissure sealant;
- entitlement to reimbursement for the costs of care as referred to in Article 18.2(k) in the case of an extraction under anaesthesia or osteotomy;
- services included in the latest version of the *Limitatieve Lijst Machtigingen Kaakchirurgie* (Exhaustive List of Authorisations for Oral Surgery). To view this list, go to **zorgenzekerheid.nl/polisvoorwaarden**;
- taking and assessing dental overview X-rays;
- taking and assessing multi-dimensional jaw X-rays;
- if the full dentures (with the exception of an immediate denture) are replaced within five years of purchase.

The care provider applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the care provider (see Articles 6.2 and 6.3) or a centre for special dentistry, as well as by a 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. surgical dental care performed by a dental surgeon, plus the associated X-rays. This does not include periodontal surgery (gum treatment), fitting dental implants, and uncomplicated extractions (removal of molar that can also be done by your dentist);
b. full removable dentures for the upper of lower jaw, either on top of dental implants (which includes the fitting of the mesostructure, push button or bar-joint system).

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:
- 25% of the costs of full dentures, other than supported by implants;
- 10% of the costs of repair or rebasing of a supported dental prosthesis;
- 10% of the authorised rate for a supported dental prosthesis for the lower jaw;
- 8% of the authorised rate for a supported dental prosthesis for the upper jaw.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written approval from Zorg en Zekerheid for:
- entitlement to care as referred to in Article 18.3(a), if it concerns an extraction under anaesthesia or osteotomy;
- services included in the latest version of the *Limitatieve Lijst Machtigingen Kaakchirurgie* (Exhaustive List of Authorisations for Oral Surgery). To view this list, go to **zorgenzekerheid.nl/polisvoorwaarden**;
- 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;
- taking and assessing multi-dimensional jaw X-rays;
- taking and assessing multi-dimensional jaw X-rays;
- all forms of care for dentures supported by implants;
- mesostructure (push button or bar-joint system), which must be applied for by a dentists;
- placement of implants by a non-contracted care provider.

The dentist applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the dentist, dental technician, dental surgeon (see Articles 6.2 and 6.3) or a centre for special dentistry, as well as by a 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
You will qualify for special oral care if you have a serious condition that would make it impossible for you to use your teeth and molars sufficiently without such care.

18.4.1 Dental care in special cases
What am I entitled to?
You are only entitled to this type of dental care if:
- you have a serious developmental disorder or growth disorder in the tooth, jaw and mouth system, or a defect in that system acquired in later life;
- you are suffering from a non-dental physical or mental disorder;
- you need to undergo medical treatment the result of which depends in part on dental care.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written approval from Zorg en Zekerheid. The dentist applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the dentist, dental technician, dental surgeon (see Articles 6.2 and 6.3) or a centre for special dentistry, as well as by a written treatment plan and an estimate of the costs involved.

Do I need to pay a personal contribution?
Insured persons from age 18 pay a personal contribution for any care that is not directly related to a disorder requiring special dental care. The personal contribution is equal to the amount that would be charged if special needs oral care did not apply.

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 if the implant serves to attach a removable denture.

What are the conditions?
- implants may only be applied for and fixed by a dentist or dental surgeon;
- the mesostructure may only be applied for and fixed by a dentist;
- the prosthesis on implants may only be applied for and fixed by a dentist or clinical dental technician.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written approval from Zorg en Zekerheid. The dentist applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the dentist, dental technician, dental surgeon (see Articles 6.2 and 6.3) or a centre for special dentistry, as well as by a written treatment plan and an estimate of the costs involved.

Do I need to pay a personal contribution?
Insured persons from age 18 pay a personal contribution for any care that is not directly related to a disorder requiring special dental care. The personal contribution is equal to the amount that would be charged if special needs oral care did not apply.

18.4.3 Orthodontics in special cases

What am I entitled to?
You are entitled to orthodontic care if you have a very severe developmental or growth disorder of the tooth, jaw and mouth system that necessitates additional diagnostics or co-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?
You will need prior written approval from Zorg en Zekerheid. The application to obtain permission from Zorg en Zekerheid must include a supporting letter from an 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 for insured persons up to age 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 specialist dental surgery as described in Article 18 and which may or may not include nursing care, paramedical care or other care:

a. an interruption of up to 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?
You will need prior written approval from Zorg en Zekerheid. The dentist applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the dentist, dental technician, dental surgeon (see Articles 6.2 and 6.3) or a centre for special dentistry, as well as by 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 Pharmaceutical care

What am I entitled to?

You are entitled to pharmaceutical care in conformity with the Healthcare Insurance Decree and Regulations and the Pharmaceutical Care Regulations as can be found on **zorgenzekerheid.nl/polisvoorwaarden**. This care encompasses the provision of medicines, advice and supervision as provided by pharmacists, dispensing general practitioners and other medically specialised suppliers ('pharmacist' below), for the purpose of medication assessment and the responsible use of medicines. These pharmacists are listed in the register of established pharmacists as referred to in Section 61 of the Medicines Act (*Geneesmiddelenwet*).

This includes:

- the dispensing of a medicine for which a prescription is required and which has actually been delivered to you;
- the dispensing of and counselling interview for a medicine that is new for your and for which a prescription is required. This applies to a medicine with the same active ingredient and administration method that has not been provided to you before, or to one that was provided to you at least twelve months ago;
- the dispensing of a medicine through an individualised distribution method if you need to receive your medicines in such a manner for one or more weeks, for example in the form of a medication roll pack or week dispenser box. The pharmacist will assess the extent to which this constitutes necessary and effective care;
- instructions for the use of a medical aid that is used for the administration of a medicine for which a prescription is required. A maximum of one instruction per aid, except in the case of identified erroneous use;
- medication assessment of chronic use of medicines that are subject to prescription based on medical, pharmaceutical and patient-specific information. You are entitled to a maximum of one such assessment per year, which is exempt from your excess;
- pharmaceutical assistance during day treatment/outpatient clinic visits, if you have had an actual personal conversation with the responsible care provider about the medication or change in medication;
- pharmaceutical assistance in connection with admission to and discharge from hospital, if you had an actual personal conversation when the hospital treatment started or immediately following the end of the treatment.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

19.2 Medicines

What am I entitled to?

You are entitled to:

a. reimbursement of registered medicines as included in the Healthcare Insurance Regulations and the Medicine Reimbursement System, and to the extent that Zorg en Zekerheid has designated those medicines;

b. reimbursement of non-branded medicines. As soon as the patent for the branded medicine expires, similar non-branded ('generic') medicines will appear on the market. From that moment onwards - which may be any moment during the year - you will be entitled only to reimbursement of the costs of the non-branded medicine or the designated preferred medicine. The reimbursement amounts for preferred medicines as listed in Zorg en Zekerheid's Pharmaceutical Care Regulations are published on our website and updated every month on **zorgenzekerheid.nl/polisvoorwaarden**. Groups of medicines with the same active ingredient are listed in Appendix 1 of the Healthcare Insurance Regulations. The medicines within this group are interchangeable. When a product category includes several medicines with the same active ingredient, strength and administration method, you are entitled only to those medicines designated by Zorg en Zekerheid. These are known as the preferred medicines. Please consult Zorg en Zekerheid's Pharmaceutical Care Regulations for an overview of active ingredients for which preferred medicines have been designated, and of the preferred medicines concerned. You can find the most recent list of preferred medicines on our website. In the course of 2021, Zorg en Zekerheid may decide to designate or change the designation of one or more preferred medicines. The preferred medicines concerned are published on **zorgenzekerheid.nl/polisvoorwaarden**. You may claim reimbursement only for such preferred medicines. We will not reimburse the costs of any other medicines that are similar in terms of active ingredient, strength and administration method;

c. in highly exceptional situations, treatment with the generic (non-branded) medicine would, in your case, be medically irresponsible. In such a situation you may qualify for reimbursement of the branded medicine. Your doctor will in that case have to state on the prescription that treatment with the branded medicine is a 'medical necessity'. To establish whether this is the case, you must have tried at least two generic (non-branded) medicines, alongside the designated preferred medicine, for a prolonged period of time, provided that this is ethically acceptable. In addition, the pharmacist must have demonstrated, in consultation with the doctor, that the effects of an excipient in one or more of the non-branded medicines are such that the use of these medicines would be medically irresponsible.
You doctor is only permitted to identify the medicine as a 'medical necessity' on the prescription if he is able to substantiate that claim. If the pharmacist has any doubts about that claim, he will contact your doctor, for

example when it appears that you have not used the preferred medicine before. Your pharmacist decides which medicine to give you on the basis of the prescription and your doctor's explanation. In the case of persistent doubt about the medical necessity, the pharmacist may also apply for a second opinion from Zorg en Zekerheid using the 'Request for Reassessment of Medical Necessity' form.

Preferred medicines and excess
Zorg en Zekerheid reserves the right to adapt the list of preferred medicines at any time. You will find the most recent list in the Pharmaceutical Care Regulations on **zorgenzekerheid.nl/polisvoorwaarden.** The costs of preferred medicines will not count towards your compulsory and voluntary excess. The costs of the pharmacy's services do, however. For example, these include the costs of dispensing a medicine and guidance on the use of new medicines. However, if you take another medicine than the preferred medicine on account of a 'medical necessity' or if the preferred medicine is not available ('logistic necessity', for example in the event of a shortage of medicines), the medicines concerned will count towards your excess.

d. the reimbursement for medicines in other groups of interchangeable medicines not covered by the preference policy. Does your medicine belong to a group of interchangeable medicines for which Zorg en Zekerheid has not designated a preferred medicine? In that case, you are entitled to a maximum reimbursement based on the lowest price of the non-branded (generic) medicine within the group of medicines concerned, with a bandwidth of 3%;

e. the reimbursement for chronically used antacids and self-care medicines, provided they are listed in the Healthcare Insurance Regulations and the Medicine Reimbursement System. Your doctor must have prescribed these medicines. The prescription should state the following facts:
   - you depend on the medicine concerned for more than six months;
   - you have been prescribed the medicine concerned in the treatment of a chronic disorder;
   - the medicine concerned is not a new medication for you.

   For the first fifteen days, the costs of the chronic self-care medicines referred to in this article are for your own account. The preference policy also applies to the reimbursement of these groups of medicines. This means that Zorg en Zekerheid will designate a preferred medicine from a group of interchangeable self-care medicines. The other medicines within that group that are similar in terms of active ingredient, strength and administration method will not be reimbursed;

f. pharmacy preparations on prescription, as referred to in Section 40(3)(a) of the Medicines Act, if there is no equivalent registered medicine and to the extent that they form part of rational pharmacotherapy. Pharmacy preparations can be medicines prepared by your own pharmacy or ordered by your pharmacy from another pharmacy. In the latter case, the technical term used is 'resold pharmacy preparation' (*doorgeleverde apotheekbereiding*). Resold pharmacy preparations only qualify for reimbursement if there is no equivalent registered medicine that is reimbursed under the basic insurance and to the extent they form part of rational pharmacotherapy. Your doctor and pharmacist will be informed accordingly, by means of a list published on www.znformulieren.nl;

g. resold pharmacy preparations under b. of this article that are part of a product category of interchangeable pharmacy preparations. For this group of medicines, the maximum reimbursement for the care provider is based on the lowest price stated in the public pharmacists' price list, within a bandwidth of 3% of the lowest price. The maximum price cannot exceed the production cost of the medicine if the pharmacy itself prepares it;

h. medicines as referred to in Section 40(3)(c) of the Medicines Act and prepared in the Netherlands by a manufacturer holding a manufacturing licence, to the extent that they form part of rational pharmacotherapy;

i. medicines as referred to in Section 40(3)(c) of the Medicines Act, to the extent that they from part of rational pharmacotherapy, that are not available in the Netherlands but that have been imported into the Netherlands and are intended for an insured person who suffers from an illness that does not occur in the Netherlands more frequently than in 1 in 150,000 inhabitants;

j. medicines as referred to in Section 40(3)(c) of the Medicines Act that are in commercial circulation in another European Union Member State or a third country and have been imported into the Netherlands, if the medicine is intended to replace a registered medicine as referred to under a. that is temporarily unavailable or not available in sufficient quantities to be supplied by the holder(s) of the market authorisation or parallel market authorisation granted under the Medicines Act or under the regulation referred to in Section 1(1)(fff) of that Act;

k. medicines as referred to in Section 52(1) of the Medicines Act if the medicine is intended to replace a registered medicine as referred to under a. that is temporarily unavailable or not available in sufficient

quantities to be supplied by the holder(s) of the market authorisation or parallel market authorisation granted under the Medicines Act or under the regulation referred to in Section 1(1)(fff) of that Act.

What are the conditions?

a. unless Zorg en Zekerheid agrees otherwise with a pharmacist/dispensing general practitioner, medicines must be prescribed by a general practitioner, medical specialist, dentist, dental specialist or midwife and must be provided by a pharmacist/dispensing general practitioner;
b. a number of medicines included in Appendix 2 to the Healthcare Insurance Regulations are subject to additional conditions and may require prior approval from Zorg en Zekerheid. This has been included in the Pharmaceutical Care Regulations; the general forms are available on: www.znformulieren.nl. The pharmacy will immediately assess whether you satisfy the stipulated conditions based on a completed medical certificate from your prescriber. You can submit the medical certificate to the pharmacy alongside the prescription or, for reasons of privacy, you can send it directly to Zorg en Zekerheid. If prior approval is required, your prescriber will ask Zorg en Zekerheid to approve the treatment;
c. for every medicine prescription, the entitlement to pharmaceutical care is limited to a period of:
   - 15 days at most or the smallest trade pack available for a new medicine;
   - at least 3 months and up to 12 months in the event of medicines in the treatment of chronic diseases (to be determined by the prescriber) whose costs do not exceed €1,000, including VAT, per month. In the case of a medicine listed in the Opium Act - benzodiazepines, hypnotics or anxiolytics - the entitlement is a maximum of 1 month per prescription. This does not apply however to medicines from the group of anti-depressants and medicines for ADHD;
   - a maximum of 1 month if the costs per medicine per month, including VAT, exceed €1,000, or the smallest trade pack if the cost of a trade pack, including VAT, exceeds €1,000, unless otherwise agreed with the pharmacist. Except in the case of a stay abroad, up to 3 months or in the event of medicines in the treatment of HIV;
   - reasons for reducing the delivery period for medicines are limited storage life of the medicine concerned, or limited availability (in the event of medicine shortages, for example);
   - in the case of anti-depressants you will only need a prescription the first time. Oral contraceptives will be provided for up to 12 months at most. If this is your first time taking oral contraceptives, the maximum period is 3 months;
   - in the case of insulin, you will only need a prescription the first time.
   - for medicines used as part of intensive care provided at home (pharmaceutical care during the palliative and terminal phases), in principle the maximum period is 15 days. A tailored care agreement can be drawn up in consultation between the insured person, the doctor or general practitioner, a district nurse and a pharmacist;
   - in all other cases, at least one month.

What am I not entitled to?

a. You are not entitled to pharmaceutical care that is not insured care within the meaning of the Healthcare Insurance Regulations;
   - information on pharmaceutical self-management for patient groups;
   - advice on pharmaceutical self-care;
   - advice on the use of prescription medication while travelling;
   - advice on the risk of illness when travelling;
   - preventive travel medicines and travel vaccinations.
b. medicines for study purposes as referred to in Section 40(3)(b) of the Medicines Act;
c. medicines that are equivalent or practically equivalent to any registered medicine not designated by the Ministry of Health, Welfare and Sport (VWS), unless specified otherwise by ministerial regulation;
d. medicines as referred to in Section 40(3)(f) of the Medicines Act;
e. medicines for the treatment of one or more new indications excluded under the Healthcare Insurance Regulations;
f. the reimbursement for some combined products. A combined product contains multiple active ingredients in a particular administration method (tablet/inhaler). In that case, only the separate medicines for the active ingredients concerned (in separate tablets, for example) are reimbursed. Zorg en Zekerheid reserves the right to implement changes in the course of the year, and will publish them on **zorgenzekerheid.nl/polisvoorwaarden**.

Does Zorg en Zekerheid need to approve this beforehand?

- a number of medicines included in Appendix 2 to the Healthcare Insurance Regulations are subject to additional conditions and may require approval from the healthcare insurer. For details, go to **zorgenzekerheid.nl/geneesmiddelen**;
- medicines that are added to Appendix 2 in the course of the year require approval from Zorg en Zekerheid as they may be subject to additional conditions. If no approval is required, this will be announced on our website. To view the additional conditions, go to **zorgenzekerheid.nl/geneesmiddelen**;

Do I need to pay a personal contribution?
The Minister of Health, Welfare and Sport (VWS) determines which medicines are reimbursed under the Healthcare Insurance Act and for which medicines you are required to pay a personal contribution. The minister will also set the maximum reimbursement price per medicine. If the price of your medicine exceeds this maximum reimbursement price, you will have to pay the part of the price over and above the set maximum. That part of the price is your personal contribution, and cannot exceed €250 per calendar year. Zorg en Zekerheid will reimburse any personal contribution costs for medicines over and above this amount. The personal contribution does not count towards the compulsory or voluntary excess. If your insurance does not commence or end on 1 January, we will calculate your personal contribution in proportion to the number of days you have been insured in the calendar year concerned.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

19.3 Diet preparations

What am I entitled to?
You are entitled to polymer, oligomer, monomer and modular diet preparations for medical use and the associated advice and guidance if an adjusted normal diet and other special diet products do not work for you and if you:
- suffer from a metabolic disorder, food allergy or resorption disorder;
- are less than two years old and have cow's milk allergy as established using a provocation test;
- suffer from or are at risk of suffering from illness-related 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.

In the case of dietary food for medical use you are entitled to the following:
- the first delivery with a starter pack containing – if therapeutically feasible – multiple flavours for a maximum of two weeks. If the consumption period is shorter than two weeks, the duration of the starter pack will be adapted accordingly;
- any subsequent (automatic) supplies for a maximum of one month;
- the dietary food is supplied individually or in the smallest trade pack available;
- the diet preparations and/or administration systems including accessories are delivered to the home address of the insured person and within 24 hours of placing the order.

What are the conditions?
- the national ZN form for diet preparations must be filled in by a dietician, doctor or general practitioner and the supplier of the preparation must have established that the conditions have been met. The national ZN form for diet preparations is available for care providers on www.znformulieren.nl;
- drip-feed preparations must be supplied by a medically specialised supplier;
- 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 national ZN form for diet preparations 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?
You will need prior written approval from Zorg en Zekerheid for:
- preparations for infants with CMA if no provocation test has been performed;
- preparations for infants with CMA for children from age 2;
- preparations for infants with CMA in a quantity of more than 1000 ml per day;
- reimbursement of diet preparations after one month;
- reimbursement of diet preparations for infants after one month.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 20: Care aids

What am I entitled to?
You are entitled to functioning care aids and bandaging materials as referred to in the Healthcare Insurance Decree and the Healthcare Insurance Regulations. The extent of the entitlement to or reimbursement of the costs is determined by the insurance agreement and the Zorg en Zekerheid Care Aids Regulations.

Those regulations include provisions regarding, among other things:
- the referral, if required, stating the indication and, if a referral is required, who should issue it;
- prior approval from Zorg en Zekerheid, if required (with respect to the initial purchase, a repeat purchase or repairs);
- the usage period of the care aid concerned;
- quantities in the case of consumable items;
- whether the insured person acquires ownership of the care aid or acquires it on loan;
- the maximum reimbursement or statutory personal contribution;
- the quality requirements to be met by the care provider that delivers the care aid.

To consult the Care Aids Regulations, go to **zorgenzekerheid.nl/polisvoorwaarden**. You may also contact Zorg en Zekerheid for this information by calling (071) 5 825 825 or by visiting one of our shops.

What are the conditions?
The care aid must be, in the opinion of Zorg en Zekerheid, necessary, effective, not unnecessarily expensive nor unnecessarily complicated.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 at which 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 the costs of which are covered in full or in part under the WLZ.
e. to your home (or to a different residence if you cannot reasonably receive the required care in your own home) if you arrive from a healthcare provider or 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.

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 a healthcare provider or 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?

- You will only qualify for patient transport if:
  a. you must undergo kidney dialysis;
  b. you must undergo oncological treatment involving chemotherapy, immune therapy or radiotherapy;
  c. you must go to and from consultations, tests and check-ups that are necessary for the treatments specified under a. and b.;
  d. you depend on long-term transport for the treatment of a long-term illness or disorder and the hardship clause applies. If the hardship clause applies in your case, it also covers seated patient transport in connection with consultations, tests and check-ups that are necessary for the treatment;
  e. you can only move using a wheelchair;
  f. your eyesight is limited to such an extent that you are unable to move without assistance;
  g. 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;
  h. you receive geriatric rehabilitation care;
  i. you must attend a day care programme to address a chronic progressive degenerative condition, a non-congenital brain injury or an intellectual disability (as part of medical care for specific patient groups (GZSP)).
- the transport must qualify as 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 a person or institution where you will receive care the costs of which are covered in full or in part under your healthcare insurance;
  c. 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);
  d. 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 the costs of which are covered in full or in part under the insurance as referred to in the WLZ.
  e. your home (or to a different residence if you cannot reasonably receive the the required care in your own home) if you arrive from a healthcare provider or institution as referred to under a. through c.

Does Zorg en Zekerheid need to approve this beforehand?

- reimbursement of transport by 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 permission for transport by an alternative means;
- you will also need prior written permission for a contribution towards lodging costs.

What else do I need to know?

- reimbursement of the costs of transport by (private) car amounts to €0.32 per kilometre. The reimbursement is calculated on the basis of the shortest usual single-journey distance. The single-journey distance is calculated using the 'shortest route' quoted by the ANWB Route Planner (www.anwb.nl/verkeer/routeplanner();
- costs of public transport or use of a car (your own car or otherwise) are reimbursed on the basis of the shortest regular distance;
- 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;
- 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 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 in advance which includes a supporting letter from the attending physician;
- on the insured person's request, the reimbursement for transport may be replaced by a contribution towards the costs of lodging (up to €76.50 per night). A reimbursement for the costs of lodging can only be provided if you meet the conditions listed in Article 21.3 and if the transport to and from an institution is required on at least three consecutive days. In the case of lodging, the insured person may claim seated patient transport for the return trip.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

21.4 Requesting seated patient transport

How can I apply for seated patient transport?

If you meet the conditions listed in Article 21.3, you may apply for seated patient transport as follows:

- if you use private or public transport, you can apply for reimbursement of the costs by submitting the Private and Public Transport Expenses Claim Form to Zorg en Zekerheid. Please remember to send a copy of your appointment card along with the form. We will then determine whether you meet the conditions for seated patient transport and calculate the reimbursement of the associated costs accordingly;
- if transport by taxi is required (for wheelchair users or otherwise), you can request permission by calling the Transport Line at telephone number (071) 5 825 700. A Transport Line staff member will determine, by telephone, whether you satisfy the conditions. If the Transport Line has granted permission for you to use a taxi (for wheelchair users or otherwise), you may contact the Netherlands Healthcare Transport Switchboard (Zorgvervoercentrale Nederland, telephone number (010) 280 81 88) to order the taxi.

If you fail to meet the conditions set out in Article 21.3 and wish to apply for seated patient transport by invoking the hardship clause, you may do so by submitting the Seated Patient Transport Application Form (**zorgenzekerheid.nl/brochures**).

You may apply for a contribution towards the costs of lodging by submitting the Lodging Reimbursement Application Form (**zorgenzekerheid.nl/brochures**).

If you use private or public transport, your claim for seated patient transport will be checked retroactively against the Private and Public Transport Expenses Claim Form and your appointment card. For questions regarding private and public transport, insured persons may contact Zorg en Zekerheid at telephone number (071) 5 825 825.

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 €108 per insured person per calendar year. The personal contribution does not apply in the case of:

- transport to and from healthcare institutions funded under the healthcare insurance or the insurance referred to in the Long-Term Care Act (Wlz). This concerns transport from the institution where you receive in-patient treatment to the institution where you need to go for a specialist examination or specialist treatment, plus the return trip to your institution;
- transport to and from institutions that are funded under exceptional medical expenses insurance. This concerns transport from the institution where you receive in-patient treatment to a person or institution where you need to go for dental treatment under your exceptional medical expenses insurance, plus the return trip to your institution;
- the transport referred to in (a) and (b) above is necessary because the specialist examination, specialist treatment or dental treatment cannot be performed/provided at your own institution;
- reimbursement for lodging costs. However, the costs of the return trip when lodging do come under your personal contribution.

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 the costs of private or public transport, you must complete the Private and Public Transport Expenses Claim Form and submit it together with your invoices and appointment card to Zorg en Zekerheid. For the submission deadlines, see Article 4.1.1(e).

Article 22: Abroad

What am I entitled to?

You are entitled to (your choice):

- care provided by a non-contracted care provider. The amount of the reimbursement can be found in Section A of Article 1.5. If we have granted you permission for the treatment, the maximum reimbursement equals 100% of the WMG (maximum) rate. If there is no WMG (maximum) rate, you will be reimbursed up to a maximum of 100% of the prevailing Dutch market rate;
- emergency care: this is medically necessary care administered within 24 hours after the complaint has started and that cannot reasonably be delayed until the insured person's return to their country of residence. You will be reimbursed for the costs of emergency care up to a maximum of 100% of the WMG (maximum)

rate. If there is no WMG (maximum) rate, you will be reimbursed up to a maximum of 100% of the prevailing Dutch market rate;
- care to which you are entitled under the provisions of the EU Regulation on social security or a treaty. The reimbursement of costs is also provided for by the EU Regulation on social security or the treaty.

Please note: Additional payments may apply in the country concerned, such as *remgelden* (personal contributions) in Belgium. The excess or personal contribution applies to such payments.

What are the conditions?
- the care satisfies the provisions of these policy conditions;
- the care provider is authorised to provide care in the country concerned;
- only your own attending physician or medical specialist in your country of residence may refer you to a care provider in another country;
- if the insured person wishes to submit an invoice prepared in a language other than Dutch, French, German or English, a certified translation must be appended. 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?
Prior permission is required for intramural care (admission for at least one night).

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 www.ggzkwaliteitsstatuut.nl, complies with the latest model Mental Healthcare Quality Charter and is observed.

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, see the 'Therapies' brochure on **zorgenzekerheid.nl/ggzdocumenten**;

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 is valid for a maximum of nine months. However, no new referral is required for follow-up treatment under the same diagnosis. If the treatment is interrupted for more than nine months, 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 (GGZ referral appointments brochure), go to **zorgenzekerheid.nl/ggzdocumenten**.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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. adopting 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 DTP 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 DTP-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/ggzdocumenten**;
- 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 www.ggzkwaliteitsstatuut.nl, complies with the latest model Mental Healthcare Quality Charter and is observed.

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 provided, you must hold a valid referral that was issued less than nine months before commencement of the care. No new referral is required for follow-up treatment under the same diagnosis, provided that the follow-up treatment starts within nine months after the end of the prior treatment. If the treatment is interrupted for more than nine months, 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 (GGZ referral appointments brochure), go to **zorgenzekerheid.nl/ggzdocumenten**.

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 up to 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's/client's personal and interpersonal faculties, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  d. the psychotherapist in cases of psychotherapy within different therapeutic reference frameworks, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  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; This concerns patients who qualify for largely psychological treatment methods and whose disorders do not require urgent treatment or admission to an institution. All of the above is subject to the condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  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, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;

g. the clinical neuropsychologist in cases where the care involves specific neurological components, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
h. the clinical geriatrician, a geriatric care specialist for (biologically) elderly patients in whose complaints multi-morbidity (of both a psychiatric and somatic nature) plays a prominent role, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
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, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist:
   - 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 a diagnosis according to DSM-5;
- help in the event of stress and burn-out, unless the problem arises from a diagnosis according to DSM-5;
- intelligence tests that do not form part of the medical treatment;
- psychological testing at school;
- guidance in the form of training courses of a non-medical nature;
- remedial education;
- help for psychological complaints in the absence of a condition that qualifies as a mental disorder under DSM-5;
- 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, see the 'Therapies' brochure on **zorgenzekerheid.nl/ggzdocumenten**;
- 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?
- 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 Zekeheid on your behalf:
  a. a letter of referral from from your general practitioner, medical specialist or company doctor;
  b. the clinical indication for hospitalisation as made by a psychiatrist or clinical psychologist;
  c. the proposed treatment plan drawn up by a psychiatrist or clinical psychologist, with details on the number of treatment minutes and activities and procedures to be performed;
  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 DTP reimbursement code and the care category.
- 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 **zorgenzekerheid.nl./ggzdocumenten**.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 psychologist/neuropsychologist;

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's/client's personal and interpersonal faculties, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  d. the psychotherapist in cases of psychotherapy within different therapeutic reference frameworks, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  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; This concerns patients who qualify for largely psychological treatment methods and whose disorders do not require urgent treatment or admission to an institution. All of the above is subject to the condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  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, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  g. the clinical neuropsychologist in cases where the care involves specific neurological components, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  h. the clinical geriatrician, a geriatric care specialist for (biologically) elderly patients in whose complaints multi-morbidity (of both a psychiatric and somatic nature) plays a prominent role, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist;
  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, on condition that all multidisciplinary consultation sessions are attended by a clinical psychologist/psychiatrist:
     - 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 www.ggzkwaliteitsstatuut.nl, complies with the latest model Mental Healthcare Quality Charter and is observed.

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 a diagnosis according to DSM-5;
- help in the event of stress and burn-out, unless the problem arises from a diagnosis according to DSM-5;
- intelligence tests that do not form part of the medical treatment;
- psychological testing at school;
- guidance in the form of training courses of a non-medical nature;
- remedial education;
- help for psychological complaints in the absence of a condition that qualifies as a mental disorder under DSM-5;
- 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 these recommendations, go to **zorgenzekerheid.nl/ggzdocumenten**.

Does Zorg en Zekerheid need to approve this beforehand?
You will have to apply for prior permission in writing if you decide to stay in a non-contracted care institution for outpatient specialist mental healthcare. To apply for this permission, the care provider must send to Zorg en Zekeheid on your behalf:
a. a letter of referral from your general practitioner, medical specialist or company doctor;
b. the indication (demonstrating your dependence on specialist mental healthcare), including a DSM-5 diagnosis established by the provider of the medical treatment;

c. the proposed treatment plan drawn up by the provider of the medical treatment and adopted by the coordinating care provider, with details on the number of treatment minutes and activities and procedures to be performed;
d. the names and professions of the care providers, including the coordinating care provider (stating the BIG registration number), who are involved in the provision of the care;
e. the DTP expense claim code and the performance code.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 24: Multidisciplinary care

24.1 Multidisciplinary care

What am I entitled to?
You are entitled to multidisciplinary 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 'multidisciplinary 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 care chain. This type of care is covered however by some of our supplementary insurance policies.

What are the conditions?
Multidisciplinary care is provided 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 multidisciplinary care, go to our website **zorgenzekerheid.nl**. You will find the overview in the 'Chain care' section under the heading 'Care and health'.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 podiatrists and/or by a pedicure commissioned by a podiatrist. This care can be provided both as part of multidisciplinary care (Article 24.1) and outside of multidisciplinary 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 podiatrist or by a pedicure contracted by a podiatrist. For more information, go to **zorgenzekerheid.nl**;
- the podiatrist 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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 25: Quit Smoking

What am I entitled to?
This is medical care administered with the purpose of changing behaviour so as to help the client to quit 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 Quit Smoking programme per calendar year;
- The care provider must be registered in the Quit Smoking Quality Register.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

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 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:
Auditive or communicative impairment: 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.

Visual impairment: 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 Ophthalmology (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 of your stay.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 27: Nursing and other care

27.1: District nursing

What am I entitled to?

You are entitled to nursing and care (district care) as provided by nurses. 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 Article 2.11 of the Healthcare Insurance Decree and does not qualify as maternity care as referred to in Article 7.

What are the conditions?

- your care needs must be assessed in advance by a nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level, based on the V&VN Dutch Nurses' Association's 'Home nursing and care indication and organisation standards';
- if the insured person is less than 18 years old, their care needs must be assessed by a paediatric nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level;
- indications issued by other professionals do not qualify as insured care;
- the care is provided by a specialist nurse, nurse, level-3 care-giver or level-2 nursing assistant. Care provided by a level-2 nursing assistant must be administered in a coordinated context under the final responsibility of a nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level;
- you are obliged to cooperate in a home visit or a telephone or written inquiry to verify the accuracy of the claims;
- you may not transfer your claim on us to a third party. You would be doing so if you went to a care provider that has not been contracted by Zorg en Zekerheid. We will transfer the reimbursement to which you (the insured person) are entitled to the bank account number (IBAN) listed in our records. You also may not give a third party permission to collect a payment or submit an invoice to us on your behalf. You will have to submit the invoice to us yourself;
- 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.

What am I not entitled to?

You are not entitled to:

- care for children up to age 18 which is aimed at eliminating the inability to care for oneself in daily activities. If the child qualifies for intensive paediatric care or in the event of palliative terminal care, the total of care provided at home in the form of nursing and care does come under the basic insurance;
- nursing and care if you have an indication under the Long-Term Care Act (WLZ). This does not apply however if the nursing takes place under the direct management of an attending medical specialist. In that case the nursing is covered by basic insurance;
- personal care (in the sense of ADL support), if you are not sufficiently able to look after yourself due to, for example, a psychiatric disorder or impairment or a mental or sensory impairment, which care should be aimed at eliminating the inability to care for yourself. This care is regulated in the WMO.

Do I need a referral?

You need a referral from a paediatrician for nursing and care for insured persons under age 18.

Does Zorg en Zekerheid need to approve this beforehand?

You will need prior written approval from Zorg en Zekerheid:

- if the care required exceeds 12 hours per day. You can find the authorisation form at **zorgenzekerheid.nl/wijkverpleging**, under 'Downloads';
- if you wish to engage a newly contracted care provider for district nursing. This concerns a care provider that has been contracted for 2021 but was not contracted in 2020. You can find out the care providers concerned in the Zorgzoeker ('Find a care provider' search function). You can find the authorisation form for newly contracted care providers at **zorgenzekerheid.nl/wijkverpleging**;
- if you wish to engage a non-contracted care provider.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

27.2 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. In this case, the Personal Budget for Nursing and Care Regulations apply in addition to the conditions specified in Article 27.1. 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/polisvoorwaarden**.

27.3 Stay in a primary care institution

What am I entitled to?
You are entitled to a medically necessary stay in an institution for inpatient primary care in connection with medical care as generally provided by general practitioners. The care comprises:
- a stay including the nursing and care inextricably linked with the facility;
- generalist medical care (care as provided by general practitioners);
- psychological aid, other than (specialist) medical mental healthcare, provided - at the request of a general practitioner, geriatric care specialist or doctor for the mentally disabled - by a behavioural expert to patients presenting (suspected) behavioural and/or cognitive issues;
- paramedical care to the extent it is inextricably linked with the reason for admission;
- care aids and bandaging materials to the extent they are inextricably linked with the reason for admission.

What are the conditions?
- the indication was issued by a general practitioner or medical specialist and admission is arranged in consultation with the institution for inpatient primary care where you will receive treatment;
- 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 inpatient primary care, the patient can be expected to eventually recover and return home, except in the case of palliative care;
- a treatment provider at the inpatient primary care institution has formulated a Care Plan specifying the estimated duration of the stay;
- the duration of the stay at an institution for inpatient primary care is at least 24 hours and will not generally exceed 91 days. The right to stay at the institution for inpatient primary care lapses after 1,095 days;
- the institution for inpatient primary care is authorised under the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, WTZi).
- 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.

What am I not entitled to?
You are not entitled to reimbursement of the costs of a stay at an institution for inpatient 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 a stay in a specialist medical care institution (e.g. hospital admission) or a specialist mental healthcare institution.

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.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 28: Combined Lifestyle Intervention (CLI)

What am I entitled to?
You are entitled to:
- a Combined Lifestyle Intervention (CLI), consisting of a treatment phase and a maintenance phase. The maximum duration of this programme is 24 months;
- the programme is aimed at the reduction of caloric intake, increase of physical activity and, where relevant, the customised addition of psychological interventions to change behaviour;
- the programme consists of an intake, individual meetings and group meetings, and an outtake;
- a lifestyle coach supervises you during the programme.

What are the conditions?
- you are entitled to the CLI if, according to the 'Obesity and Obesity Care Standard' Guidelines of the Dutch College of General Practitioners (NHG), you are at a moderately increased weight-related health risk and if you have an intrinsic motivation to adapt your lifestyle;
- you are aged 18 or older. An exception is made if you are 16 or 17 and are at a moderately (or higher) increased weight-related health risk and the treatment provider judges that you may benefit from a CLI designed for adults;

- the care provider offering the lifestyle advice is quality-registered for the CLI concerned in the register of the BLCN Dutch Lifestyle Coaches' Association or in the register of their own paramedical professional association. In the latter case, this refers to specific registration as a lifestyle coach;
- the CLI must be effective in accordance with the criteria of the Dutch National Institute for Public Health and the Environment's (RIVM) Centre for Healthy Living (www.loketgezondleven.nl/leefstijlinterventies) and must have been approved as insured care by Zorgverzekeraars Nederland;
- the general practitioner remains involved during the provision of the CLI: the CLI care provider consults with the general practitioner, regularly reports back on the results and discusses any additional care that may be needed;
- as part of the provision of the CLI, the care provider must maintain contacts with the general practitioner, the other care providers and, where appropriate, with the social domain;
- the period in which you received the CLI or part thereof but were insured with a different healthcare insurer also counts towards the maximum duration of 24 months.

What am I not entitled to?
You are not entitled to:
- the actual supervision of the exercise itself;
- Combined Lifestyle Interventions that are not proven to be effective according to the Dutch National Institute for Public Health and the Environment's (RIVM) Centre for Healthy Living and/or have not been approved as insured care by Zorgverzekeraars Nederland.

Do I need a referral?
You require a written referral from the general practitioner, internist or cardiologist.

In the event that you wish to engage a care provider with whom we have not concluded a contract, please see Article 1.5 of these policy conditions.

Article 29 Second opinion

What am I entitled to?
You are entitled to request assessment of a diagnosis, proposed treatment or district nursing indication concerning you, to be performed by a second and independent:
- doctor;
- other care provider (e.g., a psychotherapist or clinical psychologist);
- a paediatric nurse registered under the BIG (Individual Healthcare Professions) Act and trained at higher professional education (HBO) level (for a district nursing indication).

What are the conditions?
- the second opinion concerns the care referred to in Articles 2.4 to 2.15 inclusive of the Healthcare Insurance Decree;
- the care providers concerned work in the same discipline;
- you must return with the second opinion to the first care provider consulted, who will continue to coordinate the treatment.

What am I not entitled to?
- treatment by the second independent doctor or care provider without first returning to the care provider you initially consulted;
- a second opinion requested in connection with civil proceedings or for the purpose of a medical examination for a driving licence.

Do I need a referral?
You require a written referral from your treatment provider. No referral is required for district nursing care.

Section C: Information

If you have any questions, visit **zorgenzekerheid.nl** for a wealth of additional information. Alternatively, get in touch with our Contact Centre by phone on (071) 5 825 825. Available on working days from 8 am to 6 pm. You can also visit one of our shops.

MijnZZ

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

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 the original invoice(s) and send the invoice(s) online via MijnZZ (**zorgenzekerheid.nl/mijnzz**) or submit your claim via the Zorg en Zekerheid **claim app** (free download via 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 a sufficiently stamped envelope to:

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

- the original invoices will remain in the possession of Zorg en Zekerheid. We recommend that you make a copy for your own records;
- once you have uploaded an invoice, please note that you will have to keep the original invoice for at least three years after uploading. We may request that you send us the invoice during this period for the purpose of verification;
- 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 medical costs incurred abroad 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/brochures** or request it from Zorg en Zekerheid. Please 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 2021
Supplementary Insurance

Zorg en Zekerheid
zorgverzekeraar

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Definitions

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
Institutional admission, if and insofar as the insured care can only be offered at an institution on medical grounds.

Basic insurance
The health insurance in accordance with the Healthcare Insurance Act taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another health insurer.

Beautician
A beautician who is affiliated with the General Dutch Sector Organisation for Beauticians (ANBOS).

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

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 physical 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.

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.

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 ZZP 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 health care. A comprehensive description of all the care covered by a ZZP can be found on the website of the Dutch Healthcare Authority.

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.

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.

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

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.

Centre for genetic counselling
An institution which holds a licence under the terms of the Special Medical Procedures Act (*Wet op de bijzondere medische verrichtingen)* for clinical genetic testing and the provision of genetic counselling.

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 (*Wet toelating zorginstellingen*, Wtz).

Cesar/Mensendieck remedial therapist
A Cesar/Mensendieck remedial therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

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

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

Coordinating care provider
A care provider who establishes a diagnosis and determines the treatment plan in response to the patient's care need. To that end, the coordinating care provider consults with the patient in a face-to-face meeting at least once. The coordinating care provider 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 coordinating care provider communicates with the patient to evaluate the progress made and adjusts the treatment plan where necessary.

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

Dental surgeon
A dental specialist registered as a dental surgeon in the register of specialists in oral diseases and dental surgery of the Royal Dutch Dental Association (KNMT).

Dentist
A dentist registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Diagnosis/Treatment Package (DTP)
A DTP describes the defined, validated process involved in specialist medical care and specialist (secondary) mental health care, in terms of a DTP code of practice established by the Dutch Healthcare Authority under the Healthcare (Market Regulation) Act. This description includes the patient's care need, the type of care, the diagnosis and the treatment. The DTP process starts at the point at which the insured person reports a problem to the medical specialist and finishes at the end of treatment, or after 120 days in the case of specialist medical care and after 365 days in the case of specialist mental healthcare.

Dietician
A dietician who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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.

District nursing
Nursing and care as provided by nurses.

Doctor
A doctor registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Educationalist
An educationalist registered as a remedial educationalist with the Association of Educationalists in the Netherlands (NVO).

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 countries (the states that are party to the Agreement on the European Economic Area) are Liechtenstein, Norway and Iceland.

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.

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.

Generalist Basic Mental Health Care (GGZ)
Diagnostics and treatment for minor to moderate, non-complex mental or stable chronic problems.

General practitioner
A doctor registered as a general practitioner in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association (KNMG).

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

Geriatric remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and who is registered as a geriatric remedial therapist in the Quality Register for Paramedics.

GeZZondcheck
The GeZZondcheck 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.

GVS personal contribution
The Medicine Reimbursement System (GVS) is part of the entitlement schemes provided under the Healthcare Insurance Act. Medicines that are registered in the GVS are covered by health insurers under the basic insurance. A personal contribution applies to specific medicines.

Hand therapist
An occupational therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a hand therapist in the Quality Register for Paramedics.

Health insurance
The health insurance in accordance with the Healthcare Insurance Act taken out with the Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another health insurer. Also known as 'basic insurance' or 'the master policy'.

Health insurance policy
The (digital) deed concluded between the policyholder and the insurance company in which the health insurance coverage is set out.

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

Health psychologist
A health psychologist registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

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.

Hospital
A centre for specialist medical care that is admitted as a hospital or independent treatment centre (ZBC) in accordance with the rules of the Care Institutions (Accreditation) Act (*Wet toelating zorginstellingen*, Wtz).

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

Inpatient care
A stay for at least 24 hours.

Insurance
The legal relationship regulated by the insurance agreement.

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

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 laboratory cultivation of embryos;
- single or multiple intrauterine implantations of embryos to initiate pregnancy.

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

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 Dutch Association of Lactation Experts (NVL).

Lifestyle coach
A lifestyle coach is a professional who guides people to take control over their own health and welfare, explicitly based on the definition of positive health. The aim is to enable people to feel good about the life they lead, taking account of all their abilities and limitations. A lifestyle coach is registered as a lifestyle coach in the register of the Professional Association of Dutch Lifestyle Coaches (BLCN) or the relevant section of the register for paramedics.

Long-Term Care Act
The Dutch Long-Term Care Act (*Wet langdurige zorg,* Wlz).

Manual practitioner
A manual practitioner registered as a doctor in accordance with the conditions set out in Section 3 of the BIG Act and who has completed the supplementary training course in manual medicine.

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

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.

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 care provider, after an intake, by phone or otherwise, by the maternity care provider or maternity centre.

Maternity care agency 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 person.

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

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 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, and as deemed necessary by the medical adviser of Zorg en Zekerheid.

Medical specialist
A doctor registered as a medical specialist in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association (KNMG).

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

Mental health care 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*, Wtz).

Midwife
A midwife registered as such in accordance with the conditions set out in Section 3 of the BIG Act.

Multidisciplinary care
Multidisciplinary care is provided 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 multidisciplinary care, go to our website **zorgenzekerheid.nl**.

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 Act.

Nursing specialist
A nurse as registered in accordance with Section 3 of the BIG Act who specialises in acute, chronic, preventive or intensive care for somatic conditions or in mental health care.

Occupational therapist
An occupational therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

Optometrist
A paramedic who carries out checks, measurements and various supplementary medical examinations on eyes, either autonomously or under the supervision of an ophthalmologist.

Oral hygienist
An independent oral hygienist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and is authorised under Section 4 of the Healthcare (Unsupervised Activities) Decree and under the Independent Authorisation for Registered Oral Therapists (Temporary Measures) Decree.

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 Royal Dutch Dental Association (KNMT).

Orthoptist
A paramedic who diagnoses and treats disorders regarding the joint functioning and development of the eyes.

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.

Paediatrician
A physician registered as a KNMG youth healthcare physician in the Youth Healthcare Profiles Register administered by the Medical Specialisms Board of the Royal Dutch Medical Association.

Paediatric occupational therapist
An occupational therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a paediatric occupational therapist in the Quality Register for Paramedics.

Paediatric physiotherapist
A physiotherapist registered as such in accordance with the regulations referred to in Section 3 of the BIG Act and registered as a paediatric physiotherapist in the Quality Register for Physiotherapy NL of the KNGF (Royal Dutch Association for Physiotherapy) or as a paediatric physiotherapist with the Physiotherapy Quality Mark.

Paediatric remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree and who is registered as a paediatric remedial therapist in the Quality Register for Paramedics.

(Medical) pedicurist
The pedicurist must be registered with the Quality Register for Pedicurists (KRP), the Paramedical Foot Care Register (RPV) or the Quality Register for Medical Foot Care Providers (KMV). For treatment to qualify for reimbursement under basic insurance coverage, a pedicurist must hold the qualification 'foot care for diabetics'. For treatment to qualify for reimbursement under supplementary insurance coverage, a pedicurist 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 pedicurist or paramedical chiropodist is a specialised pedicurist who can treat all forms of clients' complex foot problems.

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.

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

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(1)(s) of the Medicines Act (*Geneesmiddelenwet*) or the provision of these medicines, or pharmaceutical care to which the Blood Supply Act (*Wet inzake bloedvoorziening*) applies.

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

Physician's assistant (PA)
A physician's assistant registered as such in accordance with the conditions set out in Section 3 of the BIG Act. A PA may take over and interdependently carry out a physician's tasks such as taking a case history and drawing up a treatment plan, as well as perform activities such as operations, pacemaker implantations, endoscopies, nerve blocks and central venous catheter (CVC) placements.

Physiotherapist
A physiotherapist registered as such in accordance with the conditions set out in Section 3 of the BIG Act. A remedial gymnastics masseur as referred to in Section 108 of the aforementioned Act is also deemed to be a physiotherapist.

Podiatrist
A podiatrist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

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

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

Psychiatrist
A doctor listed as a psychiatrist in the register administered by the Registration Committee for Medical Specialists (RGS) of the Royal Dutch Medical Association.

Psychosomatic physiotherapist
A physiotherapist registered as such in accordance with the regulations referred to in Section 3 of the BIG Act and registered as a psychosomatic physiotherapist in the Quality Register for Physiotherapy NL of the KNGF (Royal Dutch Association for Physiotherapy) or as a psychosomatic physiotherapist with the Physiotherapy Quality Mark.

Psychosomatic remedial therapist
A remedial therapist who is registered as such in accordance with the conditions referred to in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree 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 set out in Section 3 of the BIG Act.

Quality statute model (GGZ)
The mental health care (GGZ) quality statute model describes the quality and accountability measures mental health care providers must have in place for curative mental health care. This model has been in effect since 1 January 2017 and governs all providers of generalist basic mental health care and specialist mental health care under the Healthcare Insurance Act.

Rational pharmacotherapy
Rational pharmacotherapy is a type of treatment with a medicine in a form suitable for you, the working and effectiveness of which has been confirmed in the scientific literature. Furthermore, the medicine forms the best economic option for both the health insurer and the patient.

Reasonable distance
A reasonable distance to a contracted care provider within a fixed radius, in km, from the residence of the insured person. You can obtain this information by phoning Zorg en Zekerheid on (071) 5825 825 or by visiting one of our shops.

Registered oral hygienist
Registered oral hygienists satisfy the following conditions:
- have successfully completed the current 4-year oral care training programme, obtaining their diploma in 2006 or later;
- have entered into a written consultant-on-call agreement with a dentist (concerning such issues as after-care and pain relief);
- are included in the temporary BIG register , experimentation clause 36a;
- hold the radiation protection supervisory staff certificate.

Registered podologist
A podologist who has successfully completed a registered podologist training programme and is included in the quality register of Quality Registration and Accreditation for Healthcare Professionals (KABIZ).

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.

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 zorginstellingen*, Wtz).

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.

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.

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

Specialised Mental Health Care (GGZ)
Diagnostics and treatment of moderately/severely complex psychological ailments. The coordinating care provider has a significant share in the substantive treatment.

Specialised physiotherapist
A physiotherapist who, through supplementary training, has acquired supplementary knowledge of a specific discipline within the field of physiotherapy.

Specialised remedial therapist
A remedial therapist who, through supplementary training, has acquired supplementary knowledge of a specific discipline within the field of remedial therapy.

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.

Speech therapist
A speech therapist who satisfies the requirements set out in the Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, in accordance with Section 34 of the BIG Act.

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

'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.

User

- An existing user has either:
  a. received the reimbursement previously AND not changed the supplementary insurance; or
  b. received the reimbursement previously, has not been covered by basic or supplementary insurance for a period of time and has now taken out the same supplementary insurance as before.
- A new user has either:
  a. not received the reimbursement before; or
  b. received the reimbursement previously, but changed the supplementary insurance; or
  c. received the reimbursement previously, has not been covered by basic or supplementary insurance for a period of time and has now taken out supplementary insurance that is different from the one before.

Waiting period for orthodontic treatment

Insured persons who are receiving orthodontic treatment must have taken out supplementary insurance for orthodontic treatment with us at least twelve months prior to the start of the treatment in order to claim reimbursement.

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.

We/us/Zorg en Zekerheid

The Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

WMG rates

The rates set under or pursuant to the Healthcare (Market Regulation) Act (*Wet marktordening gezondheidszorg*, Wmg).

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.

Section A: Extent of cover

This section sets out the entitlements and/or reimbursements that you can claim 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 29 October 2020. 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/vergoedingzoeker**. Together, the insurance terms and conditions and this section constitute the 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:

- homeopathic/anthroposophical medicines;
- the following alternative treatments:
  - acupuncture
  - anthroposophy
  - chiropractic
  - craniosacral therapy
  - haptotherapy
  - (classic) homeopathy
  - manual medicine
  - natural medicine
  - orthomolecular medicine
  - osteopathy
  - (medical) Shiatsu

What are the conditions for reimbursement?
Medicines:

- the medicines must be prescribed by the doctor, listed in Section 3 of the Individual Healthcare Professions Act (BIG Act), who is treating you;
- the medicines must be provided by a pharmacist or dispensing general practitioner listed in the register of established pharmacists as referred to in Section 61 of the Medicines Act;
- the medicines must be registered in the database maintained by the CBG (Medicines Evaluation Board). The list of registered medicines can be found at www.cbg-meb.nl or alternatively the medicines are produced by one of the following manufacturers: Wala®, Weleda®, Heel®, Vogel®, Biohorma®, Vsm®, Reckeweg® or Dolyssos®.

Treatment methods:

- your treatment provider must have a valid personal AGB code for the treatment concerned (check the code on www.agbcode.nl , under 'qualifications' in ‘Search AGB register’);
- your treatment provider must be registered with a professional association designated by us for the treatment concerned. The list of professional associations that meet our criteria is an integral part of this insurance policy. For our full list of designated professional associations by treatment, check **zorgenzekerheid.nl/vergoedingenzoeker**.
- in the case of manual medicine, orthomolecular medicine or natural medicine, the treatment must be given by a doctor. This doctor must be listed in Section 3 of the Individual Healthcare Professions Act (BIG Act), and should not be your general practitioner. In addition, this doctor must have successfully completed the training programme for the alternative treatment method concerned.

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
Treatments/Consultations	No reimbursement	100%, up to a maximum of €25 per day	100%, up to a maximum of €40 per day	100%
Medicines	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 frames are to be reimbursed);
- please note that if this concerns glasses 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 or one 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 currently applicable GGD list and the website of the National Coordination Centre for Travel Advice (Landelijk Coördinatiecentrum Reizigersadvisering, LCR). For more information, see www.lcr.nl;
- the Pharmaceutical Care Regulations apply; see **zorgenzekerheid.nl/polisvoorwaarden**.

Which costs do not qualify for reimbursement?
- laboratory tests, gnat cream and gnat oil;
- missed appointments.

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 AV-Standaard AV-GeZZin Compact	AV-Sure	AV-Top AV-GeZZin AV-Plus	AV-Totaal
Contracted care provider*	No reimbursement	100%	A maximum of €80	100%
Non-contracted care provider	No reimbursement	A maximum of €80	A maximum of €80	A maximum of €150

*For a list, see **zorgenzekerheid.nl/vergoedingenzoeker**.

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 telephone (+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.

The reimbursement is 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 skiing and langlauf trip), 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; – 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.

Travel 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 place of stay abroad to the closest hospital, doctor or specialist and back again to the original place of stay 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 €0.32 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; - 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 AV-Sure AV-Standaard AV-GeZZin Compact	AV-Top AV-GeZZin AV-Plus 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 obtainable in the country the insured person is staying in 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 assistance by ANWB International Assistance (Alarmcentrale) will be 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 the Ministry of Foreign Affairs has issued a travel warning level 'orange' or 'red' (see www.nederlandwereldwijd.nl), unless, in the case of level 'orange', you are able to demonstrate that your stay was necessary (and was not a holiday) or unless the travel warning was changed during your stay and you avail yourself of the first opportunity to return to the Netherlands, irrespective of the costs;
b. costs relating to ski jumping, ski flying, skijoring, ski mountaineering, ski touring, glacier skiing, glacier trekking, 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 intend to participate in a sport that is not listed above, please contact our specialist International Team at (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 races, competitive ocean sailing and mountaineering other than on marked paths and trails, and diving (without a licence or professional supervision);
d. participating in a sport that is not listed above; in that case, please contact our specialist International Team at (declaraties@zorgenzekerheid.nl);
e. costs relating to pregnancy or delivery after the 31st week;
f. costs relating to alternative care with respect to treatment as well as medication;
g. costs relating to paramedical care, with the exception of treatment for which prior authorisation was obtained;

h. 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-GeZZin Compact	**AV-Basis** **AV-Sure** **AV-Standaard** **AV-Top** **AV-GeZZin** **AV-Plus** **AV-Totaal**
No reimbursement	A maximum of €600

Article 4: Pharmaceutical care

4.1 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 doctor or general practitioner and provided by a pharmacist listed in the register of established pharmacists as referred to in Section 61 of the Medicines Act;
- 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/polisvoorwaarden.**

How much reimbursement will I receive under my supplementary insurance?

AV-Basis **AV-GeZZin Compact** **AV-Plus**	**AV-Sure** **AV-Standaard** **AV-Top** **AV-GeZZin** **AV-Totaal**
No reimbursement	100%, from age 21 (excluding the GVS personal contribution)

4.2 Antacids

What is reimbursed?
Antacids that are not covered under the basic insurance.

What are the conditions for reimbursement?
- the antacids must be prescribed by your doctor or general practitioner and provided by a pharmacist listed in the register of established pharmacists as referred to in Section 61 of the Medicines Act;
- antacids are reimbursed under the AV policy in the event of non-chronic use;
- in the case of chronic use, they are reimbursed for the first 15 days during which they are for your own account;
- 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 preference policy and the Pharmaceutical Care Regulations apply. You can consult the Regulations on **zorgenzekerheid.nl/polisvoorwaarden.**

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard AV-Top AV-GeZZin AV-Plus AV-Totaal
No reimbursement	100%, up to a maximum of €35

4.3 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 covered by the National Immunisation 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/polisvoorwaarden.**

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Sure AV-Standaard AV-GeZZin Compact AV-Top AV-Plus	AV-GeZZin 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 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 AV-GeZZin Compact AV-Plus	AV-Basis AV-Standaard	AV-Top AV-GeZZin 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 **AV-Sure** **AV-GeZZin Compact** **AV-Plus**	**AV-Standaard**	**AV-Top**	**AV-GeZZin** **AV-Totaal**
No reimbursement	100%, up to a maximum of €75	100%, up to a maximum of €100	100%, up to a maximum of €262 for maternity care and 100%, up to a maximum of €262, 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 care agency 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 immediately 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 **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Plus**	**AV-Top** **AV-GeZZin** **AV-Totaal**
No reimbursement	A 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 care agency 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 delivery or after the adoption of a child that is 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 **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Plus**	**AV-Top** **AV-GeZZin** **AV-Totaal**
No reimbursement	A 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 **AV-Sure** **AV-GeZZin Compact** **AV-Plus**	**AV-Standaard** **AV-Top**	**AV-GeZZin** **AV-Totaal**
No reimbursement	A maximum of €40	A maximum of €75

5.5 Prenatal/antenatal course

What is reimbursed?
The costs of a female insured person taking one prenatal or antenatal class 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:
- an institution for maternity care;
- a home care organisation;
- a qualified care provider who is affiliated with and complies with the quality requirements of the 'Samen Bevallen' association;
- an obstetrician;
- a physiotherapist;
- a remedial therapy, Cesar/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 **AV-GeZZin Compact** **AV-Plus**	**AV-Basis** **AV-Standaard** **AV-GeZZin** **AV-Top** **AV-Totaal**
No reimbursement	100%, up to a maximum of €100

5.6 Breastfeeding course

What is reimbursed?
The costs of an insured person taking the 'Zorg en Zekerheid breastfeeding course' per calendar year. To register as a participant, go to **zorgenzekerheid.nl/borstvoedingscursus**.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure AV-GeZZin Compact AV-Plus	AV-Basis AV-Standaard AV-GeZZin AV-Top AV-Totaal
No reimbursement	100%, up to a maximum of €20

5.7 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 and work in accordance with the guidelines laid down by the Dutch Association of Lactation Experts (Nederlandse Vereniging van Lactatiekundigen, NVL) or the Association of Breastfeeding and Infant Care Guidance Specialists (VSBB).

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Sure AV-Standaard AV-GeZZin Compact AV-Plus AV-Top	AV-GeZZin 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 been designated by Zorg en Zekerheid. A list of Zorg en Zekerheid approved convalescent homes and care hotels can be consulted at **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 AV-GeZZin Compact	AV-Basis AV-Standaard	AV-Top AV-GeZZin AV-Plus 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 for 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 **AV-GeZZin Compact** **AV-Basis** **AV-Standaard**	**AV-Top** **AV-GeZZin** **AV-Plus** **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 guest house associated with a hospital.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard** **AV-Plus** **AV-Top**	**AV-GeZZin** **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 age 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 patients' interest group/association designated by Zorg en Zekerheid. A list of organisations designated by Zorg en Zekerheid can be found at **zorgenzekerheid.nl/vergoedingenzoeker.**

How much reimbursement will I receive under my supplementary insurance?

AV-Sure **AV-GeZZin Compact** **AV-Plus**	**AV-Basis** **AV-Standaard**	**AV-Top**	**AV-GeZZin** **AV-Totaal**
No reimbursement	50%, up to a maximum of €350	100%, up to a maximum of €300	100%, up to a maximum of €350

6.5: Informal care

6.5.1 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 Handen in Huis foundation or the Mantelaar.

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	Up to a maximum of 3 weeks

6.5.2 Informal care intermediary

What is reimbursed?
The costs of an informal care intermediary person per calendar year are eligible for reimbursement. An informal care intermediary arranges temporary professional support for informal care providers. He or she relieves the informal care provider's burden by taking care of arrangements concerning the care to be provided, finances and well-being. The purpose of the intermediary services is to prevent the informal care provider from being overburdened.

What are the conditions for reimbursement?
- you can engage the services of an informal care intermediary if you are providing informal care;
- the informal care intermediary works in an independent capacity;
- the informal care intermediary is listed in the Central Quality Register of Informal Care Intermediaries maintained by the de Beroepsvereniging voor Mantelzorgmakelaars (BMZM).

Which costs do not qualify for reimbursement?
The costs of the informal care intermediary, if you receive informal care.

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	100%, up to a maximum of €250

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 performed by a skin therapist or by a beautician who is affiliated with ANBOS (General Dutch Sector Organisation for Beautician Care) and listed for acne treatment on the ANBOS website;
- if the treatment is administered by a skin therapist, he/she will need to be registered in the Quality Register for Paramedics (quality registered status);
- the treatments are performed in accordance with the Care Profiles for Integrated Acne Therapy, a document drawn up by the Netherlands Association for Skin Therapy;
- the care profile must be stated on the invoice;
- Care Profile 0 treatments do not qualify for reimbursement;
- treatments provided by a beautician only qualify for reimbursement with Care Profile 1.

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Standaard AV-GeZZin Compact AV-Plus	AV-Sure AV-Top	AV-GeZZin 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 performed by a skin therapist or by a beautician who is affiliated with ANBOS and listed for camouflage treatment on the ANBOS website;
- if the treatment is administered by a skin therapist, he/she will need to be registered in the Quality Register for Paramedics (quality registered status);
- you must have a referral from a general practitioner and send it to Zorg en Zekerheid when requested.

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin 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 €150

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 administered by a skin therapist who is registered in the Quality Register for Paramedics (quality registered status);
- you must have a referral from a medical specialist and send it to Zorg en Zekerheid when requested.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure AV-GeZZin Compact	AV-Basis AV-Standaard	AV-Top AV-GeZZin 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 €250

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 performed by a skin therapist or by a beautician who is affiliated with ANBOS and listed for this type of treatment on the ANBOS website;

- if the treatment is administered by a skin therapist, he/she will need to be registered in the Quality Register for Paramedics (quality registered status);
- you must have a referral from a general practitioner and send it along with the first invoice.

How much reimbursement will I receive under my supplementary insurance?

	AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin 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 qualifies for reimbursement of foot care under Care Profile 1.

What is not reimbursed?
- foot care with an arthrosis indication;
- the annual foot check (which is reimbursed under the basic insurance from Care Profile 1);
- cosmetic care, such as callus removal or nail care.

What are the conditions for reimbursement?
The treatment must be performed by:
- a podiatrist who meets the requirements of the Dietician, Occupational Therapist, Speech Therapist, Oral Hygienist, Remedial Therapist, Orthoptist and Podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a podiatrist in the Quality Register for Paramedics;
- the (medical) pedicurist must be registered with the Quality Register for Pedicurists (KRP), the Paramedical Foot Care Register (RPV) or the Quality Register for Medical Foot Care Providers (KMV). A pedicure must hold an additional qualification 'foot care for diabetics' (DV) and/or 'foot care for rheumatic patients' (RV).

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	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;

- costs incurred without medical necessity;
- 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 AV-GeZZin Compact	AV-Basis AV-Standaard	AV-Top AV-GeZZin 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 AV-GeZZin Compact AV-Plus	AV-Basis AV-Standaard AV-Top AV-GeZZin 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 therapeutic soles are eligible for reimbursement for each insured person:

What are the conditions for reimbursement?
You are entitled to care from:
- a podiatrist who meets the requirements of the Dietician, Occupational Therapist, Speech Therapist, Oral Hygienist, Remedial Therapist, Orthoptist and Podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a podiatrist in the Quality Register for Paramedics;
- a podologist orpodopostural therapist who has successfully completed a registered podologist training programme and is included in the quality register of Quality Registration and Accreditation for Healthcare Professionals (KABIZ);
- an orthopaedic shoemaker or a workshop that holds SEMH-OSB (Orthopedisch Schoentechnische Bedrijven) or SEMH-OIM (Orthopedische Instrument Makerijen) certification.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure AV-GeZZin Compact	AV-Basis AV-Standaard	AV-Top AV-GeZZin 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 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 **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard** **AV-Top** **AV-GeZZin** **AV-Plus** **AV-Totaal**
No reimbursement	75%, up to a maximum of €40

8.5 Warning with a social need

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 en 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, 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 **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard**	**AV-Top** **AV-GeZZin** **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 AV-Standaard AV-GeZZin Compact AV-Top AV-Plus	AV-Sure AV-GeZZin AV-Totaal
No reimbursement	100%, up to a maximum of €40

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 require a referral from the medical specialist;
- the treatment must be carried out by a phelobologist doctor, dermatologist or phlebologist-proctologist doctor;
- the treatment must be provided 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 AV-GeZZin Compact	AV-Basis AV-Standaard	AV-Top AV-GeZZin 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 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 AV-Sure AV-Standaard AV-GeZZin Compact AV-Plus	AV-Top AV-GeZZin	AV-Totaal
No reimbursement	- 100%, up to a maximum of €300, if the treatment is carried out by a general practitioner; - 75%, up to a maximum of €300, if the treatment is carried out by a medical specialist in a hospital.	100%, up to a maximum of €300, if the treatment is carried out by a medical specialist in a hospital or by the general practitioner.

Sterilisation of women

AV-Basis AV-Sure AV-Standaard AV-GeZZin Compact AV-Plus	AV-Top AV-GeZZin	AV-Totaal
No reimbursement	75%, up to a maximum of €1,200, if the treatment is carried out by a medical specialist in a hospital.	100%, up to a maximum of €1,200, if the treatment is carried out by a medical specialist in a hospital.

9.3 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 **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Plus**	**AV-Top** **AV-GeZZin** **AV-Totaal**
No reimbursement	100%, up to a maximum of €500

Article 10: Paramedical treatments

10.1 Physiotherapy and remedial therapy

What is reimbursed?
You are entitled to physiotherapy and remedial therapy as generally provided by physiotherapists and remedial therapists, to the extent there are medical or paramedical grounds to justify such care.

What is not reimbursed?
- treatment based on the medical indication 'abrasion of the hip and knee joints';
- treatment based on the medical indication 'COPD';
- treatments to which you are entitled under your basic insurance or under the Long-Term Care Act (WLZ);
- specialised physiotherapy treatments. This does not apply to manual therapy, child physiotherapy, pelvic physiotherapy, oedema therapy, psychosomatic physiotherapy and geriatric physiotherapy treatments.

Special procedures and materials
In some cases the therapist will perform special procedures during your treatment, such as shockwave, dry needling or ultrasound imaging. Such procedures are part of the standard treatment and may not be separately invoiced to you by the therapist.

The costs of materials provided during the session, such as bandages and auxiliary bandaging, are also part of the treatment and may not be separately invoiced by the therapist either.

What are the conditions?
a. the care must be provided by any of the following care providers:

	Physiotherapy	Specialised physiotherapy excl. oedema and scar therapy	Oedema and scar therapy	Remedial therapy	Specialised remedial therapy
Physiotherapist	Yes	No	No	No	No
Specialised physiotherapist	Yes	Yes	No	No	No
Remedial therapist	No	No	No	Yes	No
Specialised remedial therapist	No	No	No	Yes	Yes
Oedema therapist or skin therapist	No	No	Yes	No	No

- the physiotherapist or specialised physiotherapist must be registered for the specialisation concerned in the Kwaliteitsregister Fysiotherapie NL or with the Physiotherapy Quality Mark (Keurmerk Fysiotherapie);
- the remedial therapist or specialised remedial therapist must be registered for the specialisation concerned in the Quality Register for Paramedics (KP) (quality registered status);
- do you qualify for supervised ambulatory training sessions in the case of stage 2 peripheral artery disease (intermittent claudication)? In that case, your physiotherapist or remedial therapist must be

registered for intermittent claudication with Chronisch ZorgNet and be known as such with Zorg en Zekerheid through registration in the Vektis AGB register;
- if you are being treated for Parkinson's disease and Parkinsonisms, your physiotherapist or remedial therapist must be registered with ParkinsonNet and be known as such with Zorg en Zekerheid through registration in the Vektis AGB register.

b. The number of treatment sessions is determined as follows:
- start of treatment:
  Have you started a new treatment programme with a physiotherapist? In that case, the physiotherapist will first examine you to exactly determine your condition and identify the right treatment for you. This counts as one treatment. If the physiotherapist then proceeds to providing the treatment, this counts as another treatment. This means that the costs of two treatments can be claimed for your first visit to the physiotherapist;
- all treatments count:
  all physiotherapy and remedial therapy treatments count towards the total. This also applies to outpatient treatments that were provided in a hospital or institution;
- manual therapy:
  as part of your treatment, a maximum of nine manual therapy treatments will be reimbursed. Treatments under the basic insurance and those under the supplementary insurance both count towards these nine treatments.

c. Group treatment:
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 treatment sessions serve as a baseline measurement, interim evaluation and/or final measurement.

d. Indication criteria for specialised physiotherapy:
In the case of manual physiotherapy, child physiotherapy, oedema therapy, pelvic physiotherapy, psychosomatic physiotherapy or geriatric physiotherapy, the disorder must be included in the domain/guideline/list of criteria of the relevant professional association (NVMT, NVFK, NVFL, NVFB, NFP and NVFG respectively) and the indication criteria laid down therein must be satisfied. If the disorder or the indication falls outside of that scope, the costs of regular physiotherapy will be reimbursed if the relevant requirements are satisfied.

Do I need a referral?
Is your condition included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) or will you be treated for hip or knee joint arthrosis, Fontaine II intermittent claudication or COPD Gold class II or higher? In that case you will need a written referral from your attending physician, the nursing specialist or the physician assistant before you can start the treatment. Alternatively, you can produce a diagnosis statement including the following details: your name, the name of the doctor who gave the diagnosis and a clear description of the diagnosis.

Is your condition not included in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) and are you not being treated for hip or knee joint arthrosis, Fontaine II intermittent claudication or COPD Gold class II or higher? you do not need a referral for treatment by a care provider. We call this 'direct accessibility'.

Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.

Does Zorg en Zekerheid need to approve this beforehand?
If you are going to receive care following a period you spent in a hospital, nursing home or rehabilitation institution (day treatment) and that care does not concern a condition included in Appendix 1 to the Healthcare Insurance Decree (List of Chronic Disorders) but is aimed to expedite your recovery following discharge or termination of the day treatment programme, you will need prior written permission for that care from Zorg en Zekerheid. Your physiotherapist will have to apply for that permission on your behalf.

What is reimbursed if I go to a non-contracted care provider?
The costs of care provided by a non-contracted care provider are reimbursed up to a maximum of 75% of the prevailing Dutch market rate. There are some exceptions:
- 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 are not reimbursed;

- the reimbursement for specialised care (e.g. child remedial therapy) by a non-contracted remedial therapist equals the reimbursement for regular treatment at a non-contracted remedial therapist (no surcharge is awarded).

How much reimbursement will I receive under my supplementary insurance?

	AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin AV-Plus	AV-Totaal
Physiotherapy (all types)	A maximum of 9 treatment sessions	A maximum of 12 treatment sessions	A maximum of 25 treatment sessions	A maximum of 40 treatment sessions
Remedial therapy (all types)		A maximum of 12 treatment sessions	A maximum of 25 treatment sessions	A maximum of 40 treatment sessions

10.1.1 Exercise programme

What is reimbursed?
A fully completed exercise programme that meets the KNGF Exercise Interventions standards or the Physiotherapy Quality Mark Foundation's guidelines and is provided in physiotherapy practices that hold a level A or B quality label. Go to **zorgenzekerheid.nl/zorgzoeker** for an overview per condition of contracted level A or B physiotherapists offering KNGF exercise programmes.

What is not reimbursed?
If you have an indication for which you are also attending an individual programme with the physiotherapist, the exercise programme will not be reimbursed.

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin AV-Plus	AV-Totaal
No reimbursement	50%, up to a maximum of €500 per 2 calendar years	75%, up to a maximum of €500 per 2 calendar years	100%, up to a maximum of €500 per 2 calendar years

10.1.2 Fitkids exercise programme or JOGG lifestyle intervention programme

What is reimbursed?
A fully completed Fitkids exercise 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 level A or B quality label. To find the details of contracted physiotherapy practices with this quality label, visit **zorgenzekerheid.nl/zorgzoeker**, call our Contact Centre (071) 5 825 825) or go to one of our insurance shops. Fitkids and JOGG each apply their own conditions for participation in the exercise programme.

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin AV-Plus	AV-Totaal
No reimbursement	50%, up to a maximum of €500 per 2 calendar years	75%, up to a maximum of €500 per 2 calendar years	100%, up to a maximum of €500 per 2 calendar years

10.2 Dietary advice

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 dietician issues the indication for dietary advice;
- the treatment for Parkinson's disease and Parkinsonisms only qualifies for reimbursement if your dietician is affiliated with ParkinsonNet;

- all dietary advice treatments count towards the maximum number of 15-minute sessions mentioned, including inpatient treatment sessions at a hospital or institution.

Do I need a referral?
Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.

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;
- dietary advice for patients with an overweight indication.

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

10.2.1 Dietary advice to insured persons under age 18

What is reimbursed?
Supplementary to the reimbursement under your basic insurance, you are entitled to reimbursement of the costs of dietary advice by a dietician. Only insured persons under age 18 qualify for reimbursement, which is provided per calendar year.

How much reimbursement will I receive under my supplementary insurance?

AV-Basis **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Plus**	**AV-Top** **AV-GeZZin**	**AV-Totaal**
No reimbursement	7 x 15 minutes	10 x 15 minutes

10.2.2 Dietary advice for specific indications from age 18

What is reimbursed?
Supplementary to the reimbursement under your basic insurance, you are entitled to reimbursement of the costs of dietary advice by a dietician in the case of one of the following indications: malnutrition, oncology and/or unintended weight loss. The reimbursement is per calendar year.

How much reimbursement will I receive under my supplementary insurance?

AV-Basis **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-GeZZin**	**AV-Top** **AV-Plus** **AV-Totaal**
No reimbursement	8 x 15 minutes

10.3 Occupational therapy

What is reimbursed?
Supplementary to the reimbursement under your basic insurance, you are entitled to reimbursement of the costs of advice, instruction, training or treatment by an occupational therapist. The reimbursement is per calendar year.

What are the conditions for reimbursement?
- the occupational therapy must be offered by an occupational therapist 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;
- all occupational therapy treatments count towards the maximum number of treatment hours mentioned, including inpatient treatment sessions at a hospital or institution.

Do I need a referral?
Are you being treated by a geriatric care specialist, a doctor for the mentally disabled and/or a behavioural scientist acting as a coordinating care provider in connection with medical care for specific groups of patients, and has that professional included any individual paramedical treatment in your treatment plan? In that case, you will need a written referral from your coordinating care provider before you can start the treatment.

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.

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

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 10 hours

10.4 Podology, podiatry, podopostural therapy
What is reimbursed?
The costs of treatments/consultations by a podologist or podo(postural)therapist per insured person per calendar year.

What are the conditions for reimbursement?
You are entitled to care from:
- a podiatrist who meets the requirements of the Dietician, Occupational Therapist, Speech Therapist, Oral Hygienist, Remedial Therapist, Orthoptist and Podiatrist Decree in accordance with Section 34 of the BIG Act and who is registered as a podiatrist in the Quality Register for Paramedics;
- a podologist orpodopostural therapist who has successfully completed a registered podologist training programme and is included in the quality register of Quality Registration and Accreditation for Healthcare Professionals (KABIZ);
- an orthopaedic shoemaker or a workshop that holds SEMH-OSB (Orthopedisch Schoentechnische Bedrijven) or SEMH-OIM (Orthopedische Instrument Makerijen) certification.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard**	**AV-Top** **AV-GeZZin** **AV-Plus**	**AV-Totaal**
No reimbursement	100%, up to a maximum of €50	100%, up to a maximum of €100	100%, up to a maximum of €125

10.5 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 or Hausdörfer treatment methods.

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Sure AV-Standaard AV-GeZZin Compact AV-Plus	AV-Top	AV-GeZZin 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 geZZondcheck 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 multidisciplinary care programme;
- the geZZondcheck check-up through our corporate care programme qualifies for reimbursement.

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard AV-Top AV-GeZZin AV-Plus AV-Totaal
No reimbursement	100%, once every two calendar years

11.2 Preventative courses

What is reimbursed?
You are entitled to reimbursement of the costs of one or more preventative courses per calendar, if provided by an approved organisation. For a full list of approved organisations, go to **zorgenzekerheid.nl/vergoedingenzoeker**.

Reimbursement is only available for the following courses:
- Weight loss when overweight
- First aid course (EHBO), reanimation course or AED training;
- More Physical Exercise for the Elderly (MBvO);
- Self-management:
  - Learning to cope with an illness or disorder;
  - Informal care training course;
  - Sleep therapy course;
  - Quit Smoking.

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;
- More Physical Exercise for the Elderly (MBvO) qualifies for reimbursement if you are 55 years old or above;
- a preventative course that you attend through a corporate care programme also qualifies for maximum reimbursement.

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 preventative courses together.

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard	AV-Top AV-GeZZin 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 €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 AV-Sure AV-Standaard AV-GeZZin Compact	AV-Top AV-GeZZin 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?
You are entitled to a preventive sports medical examination and/or sports tests. This reimbursement can only be applied for once per calendar year.

What are the conditions for reimbursement?
The sports medical examination and/or tests must be carried out by a registered sports physician in a specialised medical sports centre accredited by the Stichting Certificering Actoren in de Sportgezondheidszorg (Foundation for Sports Healthcare Accreditation, SCAS). The sports medical institution must be affiliated with the Federatie van Sportmedische Instellingen (Federation of Sports Medical Institutions, FSMI).

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Standaard AV-GeZZin Compact	AV-Sure	AV-Top AV-GeZZin 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:
- psychosocial counselling in connection with cancer: by therapists affiliated with the NVPO;
- body-oriented therapy: by therapists affiliated with the SBLP (NVPIT, NVBT and NIBA);
- Gestalt therapy: by therapists affiliated with the NVAGT;
- sexological assistance: by therapists affiliated with the NVVS;

And psychological care per insured person per calendar year comprising:
- 'Kanjer' training or resilience training provided by a therapist associated with the NVPA;
- integrative child therapy for insured persons under age 18 with an AV-GeZZin or AV-Totaal policy: by a therapist who satisfies the conditions stated by the VIT (Association of Integral Therapists) or who is affiliated with the VVvK or NVPMKT. The treatment must be multidisciplinary in nature;
- play therapy for insured persons under age 18 with an AV-GeZZin or nd AV-Totaal policy: by a remedial educationalist or a therapist affiliated with the NVVS;

- remedial teaching for insured persons under age 18 with an AV-GeZZin or AV-Totaal policy: by a remedial educationalist affiliated with the NVO (Dutch Association of Remedial Educationalists) or a practitioner who is a registered member of the LBRT (National Remedial Teachers' Union);
- dyslexia therapy for insured persons under age 18 with an AV-GeZZin or AV-Totaal policy: by a remedial educationalist or a therapist affiliated with the NVO (Dutch Association of Remedial Educationalists).

How much reimbursement will I receive under my supplementary insurance?

AV-Basis AV-Standaard AV-GeZZin Compact	AV-Sure	AV-Top AV-GeZZin 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 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 the original proof of purchase or hiring.

How much reimbursement will I receive under my supplementary insurance?

AV-GeZZin Compact	AV-Basis AV-Sure AV-Standaard AV-Top AV-GeZZin AV-Plus 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 5.2(d) and 5.3. 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 be performed and invoiced by an independent oral hygienist and a registered oral therapist. Anaesthesia, fillings and small X-rays can also be performed and invoiced by a registered oral therapist. The associated treatments are described in Articles 13.2.1 and 13.2.2. You will find the reimbursements that apply to the corresponding 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;
- taking and assessing dental overview X-rays, up to the age of 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;
- the costs of orthodontic care within the waiting period for such care;
- the costs for which you will be invoiced if you go to a non-contracted care provider for full dentures;
- trigger point treatment with botox.

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 age 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 AV-Standaard	AV-GeZZin Compact	AV-Top AV-GeZZin 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 €1,000

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;
- only a single reimbursement will be paid for the entire duration of the treatment. '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;
- insured persons who are receiving treatment must have taken out supplementary insurance for orthodontic treatment with Zorg en Zekerheid at least twelve months prior to the start of the treatment in order to claim reimbursement;
- if, during your treatment, you take out supplementary insurance with us 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.

Waiting period for orthodontic treatment
The waiting period for orthodontic treatment is 12 months. This means that you will be paying premium during the waiting period, without receiving reimbursement for orthodontic care. The waiting period starts on the commencement date of the supplementary insurance.

How much reimbursement will I receive under my supplementary insurance?

	AV-Basis AV-Sure AV-Standaard AV-Plus	AV-GeZZin Compact	AV-Top	AV-GeZZin	AV-Totaal
Existing 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, an oral hygienist or a registered oral therapist.

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	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 €1,000

The maximum amount per supplementary insurance also applies for the dental treatments referred to under Articles 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;
- the necessary dental treatments, invoiced by a dentist, an oral hygienist or a registered oral therapist. You will find the reimbursements that apply to the corresponding performance codes at **zorgenzekerheid.nl/vergoedingenzoeker**.
- 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 full dentures on implants 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.

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	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 €1,000

The maximum amount applies for the dental treatments referred to under Articles 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. The claims from both insured persons with an AV-Delen policy count towards this maximum reimbursement.

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 and provided within 12 months of the date of the 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 accident must be reported to Zorg en Zekerheid by the insured person within 60 days; see zorgenzekerheid.nl/service-en-contact/contactgegevens for the reporting options;
- the dental injury must have arisen from an accident during the term of the insurance;
- the costs must have been incurred as a direct result of the accident;
- the treatment must be carried out by an authorised care provider.

If the (definitive) treatment has to be postponed (for more than 12 months after the accident), our advising dentist will determine whether or not the postponement is necessary.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written permission from Zorg en Zekerheid:
- the dentist applies for written permission from Zorg en Zekerheid via the digital portal of VECOZO. The application must be accompanied by a supporting letter from the dentist;
- along with the application, the care provider sends a statement confirming that the dental injury was caused by an accident.

Which costs do not qualify for reimbursement?
Costs:
- arising from an illness or a morbid abnormality;
- arising from gross negligence or recklessness/intent;
- arising alcohol or substance abuse;
- arising from involvement in a fight other than for the purpose of self-defence;
- of orthodontic care;
- that were anticipated and do not arise from an accident;
- of treatment abroad;
- arising from an accident abroad later than one year following the date of the accident. 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 AV-Standaard AV-GeZZin Compact AV-Top AV-GeZZin AV-Plus AV-Totaal
No reimbursement	100%, up to a maximum of €10,000 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.

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	100%, up to a maximum of €750 by a dentist or 100%, up to a maximum of €500 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.

What are the conditions for reimbursement?

- the family member admitted must also have supplementary insurance with Zorg en Zekerheid;
- the family members live at the same address;
- the claim must state:
  - the name of the insured person admitted and that of the insured person who is visiting;
  - the name of the hopsital or rehabilitation centre;
  - 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 'shortest route' quoted by the ANWB Route Planner (www.anwb.nl/verkeer/routeplanner();
- if you travel using your own vehicle, the maximum reimbursement is €0.32 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 **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard** **AV-Top** **AV-GeZZin** **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?
Eligible for reimbursement are the costs of membership of a patients' association affiliated with the Patiëntenfederatie Nederland (Dutch Federation of Patient-Consumers, NPCF) or umbrella organisation Ieder(in), per insured person per calendar year.

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 fees for associations are for your own account;
- donations and supportive membership.

How much reimbursement will I receive under my supplementary insurance?

AV-Sure **AV-GeZZin Compact**	**AV-Basis** **AV-Standaard** **AV-Top** **AV-GeZZin** **AV-Plus** **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 personal contribution per calendar year. The costs of your personal contribution, per insured person and per calendar year, may qualify 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	100%, up to a maximum of €108

Reimbursement of the personal contribution under the WLZ/WMO

What is reimbursed?
You are entitled to reimbursement of the personal contribution towards care within the framework of the Long-Term Care Act (WLZ) or Social Support Act (WMO). This reimbursement can only be applied for once per calendar year.

What are the conditions for reimbursement?
- you receive the care at home;
- the invoice must be from the Central Administrative Office (CAK).

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	100%, up to a maximum of €200

14.5 Home care organisation membership

What is reimbursed?
The annual 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 **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Top** **AV-Plus**	**AV-GeZZin** **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 for every child insured (free of charge) under age 18, per calendar year.

What are the conditions for reimbursement?
- the invoice must clearly state the name of the insured person and the nature of the amount, being the membership fee for a sports association;
- the sports association must belong to an association affiliated with the NOC*NSF;
- sports associations tend to base their membership fees on seasons rather than calendar years. This means that a claim regarding the membership fee for 2020-2021 will be charged against the 2020 calendar year and will not be paid in 2021;
- this reimbursement also covers your child's swimming lessons.

Which costs do not qualify for reimbursement?
- separate sports cards, strip tickets or other temporary season tickets;
- sports and fitness schools.

How much reimbursement will I receive under my supplementary insurance?

AV-Basis **AV-Sure** **AV-Standaard** **AV-GeZZin Compact** **AV-Top** **AV-Plus**	**AV-GeZZin** **AV-Totaal**
No reimbursement	100%, up to a maximum of €50

Section B: Conditions of Zorg en Zekerheid supplementary insurance

1. General provisions

1.1 For whom?

This supplementary insurance is available to all persons obliged to take out insurance under the Healthcare Insurance Act who reside in the Netherlands or in another EU or EEA Member State, and to persons who have been accepted for that purpose by virtue of a decision of the Management Board of Zorg en Zekerheid. You can only take out supplementary insurance with us if you also take out a Zorg Zeker or Zorg Vrij policy with us, or if you already have such a policy. The AV-Plus policy is only available to insured persons from age 18 who also meet the aforementioned conditions.

1.2 Content and extent of the insured care

Your supplementary insurance entitles you to care, provided there are medical grounds, and to reimbursement of the costs associated with that care, as described in these policy conditions. Medical grounds are deemed to exist 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 supplementary insurance are partly determined by what the care providers concerned typically provide in terms of care.

1.3 Parties authorised to provide the care

Care under your supplementary insurance policy may be administered by any care provider of your choice. The care provided must nevertheless satisfy a number of conditions, which, where applicable, are stated under the care article concerned. We have contracted specific care providers for several types of care, including paramedics. If you go to a non-contracted care provider, you may have to pay part of the invoice yourself. Check the relevant care article for details.

1.4 Reimbursement of the costs of care

As an insured person you are entitled to care and reimbursement of the costs associated with that care up to the amounts or the number of treatments indicated in these policy conditions.

1.4.1 The reimbursement equals the amount we have agreed upon with the care provider. If no rates have been agreed, we will reimburse the costs of insured care in accordance with the current rates set under the Healthcare (Market Regulation) Act (WMG). If no WMG rate has been agreed, we will reimburse the costs in accordance with the rates published on **zorgenzekerheid.nl/vergoedingzoeker**.

1.4.2 As an insured person, you are only entitled to reimbursement of the costs of care incurred during the term of the insurance, unless in the event of an incomplete/incorrect application as referred to in Article 2.2 or in the event of fraud (see Article 5.5). The date of the treatment or delivery is the determining factor when establishing your right to reimbursement of the costs of care.

1.5 Requirements concerning your invoice

Only original invoices, or digital invoices that have been authenticated by the care provider, will be processed. When claiming reimbursement of costs incurred abroad or the costs of seated patient transport, a claim form from Zorg en Zekerheid for care provided abroad/own transport and public transport must be used; for more information, also see **zorgenzekerheid.nl/brochures.**

1.6 When will an invoice expire?

Your right to claim reimbursement of the costs of care will, in principle, expire on 31 December of the third year following the year in which the treatment took place. To prevent expiry, you should notify us in writing within the period mentioned in the previous sentence that you expressly wish to claim the reimbursement. If we have rejected your claim for reimbursement of the costs of care in part or in its entirety, your invoice will expire on 31 December of the third year following the year in which we communicated our decision to reject your claim. To prevent expiry in cases such as this, you should notify us in writing within this period that you expressly wish to claim the reimbursement.

1.7 Dutch law

This supplementary insurance is governed exclusively by Dutch law.

1.8 Applying for or terminating supplementary insurance

Whenever there is a reference to applying for or giving notice of termination of supplementary insurance, the application or termination can be effected both in writing / electronically and by telephone.

2. Applying for and commencement and termination of your supplementary insurance

2.1 How to apply for supplementary insurance

You can apply for any supplementary insurance covered by these policy conditions. By applying for supplementary insurance, you must cooperate in providing us with the information we deem necessary to be able to assess your application.

2.2 Complete your application in full and truthfully

When applying for supplementary insurance or notifying us of changes to your existing insurance, you should provide us with full and truthful details. Failure to do so will release us from any obligation to pay reimbursement and enable us to terminate your insurance with immediate effect. This is also the case if you withhold essential information from us that would have been relevant to our decision to enter into an insurance contract with you, or to do so under the same terms and conditions. In that case we will be able to invoke Title 7.17 of the Dutch Civil Code and terminate the insurance contract with immediate effect. The costs of any research we have carried out to determine whether you have completed your application truthfully and in full will be charged to you.

2.3 Conditions for you to consider when applying for supplementary insurance

Zorg en Zekerheid will not ask you to provide information about your health when you apply for supplementary insurance. We do however have a number of specific conditions:

a. if, as an existing policyholder/insured person, you wish to transfer to a supplementary package with more extensive or more limited cover, you must inform Zorg en Zekerheid accordingly on 31 December at the latest; in that case the change will apply as of 1 January of the subsequent year;
b. you cannot be insured under more than one supplementary package at the same time, except in the case of AV-Delen;
c. children qualify for the most extensive package of the parent or parents in whose policy schedule they are registered. If both parents have opted for AV-Plus, the child is insured under AV-Top;
d. children under age 18 with their own policy schedule and whose parents are not insured with us do not owe a premium and are insured under the AV-Sure policy;
e. you can only opt for AV-Delen if both of you satisfy all the following conditions:
   - you pay a premium;
   - you have the same supplementary insurance that includes reimbursement for the costs of dentistry;
   - you are stated on the same policy schedule;
f. AV-Delen insurance only relates to dental assistance as referred to in Article 13.2 of these policy conditions;
g. you can only opt for AV-GeZZin during the course of the year in connection with pregnancy if you have already taken out supplementary insurance with us. Note that you cannot switch to AV-GeZZin mid-term if your supplementary insurance policy is AV-Gemak, AV-Gemak Regio and/or Module Buitenland.

2.4 Start, end and duration of your insurance

2.4.1 Your insurance starts on 1 January of a calendar year or on another date as stated by us on the most recent policy schedule. The duration of the insurance equals the (remaining part of the) calendar year in which the supplementary insurance is effected. After each calendar year, every year your insurance will be tacitly renewed for one more calendar year, unless you give notice of termination by 31 December of the calendar year.

2.4.2 If we have requested further information from you to help us process your insurance application, the insurance policy will become effective on the first day of the month following the month in which we received the necessary information.

2.4.3 The insurance ends:

- after expiry of the agreed term, if the policyholder has given notice of termination in any year by 1 January (see Article 2.7.1);
- 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 of the insurance conditions, insurance package and/or the premium, as referred to in Article 4.1 and in the manner stipulated in Article 4.2;
- through cancellation by the insurance company as stated in Article 2.8.

2.5 Rejection of your application

We may reject your application if an insurance was previously terminated because the premium owed was not paid. We may also reject the application if the insurance was previously terminated in connection with the provisions set out in Article 2.7 or if the policyholder or insured person is registered in the incident warning system for financial institutions (external reference register).

2.6 Opt for a different supplementary insurance

2.6.1 You can only take out a different supplementary insurance with effect from the next calendar year if you inform us of your intention to do so on 31 December at the latest. In other words, you cannot switch to a different supplementary insurance package in the course of the calendar year, unless in the case of:

a. the birth of a child (only with AV-GeZZin);
b. an insured person who is 18 years old and applies for a different insurance policy from Zorg en Zekerheid in the month in which they turn 18 or in the subsequent month;
c. an insured person who is a member of a group that is covered by supplementary insurance which, due to the conditions imposed by that group, cannot be maintained;
d. an insured person who, in connection with pregnancy, opts for an AV-GeZZin policy and who meets the conditions set out in Article 2.3(g).

In cases (b) to (d) inclusive, the insurance starts on the first day of the month following the month in which Zorg en Zekerheid received the application for supplementary insurance, or on the first day of the month in which the insured person turns 18.

2.6.2 Newborn infants are registered as at their date of birth if reported within four months after their 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.

2.6.3 As soon as a child included on his or her parent's policy sheet turns 18, he or she can terminate the supplementary policy or opt for a different one. The commencement the new policy or the termination will come into effect as of the first day of the month following the month in which your child turned 18, This is subject to the condition that we have received the notice of change or termination in the month in which your child turns 18 or in the subsequent month.

2.7 Times at which you may cancel your supplementary insurance

As a policyholder, you may cancel the supplementary insurance as from 1 January of each year provided that we have received your cancellation no later than 31 December of the previous year. You may use the cancellation service provided by the Dutch healthcare insurers for this purpose. In this way you will authorise the provider of your new supplementary insurance to cancel your old policy.

2.7.2 As a policyholder, you may cancel the supplementary insurance in the interim period in writing:
a. in the event of a change in the premium and/or policy conditions as stated in Article 4;
b. when a child included in a parent's policy sheet turns 18 as described in Article 2.6.3.

2.8 Times at which we may cancel your supplementary insurance

We may terminate your supplementary insurance in writing effective from a time of Zorg en Zekerheid's choosing:
a. if you have not paid your premium by the stated deadline, as referred to in Article 3.3;
b. in the case of fraud (see Article 5.5);
c. if you have not provided us with full and correct information (see Article 2.2);
d. if the conditions described in Article 2.3 are no longer met;
e. if there are important reasons for us to take the healthcare insurance off the market.

2.9 Notifications

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

3. Premium

3.1 Who pays the premium?

The policyholder is obliged to pay the premium due for each and every insured person. The obligation to pay premiums commences on the start date of the policy and ends on the date on which the insurance ends. 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. 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 for 18-year-old
A person who turns 18 on 2 February will owe premium from 1 March.

The policyholder is obliged to pay in advance the premium and any amounts arising from domestic or foreign statutory provisions or regulations, for all insured persons. The policyholder can choose to pay the premium on a monthly, quarterly, half-yearly or yearly basis.

3.2 Settlement

You are not allowed to set off any amounts owed (such as the premium) against an amount you expect to receive from us in connection with a claim.

3.3 Overdue payment

3.3.1 If you fail to pay the premium, statutory contribution, excess, personal contribution and costs owed in time, we will send you a demand for payment. If you do not pay within the term of at least 14 days specified in the demand for payment, we will be authorised to terminate the insurance. After we have terminated your insurance, you may re-apply for it once you have paid the premium due and any costs owed. The insurance will then commence on 1 January of the next calendar year.

3.3.2 If a demand for payment has already been sent to you as a policyholder for overdue payment of any premium, statutory contributions, excess, personal contributions or costs owed, we will not be required to send you a separate, written demand for payment with a subsequent invoice.

3.3.3 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 extrajudicial costs. The amount of the extrajudicial collection costs will be determined in accordance with the Extrajudicial Collection Costs (Standards) Act (*Wet normering buitengerechtelijke kosten*) and the associated Decree, to a minimum of €40. You will owe extrajudicial costs from the moment you are in default.

3.3.4 You are under an obligation to make timely payment of your premium. If you fail to pay your premium by the premium due date, you will not be able to claim that the premium was not collected in time.

3.4 Tax on premiums

If we are liable to pay tax on the insurance premiums abroad, we will charge you for the costs. You are obliged to pay these taxes by the deadline we set for this purpose. If you fail to pay the full amount to us in time, we will terminate your supplementary insurance (see Article 3.3.1).

3.5 How is your premium calculated?

Premium base
Group discount _____-
Interim result (premium to be paid)

Internet discount _____-
Interim result (premium to be paid)

Instalment discount _____-
Premium to be paid

3.6 Instalment discount

If you opt to pay the premium on a half-yearly or yearly basis, you are entitled to a discount over the premium due. When you join a group contract, your choice may be limited to a monthly payment plan. In that case you are not entitled to the instalment discount.

3.7 Premium discount by virtue of a group contract

If you participate in a group contract, you may 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.

You can only participate in one group contract at a time.

3.8 Internet discount

You may apply for an Internet discount on your supplementary insurance. You will receive an Internet discount if you:

a. exclusively use digital correspondence (e.g. itemised claims and invoices) for all your insurance policies with Zorg en Zekerheid; and
b. grant authorisation for direct debit payment of the premiums for all of your insurance policies with Zorg en Zekerheid.

If you meet the above conditions, you qualify for a 2% discount on your supplementary insurance. The Internet discount expires at any time that you no longer meet either or both of these conditions.

4. Change in premium and policy conditions

4.1. Change in premium and policy conditions

We are authorised at all times to change the policy conditions and premium of the supplementary insurance or insurances. We will inform you as a policyholder in this regard in writing. We will determine the effective date of any such change. Changes to the premium and/or policy conditions will take effect across the board. This means that the change will apply to all insured persons.

4.2 Right of cancellation

If we decide to amend the policy conditions or the premium to your disadvantage, you will have the right to give notice of termination of your insurance within 30 days of the day on which we informed you about the change. You should give notice of termination in writing, by registered post. You have no such right of termination if a change is a result of statutory measures, regulations or provisions or if we change the insurance to your advantage.

5. Other provisions

5.1 Your obligations

a. to ask the attending doctor or medical specialist to inform Zorg en Zekerheid's medical advisor of the reason for the admission if the latter so requests;
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, 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 any liable third parties. In that case, you must provide Zorg en Zekerheid with all the necessary information and cooperate as required, free of charge;
d. unless Zorg en Zekerheid has given its written consent, it is not permitted to make an arrangement (or to cause this to be done) with the liable third party or with its insurer in respect of costs that have been or will be reimbursed by Zorg en Zekerheid;
e. 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 ask us not to do so. You will not owe any premium nor be entitled to insurance cover for any costs during the suspension period. You supplementary insurance will resume as of the last day of imprisonment, provided that we have been informed about this within 30 days of that date. If you fail to inform us within that term, 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;
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 original referral from the care provider concerned;
g. to ensure, as the policyholder, 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. Examples of such changes include:
   - marriage, or the inception of a cohabitation arrangement;
   - divorce, dissolution of a long-term cohabitation agreement;
   - death;
   - birth;
   - change of bank account number;
   - change of address;
   - change of email address;
   - start and end of a jail term.

   If the change is not communicated to Zorg en Zekerheid within 30 days, it 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 apply in the case of the birth of a child (see Article 2.6.2), death, and commencement of a term of imprisonment (see d. above);
h. if, as the policyholder or insured person, you have expressly consented to the policy and/or other communications being sent to you electronically, communications between you and Zorg en Zekerheid will be in electronic form as much as possible to the extent permitted by the law;
i. the policyholder/insured person is obliged to refrain from actions that could damage the interests of Zorg en Zekerheid;
j. the policyholder/insured person must ensure that the necessary changes are made to the policy schedule;
k. 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.

5.2. Exclusions

You are not entitled to reimbursement for (the costs of) care:

a. if the type of care or services is or could potentially be funded by virtue of a statutory act or provision, such as the Youth Act, the Long-Term Care Act (WLZ) or the Social Support Act (WMO);
b. if the type of care or services is or could potentially be funded under your healthcare insurance (basic insurance policy);
c. if the costs result from 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);
d. if the damage is caused by, related to or results from an atomic nuclear reaction, regardless of how the reaction came about. This exclusion does not apply to loss/damage caused by radioactive nuclides located outside the nuclear plant 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 (*Wet aansprakelijkheid kernongevallen*, WAK) (Bulletin of Acts and Decrees 1979225). An exception to the second and third sentences of this paragraph applies if and when, under Dutch or foreign law, a third party is liable for the damaged incurred;

e. if the care is provided by you, your partner, child, parent or other family member living as part of the household unless we have granted permission in advance;
f. if the care was received outside the Netherlands, except for the costs mentioned in Article 3 of Section A;
g. for treatments for which referral or authorisation had to be requested and which referral or authorisation was not requested nor issued in advance;
h. if the care was made necessary by an act of wilful misconduct or gross negligence;
i. 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 (see www.terrorismeverzekerd.nl).

5.3. Double cover

a. You are not entitled to care nor to reimbursement of the costs of care or provisions in connection with an illness or accident if the insured person can claim compensation 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.
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.

5.4 How we deal with your personal details

When processing your personal details, we adhere to the applicable laws and regulations, such as the General Data Protection Regulation. For details on how we do this, please consult our Privacy Statement, which is published on our website.

5.5 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 the costs 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 event of fraud, we will register you and/or the insured person in the Events Register and in the internal reference register, but also in the external reference register maintained by Stichting Centraal Informatiesysteem (CIS) (the Netherlands Central Information System Foundation) in The Hague. Fraud investigations are conducted in accordance with the Protocol for Insurers and Criminality and the Incident Warning Protocol for Financial Institutions (PIFI). In the case of fraud, or strong suspicions of fraud, we may also decide to report the case to the police.

5.6 Complaints and disputes

If you are dissatisfied with a decision that we have made or with our service, you are free to submit a complaint within 12 weeks.

You can 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, t.a.v. de Klachtencommissie, Postbus 400, 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 within one year 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.

5.7. Concluding provision

Matters not covered by these policy terms and conditions will be decided on by the Management Board of Zorg en Zekerheid. Adopted by the Members' Council on 29 October 2020 and to take effect on 01 January 2021.

Section C: Information

If you have any questions, visit **zorgenzekerheid.nl** for a wealth of additional information. Alternatively, get in touch with our Contact Centre by phone on (071) 5 825 825. Available on working days from 8 am to 6 pm. You can also visit one of our shops.

MijnZZ

Persons insured with Zorg en Zekerheid can access MijnZZ. MijnZZ allows you to view or, if applicable, change claims you have submitted, your excess, your personal details and the policy data. In addition, MijnZZ allows you to submit your invoices online. You can log in to MijnZZ 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 the original invoice(s) and send the invoice(s) online via MijnZZ (**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 claim via the Zorg en Zekerheid claim app (free download via 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 a sufficiently stamped envelope to:
  Zorg en Zekerheid
  Attn.: Afdeling Declaraties
  Postbus 428
  2300 AK LEIDEN
- the original invoices will remain in the possession 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 medical costs incurred abroad 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/brochures** or request it from Zorg en Zekerheid. Please 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;
- 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;
- the 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

zorgenzekerheid.nl

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