Zorg Gemak Policy

Policy Conditions 2023

Basic Insurance

Supplementary Insurance

Zorg en Zekerheid
Beter in jouw buurt

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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.

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 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.

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 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 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 with the patient to evaluate the progress made and adjusts the treatment plan where necessary.

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.

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 in terms of a DTP code of practice established by the Dutch Healthcare Authority under the Healthcare (Market Regulation) Act (*Wet marktordening gezondheidszorg*). 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 is completed at the end of treatment, or after 120 days in the case of specialist medical care.

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 Member 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 and Sweden. 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.

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.

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 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.

Healthcare insurance
The healthcare 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'.

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.

Informal carer
A person who provides unpaid care to a family member, friend or close acquaintance for 8 hours or more per week.

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).

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.

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

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

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

Medical pedicurist
A medical pedicurist who holds a level 4 sector or VET diploma and, as such, is qualified for the treatment of high-risk feet, such as rheumatoid and diabetic feet. The medical pedicurist must be listed as such in the Quality Register for Pedicurists (KRP), the Quality Register for Medical Foot Care Providers (KMV) or the Paramedical Foot Care Register (RPV). The medical pedicurist must also be registered with a General Database Code (AGB Code) in the Vektis AGB register.

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).

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.

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

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

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

Nurse
A nurse as registered in accordance with Section 3 of the BIG 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.

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

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.

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.

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.

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.

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.

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

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

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.

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.

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.

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.

Regional Health Service 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.

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.

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.

Regulations
The care aids as specified in the health insurance policy.

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).

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 pedicurist
A regular pedicurist who holds a level 3 sector or VET diploma plus an additional qualification for ‘Foot care for diabetics’ and/or ‘Foot care for rheumatic patients’. The pedicurist (and his or her specialisation) must be registered in the KRP or the RPV. The pedicurist must also be registered with a General Database Code (AGB Code) in the Vektis AGB register.

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.

'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.

We/us/Zorg en Zekerheid

The Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a.

Welfare organisation

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

WMG rates

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

The definitions below also apply to these policy conditions

Regio van Zorg en Zekerheid

Zorg en Zekerheid's coverage area consists of the following 20 municipalities:

- Aalsmeer
- Alphen aan den Rijn
- Amstelveen
- Bodegraven-Reeuwijk
- De Ronde Venen
- Haarlemmermeer
- Hillegom
- Kaag en Braassem
- Katwijk
- Leiden
- Leiderdorp
- Lisse
- Nieuwkoop
- Noordwijk
- Oegstgeest
- Ouder-Amstel
- Teylingen
- Uithoorn
- Voorschoten
- Zoeterwoude

Module for Care Abroad

The Module for Care Abroad is a separate supplementary insurance policy that can only be taken out by Zorg Gemak Policy holders. This insurance policy is covered by the General Terms and Conditions as well.

Section A General Terms and Conditions

Article 1: General provisions

1.1 Basis of the premium

This healthcare insurance agreement is based on:

- the Healthcare Insurance Act (*Zorgverzekeringswet*, ZVW);
- the Healthcare Insurance Decree (*Besluit zorgverzekering*);
- the Healthcare Insurance Regulations (*Regeling zorgverzekering*);
- the associated explanatory notes to sections a, b and c;
- 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, by regular mail or digitally, 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.

The Zorg Gemak Policy also is an online insurance. When taking out this insurance online, you grant Zorg en Zekerheid permission to send you the policy digitally only and
you agree that all other communication between you and Zorg en Zekerheid (including itemised claims and invoices) will be conducted online.

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 **www.zorgenzekerheid.nl/zorgzoeker**. Alternatively, you can contact us by telephone on (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 70% of the WMG (maximum) rate. If there is no Wmg (maximum) rate, Zorg en Zekerheid will reimburse the costs up to a maximum of 70% of the prevailing market rate.

If you receive nursing and care (Articles 27.1 and 27.3) from a non-contracted care provider, In that case, Zorg en Zekerheid will reimburse 70% of the invoiced amount, up to a maximum of 70% the prevailing Dutch market rate.

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

1.5.3 Turnover ceilings

With a number of care contractors, 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 contractors are under a contractual obligation to continue providing 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 contractors. Go to **www.zorgenzekerheid.nl/zorgzoeker** for a list of these care contractors, or consult your care contractor. It may be the case that you can no longer receive care from this care contractor 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 contractor that you can turn to. If you are already under the care of a contractor who has reached his turnover ceiling, this will not affect your care in any way; you will be able to complete your treatment with that care contractor.

1.6 Timely provision of care

If it is expected to be impossible for a contracted care contractor 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 contractor 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.

Zorg en Zekerheid's Care Advice & Mediation Team will be happy to advise you on a suitable care contractor 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 **www.zorgenzekerheid.nl/zorgadvies**.

Care which cannot be provided, or cannot be provided in time, by a contracted care contractor is also understood to include:

a. care that cannot be provided within a reasonable distance from your place of residence; or:
b. a situation in which no high-quality and responsible care can be provided in the vicinity of your place of residence.

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

1.7 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 2 calendar years and the care provider submits 1 claim, then the date on which treatment started will be decisive for the right to reimbursement.

1.8 Written permission, referral or prescription

1.8.1 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 2023. You received written permission for plastic surgery from your former healthcare insurer. The end date of that permission is 23 March 2023. If you receive treatment before that date, you will not need our permission.

1.8.2 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.

1.8.3 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 1.8.2. 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.

1.8.4 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).

1.9 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.

1.10 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.

1.11 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.

1.12 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 4 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 4 months after the date of birth. 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 4 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 1 month has lapsed between the end date of your previous healthcare insurance and the start of your new healthcare insurance. This particular retroactive effect referred to in the previous sentence only applies 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 1 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 the 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 6 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 2 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.
d. if we are no longer able to communicate with you online as described in Article 1.3; you must therefore ensure that we also have your email address;
e. if the premium is no longer paid by direct debit, as described in Article 3.2.

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 2 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 2 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, in accordance with Section 9d(6) of the Healthcare Insurance Act.

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 7 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 7 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 such an obligation after a certain time, the insurance agreement will lapse with retrospective effect until such time as such obligation to be covered by health insurance does not exist (or no longer exists);
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. Your premium discount, if applicable, is stated on your policy schedule.

3.1.1 Calculation of the premium

Premium base	€ -
Discount on voluntary excess	€ -
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.

The premium for the Zorg Gemak Policy can only be paid by means of a direct debit. If you opt to pay the premium on a half-yearly or yearly basis, you are entitled to a discount over the premium due.

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 2 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 4 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 6 monthly premiums, we will actually report the matter unless you inform us within 4 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 4 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 4 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 6 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. Just as the premium, you can only pay the compulsory excess by means of a direct debit.

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 between 18 and 20 years of age;
d. nursing and care (district nursing) as described in Section B, Articles 27 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. contracted multidisciplinary care services for chronic conditions to the extent these involve multidisciplinary care;
j. the Quit Smoking programmes (including medication) approved by us, which you will find on **www.zorgenzekerheid.nl/vergoedingenzoeker**;
k. the Combined Lifestyle Intervention (CLI).
l. care aids on loan;
m. NIPT on medical grounds for pregnant women.

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)

Is an amount claimed under a DTP, integrated delivery care? Then the costs are deducted from the compulsory excess for the calendar year in which the DTP 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.

If you submit your healthcare expense claims directly to us, we will deduct any available compulsory 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 Voluntary excess

3.6.1 What is voluntary excess?

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

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. Furthermore, you can only pay the voluntary excess by means of a direct debit.

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 **www.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 **www.mijnZZ.nl**, by telephone at 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. 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 DTP, integrated delivery care are deducted from the voluntary excess for the calendar year in which the DTP, integrated delivery care 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 4 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 Your obligations

a. to ask the attending doctor or medical specialist to inform the medical advisor of Zorg en Zekerheid of the reason for the admission if the medical advisor requests this;
b. to cooperate with the medical advisor 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 (possible) liable third parties, in which case Zorg en Zekerheid will provide all necessary information and/or cooperation free of charge; the insured person/policyholder is not permitted, without a written statement of approval from Zorg en Zekerheid, to come to any arrangements with the liable third party or that third party's insurer concerning the costs that have been or will be reimbursed by Zorg en Zekerheid;
d. to report to Zorg en Zekerheid within 30 days that the insured person has been remanded in custody or that his or her detention has ended, in connection with the statutory provision regarding the suspension of coverage and the obligation to pay premiums during the term of detention;
e. to submit the original and clearly specified invoices to Zorg en Zekerheid before 31 December of the third year following the year in which the treatment took place. What is decisive in this respect is the date of treatment and/or 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 patient transport, a claim form from Zorg en Zekerheid for care provided abroad, patient transport must be used; for more information, see also **www.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 2.1.2), 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), certification or vaccinations, unless provided otherwise in the applicable ministerial regulations;
c. flu vaccination (unless you belong to a risk group);
d. alternative medicine/treatment;
e. medicines to prevent illness in connection with a journey;
f. maternity package, surgical dressings and sterile hydrophilic gauze for obstetric care;
g. treatments that require a referral and for which the referral was not requested/issued in advance;
h. claims resulting from failure to attend an appointment with a care provider;
i. treatments against snoring involving uvuloplasty;
j. treatments aimed at sterilisation;
k. treatments aimed at reversing sterilisation;
l. treatment aimed at circumcision of male insured persons, unless the treatment is medically necessary;
m. plagiocephaly and brachycephaly (skull deformations in infants) treatment without craniosynostosis with a redression helmet;
n. care provided outside the Netherlands, with the exception of costs as referred to in Article 22, 'Abroad';
o. examinations for treatments which are not generally accepted scientifically or are unusual in the context of the practice of the profession or specialism, or which are not included in the legal description of what the profession entails;
p. continued hospital admission, if our medical advisor is of the opinion that such continued admission is not necessary;
q. pre-natal screening for genetic defects other than by SEO (routine ultrasonography) in the second trimester of pregnancy, where there are no medical grounds;
r. if the costs are the result of damage caused by or arising from armed conflict, civil war, insurrection, internal civil commotion, riots and mutiny as provided in Section 3.38 of the Financial Supervision Act (*Wet op het financieel toezicht*, WFT);
s. if these are the result of or are connected with an armed conflict, active participation in civil wars, civil commotion either domestically or internationally, riots, revolts and mutiny.
t. 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;

4.2.2. Double cover

You are not entitled to care nor to reimbursement of the costs of care 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 and the Financial Institutions Incident Warning System Protocol (PIFI). 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 8 weeks. You can simply lodge your complaint with us by completing the online complaints form on our website: **www.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 1 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 27 October 2022 and to take effect on 01 January 2023.

Section B: Extent of the 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.

Are you using the services of a care contractor 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 groups

What am I entitled to?
Medical care as typically provided by general practitioners to specific patient categories (GZSP) is a group of care types for vulnerable people who are (still) living at home and present complex or highly complex issues. These include 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 provided by:
- geriatric care specialists;
- doctors for the mentally disabled;
- 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 a referral from your general practitioner or from a medical specialist.

Are you using the services of a care contractor 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. In the event this concerns dental or orthodontic care to be provided by a dental surgeon, you will need a referral from a dentist or an orthodontist. Such a referral will remain valid for 1 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor with whom we have not concluded a contract? In that case 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?

Prior written permission from Zorg en Zekerheid is required for reimbursement for oral care provided by a dental surgeon if the services concerned are included in the latest version of the *Limitatieve Lijst Machtigingen Kaakchirurgie* (Exhaustive List of Authorisations for Oral Surgery). To view this list, go to **www.zorgenzekerheid.nl/polisvoorwaarden**;

Are you using the services of 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 transgenders 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 **www.zorgenzekerheid.nl/polisvoorwaarden**. 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 **www.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 **www.zorgenzekerheid.nl**.

Are you using the services of 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.

Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

6.6 Inpatient care for CAR-T cell therapy

If you receive treatment for CAR-T cell therapy at a specialised hospital, you must stay within 60 minutes' travel distance from that hospital in weeks 3 and 4 of the treatment. If you live further away from the hospital, you must move to an address within that 60-minute radius temporarily. This can be a hotel or holiday home. The presence of an informal caregiver is sufficient in such cases.

What am I entitled to?
Reimbursement of accommodation costs during weeks 3 and 4 of the CAR-T cell therapy. The reimbursement is €82 per night.

What am I not entitled to?
Reimbursement of the accommodation costs incurred by the informal caregiver.

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;
- second-trimester structural ultrasound screening, also known as the '20-week ultrasound';
- counselling session for the ultrasounds in week 13 and week 20, both to be discussed in 1 session;
- NIPT only if you have a medical indication;
- all pregnant insured persons who have had a NIPT with a 'positive' result have an indication for follow-up examination, including invasive diagnostics;
- a CTG (cardiotocogram) performed by an obstetrician in the event of reduced life signs, impending serotinicity and non-invasive intervention to turn the baby from breech presentation to vertex presentation.

If you go to a non-contracted care contractor, then check Article 1.5 of these policy conditions for more information.

What are the conditions?
The care provider who performs the first- or second- trimester ultrasound to determine the stage of pregnancy or who performs the specific diagnostic ultrasound must be included in the relevant BEN (Dutch Professional Association of Sonographers) register.

To perform a CTG, the care provider must satisfy the following conditions:
- the care provider must have laid down clearly verifiable collaboration agreements on how to perform a CTG with gynaecologists in the Association for Obstetricians;
- the care provider must satisfy the professional standard for antenatal CTG in primary obstetrics care;
- the care provider must be identified in the relevant KNOV register as authorised to perform a CTG.

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;

- if you have to stay in hospital following delivery, Zorg en Zekerheid will reimburse the costs of the stay of your healthy child for breast-feeding, for as long as Zorg en Zekerheid is required to reimburse the costs of your hospitalisation and treatment.

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.

Are you using the services of a care contractor 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. We will settle this personal contribution with you.

What personal contribution do I need to pay?
The reimbursement for mother and child is €274 per day. This amount comprises the maximum reimbursement less the personal contribution owed for mother and child:

The maximum reimbursement is 2 x €137 = €274 per day
Less: personal contribution for maternity care 2 x €19 = €38 per day

If the hospital charges an amount higher than €274 per day, you will have to pay that amount yourself, in addition to the personal contribution for maternity care. 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. For more information, consult **www.zorgenzekerheid.nl/vergoedingenzoeker** or 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Pre-conception consultation

In the policy conditions, obstetric care is described as care before, during and after delivery. This entitlement does not cover care provided before the pregnancy itself. The costs of pre-conception consultation will not be reimbursed either if you decide to go to non-contracted care provider. We will refer you to your general practitioner for pre-conception consultation.

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). You may opt to receive the information and instructions in digital form if this option is available at your maternity care organisation.

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 register for maternity care no later than in the 20th week of your pregnancy, via the Zorg and Zekerheid Maternity Hotline (Kraamlijn) on **www.zorgenzekerheid.nl/aanvragenkraamzorg**;
- 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;
- the maternity carer must be registered with the Expertise Centre for Maternity Care (KCKZ).

In the case of digital information and instructions, the care contractor must satisfy the following conditions:

- the digital information and instructions are of the same quality as information and instructions in physical form;
- you must have given your prior consent to receiving information and instructions in digital form;
- the information and instructions are based on an indication system that is in accordance with the National Indication Protocol (LIP);
- the content of the digital information and instructions complies with the guidelines issued by the Expertise Centre for Maternity Care (KCKZ);
- the care contractor must ensure that the digital environment in which the information and instructions are provided is subject to a control mechanism which verifies that the mother who has recently given birth has understood the information and instruction materials;
- a care contractor who uses digital information and instructions can claim the relevant performance code once, in combination with one of the performance codes per hour of maternity care;
- the use of digital information and instructions can replace no more than 1 hour of physical maternity care and should not result in any additional hours indicated pursuant to the LIP;
- at all times, you are entitled to the minimum of 24 hours of physical maternity care.

Zorg en Zekerheid offers reimbursement for supplementary maternity care in most of its supplementary insurance policies. For the applicable reimbursements, see **www.zorgenzekerheid.nl/vergoedingenzoeker** or 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 €4.80 per hour towards the costs of maternity care. We will settle this personal contribution with you.

Most of our supplementary insurance policies include a reimbursement for this personal contribution. For more information, consult **www.zorgenzekerheid.nl/vergoedingenzoeker** or the policy conditions of the supplementary insurance policies under Delivery-related care.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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 of a patient with an indication for rehabilitation), and initially be accompanied by, a stay at an institution for specialist medical care, such as a hospital or an Independent Treatment Centre (ZBC);
  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 or, in 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 6 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 4 weeks before the end of the first 120 days) from Zorg en Zekerheid.

Are you using the services of a care contractor 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 6 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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 3 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 1 embryo will be returned in a first or second attempt;
- if the female insured person is between 38 and 42 years of age, 2 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;
- as regards the ICSI treatment, the criteria included in the in the Subfertility guideline.

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 3 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 9 weeks and 3 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 9 weeks and 3 days).

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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 9 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 9 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 listed 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 9 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 (chronic obstructive lung disease): reimbursement for supervised remedial therapy for COPD, in the case of stage II (moderate COPD) 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 **www.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. The physiotherapist (also known as hand therapist) is not permitted to charge you separately for the costs of measuring you for and making a hand/wrist splint. These costs are reimbursed via specific treatments that include the costs for work associated with splints.

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. All of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement that you receive under your basic insurance. For more information, refer to the policy conditions for the supplementary insurance policies regarding physiotherapy. For more information, go to **www.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 Individual Physiotherapy Register, the Quality Register for Physiotherapy NL or the Individual Register of the Physiotherapy Quality Mark Foundation;
- 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 (intermitent claudication)? In that case, your physiotherapist or remedial therapist must be registered for intermitent 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;
- is a splint to be made for you and are you to be measured for that purpose? If so, your physiotherapist must have a Dutch Hand Therapist Certificate (CHT-NL) issued by the de Netherlands Association for Hand Therapy (NVHT) and must be referred to as such on the NVHT website.

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 1 treatment. If the physiotherapist then proceeds to providing the treatment, this counts as another treatment. This means that the costs of 2 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 sessions by telephone (or video phone) and 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.

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 listed in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) or will you be treated for hip or knee joint arthrosis, pelvic physiotherapy to treat urine incontinence, Fontaine II intermittent claudication, 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 listed in Appendix 1 to the Health Insurance Decree (List of Chronic Disorders) and are you not being treated for hip or knee joint arthrosis, pelvic physiotherapy to treat urine incontinence, 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.

Are you using the services of a care contractor 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 sessions by telephone (or video phone) and 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;
- is a splint to be made for you and are you to be measured for that purpose? If so, your occupational therapist must have a Dutch Hand Therapist Certificate (CHT-NL) issued by the de Netherlands Association for Hand Therapy (NVHT) *and* must be registered as hand occupational therapist in the Quality Register for Paramedics (quality-registered status).

The occupational therapist (also known as hand therapist) is not permitted to charge you separately for the costs of measuring you for and making a hand/wrist splint. These costs are reimbursed via specific treatments that include the costs for work associated with splints. Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

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.

Are you using the services of a care contractor 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 with the relevant specialisation 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.

Are you using the services of a care contractor 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 3 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, see **www.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 sessions by telephone (or video phone) and 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 or collaborative venture. 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 3 treatment hours for dietary and/or nutritional advice mentioned above for the same indication or for issues associated with that indication.

Are you using the services of a care contractor 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 transgenders

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?
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 transgenders requires prior written approval (requested by the therapist) from Zorg en Zekerheid.

Are you using the services of a care contractor 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;
- replacement or repair of the prosthesis, implanted or otherwise, as the result of careless use.

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).

Are you using the services of a care contractor 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 1 check a year;
b. incidental dental consultations;
c. removal of tartar;
d. a maximum of 2 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' on **www.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 **www.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 5 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 **www.zorgenzekerheid.nl/polisvoorwaarden**;
- entitlement to care as referred to in Article 18.3(b), if the full dentures whether or not supported by implants (with the exception of immediate dentures) are replaced within 5 years after purchase. A 5-year term of use is indicative and not determinative with regard to the insured person's entitlement to standard replacement of the dentures after 5 years;
- taking and assessing multi-dimensional jaw X-rays;
- taking and assessing multi-dimensional jaw X-rays;
- all care for the mesostructure (push button or bar-joint system) and/or a prosthesis on implants, provided the care provider acts in accordance with the guidelines issued by the Dutch Association for Oral Implantology, NVOI);
- placement of implants by a non-contracted care provider;
- replacement of a set of full dentures on implants that is more than 5 years old must be requested by a non-contracted dentist or a non-contracted dental technician.

the dentist or denta technician 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.

As regards dental care in special cases, you are entitled to anaesthesia or nitrous oxide (laughing gas) treatments if such treatments are included in a programme to help you cope with fear.

Does Zorg en Zekerheid need to approve this beforehand?
You will need prior written approval from Zorg en Zekerheid for dental care in special cases, including any anaesthesia or nitrous oxide (laughing gas) treatments if such treatments are included in a programme to help you cope with fear. 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.

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 as provided by pharmacists. Such care includes the supply of medicines, or advice and assistance as provided by pharmacists in assessing medication and the responsible use of medicine. The care is provided by public pharmacists, dispensing general practitioners and other specialised medical suppliers such as online pharmacies ('pharmacist' bellow). These pharmacists are listed in the register of established pharmacists as referred to in Section 61 of the Medicines Act (*Geneesmiddelenwet*). Some types of care, such as a pharmaceutical consultation or a medication assessment interview, are charged to Zorg en Zekerheid separately, i.e. in addition to the provision of the medicine concerned. Article 19 and all of its provisions are subject to the Pharmaceutical Care Regulations, which are available on **www.zorgenzekerheid.nl/polisvoorwaarden**.

Pharmaceutical care comprises the following:

- the dispensing of a medicine for which a prescription is required and which has actually been delivered to you;
- the dispensing of plus counselling interview for a medicine that is new for your and for which a prescription is required. A new medicine is understood to be a medicine with the same active ingredient and administration method that has not been provided to you before or that was provided to you at least 12 months ago;
- the provision of medicines once every week or every number of weeks. This type of provision is known as an individualised distribution method. This is only possible when it is necessary from a medical and/or pharmaceutical perspective for you to take your medicines by way of an individualised method. In addition, an intake interview must be held, the use and medical necessity must be evaluated periodically and you and your doctor (and/or your carer) must be issued a full medication overview including the times you should take those medicines. The pharmacist and your prescriber 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 1 instruction per aid, except in the case of identified erroneous use;
- a medication assessment interview. Together with you and your prescriber, the pharmacist will assess the chronic prescription medicine use based on the relevant medical, pharmaceutical and patient-related information. This is only possible if deemed necessary from a medical and/or pharmaceutical perspective - which, in principle, is once a year. The medication assessment interview 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.

Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions. Article 1.5 also applies to medicines and to the dispensing interview.

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 (see b. and c.);

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 generic medicine. In addition, Zorg en Zekerheid applies the preference policy 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. This means that in that case only the costs of the designated medicine will be reimbursed, and those of the non-branded medicine (if applicable) will not. Reimbursement of preferred medicines as included in the Pharmaceutical Care Regulations. These regulations are available on our website and are updated on a monthly basis on **www.zorgen zekerheid.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. 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 2023, Zorg en Zekerheid may decide to designate or change the designation of one or more preferred medicines. The preferred medicines concerned are published on **www.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 designated preferred medicine or the generic (non-branded) medicine would, in your case, be medically irresponsible. In such a case, you may qualify for reimbursement of the most effective non-designated medicine, based on medical necessity. To that end, your doctor will have to state on the prescription that treatment with the medicine concerned is a 'medical necessity' and must also be able to substantiate that claim if requested by Zorg en Zekerheid. For example, by referring to evidence that a particular excipient (not the active ingredient itself) in one or more non-branded medicines produces such effects in your body that your prescriber is of the opinion that it would not be medically responsible for you to use those medicines. In such a case, your pharmacist will decide which most effective medicine to give you on the basis of the prescription and your doctor's explanation. If Zorg en Zekerheid has doubts about the grounds for medical necessity, they will contact your doctor. If the pharmacist has doubts about the medical necessity, he or she may apply for a second opinion from Zorg en Zekerheid using the 'Request for Reassessment of Medical Necessity' Form.

Preferred medicines
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 **www.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.

Preference policy and excess
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.
If you use a medicine other than the preferred medicine, the pharmacist should claim the costs directly from Zorg en Zekerheid. You do not have to pay for those medicines yourself at the pharmacy.

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;

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. Reimbursement is conditional upon the following:
   - you depend on the medicine concerned for more than 6 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 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 and, if applicable, the provisions of the following paragraph are met (lowest price in the case of interchangeable pharmacy preparations). 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 contractor is based on the lowest price stated in the public pharmacists' price list. 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 (imported medicines), if the medicine is intended to replace a medicine registered in the Netherlands 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. You are only entitled to reimbursement of imported medicines if the medicines concerned have been approved by the Inspectorate for Health and Youth Care (IGJ).

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, medicines must be prescribed by a general practitioner, medical specialist, dentist, dental specialist or midwife and must be dispensed by a pharmacist;
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. For the conditions concerning the medicines in Appendix 2 and the associated forms, go to www.znformulieren.nl. Medicines that come under Appendix 2, group 4, are subject to specific conditions formulated by Zorg en Zekerheid and are mentioned in the Pharmaceutical Care Regulations. Your prescribing doctor is responsible for filling in the medical certificate. The pharmacy will immediately assess whether you satisfy the stipulated conditions based on a completed medical certificate from your prescriber. You should submit the medical certificate to the pharmacy along with the prescription. 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 upon commencement of the use of a new medicine. This also applies to anti-depressants and ADHD medicines;
    - 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. This also applies to anti-depressants and ADHD medicines;
    - at least 1 month before any follow-up dispensation if the medicine is listed in the Opium Act, such as opioids, benzodiazepines and hypnotics;
    - a maximum of 1 month if the costs per medicine per month, including VAT, exceed €1,000 (expensive medicines), or the smallest trade pack if the cost of a trade pack, including VAT, exceeds €1,000, unless

otherwise agreed with the pharmacist. As regards expensive medicines, after the 6-month titration period, medicines in this group can be dispensed for no more than 3 months;
- up to a maximum of 6 months if you are staying abroad. By way of exception to the above, up to a maximum of 3 months for medicines in the group of expensive medicines and roll-pack medicines (individualised distribution);
- a maximum of 12 months if it concerns oral contraceptives. If this is your first time taking oral contraceptives, the maximum period is 3 months;
- as regards the use of insulin, you will only need a prescription the first time. You will need a new prescription upon an insulin change;
- in principle for a maximum of 15 days for medicines used as part of intensive care provided at home (pharmaceutical care following discharge and/or during the palliative and terminal phases). 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;
- at least 2 weeks in the case of the supply of medicines with an individualised distribution method, unless there is a medical and/or pharmaceutical need to deviate from this.

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).

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 **www.zorgenzekerheid.nl/polisvoorwaarden**.
g. costs of transport of the imported medicine.

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 **www.zorgenzekerheid.nl/geneesmiddelen**;
- Medicines in group 4, Appendix 2 that are added to Appendix 2 in the course of the year require per approval from Zorg en Zekerheid as they may be subject to additional conditions. If no approval is required, this will be mentioned in the Pharmaceutical Care Regulations on our website;
- reimbursement of an imported medicine requires prior permission from Zorg en Zekerheid;
- to qualify for reimbursement of expensive medicines and roll-pack medicines (individualised distribution) as referred to in Article 19.2, 'What are the conditions?', letter c, you will need permission if you stay abroad for more than 3 months;
- for starting an individualised distribution method with 1 to 4 medicines, you will need prior permission from Zorg en Zekerheid;
- in the case of expensive medicines and supply of roll-pack medicines (individualised distribution), Zorg en Zekerheid will grant permission, only after authorisation, for reimbursement for a period of up to 6 weeks.

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. The Minister of Health, Welfare and Sport determines whether a maximum applies or whether the maximum price must be changed, which will have consequences for your personal contribution. 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.

Are you using the services of a care contractor 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 (for the assessment of which your attending physician or dietician must fill in a medical certificate, to be found at www.znformulieren,nl) and if you:

- suffer from a metabolic disorder, food allergy or resorption disorder;
- are less than 2 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 liquid nutrients for medical use you are entitled to the following:

- a starter pack containing – if therapeutically feasible – multiple flavours and variants for a maximum of 2 weeks. If the consumption period is shorter than 2 weeks, the duration of the starter pack will be adapted accordingly;
- any subsequent (automatic) supplies for a maximum of 1 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?

- based on the completed ZN form for diet preparations, the supplier of medical nutrition has ascertained that the conditions are met. If supply is arranged via the pharmacy, only compliance with the conditions with respect to dietary liquid nutrition can be ascertained;
- drip-feed preparations should only 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.

Are you using the services of a care contractor 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:

- whether the insured person acquires ownership of the care aid or acquires it on loan;
- 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 minimum usage period of the care aid concerned;
- the maximum quantities in the case of consumable items;
- the maximum reimbursement or statutory personal contribution;
- the quality requirements to be met by the care contractor that delivers the care aid.

You can consult the Care Aids Regulations on **www.zorgenzekerheid.nl/polisvoorwaarden**. You can also obtain information by phoning Zorg en Zekerheid on (071) 5825 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.

Are you using the services of a care contractor 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:
- ambulance transport, which refers to transportation by ambulance when medical assistance is required during the journey;
- patient transport, which refers to transportation by public transport, (wheelchair) taxi or car (including a private car) without the need for medical assistance during the journey.

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?
This concerns ambulance transport:
a. to a hospital, person or healthcare institution where the insured person will receive care the costs of which are covered in full or in part under the healthcare insurance;
b. to a healthcare institution where the costs of your stay will be covered in full or in part under the WLZ;
c. to a person or healthcare 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 hospital, care provider or other healthcare 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 care provider or healthcare institution as referred to under a. through d.

What else do I need to know?
The ambulance 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 2 companions.

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

The costs of public transport to be reimbursed are calculated on the basis of the shortest route and the fares mentioned on public transport website www.9292.nl.

What are the conditions?
You will only qualify for patient transport if you satisfy one of the conditions mentioned under 'What are the conditions?' in Article 21.2 and 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 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. you eyesight is limited to such an extent that you are unable to move without assistance. This will be determined with reference to the guidelines of the professional association;
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 undergo day treatment as part of a treatment programme to address chronic progressive degenerative conditions, non-congenital brain injuries or an intellectual disability.

Does Zorg en Zekerheid need to approve this beforehand?
- Reimbursement of patient transport by (wheelchair) taxi requires prior written approval from Zorg en Zekerheid. For this purpose you must request the patient transport as described in Article 21.4;
- if the patient transport is not possible by public transport, (wheelchair) taxi or privately owned car, you may request Zorg en Zekerheid in advance for permission for patient 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 €0.37 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 (at the lowest available fare) are reimbursed on the basis of the shortest regular distance. The distance will be calculated on the basis of the shortest route and the lowest available fare (second class) according to public transport website 9292.nl;
- patient transport also includes the transport of a companion if medically necessary, or if the patient is a child under age 16. In exceptional cases, Zorg en Zekerheid may permit the transport of 2 companions. If you wish to use a companion, you must apply for permission in advance;
- 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 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 patient transport may be replaced by a contribution towards the accommodation expenses (up to €82.00 per night). A reimbursement for accommodation expenses can only be provided if you meet the conditions listed in Article 21.3 and if the patient transport to and from an institution is required on at least 3 consecutive days. In the case you need accommodation, the insured person may claim reimbursement of the costs of patient transport for the return trip.

In order to maximise the efficiency of transport by (wheelchair) taxi, you may be transported together with other people. To make patient transport as agreeable as possible, we have made agreements with our transport company regarding combined transportation (e.g. detours and pick-up times).

Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

21.4 Applying for patient transport

How can I apply for patient transport?
If you meet the conditions in Article 21.3, you may apply for patient transport as follows:
- if transport by taxi is required (for wheelchair users or otherwise), you can request permission by submitting the 'Patient Transport' application form (**www.zorgenzekerheid.downloands**) or by calling the Transport Line at telephone number (071) 5 825 700. If you have received permission to use a (wheelchair) taxi, you can book your transport at Zorgvervoercentrale Nederland (ZCN) using the ZCN Transport App or by calling telephone number (010) 280 81 82;
- you do not need to ask for permission in advance for reimbursement of the costs of private or public transport if you meet the conditions in Article 21.3.

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

You may apply for a contribution towards accommodation expenses by submitting the Accommodation Reimbursement Application Form (**www.zorgenzekerheid.nl/brochures**).

21.5 Personal contribution towards patient transport

Do I need to pay a personal contribution?

The costs of patient transport are subject to a personal contribution of €113 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 patient transport from the WLZ institution where you receive in-patient treatment to the healthcare institution where you need to go for a specialist examination or specialist treatment, plus the return trip to your WLZ institution;
- transport to and from institutions that are funded under exceptional medical expenses insurance. This concerns transport from the WLZ 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 WLZ 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 WLZ institution;
- reimbursement for accommodation expenses. Please note: the costs of patient transport to and from your accommodation do come under your personal contribution.

A number of Zorg en Zekerheid's supplementary insurance policies offer reimbursement of the personal contribution towards patient transport. For more information, refer to the policy conditions for supplementary insurance policies in Article 14.3.

21.6 How to claim the costs of patient transport or accommodation

How can I claim the costs incurred?

To claim the costs of private transport, public transport or accommodation retroactively, you must fill in the Claim Form for Transport and Accommodation Costs. You should send the appointment card and, in the case of public transport, the invoices, to Zorg en Zekerheid along with the claim form. We will then use these details to assess the entitlement to reimbursement of patient transport and/or accommodation.

For the submission deadlines, see the conditions in Article 4.1.1(e). For questions regarding patient transport or the reimbursement of accommodation expenses, please contact Zorg en Zekerheid at telephone number (071) 5 825 825.

Article 22: Abroad

What am I entitled to?

You are entitled to (your choice):

- care provided abroad by a non-contracted foreign or Dutch 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 abroad that is provided by a foreign or Dutch care provider 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 abroad 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 abroad from a foreign or Dutch care provider 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.

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 1 night).

Article 23: Mental healthcare

What am I entitled to?
You are entitled to mental healthcare as typically provided by psychiatrists and clinical psychologists. Specialist mental healthcare is available to insured persons from age 18.

What are the conditions?
- this should involve an independent practice or a mental healthcare institution and a coordinating treatment provider who has drawn up the indication and is able to show proof of at least meeting the training and other requirements and having the competencies necessary in view of the complexity of the problems concerned as required under the applicable National Mental Healthcare Quality Charter (see www.zorginzicht.nl/kwaliteitsinstrumenten/ggz-landelijk-kwaliteitsstatuut);
- this should involve an independent practice or mental healthcare institution and a coordinating treatment provider who has drawn up the indication and is able to show proof of assuming all the tasks and responsibilities he/she is charged with under the applicable National Mental Healthcare Quality Charter in full;
- at a mental healthcare institution, fellow treatment providers may be engaged. A fellow treatment provider is authorised to carry out part of the treatment as coordinated by the coordinating care provider;
- this should involve a mental healthcare institution where the coordinating care provider who has drawn up the indication has a substantial share in the treatment and care process;
- this should involve an independent practice where the coordinating care provider who has drawn up the indication provides most or all of the treatment and care himself/herself;
- only care providers included in Zorg en Zekerheid's list of consultation-registering professions or list of curative mental healthcare professions can perform tasks as fellow treatment providers. Both these lists are available on **www.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 care contractor holds a valid quality charter under the applicable National Mental Healthcare Quality Charter. The National Mental Healthcare Quality Charter is included in the Quality Standards and Measurement Instruments Register of the National Health Care Institute (Zorginstituut Nederland). The care contractors must submit the quality charter to www.ggzkwaliteitsstatuut.nl and demonstrably comply with all of its provisions;
- you may not transfer your claim on us to a third party. This is a stipulation as referred to in Section 3:83(2) of the Dutch Civil Code. You would be doing so if you went to a care contractor that has not been contracted by Zorg en Zekerheid. We will transfer the reimbursement to which you (the policyholder) 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.

Do I need a referral?
A referral from a general practitioner, company doctor or medical specialist is required for 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 patient who is being referred;
- the reason for the referral (the diagnostic details need not be visible);
- the party being referred to;
- 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 9 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 9 months after the end of the prior treatment. If the treatment is interrupted for more than 9 months, a new referral will be required to qualify for follow-up treatment.

We abide by the 'Referral Agreements for Mental Healthcare' of the Ministry of Health, Welfare and Sport dated 1 January 2020. To view this document, go to **www.zorgenzekerheid.nl/ggzdocumenten**.

23.1 Outpatient mental healthcare from age 18

What am I entitled to?

You are entitled to outpatient mental healthcare:

- at an independent practice;
- at an institution for mental healthcare;
- insured persons who turn 18 during the course of the treatment (which began under the Youth Act) qualify for the transitional scheme if the treatment is to be continued or completed under the Healthcare Insurance Act. If the patient/client wishes to maintain the existing treatment relationship and continue the care with the existing (coordinating) care provider but is prevented from doing so by the obligation arising from the National Mental Healthcare Quality Charter, the patient/client can avail themselves of the transitional scheme. This is subject to the following conditions:
  - the patient was already being treated by the coordinating care provider before turning 18;
  - the coordinating care provider is registered as a post-Master in the Quality Register for Youth Care Providers (SKJ) or the Individual Healthcare Professions (BIG) Register;
  - continuation of the treatment is aimed at completing the treatment or transferring it;
  - the maximum treatment period is 365 days following the day the patient/client turns 18;
  - continuation of the treatment is subject to the same preconditions as those that apply under the Youth Act and the policy rules for curative mental healthcare.

  Contractors who only provide care on the basis of this transitional scheme under the Healthcare Insurance Act are not required to formulate a quality charter.

What am I not entitled to?

- 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;
- 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;
- 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, We will do so based on the 'GGZ Therapies' recommendation of Zorgverzekeraars Nederland or any subsequent additional recommendations. To view these recommendations, go to **www.zorgenzekerheid.nl/ggzdocumenten**;
- specialised care or addiction treatment care primarily aimed at resocialisation.

Does Zorg en Zekerheid need to approve this beforehand?

You will have to apply for prior permission in writing if you decide to stay at a non-contracted care institution for outpatient mental healthcare. To apply for permission, the care provider must send to Zorg en Zekerheid on your behalf:

a. a letter of referral from your general practitioner, medical specialist or company doctor;
b. the indication (demonstrating your dependence on mental healthcare), including a DSM-5 diagnosis established by the coordinating care provider who has also drawn up the indication;
c. the treatment plan drawn up and adopted by the coordinating care provider who drew up the indication, in consultation with the patient and any fellow treatment providers and consulted colleagues, including the number of minutes of treatment and the activities to be performed;
d. the names and professions of the care providers, including the indicating and coordinating care provider (stating the BIG registration number), who are involved in the provision of the care;
e. the type of care need and the performance code.

Are you using the services of a care contractor with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

23.2 Clinical mental healthcare 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 3 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 3 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 3 years (1,095 days);
- normal medical 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;
- the admission is medically necessary as part of the treatment;
- insured persons who turn 18 during the course of the treatment (which began under the Youth Act) qualify for the transitional scheme if the treatment is to be continued or completed under the Healthcare Insurance Act. If the patient/client wishes to maintain the existing treatment relationship and continue the care with the existing (coordinating) care provider but is prevented from doing so by the obligation arising from the National Mental Healthcare Quality Charter, the patient/client can avail themselves of the transitional scheme. This is subject to the following conditions:
  - the patient was already being treated by the coordinating care provider before turning 18;
  - the coordinating care provider is registered as a post-Master in the Quality Register for Youth Care Providers (SKJ) or the Individual Healthcare Professions (BIG) Register;
  - continuation of the treatment is aimed at completing the treatment or transferring it;
  - the maximum treatment period is 365 days following the day the patient/client turns 18;
  - continuation of the treatment is subject to the same preconditions as those that apply under the Youth Act and the policy rules for curative mental healthcare.

  Contractors who only provide care on the basis of this transitional scheme under the Healthcare Insurance Act are not required to formulate a quality charter.

What am I not entitled to?

- 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 mental healthcare. To apply for this permission, the care provider must send to Zorg en Zekerheid on your behalf:
  a. a letter of referral from your general practitioner, medical specialist or company doctor;
  b. the indication for admission to an institution as adopted by the coordinating treatment provider who has drawn up the indication;
  c. the treatment plan drawn up and adopted by the coordinating care provider who drew up the indication, in consultation with the patient and any fellow treatment providers and consulted colleagues, including the number of minutes of treatment and the activities to be performed;
  d. the names and professions of the care providers, including the indicating and 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 type of care need and the performance code.
- Continuation of a stay that takes or is expected to take longer than 1 year (second and third years of stay) requires prior written approval (which must be applied for at least 2 months before the end of the first year) from Zorg en Zekerheid.

  The application should state the reasons why the stay is necessary, the accommodation class and an indication of the expected duration of the continued stay. In individual cases, the medical advisor may request access to the treatment plan. An admission checklist must be available that reflects the long-term indication. Such a checklist for continued stay at an institution is available on **www.zorgenzekerheid.nl/ggzdocumenten**.

Are you using the services of a care contractor 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.

What am I not entitled to?
Self-management courses not provided by a general practitioner or medical practice assistant are expressly excluded from the chain.

What are the conditions?
Multidisciplinary care is provided in the event of a specific chronic condition (COPD, CVRM and diabetes mellitus type 2). The general practitioner acts as the primary treatment provider and 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.

Are you using the services of a care contractor 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 preventive foot care as generally provided by general practitioners to insured persons with an elevated risk of foot ulcers. This care can be provided by podiatrists, medical pedicurists or specialised pedicurists. Medical or specialised pedicurists provide the care on the instruction of 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 as described in the care module entitled 'Prevention of Diabetic Foot Ulcers, 2019'. This also applies if diabetes mellitus is *not* the cause of the elevated risk of foot ulcers. The same care profiles are used in this case. An exception is the annual foot check, for which Care Profile 1 is the minimum;
- the care must be provided by a podiatrist, a medical pedicurist or a specialised pedicurist;
- if the elevated risk of foot ulcers is caused by diabetes mellitus types 1 or 2, the care can be provided by a specialised pedicurist who holds an additional 'Foot care for diabetics' qualification, as well as by a podiatrist or medical pedicurist;
- if the cause is to be found in a condition other than diabetes mellitus types 1 or 2, the care can be provided by a specialised pedicurist who holds an additional 'Rheumatoid foot' qualification, as well as by a podiatrist or medical pedicurist;
- care provided by the medical pedicurist or specialised pedicurist only qualifies for reimbursement if the pedicurist is contracted by a podiatrist; For more information, go to **www.zorgenzekerheid.nl**;
- the care provider must be registered with a suitable General Database Code (AGB Code) for a podiatrist or pedicurist in the Vektis AGB register.

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.

Are you using the services of a care contractor 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?
The Quit Smoking programme comprises medical care aimed at changing behaviour so as to help the client quit smoking. To support the effort to quit smoking, you are entitled to the medicines prescribed for this purpose. You can attend the programme as part of a group or on an individual basis. Both the medical care and the medicines provided in support of the Quit Smoking programme are exempt from your excess.

What are the conditions?
- you are entitled to only 1 Quit Smoking programme per calendar year;
- the care contractor must be registered in the Quit Smoking Quality Register.

Are you using the services of a care contractor 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.

Are you using the services of a care contractor 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. District nursing concerns care provided in the patient's own environment (i.e. at home), at work or during day-care activities. The care is not associated with a stay as referred to in Article 2.12 of the Healthcare Insurance Decree and does not qualify as maternity care as referred to in Section 2.11 of that decree.

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 nursing specialist, nurse or Level-3 care-giver.
- 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. This is a stipulation as referred to in Section 3:83(2) of the Dutch Civil Code. You would be doing so if you went to a care contractor that has not been contracted by Zorg en Zekerheid. We will transfer the reimbursement to which you (the policyholder) 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;
- if the patient only needs care and there is no medical context within which such care is provided, this comes under the Social Support Act (WMO). For example, this concerns support during daily activities if you are not sufficiently able to care for yourself, due to a psychiatric condition or impairment, for example, or to a mental or sensory disability.

Do I need a referral?

You do not need a referral to qualify for nursing and care.

Does Zorg en Zekerheid need to approve this beforehand?

You will need prior written permission from Zorg en Zekerheid:

- if you wish to engage a newly contracted care contractor for district nursing. This concerns a care contractor that has been contracted for 2023 but was not contracted in 2022. You can find the care contractors concerned on **www.zorgenzekerheid.nl/zorgzoeker**.
- if you wish to engage a non-contracted care provider.
  To apply for permission, use the form available for that purpose on **www.zorgenzekerheid.nl/brochures**;

Are you using the services of a care contractor 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 **www.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 must be drawn up by the general practitioner or medical specialist, an A&E physician or geriatric care specialist; admission is subject to consultation with the admitting treatment provider;
- the care must be provided by a care-giver within the meaning of the Individual Healthcare Professions Act, at level 3 or higher. The primary nurse is a nurse with Level 4 accreditation or higher;
- upon admission to 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 Healthcare and Care Contractors (Accreditation) Act (*Wet toetreding zorgaanbieders*, WTZA).
- 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 2 weeks before the end of the 91-week period.

Are you using the services of a care contractor 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 reducing caloric intake and increasing physical activity to support the change in 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 as a lifestyle coach. 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 GLI must have an initial indication of effectiveness designation 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 care provider offering the lifestyle advice must be able to show a valid licence from the licence holder of the CLI programme being offered or is the licence holder himself or herself;
- 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 need a written referral from the general practitioner, internist or cardiologist.

Are you using the services of a care contractor 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

Any questions? Visit **www.zorgenzekerheid.nl** for a wealth of additional information. Alternatively, you can get in touch with our Contact Centre by phone on (071) 5 825 825. They are 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 **www.zorgenzekerheid.nl/mijnzz**.

How do I get my invoice reimbursed?

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

You can submit invoices as follows:

- write your personal customer number on your original invoice(s) and submit your invoice(s) online via MijnZZ **www.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;
  or:
- submit your invoice using the **Zorg en Zekerheid claim app** (free download from the App Store or Google Play Store);
- 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 **www.zorgenzekerheid.nl/brochures** or request it from Zorg en Zekerheid. You can send the original invoice with the claim form postage paid to:

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

A single IBAN

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

Policy Conditions 2023 Supplementary Insurance AV-Gemak

Zorg en Zekerheid
Beter in jouw buurt

Basic Insurance

Supplementary Insurance

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 and the maximum amount of reimbursement you are entitled to, as adopted by the Members' Council on 27 October 2022. 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 **www.zorgenzekerheid.nl/vergoedingenzoeker**. Together, the insurance terms and conditions and this section constitute the Terms and Conditions for your supplementary insurance with Zorg en Zekerheid.

Article 1: Paramedical treatments

1.1 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);
- non-contracted physiotherapy and remedial therapy.

Non-contracted physiotherapy and remedial therapy
Please note: if you go to a non-contracted physiotherapist or remedial therapist, you will not receive any reimbursement. A list of contracted care providers can be found at **www.zorgenzekerheid.nl/zorgzoeker**.

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.

The physiotherapist (also known as hand therapist) is not permitted to charge you separately for measuring you for and making a hand/wrist splint. These costs are reimbursed via specific treatments that include the costs for work associated with splints.

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 Individual Physiotherapy Register, the Quality Register for Physiotherapy NL or the Individual Register of the Physiotherapy Quality Mark Foundation;
- 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.
- is a hand splint to be made for you and are you to be measured for that purpose? If so, your physiotherapist must have a Dutch Hand Therapist Certificate (CHT-NL) issued by the de Netherlands Association for Hand Therapy (NVHT) and must be referred to as such on the NVHT website.

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 sessions by telephone (or video phone) and 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, COPD Gold class II or higher, or for urine incontinence through pelvic floor physiotherapy? 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, COPD Gold class II or higher, or for urine incontinence using pelvic floor physiotherapy? 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. For the maximum reimbursements for non-contracted care, go to **www.zorgenzekerheid.nl/nietgecontracteerd**. 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).

A list of contracted care providers can be found at **www.zorgenzekerheid.nl/zorgzoeker**.

How much reimbursement will I receive under my supplementary insurance?

AV-Gemak **AV-Gemak Regio**
A maximum of 9 treatment sessions * reimbursement in conjunction with remedial therapy

Article 2: 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 2.1.1 and 2.1.2. You will find the reimbursements that apply to the corresponding care categories at **www.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?

- dental care for insured persons under 18 (these costs primarily fall within the scope of the basic insurance);
- statements of good dental health;
- appointments not cancelled in time;
- the costs of X-ray diagnostics combined with an examination exceeding €35 per calendar year;
- the costs of M01 (preventive information), M02 (evaluation) and M03 (dental cleaning) together in excess of 15 minutes per calendar year;
- the costs of orthodontic treatment (F codes);
- the costs of dental implants (J codes);
- the costs of dentures (P codes);
- replacement or repair of equipment as the result of careless use;
- taking and assessing multi-dimensional jaw X-rays;
- medical procedures or treatments by a dental technician;
- bleaching of elements;
- a trigger point botox treatment.

2.1 Dental care for insured persons from age 18

2.1.1 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-Gemak **AV-Gemak Regio**
75%, up to a maximum of €250

The maximum amount per supplementary insurance also applies for the dental treatments referred to under Articles 2.1.1 and 2.1.2 together.

2.1.2 Other dental treatments

What is reimbursed?

- the necessary dental treatments, invoiced by a dentist;
- the necessary dental treatments, invoiced by an independent oral hygienist or registered oral hygienist. You will find the reimbursements that apply to the corresponding care categories at **www.zorgenzekerheid.nl/vergoedingenzoeker**;
- mouth protectors made and invoiced by a dentist.

How much reimbursement will I receive under my supplementary insurance?

AV-Gemak **AV-Gemak Regio**
75%, up to a maximum of €250

The maximum amount applies for the dental treatments referred to under Articles 2.1.1 and 2.1.2 together.

2.2 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?

- You are required to report the accident to us within 690 days. See **www.zorgenzekerheid.nl/verhaalszaken** for instructions on how to report the accident to us;
- 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;
- that were anticipated and do not arise from an accident;
- of treatment abroad;
- of orthodontic care;
- arising from an accident abroad later than one year following the date of the accident.

How much reimbursement will I receive under my supplementary insurance?

AV-Gemak **AV-Gemak Regio**
100%, up to a maximum of €10,000 per event

Article 3: Optic care

3.1 Spectacle lenses, spectacle frames, contact lenses and premium lenses

What is reimbursed?
Every three calendar years, to be counted from the date of purchase of the spectacles or contact lenses, the purchasing costs of spectacle lenses, spectacle frames and contact lenses or premium lenses for each insured person are eligible for reimbursement.

If you take out a different supplementary insurance policy with us, 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.

If you received reimbursement for spectacles or contact lenses from us in 2022, you will not qualify for a new pair of spectacles or for new contact lenses, if required, until 2024, in derogation from the above and if you have supplementary insurance.

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 spectacle lenses, spectacle frames, contact lenses and premium lenses combined.

AV-Gemak Regio	**AV-Gemak**
No reimbursement	A maximum of €25 once every two calendar years

Article 4: Pharmaceutical care

Under your supplementary insurance, you will only be eligible for reimbursement if the provisions of Article 19 of Zorg en Zekerheid's basic healthcare insurance (including the Pharmaceutical Care Regulations) and the resulting conditions, such as the prescription regulations, medical necessity stipulations and generic substitution (preferred medicines policy and lowest-price policy) are satisfied.

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 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;
- oral contraceptives ('the pill') are subject to a maximum delivery period of twelve months. If this is your first time taking oral contraceptives, the maximum period is 3 months;
- 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 **www.zorgenzekerheid.nl/polisvoorwaarden.**

What am I not entitled to?
You are not entitled to any GVS personal contribution.

How much reimbursement will I receive under my supplementary insurance?

AV-Gemak Regio	AV-Gemak
No reimbursement	100%, from age 21 (excluding the GVS personal contribution)

Article 5 Reimbursement for sport

5.1 Sports association membership

What is reimbursed?
The membership fee for a sports association for every paying insured person (from 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 2022-2023 will be charged against the 2021 calendar year and will not be paid in 2023.

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-Gemak Regio	AV-Gemak
100%, up to a maximum of €25	No reimbursement

Module for Care Abroad

The Module for Care Abroad is a separate supplementary insurance. The Module for Care Abroad only covers reimbursement of the costs of urgent care abroad.

1.1 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 assistance abroad will be reimbursed if the following conditions are met:

- the costs have been incurred during a holiday or business trip, work placement or period of study;
- upon departure to a foreign country it could not be foreseen that the medical care would be needed;
- obtaining medical care was not the sole reason or one of the reasons for the stay abroad;
- it would not be medically justifiable to delay the treatment until the person returns to the Netherlands;
- in the case of hospital admission, long-term medical treatment or more than two treatments at the outpatients' clinic, ANWB International Assistance (ANWB Alarmcentrale) is contacted promptly. This service should preferably be contacted by calling (+31 71 5 825 444), by e-mail (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.

1.2. Medical costs

What is reimbursed?

The medical costs of the following types of urgent and necessary care 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 €0.37 per kilometre. The reimbursement will in all cases be limited to a maximum of € 115 per holiday and/or business trip;
- medicines or bandaging aids on prescription from a doctor or medical specialist abroad.

What are the conditions for reimbursement?

The General Terms and Conditions referred to in Article 1.1 are met.

How much reimbursement will I receive under my supplementary insurance?

Module for Care Abroad
100%

1.3 Medically necessary repatriation to the Netherlands and dispatch of medicines

What is reimbursed?

The following costs are eligible for reimbursement:

- medically necessary repatriation to the Netherlands of the ill or injured insured person (including the required and medically necessary persons accompanying him or her);
- transfer of the insured person's mortal remains to the Netherlands, and;
- the dispatch of medicines that are urgently needed and medically necessary.

What are the conditions for reimbursement?

- the repatriation mentioned above (including persons accompanying the insured person), the transfer of the insured person's mortal remains and/or sending of medicines was performed by or on the instruction of ANWB International Assistance, following prior approval;
- medicines can be sent insofar as permitted by customs regulations;
- there must be an urgent medical need for the medicines, which must not be available in the country the insured person is staying in and must be prescribed by a doctor;
- the General Terms and Conditions referred to in Article 1.1 of the Module for Care Abroad are met.

Which costs do not qualify for reimbursement?

The costs of repatriation on social (non-medical) grounds do not qualify for reimbursement.

How much reimbursement will I receive under my supplementary insurance?

Module for Care Abroad
100%

1.4. 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). This does not apply if, in the case of level 'orange', you are able to demonstrate that your stay was necessary (and was not a holiday) or if the travel warning was changed during your stay and you take the first opportunity to return to the Netherlands, irrespective of the costs;
b. costs arising from high-risk sports such as hang-gliding, parachute jumping and fighting sports, bicycle racing competitions, rugby, wild water sports, horse racing, competitive ocean sailing and mountain trekking other than on marked paths and trails, and diving (without a licence or professional supervision), ski jumping, ski flying, ski mountaineering, off-piste ski touring, off-piste glacier skiing, off-piste 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));
c. costs relating to pregnancy or delivery after the 35th week;
d. costs relating to alternative care with respect to treatment as well as medication;
e. costs of paramedical care, with the exception of treatment for which Zorg en Zekerheid has granted prior authorisation;
f. costs relating to dental care;
g. 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.

1.5 Physiotherapy while on holiday

What is reimbursed?

Physiotherapy while on holiday, on business trips or during an internship or study period in connection with a chronic condition.

What are the conditions for reimbursement?

The care should satisfy the provisions as included in Article 1.1, Physiotherapy (Section A).

Does Zorg en Zekerheid need to approve this beforehand?

You will need prior written approval from Zorg en Zekerheid.

How much reimbursement will I receive under my supplementary insurance?

Module for Care Abroad
100%

Section B Conditions of Zorg en Zekerheid supplementary insurance

1. General provisions

1.1 For whom?

The AV-Gemak and Module for Care Abroad supplementary insurances are 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.

The AV-Gemak Regio supplementary insurance is open to all persons obliged to take out insurance under the Healthcare Insurance Act who, according to the Key Register of Persons, reside in the Zorg en Zekerheid region.

You can only take out AV-Gemak Regio, AV-Gemak and/or Module for Care Abroad insurance with us if you already have or also take out a Zorg Gemak Polis with us.

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 **www.zorgenzekerheid.nl/vergoedingenzoeker**.

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 **www.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

Where reference is made to applying for or cancelling your supplementary insurance, the application or cancellation can only be effected digitally.

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

2.1 How to apply for supplementary insurance

You can apply digitally 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 inform us fully and truthfully. If you fail to do so, we will not be obliged to reimburse any costs and we will be authorised to terminate your insurance immediately without observing a notice period. 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 agreement with you, or to do so under the same terms and conditions. In that case, we will be able to invoke the provisions in Title 17, Book 7 of the Dutch Civil Code and terminate the insurance agreement with immediate effect. If we incur investigation costs to determine whether you have completed your application in full and truthfully, we will charge on those costs to you.

2.3 Conditions for AV-Gemak Regio, AV-Gemak and Module for Care Abroad

The following conditions apply to the insurance:

a. if, as an existing policyholder/insured person, you wish to transfer to a supplementary insurance policy 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. Registration cannot be made to apply retroactively.
b. you cannot be insured under more than one supplementary package at the same time, except in the case of the Module for Care Abroad. The Module for Care Abroad is available in combination with AV-Gemak Regio and AV-Gemak;
c. children qualify for the most extensive package of the parent or parents in whose policy schedule they are registered;
d. these types of supplementary insurance are an online insurance. If you have taken out this insurance, you have granted permission to Zorg en Zekerheid to send you the policy and other correspondence (such as itemised claims and invoices) digitally. All communication between you and Zorg en Zekerheid will be conducted online;
e. the premium for these supplementary insurances can only be paid by means of a direct debit.

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 this calendar year ends, your insurance will be tacitly renewed each year for a period of one 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;
- the AV-Gemak Regio supplementary insurance ends on 1 January of the following calendar year if you move to an area outside the Zorg and Zekerheid region.
- 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 4.2 and in the manner stipulated in Article 4.3;
- 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 current calendar year, unless in the case of:

- an insured person turning 18;
- 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.

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 after the date of birth, 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

2.7.1 As a policyholder, you may cancel your supplementary insurance in writing with effect from 1 January of each year. We must however have received your notice of termination by 31 December of the previous year at the latest. 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 cancel 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 Articles 1.1 and 2.3 are no longer met;
e. if there are important reasons for us to take the insurance off the market.

2.9 Notifications

Notifications sent to your last address and/or email address known to us will be 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 reapply 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, subject 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
Surcharge for the Module for Care Abroad
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.

3.7. Payment of premium

The premium for the AV Gemak Regio, AV Gemak and Module for Care Abroad can only be paid by means of a direct debit.

4. Change in premium and policy conditions

4.1 Change in premium and policy conditions as of the renewal date

We are entitled to change the premium and policy conditions of the supplementary insurance policy/policies with effect from 1 January, on which date the insurance is tacitly renewed for another calendar year. We will inform you as a policyholder about this in writing in advance. 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 Change in premium and policy conditions during the term of the insurance

We are authorised at all times to change the policy conditions and premium of the supplementary insurance policy/policies. We will inform you as a policyholder about this in writing in advance. 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.

4.3 Right of cancellation

If we decide to change the policy conditions or the premium, as referred to in Article 4.2, 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 the medical advisor of Zorg en Zekerheid of the reason for the admission if the medical advisor requests this;
b. to cooperate with the medical advisor 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 relationship;
   - divorce, dissolution of a long-term cohabitation relationship;
   - 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 or 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 this arose; 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 the reimbursement of costs or care aids or services, if the insured person can claim compensation for the resulting costs under statutory insurance cover, government-imposed insurance or any type of subsidy scheme, or would have been able to claim such compensation under an agreement other than this insurance agreement if this insurance agreement had not been concluded.
b. This insurance will only apply to the excess of loss exceeding the cover provided under the insurance policies and arrangements referred to in paragraph a. or that would have been provided thereunder if the present insurance 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 Financial Institutions Incident Warning System Protocol (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: **www.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 Insurance 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 27 October 2022 and effective from 1 January 2023.

Section C: Information

Any questions? For more information, please go to **www.zorgenzekerheid.nl**. Alternatively, you can get in touch with our Contact Centre by phone on (071) 5 825 825. They are 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 **www.zorgenzekerheid.nl/mijnzz**.

How do I get my invoice reimbursed?

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

- Write your personal customer number on your original invoice(s) and submit your invoice(s) online via MijnZZ (**www.zorgenzekerheid.nl/mijnzz**).
  or:
- submit your invoice using the **Zorg en Zekerheid claim app** (free download from the App Store or Google Play Store);
- you are obliged to keep the original invoice for three years after uploading. Within this period, we remain entitled to inspect the invoice. The deadline for submitting invoices is 31 December of the third year after the year in which the treatment was carried out.
- there are a number of medical treatments for which you will need to ask for approval beforehand; a list of these can be found in these policy conditions in Section A, Extent of the cover.

How do I get my invoice for medical costs incurred abroad reimbursed?

- when it comes to claiming costs incurred abroad, you must submit both the original invoice and a claim form (*declaratieformulier*). This form can be found on **www.zorgenzekerheid.nl/brochures.** You can send the original invoice with the claim form postage paid to:
  Zorg en Zekerheid
  Attn.: Afdeling declaraties Buitenland
  Postbus 428
  2300 AK LEIDEN
- the original invoices must be itemised such that without the need for further queries Zorg en Zekerheid can deduce the reimbursement it is obliged to pay. Computerised invoices must be authenticated by the care provider;
- invoices should preferably be drawn up in French, German or English. Original invoices in other languages must be drawn up and/or translated such that without the need for further queries Zorg en Zekerheid can deduce the reimbursement it is obliged to pay;
- if Zorg en Zekerheid deems it necessary for the submitted invoice(s) to be translated, then Zorg en Zekerheid can require the insured person to have the invoice(s) translated by a sworn translator;
- the translation costs referred to in the previous subsection will not be eligible for reimbursement;
- 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
Beter in jouw buurt

Postbus 400
2300 AK Leiden

zorgenzekerheid.nl
071 - 582 58 25

K.v.K. 28050216
AFM nummer 12001019

Onderlinge Waarborgmaatschappij
Zorgverzekeraar Zorg en Zekerheid u.a.