Zorg Gemak Policy

Policy Conditions 2025

Zorg en Zekerheid
Beter in jouw buurt

Basic Insurance

Supplementary Insurance

Zorg Gemak Policy

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Basic Insurance

Zorg en Zekerheid
Beter in jouw buurt

Basic Insurance

Supplementary Insurance

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

Basic insurance
The healthcare insurance in accordance with the Healthcare Insurance Act, as taken out with Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare 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 aids
The care aids as specified in the healthcare insurance policy.

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

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

Care provider
An institution that, or professional who, provides care and/or assistance, including a care aids supplier as referred to in the Care Aids Regulations (*Reglement Hulpmiddelen*).

Central care provider
A properly qualified professional who provides guidance for the child and the family/system by coordinating the required support, in order to strengthen self-management by the child/family.

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 rules imposed by the Healthcare and Care Providers (Accreditation) Act (Wet toelating zorgaanbieders, WTZa).

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.

Contracted care

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

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 physician 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.

Employer's group scheme

A group scheme between an employer and Zorg en Zekerheid in which the insured person participates. This scheme includes special agreements for the supplementary insurances in these policy conditions, for example with respect to a group discount and extra reimbursements. Other group schemes and group agreements are not included. Group agreements that do not provide for extra reimbursements for the insured person are also excluded.

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), Czechia (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 healthcare 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 physician 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 who is registered as such in accordance with the conditions set out in Section 3 of the BIG Act and who is registered as a geriatric physiotherapist in the Quality Register of Dutch Physiotherapists of the Royal Dutch Association for Physiotherapy (KNGF) or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie.

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

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

Group
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.

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 healthcare insurers under the basic insurance. A personal contribution applies to specific medicines.

Hand 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 hand occupational therapist in the Quality Register for Paramedics.

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, as taken out with Onderlinge Waarborgmaatschappij Zorgverzekeraar Zorg en Zekerheid u.a. or another healthcare insurer. Also known as 'basic insurance' or 'the master policy'.

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

Healthcare insurer
The insurer that has been accredited as such and provides insurance within the meaning of the Healthcare Insurance Act (Zorgverzekeringswet), hereinafter to be referred to as Zorg en Zekerheid.

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

Hospital
A centre for specialist medical care that has been accredited as a hospital or independent treatment centre (ZBC) in accordance with the rules imposed by the Healthcare and Care Providers (Accreditation) Act (Wet toelating zorgaanbieders, WTZa).

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 caregiver
A person who provides eight or more hours of unpaid care per week for a family member, friend or close acquaintance.

Inpatient care
A stay lasting at least 24 hours.

Insurance
The legal relationship regulated by the insurance agreement.

Insurance agreement
The insurance agreement entered into between a policyholder and 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
Research by a laboratory that has been accredited as such in accordance with the Healthcare and Care Providers (Accreditation) Act (*Wet toelating zorgaanbieders*, WTZa).

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

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

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

Manual practitioner
A manual practitioner who is registered as a physician 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 who is registered as such in accordance with the conditions set out in Section 3 of the BIG Act and who is registered as a manual therapist in the Quality Register of Dutch Physiotherapists of the KNGF (Royal Dutch Association for Physiotherapy) or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie.

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 physician, 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 physician 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 the article headed Care Abroad in the supplementary insurance policy.

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

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

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

Municipal Health Service physician
A physician who works for a Municipal Health Service in the field of public health, forensic medicine and medical aid in emergency situations, natural disasters and suchlike.

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 registered in accordance with Section 3 of the BIG Act.

Nursing specialist
A nurse 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 who is registered as such in accordance with the conditions set out in Section 3 of the BIG Act and who is registered as an oedema therapist in the Quality Register of Dutch Physiotherapists of the Royal Dutch Association for Physiotherapy (KNGF) or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie.

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

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

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

Orthodontist
A dental specialist included in the register of persons specialising in dento-maxillary orthopaedics maintained by the Royal Dutch Dental Association (KNMT).

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

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 who is registered as such in accordance with the conditions set out in Section 3 of the BIG Act and who is registered as a paediatric physiotherapist in the Quality Register of Dutch Physiotherapists of the Royal Dutch Association for Physiotherapy (KNGF) or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie.

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.

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

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

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.

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.

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

Psychosomatic physiotherapist
A physiotherapist who is registered as such in accordance with the conditions set out in Section 3 of the BIG Act and who is registered as a psychosomatic physiotherapist in the Quality Register of Dutch Physiotherapists of the Royal Dutch Association for Physiotherapy (KNGF) or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie.

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.

Rational pharmacotherapy
Assessment based on rational pharmacotherapy applies to non-registered medicines and in the event a situation may arise in which such medicines may be reimbursed under the basic healthcare insurance policy. Rational pharmacotherapy is a type of treatment with a medicine in a form suitable for the insured person, the working and effectiveness of which has been confirmed in accordance with current scientific and practical standards. Furthermore, the medicine must form the best economic option for both the healthcare insurer and the insured person.

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 calling Zorg en Zekerheid on +31 (0)71 582 58 25 or by visiting our shop.

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 four-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.

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 accredited under or pursuant to the rules imposed by the Healthcare and Care Providers (Accreditation) Act (Wet toelating zorgaanbieders, WTZa).

Remedial educationalist

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

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 with the KRP (Quality Register for Pedicurists) or the RPV (Paramedical Foot Care Register). 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.

Waiting period for orthodontic treatment

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

We/us/Zorg en Zekerheid

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 healthcare insurance

This healthcare insurance agreement is based on:

a. the Healthcare Insurance Act (Zorgverzekeringswet, ZVW);
b. the Healthcare Insurance Decree (Besluit zorgverzekering);
c. the Healthcare Insurance Regulations (Regeling zorgverzekering);
d. the associated explanatory notes to sections a, b and c;
e. the information you supplied to us 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 comprises 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. In contrast to the first sentence in this article, this health insurance is not available to persons whose previous health insurance has been cancelled or dissolved due to fraud within five years immediately preceding the request to take out the insurance.

1.3 Form of the healthcare insurance

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 itermised 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 this is the case 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 current scientific and practical standards. 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. A healthcare provider must comply with the relevant guidelines, quality standards/frameworks and all other documents that have the nature of a quality standard for the professional group concerned in order to qualify for reimbursement.

1.5 Parties authorised to provide the care

1.5.1 Contracted care provider

The contracted care is provided by a care provider with whom we have concluded an agreement for the relevant type of care: 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 +31 (0)71 582 58 25 or in person at our shop.

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 care providers. These agreements include arrangements concerning 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 an agreement 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 your treatment yourself.

If you receive mental healthcare (Article 23) from a non-contracted care provider, Zorg en Zekerheid will reimburse the costs up to a maximum of 70% of our average contracted rate.

If you receive nursing and care (Article 27.1) from a non-contracted care provider, Zorg en Zekerheid will reimburse 75% of the invoice up to a maximum of 75% of our average contracted rate.

Zorg en Zekerheid reimburses care provided by a non-contracted care provider, with the exception of mental healthcare and nursing and care, 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 our average contracted 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.

If the reimbursement of non-contracted care included in this article proves a demonstrable effective impediment for an average care user in a modal income situation, we will reimburse an amount that is high enough to overcome this effective impediment. You can find information on how to appeal against an impediment at **www.zorgenzekerheid.nl/hinderpaal**.

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 providers 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 providers. 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 provider during the year in question. If so, please call our Care Advice & Mediation Team on +31 (0)71 582 58 28 or send an email to zorgadvies@zorgenzekerheid.nl. One of our consultants will then help you find a care provider that you can go to. If you are already under the care of a care provider who has reached the turnover ceiling, this will not affect your care in any way. You will be able to complete your treatment with that care provider.

1.6 Timely provision of care

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

When determining the timing of timely provision of care, we take as our starting point 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 allocate the costs claimed. If a treatment is spread across two calendar years and the care provider submits one claim, then the date on which treatment started will be decisive for the right to reimbursement.

1.8 Written permission, referral or prescription

1.8.1 Written permission

For some types of care you need our prior written permission before you are entitled to the care or to reimbursement of the costs of care. For each type of care, Section B of these terms and conditions specifies whether you need such written permission. This applies both to contracted and non-contracted care (unless 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 indicated in the permission. Reimbursement will then take place in accordance with these policy conditions.

Example:
You switched to us with effect from 1 January 2025. You received written permission for plastic surgery from your former healthcare insurer. The end date of that permission is 23 March 2025. 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 must 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 is 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 might 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 might be entitled to reimbursement of the costs of other types of care than those mentioned in these policy conditions. This is possible 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

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 does an invoice expire?

Your entitlement to reimbursement of the costs of care lapses 3 years after the date on the invoice for the treatment. If an invoice for treatment does not specify a date, your right to reimbursement of the costs of the care will expire on 31 December of the third year following the year in which the treatment took place. If we have rejected all or part your request for reimbursement of the costs of care, your invoice will expire 3 years following rejection. To prevent expiry, you must 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 From what date will you be insured?

In principle, your healthcare insurance and that of any co-insured persons comes into effect on the date we receive your fully completed application (or application form). The effective date of your healthcare insurance is stated on the policy schedule.

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

2.1.2 If we receive the healthcare insurance application within four months of the person in question becoming subject to the obligation to take out healthcare insurance, the effective date of the insurance is the date on which that obligation arose. In the event of a newborn child, therefore, it is important that you take out insurance for your child with us within four months after the 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 one month has lapsed between the end date of your previous healthcare insurance and 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 conditions of the insurance have been amended with negative consequences for the insured person;
c. the premium base has been adjusted 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 Moments when you may cancel your insurance

As a policyholder, you may terminate your healthcare insurance in writing with effect from 1 January of each year. In that case, we must have received your notice of termination by 31 December of the preceding year. If we have not received it, we will renew your healthcare insurance tacitly for a period of 1 year. If you have given notice of termination by 31 December, the healthcare insurance will end with effect from 1 January of the subsequent year and you will have until 1 February to arrange 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 give your new healthcare insurer permission to terminate your existing insurance policy or policies and to enter into a new healthcare insurance with you. In this case, too, you need to have applied for 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 asked to present evidence to prove you are switching from one group contract to another;

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

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

2.3 Moments when you may not cancel your insurance

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

2.4 Moments when 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 Moments when we may suspend your insurance cover

We may suspend your healthcare insurance cover in the event of premium arrears and any collection charges as described in Article 3.4 ‘Payment arrears’.

2.6 When your insurance will end by operation of law

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

a. we are no longer allowed to offer or execute healthcare insurance policies due to amendment to or revocation of our licence to work in the insurance industry. We will notify you of this no later than two months in advance, stating the reason and the date on which the insurance ends;
b. the insured person dies (you must 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 of the death of an insured person, the end of an insured person’s obligation to take out insurance or an insured person’s employment as a member of the military in active service. Any overpayment in premiums will be refunded to you or offset against the reimbursement we paid to you for care to which you were no longer entitled. Any healthcare costs unduly reimbursed to you that exceeds the amount of premium payments refunded to you will be charged to you.

2.7 Healthcare insurance of uninsured persons

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

We are authorised to rescind a healthcare insurance policy taken out by the CAK on your behalf on grounds of an error if it can be concluded in retrospect that you were not obliged to take out insurance at that point in time. In this regard we derogate from Section 931, Book 7 of the Dutch Civil Code, in accordance with Section 9d(6) of the Healthcare Insurance Act.

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 Adjustment of premium and premium base and amendment to conditions

2.8.1 Adjustment of premium and amendment to conditions

We are entitled to amend the conditions and/or adjust the 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. An amendment to the conditions or adjustment of the premium base will not come into effect until seven weeks following the date on which it was made known to you.

2.8.2 Right of cancellation

If we decide to amend the conditions or adjust the premium base to your disadvantage, you will have the right to give notice of termination of your insurance within seven weeks of the day on which we informed you about the change. You must give notice of termination in writing, by registered post. The right to terminate your insurance does not apply if the amendment to the conditions and/or adjustment of 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 from the time the 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 must 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, the premium is owed up to and including the date of death.

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

The policyholder has to pay the premium in advance and 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 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

You are not permitted to set off any amounts you owe (such as the premium) against the reimbursements you are owed by us. We may, however, set your debt off against money you are still entitled to under your insurance.

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 demand for payment. You will then have thirty days from the date of receipt of this demand for payment to pay the amount or amounts due. If you fail to pay within the set deadline, you will no longer be entitled to any medical treatments (or reimbursement of the costs of any medical treatments) that took place after the first day following the payment deadline.

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

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

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

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

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

3.4.5 We will immediately 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 you are in default as regards the full payment of the amount we are claiming from you and the provisions of Section 96(6), Book 6 of the Dutch Civil Code have been complied with, you will owe us extrajudicial collection costs. The extrajudicial collection costs are determined and calculated in accordance with the Extrajudicial Collection Costs (Fees) Decree as established on the basis of Section 96(5), Book 6 of the Dutch Civil Code.

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.

Example:
This may involve situations such as a hospital admission, in which case we will reimburse the admission costs. You will then receive an invoice from us for the payment of your compulsory excess.

3.5.2 The 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) that are related to general practitioner care. If, at the general practitioner's request, the laboratory tests are performed by a different care 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 of maternity care and obstetric care as well as the placement of an IUD by a midwife. The costs of any associated care, however, are covered by the excess, such as the costs of any ambulance transport, medicines or tests performed elsewhere and charged separately.
c. contraceptives for insured persons between 18 and 20 years of age;
d. nursing and care (district nursing) as described in Section B, Articles 21 and 27.1;
e. donor transport, if the donor has healthcare insurance and the costs can be charged to that insurance. In that case, we will reimburse the costs of public transport at the lowest fare. If there is a medical need to travel by car, we will reimburse the costs of transport by car;
f. costs of care of donors related to the donation that are incurred after 13 weeks or, in the case of a liver transplant, after 26 weeks following the donation when the donor is still alive;
g. medicines listed by us as ‘preferred’ in the ‘Reglement Farmaceutische Zorg’ (Pharmaceutical Care Regulations). Please note that pharmacy services, such as the cost of dispensing medicine, the counselling interview in the case of a new medicine or inhalation instructions, are not exempt from this excess. See also 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. For details, go to **www.zorgenzekerheid.nl/vergoedingenzoeker**;
k. the Combined Lifestyle Intervention (CLI);
l. care aids on loan;
m. NIPT on medical grounds for pregnant women;

n. the costs of care that can be qualified as remunerated care under the Healthcare Insurance Act, in the case of cross-domain and cross-sector cooperation;
o. the costs of the exploratory interview.

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 Calculation of the amount of the compulsory excess

Unless the insurance starts or ends on 1 January due to the insured person 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 reaching the age of 18. We will then calculate the amount of the excess for the period up to 1 January of the following calendar year. This period includes 61 days. A calendar year (other than a leap year) has 365 days. The deductible is: €385 x 61 divided by 365 is €64.34 and is rounded to €64.

3.5.5 Compulsory excess for Diagnosis-Treatment Package (DTP)

Is an amount being claimed under a DTP or for integrated delivery care? In that case, the costs are deducted from the compulsory excess for the calendar year in which the DTP or integrated delivery care started.

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 claims for the costs of care directly to us, we will deduct any available compulsory excess from the reimbursements due.

The 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 a 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 a voluntary excess 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 under 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 from 1 January of the new calendar year. This means you cannot retroactively change your voluntary excess from, for instance, €500 to
€100.

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.zorgenzekerheid.nl/mijnzz**, by telephone on +31 (0)71 582 58 25 or in person at our shop.

3.6.4 Calculation of 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 reaching the age of 18.
>
> In that case we will not claim the full amount of the voluntary excess (€100). This is because we will also take into account 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

And so on.

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 or under integrated delivery care are deducted from the voluntary excess for the calendar year in which the DTP or integrated delivery care was started.

3.6.6 Payment of the voluntary excess

If we pay the costs of your treatment directly to your care provider, we will charge or recover any available voluntary excess. In the event we decide to recover the amount, you will receive a written request from us asking you to effect payment within 14 days, or a notice informing you that we will deduct the amount to be recovered by direct debit within 14 days.

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

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

3.6.7 Voluntary excess after 18th birthday

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

Article 4: Other provisions

4.1. Your obligations

a. to ask the attending physician or medical specialist to inform the medical advisor of Zorg en Zekerheid of the reason for admission if the medical advisor requests this;
b. to cooperate with the medical advisor or others at Zorg en Zekerheid who are tasked verification, to enable them to obtain all required information, with due observance of the privacy regulations. This is understood to include cooperation with respect to obtaining a second opinion from an independent specialist, on the referral of Zorg en Zekerheid. 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 liable (or potentially 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 written consent from Zorg en Zekerheid, to come to an arrangement with the liable third party or that third party's insurer in respect of 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 prison term has ended, in connection with the statutory provision regarding the suspension of coverage and the obligation to pay premiums for the duration of the prison term;
e. to submit the original and clearly itemised invoices to Zorg en Zekerheid within three years of the date of the invoice for the treatment. If there is no date on the invoice for the treatment, you must submit your original and clearly itemised invoice to Zorg en Zekerheid before 31 December of the third year following the year in which the treatment took place. In this respect, the date of treatment and/or the date on which care was provided is decisive, and not the date of the invoice concerned. If 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 started. If these invoices are submitted later, you will no longer be entitled to reimbursement of 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:
   - the end of the statutory obligation to be insured;
   - divorce, end of a long-term cohabitation relationship 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 prison term.

   If the change is not communicated to Zorg en Zekerheid within 30 days, it will only take effect from the date it is reported and will have no retroactive effect from the date of the change. The following exceptions apply: the end of the statutory obligation to be insured, birth (see Article 2.1.2), death, and the start of a prison term (the healthcare insurance will be suspended from the date of placement in a penitentiary institution) and its end (the healthcare insurance will recommence on the date that the prison term ends).

4.2 Not covered by the insurance

4.2.1 Exclusions

You are not entitled to reimbursement of costs relating to:

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 in the context of 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. anti-snoring treatments involving uvuloplasty;
j. treatments aimed at sterilisation;
k. treatments aimed at reversing sterilisation;

l. treatments aimed at circumcision of male insured persons, unless the treatment is medically necessary;
m. plagiocephaly and brachycephaly (skull deformations in infants) treatment without craniosynostosis with a redression helmet;
n. care provided outside the Netherlands, with the exception of costs as referred to in Article 22, Abroad;
o. examinations for treatments which are not generally accepted scientifically or are unusual in the context of the practice of the profession or specialism, 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 no longer necessary;
q. prenatal 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 given permission in advance;

4.2.2 Double cover

You are not entitled to care or 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 care provider;
b. our liability, if any, for damage resulting from our own shortcomings is limited to the amount of the costs we would have had to reimburse if the healthcare insurance had been executed properly, except in the case of wilful misconduct or gross negligence.

4.3 Entitlement to care as a result of terrorism

If 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. The Clauses Sheet is available at www.terrorismeverzekerd.nl.

4.4 How we handle your personal data

In order to take out health insurance or to change or terminate your policy, you 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 store your personal data in our register of personal data. When processing your personal data, we comply with the applicable laws and regulations, such as the General Data Protection Regulation. For details on how we do this, please see our Privacy Statement, which is published on our website.

What else do we do with your personal data? We:
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 checks and/or surveys 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. You can notify us to this effect 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 Healthcare Insurers. In accordance with the Incident Warning Protocol for Financial Institutions, we 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 all reimbursements paid out as from the date the fraud was originally committed. In addition, we will charge you for the costs of investigating the fraud.

We 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 from the date the fraud was originally committed, or if your name is on a sanctions list.

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 eight weeks. You can easily 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. Complaints Committee
P.O. Box 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 (SKGZ), P.O. Box 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 deliver a judgement in the form of a binding opinion. Please submit your complaint in writing to the following address: NZa P.O. Box 3017 3502 GA Utrecht.

4.7 Final 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 30 October 2024 and effective from 1 January 2025.

Section B Extent of the cover

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 physician/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) with which the general practitioner is affiliated;
- relevant testing, including laboratory testing prescribed by the general practitioner, which is invoiced by the general practitioner, a hospital or a laboratory.
- a preconception consultation with a general practitioner or an authorised and competent midwife acting in accordance with the applicable guideline of the Dutch College of General Practitioners (NHG).

What are the conditions?
The extent of this care 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

5.2 Medical care for members of specific patient groups

What am I entitled to?
Medical care for specific patient categories (GZSP) is a group of care types for vulnerable people who still live at home and present complex or highly complex issues, as a result of which they are increasingly limited in terms of their self-reliance and their self-management capabilities. The care is focused on the somatic, psychological and/or behavioural fields. This concerns, among others:
- people with complex disorders, such as psychogeriatric problems;
- people with chronic progressive degenerative diseases, such as Parkinson's disease, Huntington's disease and multiple sclerosis;
- people with a non-congenital brain injury;
- people with an intellectual disability.

Treatment is often focused on teaching skills or behaviours so patients are better able cope with the consequences of a condition, disorder or disability. Depending on the demand for care, the care is offered individually or in a group context. This is often multidisciplinary care under the direction of the coordinating care provider for medical care to specific patient categories (GZSP). The general practitioner can also take a monodisciplinary approach and rely on the expertise of a geriatric care specialist (or a physician for people with an intellectual disability) to advise on complex situations in home situations. The care is laid down in a treatment plan and delivered according to the principles of medical care to specific patient categories (GZSP).

Medical care to specific patient categories (GZSP) intended for people with a minor intellectual disability and severely impaired behaviour is only reimbursed if the care is provided by a De Borg institution and if previous specialised mental healthcare or intellectual disability care did not lead to adequate results.

What am I not entitled to?
You are not entitled to reimbursement 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

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

6.1. General

Reimbursement of the costs of the types of care referred to in Articles 6 to 16 inclusive (with the exception of acute care) requires a prior referral from your general practitioner, corporate physician, youth healthcare physician, medical specialist (including a sports physician) or physician assistant, emergency assistance physician, nursing specialist, Municipal Health Service physician, infectious diseases specialist, geriatric care specialist, physician for people with an intellectual disability, optometrist and orthoptist (can only issue a referral to an ophthalmologist), chief audiologist 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 care or orthodontic care to be provided by a dental surgeon, you require a referral from a dentist or an orthodontist. Care providers must not issue referrals for themselves, nor may they issue referrals for a partner, child, parent or any other family member residing with them. A referral will remain valid for one year, unless the party issuing it has specified a different term.

The extent of the care to be provided 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 condition 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

6.1.1 Conditionally qualifying treatments

Some treatments have been conditionally included in the basic insurance in accordance with Section 2.1(5) of the Healthcare Insurance Decree (BZ) and Article 2.2 of the Healthcare Insurance Regulations (RZ). This concerns treatments whose efficacy has not yet been sufficiently demonstrated. However, they do qualify for temporary reimbursement under the basic insurance. The Minister of Health, Welfare and Sport may conditionally admit new treatments in the course of the calendar year. To view the 'Conditionally qualifying treatments', go to www.zorginstituutnederland.nl.

6.2 Inpatient care (hospital admission)

What am I entitled to?

You are entitled to:

- medical specialist treatments and the stay, whether in combination with nursing and care or otherwise;
- the paramedical care and medicines associated with the treatment (with the exception of medicines excluded under Article 2.1 of the Healthcare Insurance Regulations), and care aids and bandaging materials, 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 specialist medical assistance in combination with a stay in a centre for specialist medical care.
- in the case of a stay, entitlement is restricted 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 up to 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 leave and holiday leave will count towards the calculation of the 1,095 days.

Do I need prior permission from Zorg en Zekerheid?

In the case of treatments on the most recent version of the Exhaustive List of Specialist Medical Care, prior written permission from Zorg en Zekerheid is required for some specialist medical treatments. To view this list, go to **www.zorgenzekerheid.nl/brochures**.

Are you using the services of a care provider 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 materials associated with the treatment.

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

Do I need prior permission from Zorg en Zekerheid?
In the case of treatments on the most recent version of the Exhaustive List of Specialist Medical Care, prior written permission from Zorg en Zekerheid is required for some specialist medical treatments. To view this list, go to **www.zorgenzekerheid.nl/brochures.** 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 Exhaustive List of Authorisations for Dental Surgery (Limitatieve Lijst Machtigingen Kaakchirurgie). To view this list, go to **www.zorgenzekerheid.nl/brochures**.

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 involving plastic surgery

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;
- electrolysis for transgender people as referred to in Article 17.5 of these policy conditions.

Do I need prior permission from Zorg en Zekerheid?
You must have prior written permission from Zorg en Zekerheid for a limited number of procedures. These procedures are included in the Exhaustive List of Specialist Medical Care with DTP care products for which permission is required. To view this list, go to **www.zorgenzekerheid.nl/brochures.** The granting of permission may be subject to further medical conditions. Plastic surgical interventions are assessed using the 'Guide for the assessment of treatments involving plastic surgery' ('*Werkwijzer beoordeling behandelingen van plastisch-chirurgische aard*'). That guide provides a more detailed explanation of when you are entitled to such care, based on the stated criteria. The guide was written by the Dutch Association of Public Health Physicians (VAV), Zorgverzekeraars Nederland (ZN) and the National Health Care Institute (Zorginstituut Nederland). This guide can be found at **www.zorgenzekerheid.nl/brochures.**

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 agenesis 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, except, 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 specialist medical 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 specialist medical 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 a primary diagnostics examination provided it is carried out by:
- a general practitioner practice;
- a primary diagnostics centre (EDC);
- a hospital or independent treatment centre (ZBC);
- a midwife (see Article 7 for the applicable conditions).

What are the conditions?
For all primary diagnostics, a request must have been submitted by the general practitioner, geriatric care specialist or physician for the intellectually disabled.

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

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.

6.6 Reimbursement of costs of stay related to 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 for the costs of your stay is a maximum of €91 per night.

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

Do I need prior permission from Zorg en Zekerheid?
For the reimbursement of accommodation costs for CAR-T cell therapy, you must have prior written permission from Zorg en Zekerheid.

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:
- 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 a follow-up examination, such as invasive diagnostics. Pregnant insured persons with a medical history or abnormal ultrasound scan may also have an indication for a follow-up examination;
- a CTG (cardiotocogram) performed by a midwife in the event of reduced life signs, impending serotinicity and non-invasive intervention to turn the baby from breech presentation to vertex presentation.

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.

What are the conditions?
The care provider who performs the first-trimester 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 with gynaecologists on how to perform a CTG in the context of the Collaborative Arrangements for Obstetric Care (*Verloskundig Samenwerkingsverband*);
- 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 midwives. This includes the care provided before, during and after delivery. In the context of delivery, the following situations may occur:

Delivery and/or postnatal care on medical grounds in a hospital
What am I entitled to?
You are entitled to:
- specialist medical (obstetric) care, as referred to in Article 6, in combination with treatment and nursing as well as a stay in the hospital 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 and for developing a secure attachment between the mother and child, 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 midwife, the general practitioner or the medical specialist.

Do I need a referral?
A specific referral by a midwife or general practitioner is required.

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

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.

Delivery and/or postnatal 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-care and aftercare) by a midwife or a general practitioner active in obstetrics;
- the use of the hospital’s delivery room or birth centre during the delivery, including childbirth assistance provided by the hospital or birth centre.

Do I need to pay a personal contribution?
A personal contribution is payable for both you and your child for delivery and/or postnatal care without medical grounds in a hospital or birth centre. We will settle this personal contribution with you.

What personal contribution do I need to pay?
The reimbursement for mother and child is €261 per day. This amount comprises the maximum reimbursement less the personal contribution for the mother and child:

The maximum reimbursement is 2 x €152 = €304 per day
Less: personal contribution for maternity care 2 x €21.50 = €43 per day

If the hospital charges an amount higher than €304 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 birth centre and/or the maternity bureau that will provide 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 postnatal period (the period of ten days counting from the day of delivery) has expired, you will retain an entitlement to the remaining days of postnatal care.

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.

Delivery and/or postnatal care at home

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

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.

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 OB/GYN 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 number of hours of maternity care you receive will be assessed, in consultation with you, by the maternity carer / maternity care provider acting in consultation with the midwife or gynaecologist, based on the most recent National Maternity Care Indication Protocol.

What are the conditions?
- you must register for maternity care by a maternity centre no later than the 20th week of your pregnancy. For our contracted offering, please visit **www.zorgenzekerheid.nl/zorgzoeker**;
- in the event of a stay in hospital: if you and your child leave the hospital together before the postnatal period (the period of six weeks counted from the day of delivery) has expired, you will retain an entitlement to the remaining days of postnatal care in accordance with the National Indication Protocol for Maternity Care. The day of discharge is not counted as a day in hospital;
- maternity care must be provided by a maternity centre that meets the membership requirements of the Sector Organisation for Maternity Care (Bo Geboortezorg);
- 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 provider must satisfy the following conditions:
- digital information and instructions can only be offered to insured persons who also receive maternity care at home from the care provider;
- only maternity carers who satisfy the conditions described in this article may be used for video calls;

- the statutory own contribution does not apply in the case of digital information and instructions;
- the digital information and instructions must be of the same quality as information and instructions provided in physical form;
- you must have given your prior consent to receiving information and instructions in digital form;
- the information and instructions must be based on an indication system that is in accordance with the National Indication Protocol (LIP);
- the content of the digital information and instructions must comply with the guidelines issued by the Expertise Centre for Maternity Care (KCKZ);
- the care provider 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 just given birth has understood the information and instruction materials;
- another check is performed in the home situation to verify you have correctly understood the information you received in the form of digital information and instructions;
- provided that the following condition is met, the use of digital information and instructions replaces no more than six hours of physical maternity care and must not lead to an increase in the number of indicated hours according to the LIP;
    - the digital information and instructions (other than video calls) replace a maximum of one hour of physical maternity care.
- you are at all times entitled to the minimum of 24 hours of physical maternity care.
- the aim is to minimise digital information and instructions per hour by means of video calls, and to use this when this is appropriate in each individual case.

Zorg en Zekerheid offers reimbursement for supplementary maternity care under 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 €5.40 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 8: Rehabilitation

8.1 Rehabilitation

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

What are the conditions?
- there must be a congenital or acquired disorder of the musculoskeletal system or a congenital or acquired neurological disorder that negatively affects the ability to move the spine, torso or limbs;
  or
- there must be a condition that is not primarily situated in the musculoskeletal system or its control, but which, on a secondary level, negatively affects the ability to move the spine, torso or limbs, such as burns, chronic pain or severe de-conditioning (in the case of cancers);
- 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 for clinical rehabilitation, there must be an expectation that better results will be achieved in the short term with clinical rehabilitation than with non-clinical rehabilitation.

Do I need prior permission from Zorg en Zekerheid?
In order to for the healthcare insurer to determine whether you are entitled to care, you must 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

8.2 Geriatric rehabilitation

What am I entitled to?
You are entitled to:
Geriatric rehabilitation that includes integral and multidisciplinary rehabilitation care, as generally provided by geriatric care specialists in connection with vulnerability and complex multi-morbidity with the aim of restoring or improving the insured person's functioning and participation in society.

What are the conditions?
- 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;
- you are not entitled to geriatric rehabilitation if prior to your treatment in hospital or an independent treatment centre (ZBC) 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);

Do I need prior permission from Zorg en Zekerheid?
Continuation of treatment of a medical indication which takes, or is expected to take, longer than 120 days from the 121th day requires prior written permission from Zorg en Zekerheid (this must be applied for at least 4 weeks before the end of the first 120-day period. It is also necessary to apply in writing for prior permission from Zorg en Zekerheid in the event of a change in the indication for geriatric rehabilitation care (GRZ) that results in the early termination of an ongoing geriatric rehabilitation treatment and the start of a new geriatric rehabilitation treatment.

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.

Article 9: Organ transplants

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

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

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.

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.

Do I need prior permission from Zorg en Zekerheid?
You require advance written permission from Zorg en Zekerheid for the reimbursement of non-medical costs associated with home dialysis, to which further administrative conditions and/or other conditions may apply.

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.

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 necessary equipment, 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 the context of this article.

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.

Article 12: Cancers 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 14: Advice on 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 15: Audiological care

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

Do I need a referral?
You must be referred by a general practitioner, corporate physician, paediatrician, youth healthcare physician or an ear, nose and throat (ENT) specialist.

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.

Article 16: Fertility-related care

16.1 IVF
What am I entitled to?
We reimburse the costs of the first three IVF attempts to become pregnant per treated female insured person (including the medicine and the required storage of the embryos).

What are the conditions?
- there must be medical grounds;
- the female insured person must be less than 43 years old when the attempt is initiated;
- an insured person who is over 43 years old and who made the IVF attempt before she reached the age of 43 is entitled to have the attempt completed;
- if the female insured person is younger than 38 a maximum of one embryo will be returned in a first or second attempt;
- if the female insured person is between 38 and 42 years of age, two embryos can be returned in a first or second attempt, if this is justified on medical grounds;
- the treatment must be performed at an IVF centre licensed to apply IVF treatments under the Special Medical Procedures Act (WBMV);
- the costs of embryo storage are reimbursed only if the individual insured person is entitled to reimbursement for IVF or ICSI treatment under her healthcare insurance;
- as regards the ICSI treatment, the criteria included 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 three attempts have been made between a successful follicle puncture and the time when a pregnancy has been continuous for ten weeks, counting from the time of the follicle puncture, and if the implantation of cryopreserved embryos did not result in a continuous pregnancy of nine weeks and three days, counting from the implantation, are not reimbursed.

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 12 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

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

What are the conditions?
- there must be medical grounds;
- the female insured person must be less than 43 years old.

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

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.

Article 17: Paramedical care

17.1 Physiotherapy and remedial therapy

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

For persons under age 18

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

Please note: Once 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 21st 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 nine sessions of pelvic physiotherapy for urine incontinence as part of a ‘stepped care’ programme;
- an exercise intervention to prevent falls:
  for insured persons with a high risk of falls, the preventive exercise intervention OTAGO (individually or in a group), or ‘In Balance’, if the fall risk test shows that you have a high risk of falls and the fall risk assessment shows that, owing to underlying or additional somatic or psychological problems, there is an indication for a preventive exercise intervention, at the level of a physiotherapist, that is also supervised by a physiotherapist or remedial therapist. This care comprises a maximum of one exercise intervention to prevent falls per twelve months;
- intermittent claudication:
  a maximum of 37 supervised remedial therapy sessions over a 12-month period in the case of Fontaine stage 2 peripheral artery disease (intermittent claudication);
- osteoarthritis:
  reimbursement for a maximum of 12 supervised remedial therapy sessions in the case of osteoarthritis of the hip or knee joint over a period of no more than 12 consecutive months;
- COPD (chronic obstructive pulmonary disease):
  reimbursement for supervised remedial therapy sessions for COPD, in the case of stage II (moderate COPDS) or higher of the GOLD Classification for spirometry.
- rheumatoid arthritis:
  long-term personal active physiotherapy for insured persons with rheumatoid arthritis with severe functional limitations.

Appendix 1 Healthcare 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 bandaging materials and auxiliary bandaging materials, 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 further details, go to **www.zorgenzekerheid.nl/zorgverzekeringen**.

What are the conditions?

a. The care must be provided by the following care providers:

	Physiotherapy	Specialised physiotherapy excluding 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 Quality Register for Physiotherapy NL or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie, and this registration must be recorded in the Vektis AGB register;
- the remedial therapist or specialised remedial therapist must be registered for the specialisation concerned in the Quality Register for Paramedics (KP) (quality registered status), and this registration must be recorded in the Vektis AGB register;
- 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 Parkinsonism symptoms, 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;
- are you eligible for an exercise intervention to prevent falls? your physiotherapist or remedial therapist must have a valid licence for the intervention in question. The Balans and OTAGO group interventions must satisfy the criteria for reimbursement within the Healthcare Insurance Act as outlined in the memorandum ‘Exercise interventions to prevent falls within the Healthcare Insurance Act’ issued by VeiligheidNL;
- are you being treated for rheumatoid arthritis with severe functional limitations? your physiotherapist or remedial therapist must have followed the training modules developed for this purpose;

- is a splint to be made for you and are you to be measured for that splint? If so, your physiotherapist must have a Dutch Hand Therapist Certificate (CHT-NL) issued by the 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 started a new treatment programme with a physiotherapist? In that case, the physiotherapist will first examine you and exactly determine your condition to identify the right treatment for you. This counts as one treatment session. If the physiotherapist then proceeds to provide the treatment, this counts as another treatment. This means that the costs of two treatment sessions 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 the same condition, whether or not the individual sessions are given by another physiotherapist and/or remedial therapist. This does not apply if the individual treatment sessions are used for initial measurement, interim evaluation and/or final measurement or for individual treatment sessions given in addition to an exercise intervention to prevent falls given in a group setting.

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 osteoarthritis of a hip or knee joint, pelvic physiotherapy to treat urine incontinence, Fontaine II intermittent claudication, COPD Gold class II or higher, or for rheumatoid arthritis with severe functional limitations? 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 physician who gave the diagnosis and a clear description of the diagnosis. You can go to a physiotherapist or remedial therapist without a referral for conditions other than those listed above. We call this 'direct accessibility'.

For an exercise intervention to prevent falls, you need a written referral from the attending general practitioner or specialist in geriatric care.

Are you being treated by a geriatric care specialist, a physician 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 need a written referral from your coordinating care provider before you can start the treatment.

Do I need prior permission from Zorg en Zekerheid?
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 at expediting your recovery following discharge or termination of the day treatment programme, you will require written permission from Zorg en Zekerheid.. Your physiotherapist must apply for that permission on your behalf.

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.

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 a hand occupational therapist or a paediatric occupational therapist, must be included in the Quality Register for Paramedics (quality registered status); This registration is recorded in the Vektis AGB register;
- 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 over the telephone (or video phone) and to outpatient treatment sessions that were provided in a hospital or institution;
- the treatment for Parkinson's disease and Parkinsonism sypmtoms only qualifies for reimbursement if your occupational therapist is affiliated with ParkinsonNet. This registration is recorded in the Vektis AGB register;
- is a splint to be made for you and are you to be measured for that splint? 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). This registration as a hand occupational therapist is recorded in the Vektis AGB registry.

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 provider 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 physician for the intellectually 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

17.3 Speech therapy

What am I entitled to?

You are entitled to speech therapy as generally provided by speech therapists.

What are the conditions?

- the treatment must be performed by a speech therapist;
- the treatment must serve a medical purpose;
- the treatment can be expected to restore or improve the speech function or the ability to speak;
- the speech therapist must be registered in the Quality Register for Paramedics (quality registered status); This registration is recorded in the Vektis AGB register;
- 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; This registration is recorded in the Vektis AGB register;
- the treatment for Parkinson's disease and Parkinsonism symptoms only qualifies for reimbursement if your speech therapist is affiliated with ParkinsonNet. This registration is recorded in the Vektis AGB register.

Do I need a referral?

- Are you being treated by a geriatric care specialist, a physician for the intellectually 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

17.4 Dietetic care

What am I entitled to?
You are entitled to receive dietetic care with a medical objective as typically provided by dieticians, up to a maximum of three treatment hours per calendar year.

A number of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement received on account of basic insurance for persons who are overweight or underweight. For more information, go to **www.zorgenzekerheid.nl/vergoedingenzoeker** or see the policy conditions for supplementary insurance policies (under 'Preventive 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); This registration is recorded in the Vektis AGB register;
- all dietetic treatments count towards the specified maximum number of treatment hours. This also applies to sessions over the telephone (or video phone) and to outpatient treatment sessions that were provided in a hospital or institution;
- the treatment for Parkinson's disease and Parkinsonism symptoms only qualifies for reimbursement if your dietician is affiliated with ParkinsonNet. This registration is recorded in the Vektis AGB register.

Do I need a referral?
- Are you being treated by a geriatric care specialist, a physician for the intellectually 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?
Dietetic care 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 arrangement. 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

17.5 Electrical epilation or laser treatment for 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 treatment must form part of a multidisciplinary treatment;
- the skin therapist must be registered in the Quality Register for Paramedics (quality registered status). This registration is recorded in the Vektis AGB register.

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

Do I need prior permission from Zorg en Zekerheid?
Reimbursement of more than ten electrolysis and or laser hair removal treatment sessions for transgender persons requires prior written approval (requested by the therapist) from Zorg en Zekerheid.

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.

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 therapist 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

18.2 Oral care under age 18
What am I entitled to?
You are entitled to:
a. one periodic check (periodic preventive dental check) a year, unless there are dental-medical grounds for more than one check a year;
b. incidental dental consultations;
c. removal of tartar;
d. a maximum of two fluoride treatments a year (unless more treatments in any one year are necessary), commencing from the appearance of the first element of a permanent set of teeth;
e. sealing using fissure sealant;
f. periodontal care (for tissue that attaches a tooth or molar to the jaw);
g. anaesthesia;
h. endodontic care, with the exception of external whitening;
i. fillings (restoration of tooth sections with plastic materials);
j. treatment for complaints of the jaw joint (gnathological care);
k. dental surgery performed by a dentist or a dental surgeon, with the exception of the insertion of dental implants;
l. X-rays, except for orthodontic purposes;
m. removable dentures (frame prostheses, partial prostheses (plate) or full dentures).

For details of treatments and the associated performance codes that qualify for reimbursement at an independent oral hygienist or registered oral therapist, please see the document 'Reimbursements for treatment by independent oral hygienists or registered oral therapists' 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.
- cosmetic dental treatments (K codes).

Most of Zorg en Zekerheid's supplementary insurance policies provide for a supplement to the reimbursement for oral care that you receive under 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.

Do I need prior permission from Zorg en Zekerheid?
You 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.
- periodontal care (for tissue that attaches a tooth or molar to the jaw);
- treatment for complaints of the jaw joint (gnathological care);

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 under 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.

Do I need prior permission from Zorg en Zekerheid?
You 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 dental overviewX-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);
- insertion 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 dental 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.

Do I need prior permission from Zorg en Zekerheid?
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 aimed at helping 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.

Do I need prior permission from Zorg en Zekerheid?
You need to have 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, 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 of dental surgical care of a specialist nature or by disciplines other than the dental discipline.

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

Do I need prior permission from Zorg en Zekerheid?
You need to have prior written permission 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.

Do I need prior permission from Zorg en Zekerheid?
You need to have 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, 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 and/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 supplied to you;
- the dispensing of, plus counselling interview for, a medicine that is new for you 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 physician (and/or your informal caregiver) must be issued with a full medication overview including the times you must 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 care aid that is used for the administration of a medicine for which a prescription is required. A maximum of one instruction per care 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 provider 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.);

b. Groups of medicines with the same active ingredient are listed in Appendix 1 of the Healthcare Insurance Regulations. We choose a preferred medicine for certain active substances. You are only entitled to these preferred medicines. You can find a list of preferred medicines in the Pharmaceutical Care Regulations on our website. This list is updated monthly. We will not reimburse the costs of any other medicines that are similar in terms of active ingredient, strength and administration method. If treatment with a preferred medicine is not medically justifiable, your physician will specify 'medical necessity' on the prescription. You will then be entitled to another medicine as provided for in this article under c.

   You can find the most recent list of preferred medicines on our website. In the course of 2025, 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**.

c. by way of an exception, treatment with the preferred medicine may not be medically justifiable for you. In that case, you may qualify for reimbursement of the most effective non-designated medicine, based on medical necessity. To that end, your physician must state on the prescription that treatment with the medicine concerned is a 'medical necessity' and must also be able to substantiate that assertion 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 that case, your pharmacist will decide which most effective medicine to give you on the basis of the prescription and your physician's explanation. This will normally be another generic (unbranded) medicine. If Zorg en Zekerheid has doubts about the substantiation of the medical necessity, it will contact your physician. 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 adjust 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
If, however, 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 must claim the costs directly from Zorg en Zekerheid. You do not have to pay for those medicines yourself at the pharmacy.

d. the reimbursement of medicines in groups of interchangeable medicines (Appendix 1A of the Healthcare Insurance Regulations) unique medicines (Appendix 1B) and medicines with additional legal conditions (Appendix 2) that are not covered by the preference policy;

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 physician 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 (under g) are met . Your physician 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.

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 permission 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 physician 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 must submit the medical certificate to the pharmacy along with the prescription. If prior permission is required, your prescriber will ask Zorg en Zekerheid to give permission for 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 six-month titration period, medicines in this group can be dispensed for no more than three months;
    - up to a maximum of six months if you are staying abroad. By way of exception to the above, up to a maximum of three months following a titration period of six months for medicines in the group of expensive medicines and roll-pack medicines (individualised distribution); For expensive medicines and the supply of medicines with an individualised distribution method, Zorg en Zekerheid will only grant permission for reimbursement for a maximum of six months following approval of an application for authorisation;
    - a maximum of 12 months in the case of oral contraceptives. If this is your first time taking oral contraceptives, the maximum period is three 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 arrangement may be agreed in consultation between the insured person, the physician 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 the 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 clinical research 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.

Do I need prior permission from Zorg en Zekerheid?
- A number of medicines included in Appendix 2 to the Healthcare Insurance Regulations are subject to additional conditions and may require permission 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 permission from Zorg en Zekerheid as they may be subject to additional conditions. If no permission 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;
- starting an individualised distribution method with 1 to 4 medicines requires prior permission from Zorg en Zekerheid;
- in the case of expensive medicines and the 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 months.

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 €250. 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

19.3 Diet preparations
What am I entitled to?
You are entitled to polymer, oligomer, monomer and modular diet preparations for medical use and the associated advice and guidance if an adjusted normal diet and other special diet products do not work for you. To assess this, the attending physician or dietician must fill in a medical certificate, which can be found at www.znformulieren.nl. It will be assessed whether 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 delivery systems, including accessories, are delivered to your home address within 24 hours of the order or in accordance with the agreement with your supplier.

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 must 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 20 Care aids

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

Those regulations include provisions regarding, among other things:
- 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 must issue the referral;
- prior permission from Zorg en Zekerheid, if required (with respect to the initial purchase, a repeat purchase or repairs);
- the usage period of the care aid concerned;
- the maximum quantities in the case of consumable items;
- the maximum reimbursement and statutory personal contribution;

The Care Aids Regulations are available at **www.zorgenzekerheid.nl/polisvoorwaarden**. You can also obtain information by phoning Zorg en Zekerheid on +31 (0)71 582 58 25 or by visiting our shop.

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 materials 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 21: Patient transport

21.1 General provisions
A distinction is made in patient transport between:
- 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, taxi (including a wheelchair-accessible taxi) or car (including your own 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 maximum distance of 200 kilometres, unless Zorg en Zekerheid gives written permission for transport over a greater 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 or other care provider:
    - 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 as referred to under a. to d. inclusive.

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 by public transport, taxi (including a wheelchair-accessible taxi) or car (including the insured person's own car) on medical grounds

What am I entitled to?
You are entitled to medically necessary patient transport by public transport (at the lowest available fare), car (including your own car) or taxi (including a wheelchair-accessible taxi). This must concern 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 greater distance.

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 (except Article 21.2.c 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. for the treatment of a long-term illness or condition, you are dependent on long-term patient transport over a specific distance and/or with a specific travel time, the refusal of which transport would result, overall, in an unfair situation for you. We refer to this a the hardship clause. 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 in the vicinity (intensive paediatric care);
h. you receive geriatric rehabilitation care;
i. you receive day treatment in a group as part of a treatment programme to address chronic progressive degenerative conditions, non-congenital brain injuries or an intellectual disability. The basic insurance reimburses this care programme as medical care for specific patient groups (GZSP).

Do I need prior permission from Zorg en Zekerheid?
- Reimbursement of patient transport by taxi (or wheelchair-accessible taxi) requires prior written permission from Zorg en Zekerheid. For this purpose you must request the patient transport as described in Article 21.4;
- for patient transport by public transport, taxi (including a wheelchair-accessible taxi) or car (including your own car) on the basis of the hardship clause, you must apply for permission in advance in writing and submit a statement from the attending physician;
- if the patient transport is not possible by public transport, taxi (or wheelchair-accessible taxi) or car (including your own car), you may apply to Zorg en Zekerheid in writing in advance for permission for patient transport by an alternative means;
- you will also need prior written permission for a contribution towards accommodation costs.

What else do I need to know?
- patient transport by public transport, taxi (including a wheelchair-accessible taxi) or car (including your own car) also includes transportation of a companion if necessary, or if the patient is a child under age 16. Permission from Zorg en Zekerheid is required for persons accompanying the patient in the case of patient transport by public transport or taxi (including a wheelchair-accessible taxi). In exceptional cases, Zorg en Zekerheid may permit the transport of two companions;
- 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 the public transport website www.9292.nl;

- the reimbursement for the costs of transport by car (including your own car) amounts to €0.40 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). There is no reimbursement for the outbound or return journey if the insured person does not also travel;
- on the insured person's request, the reimbursement for patient transport may be replaced by a contribution towards the accommodation expenses (up to €91 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 three consecutive days. If accommodation is required, 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 taxi (including by wheelchair-accessible 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 provider 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:

- you can request permission by completing the 'Patient Transport ('Ziekenvervoer') Application Form' (**www.zorgenzekerheid.nl/brochures**). If you have received permission to use a taxi (or wheelchair-accessible taxi), you can arrange your transport with Zorgvervoercentrale Nederland (ZCN) using the ZCN Transport App or by calling telephone number +31 (0)10 280 81 82; Do you have an urgent request? In that case, you can first contact Zorg en Zekerheid by telephone on +31 (0)71 582 57 00;
- if you wish to apply for patient transport by invoking the hardship clause, as referred to in 21.3, you may do so by submitting the 'Patient Transport ('Ziekenvervoer') Application Form' (**www.zorgenzekerheid.nl/brochures**);
- you can request permission for an allowance for accommodation costs by completing the 'Accommodation Allowance' ('Logeervergoeding') 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 €126 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 institution for long-term care 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 institution for long-term care;
- transport to and from institutions that are funded under exceptional medical expenses insurance. This concerns transport from the institution for long-term care where you receive in-patient treatment to a person or institution where you need to go for dental treatment under your exceptional medical expenses insurance, plus the return trip to your institution for long-term care;
- the transport referred to in the first and second bullet points is necessary because the specialist examination, specialist treatment or dental treatment cannot be performed/provided at your own institution for long-term care;
- the 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 must 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 this information 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 call Zorg en Zekerheid on +31 (0)71 582 58 25.

Article 22: Abroad

What am I entitled to?
You are entitled to (your choice):
- care provided by a contracted care provider abroad;
- reimbursement of the costs of care provided abroad by a non-contracted foreign or Dutch care provider. The amount of the reimbursement can be found in Section A, under 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 provided abroad by 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.

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

What are the conditions?
- the care satisfies the provisions of these policy conditions;
- the care provider is authorised to provide care in the country concerned;
- only your own attending physician or medical specialist in your country of residence may refer you to a care provider in another country;
- if the insured person wishes to submit an invoice prepared in a language other than Dutch, French, German or English, a certified translation must be attached. Original invoices in other languages must be drawn up and/or translated in such a way that Zorg en Zekerheid can determine the reimbursement due without having to make further enquiries.

Do I need permission?
Prior permission is required for intramural care (admission for at least one 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 must 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 must 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 in full all the tasks and responsibilities he/she is charged with under the applicable National Mental Healthcare Quality Charter;
- 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 must 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 must 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 provider 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 providers 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 83(2), Book 3 of the Dutch Civil Code. You would be doing so if you went to a care provider that has not been contracted by Zorg en Zekerheid. We will transfer the reimbursement to which you (the policyholder) are entitled to the bank account number (IBAN) listed in our records. You must also 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, corporate physician 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 data of the patient 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 care provider or coordinating care provider but is prevented from doing so by the obligation arising from the National Mental Healthcare Quality Charter, the patient/client can make use 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.

  In addition to the above, you are also entitled to an ‘exploratory meeting’: a meeting with social care workers and mental healthcare professionals to determine the care needs of people with mental health problems who also have other problems, such as debts or loneliness. The aim is to help people quickly and in the right areas.

  Care providers 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 ‘Mental Healthcare 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.

Do I need prior permission from Zorg en Zekerheid?
You must 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 corporate physician;
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 provider 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 materials 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 care provider or coordinating care provider but is prevented from doing so by the obligation arising from the National Mental Healthcare Quality Charter, the patient/client can make use 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.

  Care providers 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).

Do I need prior permission from Zorg en Zekerheid?
- you must 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 corporate physician;
  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 one year (second and third years of stay) requires prior written permission from Zorg en Zekerheid (this must be applied for at least two months before the end of the first year).

The application for permission must 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 a continued stay at an institution is available on **www.zorgenzekerheid.nl/ggzdocumenten**.

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.

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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

24.2 Foot care not provided by multi-disciplinary care

What am I entitled to?
You are entitled to 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;
- one of the following conditions must be present:
  - diabetes mellitus;
  - an inactive Charcot foot;
  - a prior history of a foot ulcer or amputation;
  - end-stage renal failure or dialysis that increases the risk of a foot ulcer.
- there must be at least a slightly elevated risk of foot ulcers. The podiatrist determines which care package you are eligible for, depending on your risk profile. To this end, the deliverables under the current 'Other Medical Care Policy Rule' of the Dutch Healthcare Authority (NZa) are applied;
- the care must be provided by a podiatrist, a medical pedicurist or a specialised pedicurist;
- if the high 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 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 25: Quit Smoking

What am I entitled to?

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 provider must be included in the Quit Smoking Quality Register.

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.

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 must be aimed at coping with, eliminating or compensating for the impairment 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

Article 27: Nursing and other care

27.1 District nursing

What am I entitled to?
You are entitled to nursing and care (district care) as provided by nurses. the care relates to the need for the medical care referred to in Section 2.4 of the Healthcare Insurance Decree or a high risk of such a need. 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 Bachelor’s or Master’s degree 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 Bachelor’s or Master’s degree 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. Care can only be provided by a level 2 nursing assistant or other care staff if Zorg en Zekerheid and the respective care provider have contractually agreed additional conditions and quality requirements with regard to the deployment of level 2 nursing assistants or other care staff. The additional conditions and quality requirements can be found in the “Joint purchasing text and conditions for the deployment of nursing assistants (level 2) and other care staff in district nursing (purchasing policy 2025)”. Go to www.zn.nl and search for ‘nursing assistants (‘*helpenden*’) using the search function;
- 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 provider 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 must also 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;
- your claim for reimbursement must include the care needs assessment (name of assessor and assessed number of hours of care) and the name of the care provider. The diagnostic details do not need to be visible.

What am I not entitled to?
You are not entitled to:
- 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.

Do I need prior permission from Zorg en Zekerheid?
You need prior written permission from Zorg en Zekerheid:
- if you wish to engage a newly contracted care provider for district nursing. This is a care provider that has been contracted for 2025 but was not contracted in 2024. 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 provider with whom we have not concluded a contract? Please see Article 1.5 of these policy conditions.

27.2 Reimbursement in the form of a Personal Budget (Zvw-pgb)
You may qualify for reimbursement for the costs of nursing and care in the form of a Personal Budget. You will need prior written permission from Zorg en Zekerheid for the care concerned. This budget will enable you to purchase district nursing services yourself. In this case, the Personal Budget for Nursing and Care Regulations apply in addition to the conditions specified in Article 27.1. These regulations state the conditions you will have to meet in order to qualify for a Personal Budget (Zvw-pgb). To view the Regulations, go to **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 physician for the mentally disabled - by a behavioural expert to patients presenting suspected or actual 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 Level 3 (or higher) caregiver within the meaning of the Individual Healthcare Professions Act. 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 accredited under the Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorgaanbieders, WTZA).
- your claim for reimbursement must include the referral issued by the general practitioner or medical specialist. The diagnostic details on the referral do not need to 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.

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.

Article 28: Combined Lifestyle Intervention (CLI)

28.1 CLI for adults

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 indication criterial of the National Health Care Institute (Zorginstituut Nederland), 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 be 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 require a written referral from the general practitioner, internist or cardiologist.

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.

28.2 Chain approach for overweight or obese children

What am I entitled to?
You are entitled to:
- supervision and coordination by the central care provider, consisting of a broad medical history, a possible intermediate phase, a treatment phase, a maintenance phase and a guidance phase;
- 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, group meetings, and an outtake;
- guidance of parents / carers
- a children’s lifestyle coach supervises you during the programme.

What are the conditions?
- you are entitled to reimbursement from the central care provider and the CLI if you are at a moderately increased weight-related health risk according to the FMS Guideline on Overweight and Obesity in Adults and Children, and if you have an intrinsic motivation to make changes to your lifestyle;
- a CLI for children under the age of 18 must be supervised and coordinated by the central care provider and be part of the chain approach;
- the care provider offering the lifestyle advice is quality-registered as a children's lifestyle coach. Registration is in the register of the BLCN Dutch Lifestyle Coaches' Association or in a comparable register approved by Zorgverzekeraars Nederland; a link to the register can be found on **www.zorgenzekerheid.nl/vergoedingenzoeker**;
- The central care provider must be registered in a quality register approved by Zorgverzekeraars Nederland; a link to the register can be found at **www.zorgenzekerheid.nl/vergoedingenzoeker**;
- the CLI must have an initial indication of effectiveness designmnation 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) or must have been approved as insured care by Zorgverzekeraars Nederland;
- the CLI programs that are eligible for reimbursement can be found using the Reimbursement Finder on **www.zorgenzekerheid.nl/vergoedingenzoeker**.
- 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 be the licence holder himself or herself;
- the general practitioner remains involved during the provision of the CLI: the central care provider consults with the general practitioner, regularly reports back on the results and discusses any additional care that may be needed;
- within the CLI, a care provider must maintain contact with the central care provider. The central care provider ensures coordination with 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;
- your municipality must have implemented the chain approach and must have agreed collaborative arrangements concerning this with a healthcare insurer;
- the care must be effective. In view of the new approach and the need to create a sufficiently effective offer, this care will not yet be available for all insured persons in 2025.

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 your GP, paediatrician or youth healthcare physician.

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:
- physician;
- other care provider (e.g., a psychotherapist or clinical psychologist);
- BIG-registered nurse trained at Bachelor's or Master's degree level (indication for district nursing).

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 physician 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.

Do I need prior permission from Zorg en Zekerheid?
You need prior written permission from Zorg en Zekerheid for a second opinion in the context of a Personal Budget (Zvw-pgb).

Section C Information

Any questions? For more information, please visit **www.zorgenzekerheid.nl**. Alternatively, you can get in touch with our Contact Centre by phone on +31 (0)71 582 58 25. They are available on working days from 8 am to 6 pm. You can also visit our shop.

MijnZZ

Persons insured with Zorg en Zekerheid can access MijnZZ. In MijnZZ, you can 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 only reimburses costs on the basis of the original invoices (i.e. not receipts) or computer invoices authenticated by the care provider.

You can submit invoices as follows:

- write your personal customer number on your original invoice and submit the invoice online via MyZZ (**www.zorgenzekerheid.nl/mijnzz**) or submit your claim via Zorg en Zekerheid app (free download via the App Store or Google Play Store);
  or;
- submit your invoice using the Zorg en Zekerheid 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.

Have you experienced a demonstrable effective impediment (Article 1.5.2) with regard to reimbursement of the costs of non-contracted care and do you want to appeal against this impediment? If so, go to **www.zorgenzekerheid.nl/hinderpaal**.

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 submit the original invoice with the expense claim form via the Zorg en Zekerheid app, or send it postage paid to:

Zorg en Zekerheid
Attn.: Foreign Claims Department
P.O. Box 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, insofar as possible, use the IBAN it also uses for the collection or payment of premiums. This IBAN is stated on your policy schedule.

Policy Conditions 2025 Supplementary Insurance AV-Gemak

Zorg en Zekerheid
Beter in jouw buurt

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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 30 October 2024. The reimbursement of 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 'COPD';
- treatments to which you are entitled under your basic insurance or under the Long-Term Care Act (WLZ);
- treatments in the context of exercise intervention aimed at preventing falls.

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 must not be separately invoiced to you by the therapist.

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

The physiotherapist (also known as hand therapist) is not permitted to invoice 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 the following care providers:

	Physiotherapy	Specialised physiotherapy excluding 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 Quality Register for Physiotherapy NL or the register of individual physiotherapists of Stichting Keurmerk Fysiotherapie, Foundation, and this registration must be recorded in the Vektis AGB register;

- the remedial therapist or specialised remedial therapist must be registered for the specialisation concerned in the Quality Register for Paramedics (quality registered status), and this registration must be recorded in the Vektis AGB register;
- 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 to Zorg en Zekerheid, by means of registration in the Vektis AGB register;
- if you are being treated for Parkinson's disease and Parkinsonism symptoms, your physiotherapist or remedial therapist must be registered with ParkinsonNet and be known as such to Zorg en Zekerheid, by means of registration in the Vektis AGB register.
- is a hand splint being made for you and will you be measured for this? 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 and exactly determine your condition to identify the right treatment for you. This counts as one treatment session. If the physiotherapist then proceeds to provide the treatment, this counts as another treatment session. This means that the costs of two treatment sessions can be claimed for your first visit to the physiotherapist;
   - all treatment sessions count:
   - all physiotherapy and remedial therapy treatments count towards the total. This also applies to sessions over the telephone (or video phone) and to outpatient treatment sessions that were provided in a hospital or institution;
   - manual therapy:
   - as part of your treatment, a maximum of 9 manual therapy treatment sessions will be reimbursed. Treatments under the basic insurance and those under the supplementary insurance both count towards these nine treatment sessions.

c. Group treatment:
   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 the individual sessions are 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 Healthcare Insurance Decree (List of Chronic Disorders) or will you be treated for osteoarthritis of a hip or knee joint, Fontaine II intermittent claudication, COPD Gold class II or higher, or for urine incontinence by means of 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 physician who gave the diagnosis and a clear description of the diagnosis.

Is your condition not included in Appendix 1 to the Healthcare Insurance Decree (List of Chronic Disorders) and are you not being treated for osteoarthritis of a hip or knee joint arthrosis, Fontaine II intermittent claudication, COPD Gold class II or higher, or for urine incontinence by means pelvic floor physiotherapy? In that case, 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 physician 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 need a written referral from your coordinating care provider before you can start the treatment.

Do I need prior permission from Zorg en Zekerheid?
If you are going to receive care immediately 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 at expediting 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?
in the case of care provided by a non-contracted care provider, the costs of care are reimbursed up to a maximum of 75% of our average contracted rate; For details of the maximum reimbursements for non-contracted care, go to **www.zorgenzekerheid.nl/nietgecontracteerd**.

A list of contracted care providers is available at **www.zorgenzekerheid.nl/zorgzoeker**.

How much will I be reimbursed under my supplementary insurance?

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

Article 2: Dental care

What are the general terms and conditions for the reimbursement of the costs of dental care as referred to in Article 2.1.1 to 2.2?
The costs of dental treatment are only reimbursed if, in Zorg en Zekerheid's opinion, that treatment is effective, is in line with usual professional practice, and is not unnecessarily expensive or complicated. As care provided under the supplementary insurance is a 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, as well as dental check-ups and gum treatments, may be performed and invoiced by an independent oral hygienist and 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. The reimbursements that apply to the corresponding care categories can be found 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 per 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 combined costs of M01 (preventive information), M02 (evaluation) and M03 (dental cleaning) in excess of 15 minutes, per calendar year;
- the costs of orthodontic treatment (F codes);
- the costs of implants (J codes), with the exception of the provisions of Article 2.2;
- the costs for dentures (P codes), with the exception of the provisions of Article 2.2;
- 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;
- cosmetic dental treatments (K codes);
- therapeutic injection (G code).

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 will I be reimbursed 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 combined.

2.1.2 Other dental treatments

What is reimbursed?
- 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 will I be reimbursed 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 combined.

2.2 Accident-related dental care cover

What is reimbursed?
The costs of dental care 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 must report the accident to us within 60 days. See **www.zorgenzekerheid.nl/verhaalszaken** for information 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 it is necessary to postpone the treatment (or definitive) treatment has to be postponed (more than 12 months after the accident), our advising dentist will determine whether or not the postponement is necessary.

Do I need prior permission from Zorg en Zekerheid?
- you need to have 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;
- when submitting the application, the care provider must also issue 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 pathological abnormality;
- arising from gross negligence or recklessness / wilful misconduct;
- arising from alcohol and/or substance abuse;
- arising from involvement in a fight other than for the purpose of self-defence;
- as a consequence of eating food;
- that were anticipated and do not arise from an accident;
- of treatment abroad;
- of orthodontic care.

How much will I be reimbursed under my supplementary insurance?

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

Article 3: Optical care

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

What is reimbursed?
Every 3 calendar years, to be counted from the date of purchase of the spectacles or contact lenses, the purchase 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 already reimbursed to you under that previous insurance policy when we calculate the maximum reimbursement to which you are entitled under your new supplementary insurance policy.

What are the conditions for reimbursement?
to be eligible for reimbursement, lenses must have a strength of at least 2.25 dioptres (even if only the frames are to be reimbursed);

How much will I be reimbursed under my supplementary insurance?
The maximum reimbursement applies to the costs of spectacle lenses, spectacle frames, contact lenses and premium lenses combined.

AV-Gemak Regio	AV-Gemak
No reimbursement	Maximum of €25 once every three 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 provisions (such as the preferred medicines policy) are satisfied.

4.1 Contraceptives

What is reimbursed?
The costs of contraceptives (oral medicines, care aids). These costs also include the costs of the work/operation carried out by the general practitioner or midwife.

What are the conditions for reimbursement?
- the contraceptives must be prescribed by your physician 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 contraceptive pill’) are subject to a maximum delivery period of twelve months. If this is your first time taking oral contraceptives, the maximum period is three months;
- in the case of provision by a non-contracted care provider, the costs of care are reimbursed up to a maximum of 100% of our average contracted rate;
- the preference policy and the Pharmaceutical Care Regulations apply. The regulations are available at **www.zorgenzekerheid.nl/polisvoorwaarden**.

How much will I be reimbursed 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 fee

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 fact that the amount payable is a fee for membership of 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 for the membership fee for 2024-2025 is chargeable against the 2024 calendar year and will not be reimbursed in 2025.

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

How much will I be reimbursed 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 must 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 your return to the Netherlands;
- in the case of hospital admission, long-term medical treatment or more than two treatments at an outpatient department, ANWB International Assistance (ANWB Alarmcentrale) must be contacted without delay. This service should preferably be contacted by calling +31 (0)71 582 54 44, or possibly by email (alarmcentrale@anwb.nl) or fax (+31 (0)70 314 70 40);
- when claiming the costs of medicines and bandaging materials, a copy of the prescription or proof of the consultation with a general practitioner/medical specialist must also be submitted.

The reimbursement is per calendar year.

1.2. Medical costs

What is reimbursed?

The medical costs of the following types of urgent, medically necessary care are eligible for reimbursement:

- medical care provided by a physician or medical specialist;
- hospital nursing in the lowest category;
- medically necessary ambulance transportation from the place of stay abroad to the closest hospital, physician 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 the costs at a rate of €0.40 per kilometre. The reimbursement will in all cases be limited to a maximum of €115 per holiday and/or business trip;
- medicines or bandaging materials on prescription from a physician or medical specialist abroad.

What are the conditions for reimbursement?

The General Terms and Conditions referred to in Article 3.2 are met.

How much will I be reimbursed 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) if, according to the physician at the alarm centre, one of the following points applies:
  1. The medical care in the country where the insured person is located is, in the opinion of the physician at the alarm centre, of an insufficient level or cannot be given to a sufficient extent or quickly enough, as a result of which repatriation or evacuation, accompanied by medically necessary persons and facilities, to a place where this medical care can be given must take place. Medical care is said to be of an insufficient level if:
     - the physicians where the patient is located do not have sufficient medical knowledge to treat the patient's condition, or
     - the local facilities are insufficient to the condition adequately (diagnosis, treatment, nursing).
  2. Following repatriation to the Netherlands (or the border areas in Belgium or Germany), the patient's treatment must be continued in the form of a hospital admission, in the opinion of the physician at the alarm centre.
  3. In connection with a serious case history, treatment in the Netherlands by the patient's own treatment provider is considered desirable for the insured person and/or the insured person's recovery (e.g. in the case of a psychiatric condition or cancer), in the opinion of the attending physician at the alarm centre. There is no need for any readmission in the Netherlands. There must be an acute and unforeseen need for care during the person's stay abroad.
- the dispatch of medicines that are urgently needed and medically necessary.

- transfer of the insured person's mortal remains to the Netherlands, and;

What are the conditions for reimbursement?
- the aforementioned repatriation (including persons accompanying the insured person), the transfer of the insured person's mortal remains and/or the dispatch of medicines was performed by ANWB International Assistance, following prior approval; In the case of concurrent insurance, this may also be performed by another alarm centre, in consultation with ANWB International Assistance;
- medicines may be dispatched insofar as this is permitted by customs regulations;
- there must be an urgent medical need for the medicines, which must not be available in the country where the insured person is staying and must be prescribed by a physician;
- the General Terms and Conditions referred to in Article 3.2 are met.

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

How much will I be reimbursed 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 medical and/or dental care costs and/or costs from your supplementary insurance for assistance provided abroad in the following cases:

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 similar sports, 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 related to dental care for insured persons with the Module for Care Abroad;
e. costs relating to alternative care (treatment and/or medication);
f. costs of paramedical care, with the exception of treatment for which Zorg en Zekerheid has granted prior permission;
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 in such a way that Zorg en Zekerheid can determine the reimbursement due without having to make further enquiries.

1.5 Physiotherapy while on holiday
What is reimbursed?
Physiotherapy while on holiday, on business trips or during a work placement or period of study in connection with a chronic condition.

What are the conditions for reimbursement?
The care must satisfy the conditions set out in Article 1.1, Physiotherapy (Section A).

Do I need prior permission from Zorg en Zekerheid?
You need to have prior written permission from Zorg en Zekerheid.

How much will I be reimbursed 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 insurance policies 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 this is the case 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. A healthcare provider must comply with the relevant guidelines, quality standards/frameworks and all other documents that have the nature of a quality standard for the professional group concerned in order to qualify for reimbursement.

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 set out in the relevant care article. We have contracted specific care providers for several types of care, including paramedical care. If you go to a non-contracted care provider for care, you might have to pay all or part of the invoice yourself. Please refer to the relevant care article for information.

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 treatment sessions indicated in these policy conditions.

1.4.1 The reimbursement is the amount we have agreed 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, whereby the injury or damage must have occurred during the term of the supplementary insurance, except in the case of physiotherapy. In the event of an incomplete/incorrect application as referred to in Article 2.2 or fraud (see Article 5.5), you are not entitled to reimbursement of the costs of care. The date of the treatment or supply 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 care aids that support self-reliance or patient transport, a claim form for care provided abroad / care aids that support self- reliance / own transport and public transport, provided by Zorg en Zekerheid, must be used. See also **www.zorgenzekerheid.nl/brochures**.

1.6 When does an invoice expire?

Your entitlement to reimbursement of the costs of care lapses 3 years after the date on the invoice for the treatment. If an invoice for treatment does not specify a date, your right to reimbursement of the costs of the care will expire on 31 December of the third year following the year in which the treatment took place. To prevent expiry, you must notify us in writing, within the period mentioned in the previous sentence, that you expressly wish to claim the reimbursement. If we have rejected all or part your request for reimbursement of the costs of care, your invoice will expire 3 years following rejection. To prevent expiry in cases such as this, you must 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. Application 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 the provision of 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 must inform us fully and truthfully. If you fail to do so, we will not be obliged to reimburse any costs and we may 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 recharge 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 switch 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 included;
d. these types of supplementary insurance are online insurance policies. 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 takes effect on 1 January of a calendar year or on the day that your basic insurance takes effect during the calendar year. The duration of the insurance is the calendar year (or remaining portion of the calendar year) in which the supplementary insurance is taken out. 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 before 1 January (see Article 2.7.1);
- at the moment 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 and/or adjustment of the 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 2.8 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, except 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.

2.6.2 Newborn infants are registered with effect from the date of birth if reported within four months after their birth. If your newborn child is not registered within four months after their birth, the effective date of the insurance is the date the child was reported and the insurance will have no retroactive effect from the date of birth.

2.6.3 As soon as a child included in his or her parent's policy schedule turns 18, he or she can terminate the supplementary policy or opt for a different one. The commencement of the new policy or the termination will come into effect on 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 Moments when 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 give the provider of your new supplementary insurance permission 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 an adjustment of the premium and/or amendment to the policy conditions as stated in Article 4;
b. when a child included in a parent's policy schedule turns 18 as described in Article 2.6.3.

2.8 Moments when we may cancel your supplementary insurance

We may cancel your supplementary insurance in writing with effect 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 you cancel the basic insurance and take out another basic insurance policy with us;
f. 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 insured person. The obligation to pay premiums commences on the start date of the policy and ends on the date the insurance ends. An insured person who has not yet reached the age of 18 and is co-insured under the supplementary insurance of the parent as described in Article 2.3 does not have to pay a premium. 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, the 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 the 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 Offsetting

You are not permitted to set off any amounts you owe (such as the premium) against the reimbursements you are owed by us. We may, however, set your debt off against money you are still entitled to under your insurance.

3.3 Overdue payment

3.3.1 If you fail to pay on time the premium, statutory contribution, excess, personal contribution or costs you owe, 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 may 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, in connection with the 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 you are in default as regards the full payment of the amount we are claiming from you and the provisions of Section 96(6), Book 6 of the Dutch Civil Code have been complied with, you will owe us extrajudicial collection costs. The extrajudicial collection costs are determined and calculated in accordance with the Extrajudicial Collection Costs (Fees) Decree as established on the basis of Section 96(5), Book 6 of the Dutch Civil Code.

3.3.4 You must pay your premium on time. If you fail to pay your premium by the premium due date, you will not be able to invoke the fact that the premium was not collected in time.

3.4 Insurance premium tax

If we have to pay tax on the insurance premiums abroad for you, we will charge this tax to you. You must pay this tax by the deadline we set for this purpose. If you fail to pay this amount to us on 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 on 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 direct debit.

4. Adjustment of premium and amendment to conditions

4.1. Adjustment of premium and amendment to conditions with effect from the renewal date

We are entitled to adjust the premium and amend the 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 the policyholder, about this in writing in advance. An adjustment to the premium and/or amendment to the conditions will take effect across the board. This means that the adjustment and/or amendment will apply to all insured persons.

4.2 Adjustment of premium and amendment to conditions during the term of the insurance

We are authorised at all times to adjust the premium and amend the conditions of the supplementary insurance policy/policies. We will inform you, as the policyholder, about this in writing in advance. We will determine the effective date of any such change. An adjustment to the premium and/or amendment to the conditions will take effect across the board. This means that the adjustment and/or amendment will apply to all insured persons.

4.3 Right of termination

If we decide to amend the conditions of the insurance and/or adjust 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 amendment or adjustment. You must give notice of termination in writing, by registered post. You have no such right of termination if the amendment or adjustment 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 physician or medical specialist to inform the medical advisor of Zorg en Zekerheid of the reason for admission if the medical advisor requests this;
b. to cooperate with the medical advisor, or others at Zorg en Zekerheid who are tasked with verification, to enable them to obtain all required information, with due observance of the privacy regulations. This is understood to include cooperation with respect to obtaining a second opinion from an independent specialist, on the referral of Zorg en Zekerheid. 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 (or potentially 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 come to an arrangement (or cause this to happen) with the liable third party or with its insurer in respect of the costs that have been or will be reimbursed by Zorg en Zekerheid;
e. in the case of a prison term, the cover under supplementary insurance will be suspended for the insured person in question with effect from the first day of the prison term, unless you ask us not to do so. During the suspension period, you will not owe any premium and will not be be entitled to insurance cover for any costs. Your supplementary insurance will take effect again on the end date of the prison term (this does not apply in the case of an application for insurance via your municipality, for which you must submit a new application to your municipality), provided that this is communicated to us within thirty days of that date. If you fail to inform us within that period, the cover under your supplementary insurance will not resume until we have been notified and will have no retroactive effect from the end date of the prison term;
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 entering into of a cohabitation relationship;
    - divorce, termination 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 prison term.

    If the change is not communicated to Zorg en Zekerheid within 30 days, it will only take effect from the date it is reported and will have no retroactive effect 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 the start of a prison term (see d. above);
h. if, as the policyholder/insured person, you have given explicit permission to have the policy and/or other communications sent to you electronically, communications between you and Zorg en Zekerheid will take place in digital form as much as possible to the extent permitted by the law;
i. the policyholder/insured person is obliged to refrain from actions that could damage the interests of Zorg en Zekerheid;
j. the policyholder/insured person must ensure that the necessary changes are made to the policy schedule;
k. all consequences arising from failure to fulfil the above obligations or to do so in time will be for the risk of the policyholder/insured person.

5.2 Exclusions

You are not entitled to reimbursement for care / 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 (*Jeugdwet*), 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, an 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 (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 given permission in advance;

f. if said care provider has made a referral to himself or herself for a partner, child, parent or other family member living as part of the household;
g. if the care was received outside the Netherlands, except for the costs mentioned in Article 3 of Section A;
h. for treatments requiring a referral and/or permission and for which no referral or permission was requested or provided beforehand;
i. if the care was made necessary by an act of gross negligence or wilful misconduct;
j. if they are the result of or related to terrorism, insofar as not determined otherwise in the Terrorism Cover Clauses Sheet 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 of 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 applies only 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 under them if this insurance had not existed.

5.4 How we handle your personal data

When processing your personal data, we comply with the applicable laws and regulations, such as the General Data Protection Regulation. For details of how we do this, please see 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 all reimbursements paid out as from the date the fraud was originally committed. In addition, we will charge you for the costs of investigating the fraud.

We 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 from the date the fraud was originally committed, or if your name is on a sanctions list.

In the event of fraud, we will not only 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 the Netherlands Central Information System Foundation (Stichting Centraal Informatiesysteem, CIS) 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 easily lodge your complaint with us by completing the online complaints form on our website at **www.zorgenzekerheid.nl/klacht**.

Alternatively, you can submit your complaint to our Complaints Committee: Zorg en Zekerheid, Attn. Complaints Committee, P.O. Box 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 (SKGZ), P.O. Box 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 30 October 2024 and effective from 1 January 2025.

Section C Information

Any questions? For more information, please visit **www.zorgenzekerheid.nl**. Alternatively, you can get in touch with our Contact Centre by phone on +31(0)71 582 58 8 25. They are available on working days from 8 am to 6 pm. You can also visit our shop.

MijnZZ

Persons insured with Zorg en Zekerheid can access MijnZZ. In MijnZZ, you can view or, if applicable, change claims you have submitted, your excess, your personal details and the policy data. You can also use MijnZZ to submit claims for invoices online. You can log into 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 and submit it online via MijnZZ (**www.zorgenzekerheid.nl/mijnzz**).
  or
- submit your claim using the Zorg en Zekerheid app (free download from the App Store or Google Play Store);
- you must 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 3 December of the third year after the date of the invoice for the treatment. If there is no date on the invoice issued for the treatment, the submission period ends on 31 December of the third year following the year in which the treatment took place;
- there are a number of medical treatments for which you will need to request permission 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. You can download this form from **www.zorgenzekerheid.nl/brochures**. You can submit the original invoice with the claim form via the Zorg en Zekerheid app, or send it postage paid to:

  Zorg en Zekerheid
  Attn. Foreign Claims Department
  P.O. Box 428
  2300 AK LEIDEN

- the original invoices must be itemised in such a way that Zorg en Zekerheid can deduce the reimbursement it is obliged to pay without the need to make further enquiries. 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 in such a way that Zorg en Zekerheid can deduce the reimbursement it is obliged to pay without the need to make further enquiries;
- if Zorg en Zekerheid deems it necessary that the submitted invoice(s) are 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 are not eligible for reimbursement;
- the reimbursement of the costs incurred will be made in the Netherlands in euros. This will take into account the exchange rate in accordance with the guidelines published by the European Central Bank (ECB). If no such rate is available, then the exchange rate on the day of treatment will be used unless that rate clearly differs from the parallel rate or no rate was quoted.

A single IBAN

You do not need to state your IBAN when making a claim. When paying out your claims, Zorg en Zekerheid will, insofar as possible, use the IBAN it also uses for the collection or payment of premiums. 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.