# Insured in 2024

It is easy **to organise it** yourself with Mijn VGZ

# Policy Conditions

VGZ Basis Keuze

COÖPERATIE VGZ

**Voorop in gezondheid en zorg. Voor iedereen.**

# Welcome to VGZ

These are the policy conditions that apply to your VGZ healthcare insurance. For more information, for example about claim forms or our healthcare insurance, please visit www.vgz.nl.

### Mijn VGZ

Via Mijn VGZ, you can change your policy, check your claims and pay your premium.

You can directly log in securely on mijnvgz.nl with your DigiD.

### VGZ app

Did you hear about the VGZ app? With this app, claim forms are submitted super fast, you can see all your budgets and reimbursements, and it is easy to pay invoices with iDeal. Your healthcare card and the number of the VGZ emergency centre are always at hand. The app has secure DigiD logon.

## Arranging your healthcare insurance online

You can easily arrange everything for your healthcare insurance online via My VGZ or the VGZ app. For all contact options, visit vgz.nl/service-and-contact.

## Contracted care providers

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

## Requesting approval

Would you like to know which healthcare services and treatments are subject to our prior approval (authorisation)? You can find this in these policy terms and conditions. Go to vgz.nl/reimbursements/machtiging for all the information.

## Easy online claim forms

It is easy to submit claim forms online through mijnvgz.nl. Or do it even faster in the VGZ app. The app has secure DigiD logon.
You will receive your reimbursement in your account within 10 working days.

Do you prefer to send a claim form by post? Then please send the original invoice to:
VGZ
PO Box 25030
5600 RS Eindhoven, the Netherlands

Sometimes we ask you to fill out and submit a claim form. This is available from our website.

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# I. General Section

## Article 1. Insured care

### 1.1. Contents and scope of the covered healthcare

VGZ Basis Keuze is an in-kind policy of the healthcare insurer, further referred to as 'the healthcare policy'. Pursuant to this healthcare policy, you are entitled to healthcare in kind as set out in these policy conditions. You are also entitled to healthcare advice and healthcare mediation.

**Healthcare advice and mediation**

Our Healthcare Advice and Mediation department advises you about the healthcare provider you can consider for your healthcare issue. Please also contact our Healthcare Advice and Mediation department if you are confronted with a non-acceptable long waiting list for visiting a policlinic or for hospitalisation, for example. You can reach this department through our website.

**Medical necessity**

You are entitled to (reimbursement of the cost of) healthcare as set out in these policy conditions if you are in reasonableness relying on the relevant form and content of healthcare, provided that the form of healthcare is effective and efficient. A key factor in the content and scope of the healthcare form is 'what the relevant healthcare providers generally offer'. Other factors in the content and scope of the healthcare are the status of science and medical practice. This is determined using the Evidence-Based Medicine (EBM) method. If a standard of care (the status of science and medical practice) is not available, the content and form of care are determined by what is considered responsible and adequate care within the discipline concerned.

### 1.2. Authorised healthcare providers

Your healthcare provider must meet certain conditions. The relevant healthcare provision sets out which healthcare providers may provide the healthcare services and the supplementary conditions the healthcare provider must fulfil. If the care provider does not meet the applicable conditions, you are not entitled to reimbursement.

### 1.3. Care provided by a contracted healthcare provider

Care in kind is provided by a care provider with whom we have concluded a contract for the relevant healthcare: a contracted care provider. An overview of our contracted care providers and the care they may or may not provide on the basis of the contract is available from our website.

The healthcare provider receives the fee for the healthcare provided from us directly. This is done on the basis of the rate agreed with the healthcare provider concerned.

We make agreements with healthcare providers on the quality, price and service of the healthcare to be delivered. Your interests are our number one priority. And if you select a contracted healthcare provider, this will make a difference in costs for you and us. If you selected a healthcare provider that we have not contracted for the relevant care, please take into account that you will have to pay some of the invoice yourself.

Sometimes we make agreements with healthcare providers about the volume of healthcare that any provider may fulfil for a patient: a volume limit or a financial ceiling. This applies only to certain forms of healthcare. More information is available from our website. The Zorgzoeker reference shows the healthcare providers that we have made agreements with regarding the volume of healthcare. Does a volume contract or a financial ceiling prevent you from using a healthcare provider? Please contact our Healthcare Advice and Mediation department. We will make sure that you can find another care provider.

Exceptions:

- If you need urgent treatment
- If you have started treatment already
- If you need care for your newborn
- If you are pregnant.

## 1.4. Care provided by a non-contracted care provider

Are you going to a care provider that does not have a contract with us for the care that concerns you? Then part of the invoiced amount may be charged to you. The cost of the (covered) healthcare will be reimbursed up to 70% of the average rates as agreed with the relevant healthcare providers for the relevant forms of healthcare ('average contracted rates'). If no rates have been agreed with healthcare providers for the care in question and Wmg rates apply, the costs will be reimbursed up to a maximum of 70% of the Wmg rates

Please find the maximum reimbursements in the 'List of maximum reimbursements non-contracted healthcare providers'. This list is available from our website. The maximum reimbursements were determined without factoring in your excess or personal contribution. These amounts will be set off against the maximum reimbursement.

**Acute healthcare**

If there is a case of acute care that is provided by a non-contracted healthcare provider, you are entitled to reimbursement of the costs up to the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands. Please inform us about such healthcare as soon as possible.

**General practitioner care**

Would you prefer to visit a GP or healthcare group with whom we have not concluded a contract for general practitioner care as set out in Article 11, GP Care (1, 2 and 3.1)? Then you are entitled to reimbursement of the cost of healthcare up to a maximum of the applicable Wmg rates. For testing requested by the general practitioner for you and carried out by a different, non-contracted care provider (for example an X-ray or a blood test) we reimburse the costs up to a maximum of 70% of the average contracted rate.

**Hardship clause**

The Health Insurance Act states that everyone is entitled to reimbursement for non-contracted care. Do you choose payment by a non-contracted healthcare provider? Then you will receive a maximum reimbursement of 70% of the average contracted rate. As a health insurer, we may determine the amount of this reimbursement at our discretion. However, the personal contribution may not prevent you from going to a non-contracted care provider (obstacle criterion). Do you think the amount of this contribution is an obstacle (i.e. prevents you from receiving care)? Then you may request application of the hardship clause. You can contact our Complaints Management Department for this. Indicate why you invoke the hardship clause in your situation. Whether or not your appeal is granted depends on factors such as the amount of the costs and the type of care.

**Prohibition on assignment**

You cannot transfer your claim on us for Nursing and Care (Article 14), Mental Healthcare (Articles 25 and 37), Pharmaceutical care (Article 34 Medications) and Medical aids (Article 36) to care providers or others with whom we have not concluded a contract for this care (prohibition on assignment). This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code.

## 1.5. Submission of invoices

Most healthcare providers send us their invoices directly. If you have received an invoice, you can submit your claims online through the My environment or through the app. You must keep the original invoice for one year after submitting the claim. We may request the invoices for inspection. If you are unable to submit the invoices, we may recover the amounts paid out to you, or settle the relevant amounts with amounts due to you. Submitting claim forms by post is also possible. Please attach the original invoice. For more information, please check page 2. Please don't send a copy or a reminder. We only accept original invoices. You can submit invoices up to a maximum of 3 years after the start of treatment.

The invoice should at least list the following details:

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

- Type of treatment, amount per treatment and date of treatment
- Name and address of the care provider.

The invoices and any relevant documents must be itemised allowing for directly and unambiguously deducing which amount of reimbursement we are required to pay. We deduct any excess and statutory personal contribution from the reimbursement. For conversion of foreign invoices in currencies other than euros, we use the historical rates available from www.XE.com This is based on the rate on the day you were treated. Invoices and other relevant documents must be written in Dutch, German, English, French or Spanish. If we deem it necessary, we may ask you to have an invoice translated by a sworn translator. We will not refund the translation expenses.

## 1.6. Punctual healthcare

If a contracted healthcare provider is not expected to be able to provide the care or to provide it on time, you are entitled to care mediation. We may grant approval to see a non-contracted healthcare provider for the relevant healthcare. In such cases we reimburse the costs up to the statutory Wmg rates. If no Wmg rates have been determined, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands.
To determine if healthcare was provided in due time, we take into consideration:
- Specific medical factors
- General, socially acceptable waiting lists based on psychological, social and ethical factors.

## 1.7. Direct payment

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

## 1.8. Settlement of costs

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

## 1.9. Referral, prescription or approval

For some forms of healthcare, you require a referral, prescription and/or prior approval in writing demonstrating that you are dependent on this healthcare. Details are set out in the relevant healthcare article.
A prior referral, prescription and/or approval is not required for emergency healthcare, i.e. healthcare that cannot reasonably be postponed.

**Referral or prescription**

Does the healthcare article set out that you require a referral or a prescription? Then you can request one from the relevant healthcare provider referred to in the Article. This is generally the general practitioner.

**Permission (authorisation)**

In some cases you also require our permission prior to receiving the healthcare. This permission is referred to as prior approval. If you have not obtained prior approval where required, then you are not entitled to healthcare or to reimbursement of the cost of the relevant healthcare.

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

Are you going to a care provider that does not have a contract with us for the care that concerns you? In that case, you need to request our approval in advance. Before granting authorisation, we verify that your healthcare provider is of impeccable conduct. If this is not the case, this may affect the response to your application for authorisation.

If you have authorisation for insured care, it also applies if you switch to another healthcare insurer or if you received authorisation from your previous insurer.

## 1.10. When are you entitled to reimbursement of the cost of covered healthcare?

You are entitled to (reimbursement of the cost of) care if the care has been provided during the term of your healthcare insurance. Should these Policy Conditions refer to a year or calendar year, the actual date of treatment or date on which services/goods were provided as stated by the healthcare provider will determine the year or calendar year to which the relevant costs should be allocated. If a treatment falls in two calendar years and the healthcare provider may charge the cost as a single amount (for example a Diagnosis Treatment Combination), we will reimburse these costs if the treatment was started within the term of the insurance policy and the cost will be allocated to the calendar year of the first treatment.

## 1.11. Exclusions

You are not entitled to:

- Types of healthcare or healthcare services that are funded pursuant to legal regulations, including the Wlz (Long-Term Healthcare Act), the Youth Act or the 2015 Wmo (Social Support Act);
- Reimbursement of personal contributions or excess payable under the terms of the healthcare insurance, except if and where these policy conditions determine otherwise;
- Reimbursement of fees for not appearing at your appointment with a healthcare provider (the 'no-show fee');
- Reimbursement of fees for written statements, mediation fees charged by third parties without our prior approval in writing, administrative fees or charges incurred by past-due payment of invoices from healthcare providers;
- Compensation for injuries/losses that are an indirect consequence of our acts or omissions
- (Reimbursement of the costs of) care caused by or arising from armed conflict, civil war, insurrection, domestic disorder, rioting and mutiny occurring in the Netherlands, as set out in Article 3.38 of the Wft Act (Financial Supervision Act).

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

If you need healthcare as a result of one or more terrorist events, then the following rule applies. If the total amount of claims submitted within a year or calendar year for non-life, life or in-kind funeral insurers (including healthcare insurers) according to the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT or Dutch Reinsurance Company for Terrorism-Related Claims) exceeds the maximum amount that this company reinsures annually, you are entitled to only a certain percentage of the cost or value of the healthcare. The NHT determines the exact percentage. This applies for non-life, life and funeral insurers (including healthcare insurers) that are subject to the Financial Supervision Act. The exact definitions and provisions for the above-mentioned entitlement are included in NHT's Clauses Sheet Terrorism Cover.

If after a terrorist act an additional amount is provided under Section 33 of the Zvw (Healthcare Insurance Act) or Section 2.3 of the Besluit Zorgverzekering (Healthcare Insurance Decree), you are entitled to an additional scheme as set out in Section 33 of the Healthcare Insurance Act or Section 2.3 of the Healthcare Insurance Decree.

**Guarantee pay-out on terrorism-related claims**

In order to be able to guarantee that you will receive payment on terrorism-related claims, (almost all) insurers in the Netherlands are party to NHT (the Dutch Reinsurance Company for Terrorism-Related Claims). We are also a member.
The NHT issued regulations that ensure pay-out of at least part of any terrorism-related claim.

The NHT has set a maximum to the total amount to be paid out relating to terrorist actions. The maximum amounts to 1 billion euros per year for all insured together.
If the total claim amount is higher, each insured that submitted a claim will receive pay-out at an equal percentage of the maximum amount. NHT set out the rules for due processing of loss claims in the Protocol for Processing Claims.

In reality, this may mean you are not paid out the full amount claimed. But it
also means that you are assured that you will at least be compensated some or all of the losses or cost.

# Article 2. General provisions

## 2.1. Basis and contents of the healthcare insurance

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

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

## 2.2. Place of work

The healthcare insurance policy can be taken out by any person subject to mandatory healthcare insurance residing in the Netherlands or abroad.

> The healthcare insurer operates throughout the Netherlands. If you are subject to mandatory insurance, you may continue this healthcare policy. Persons subject to mandatory insurance residing abroad are also entitled to concluding this insurance.

## 2.3. Relevant documents

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

- Healthcare Insurance Decree
- Appendix 1 to the Healthcare Insurance Decree
- Clause sheet terrorism cover
- National Maternity Care Indication Protocol (LIP)
- List of maximum reimbursements for non-contracted healthcare providers
- List GGZ Therapies (Mental Healthcare)
- Limitative List Authorisations Specialist Medical Care
- Limitative List Authorisations Dental Surgery
- Overview of contracted healthcare providers
- Premium Appendix
- Healthcare Insurance Scheme
- Pharmaceutical Care Regulations
- Medical Aids Regulations
- Nursing and care personal budget regulations
- Methodology for assessment of plastic surgery treatments
- Standard of Care Obesity.

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

## 2.4. Fraud

If we suspect fraud, we will conduct an investigation (or have one conducted). You are required to cooperate with this investigation and provide us with relevant and accurate information. During this investigation, we will not pay out any of your claims. Does the investigation reveal that you have, or someone else on your behalf has, committed fraud (for some or all of the relevant claims)? Then your right to (reimbursement of the cost of) care will lapse. In addition, we will recover from you any amounts paid out on the relevant claims. You are also required to pay the costs resulting from the fraud investigation.

**Reporting and registration**

In the event of fraud, we reserve the right to report the event to the police. We may also record, or have another party record, your information and that of co-perpetrators and accomplices:

- In our Incident Register
- In the CIS Foundation's External Referral Register (EVR) .

**Termination of insurance policy/policies**

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

**Fraud by healthcare providers**

We list any healthcare providers who commit fraud on the External Referral Registry (EVR). We do not reimburse care from healthcare providers listed in this registry and inform the relevant healthcare providers accordingly. Prior to providing care, the healthcare provider is required to inform you that we will not reimburse their care.

### 2.5. Private data protection

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

### 2.6. Notifications

Communications sent to the last address known to us will be deemed to have reached you. If you want to receive all communications from us electronically, you can indicate this in the My environment or in the app.

### 2.7. Membership of the Cooperative VGZ

Upon acceptance to this healthcare insurance policy, you, as the policyholder, also become a member of the cooperative society Coöperatie VGZ U.A., unless you notify us in writing that you do not wish to do so. This Coöperatie represents the interests of its members in the field of healthcare or other insurance. You may terminate your membership at any time, subject to a one-month notice period. Membership ends in any case on the date the insurance contract ends.

### 2.8. Cooling-off period

As a policyholder, you have a cooling-off period of 14 days when you take out the health insurance. You are entitled to cancel the insurance policy in writing within 14 days of signing the contract. In that event the insurance contract is deemed to have never been concluded.

### 2.9. Prioritisation

Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Healthcare Insurance Act have or ought to have an effect on the healthcare policy, these will be deemed to form an integral part of these policy conditions. Insofar as the provisions set out in Title 7.17 of the Dutch Civil Code or in the Healthcare Insurance Act are conflicting with the provisions of this contract, the provisions of the Healthcare Insurance Act will be leading, followed by the provisions of Title 7.17 of the Dutch Civil Code, followed by the provisions of this healthcare insurance.

### 2.10. Dutch law

This healthcare insurance is governed by Dutch law.

## Article 3. Premium

### 3.1. Premium base and premium discounts

The premium base is the premium without premium discount for any voluntary excess. The premium base and premium discounts applicable to you are set out in your policy schedule.

**Premium discount for voluntary excess**

If you opt for a voluntary excess, you will receive a discount on the premium. This discount is listed on your policy schedule and on the premium annex on our website.

## 3.2. Who pays the premium?

The policyholder is required to pay premiums. No premium is due for an insured person under age 18 until the first day of the calendar month following the person's 18th birthday. Upon death of an insured, premium is due only up to the date of death. After a change of the insurance policy, we will recalculate the premium as per the effective date of the change.

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

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

3.3.1. You are required to pay the premium and (foreign) statutory contribution monthly in advance for all insured, unless otherwise agreed.

3.3.2. if you do not use digital mail, you will pay a fee for paper post. The cost amounts to €1.25 per month. You do not pay any fees for the policy and the European healthcare insurance Card (EHIC). More information on paper post costs is available from our website.

3.3.3. You will pay the premium, excess, personal contributions, fees for paper invoices and benefits paid to you in error using the payment method agreed with us.

**Payment options**

a. You authorise us for automatic direct debit of the amounts due (see also Article 3.3.4).
b. You make use of the option of receiving a digital invoice free of charge via Mijn Omgeving. In that case you are expected to personally ensure on-time payment. Direct online payment via iDeal is an option.
c. Your employer deducts the premium and any charges for paper post from your salary and remits these amounts to us.
d. You make use of the option of receiving a paper invoice. In that case you are expected to personally ensure on-time payment. You will also receive a paper invoice if the direct debit transaction cannot be executed.

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

## 3.4. Settlement

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

## 3.5. Payment overdue

3.5.1. If you do not pay the premium, statutory contributions, personal contributions, excess, paper post charges and any amounts paid out to you in error before the due date, we will send you a reminder. If you do not pay within the term of at least 14 days as stated in the reminder letter, we may suspend cover of the healthcare insurance policy/policies. In that case you are not entitled to healthcare and reimbursement of healthcare costs from the last premium due date before the reminder. Your obligation to pay the premium will continue during any period of suspension. Entitlement to (reimbursement of costs of) healthcare is restored on the date following the date on which the amount due plus any fees were received.
We reserve the right to terminate the healthcare insurance policy if payments are in arrears. The insurance will not be terminated retroactively in that case.

3.5.2. If you have already been reminded for failure to pay premiums, statutory contributions, excess, personal contributions, paper post charges or any amounts paid out to you in error, we are not required to give you separate written notice if you fail to pay a subsequent charge on time.

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

3.5.4. If we terminate the insurance because you have not paid the premium on time, we reserve the right to refuse an insurance agreement with you for a period of 5 years.

3.5.5. Consequences of not paying 2 or more monthly premiums:

a. As a policyholder, do you have premium arrears amounting to 2 monthly premiums? we offer you as policy holder a payment schedule. We will give you 4 weeks to decide to accept our offer for a payment schedule. We will also inform you relating to the consequences of non-acceptance of our offer and your arrears run up to 6 or more monthly premiums.

b. If you have payment arrears amounting to four monthly premiums, you will receive a warning that we will register you with the CAK for the defaulters scheme once the payment arrears amount to six monthly premiums, unless we conclude a payment scheme with you after all.

c. If you as policy holder have payment arrears amounting to six monthly premiums or more, we will register you with the CAK for the defaulters scheme and you will be obliged to pay the CAK an administrative premium. For the period you owe the CAK an administrative premium, you will not owe us any premium. The administrative premium to the CAK is higher than the premium you would normally pay us.

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

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

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

## Article 4. Other obligations

You have the following obligations:

- Inform us of any facts that mean (or could mean) that expenses may be recovered from third parties with actual or potential liability, and to provide us with the necessary information in this context. You may not make any arrangements with a third party without our prior approval in writing. You must refrain from any actions that may harm our interests;
- Cooperate with our medical advisor or employees in order to obtain all information required for (inspection of) the actual execution of the healthcare insurance cover;
- Ask the healthcare provider to disclose the reason for hospitalisation to our medical advisor;
- Report to us any facts and conditions that may be relevant to correct execution of the insurance policy as soon as possible. This includes end of mandatory insurance, start and end of detention, separation or divorce, birth, adoption, or a change in bank or giro account number. We are not liable for any risks in the event of non-compliance with the above provisions.

If you fail to fulfil your obligations and this harms our interests, we reserve the right to suspend your right to (reimbursement of the costs of) the covered healthcare.

## Article 5. Change to premium/premium base and conditions

### 5.1. Change to conditions

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

### 5.2. Cancellation right

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

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

## 6.1. Start date and term

6.1.1. The insurance contract becomes effective on the date on which we receive your application or application form. You will receive a confirmation of receipt stating the date on which we received your application. If you are subject to mandatory insurance and you do not yet have a BSN (citizen service number), you can still be registered as an insured.

6.1.2. Sometimes we are unable to derive from the application whether or not concluding a healthcare policy with the person to be insured is mandatory for us. In such cases we will request information from you that would prove that concluding a healthcare policy with you is mandatory. The healthcare policy will only become effective on the day we receive such additional information. You will receive a confirmation of receipt stating the date on which we received your additional information.

6.1.3. If you have a different healthcare policy on the day as set out in Article 6.1.1 or 6.1.2, the healthcare insurance policy will become effective on the later date you indicated.

6.1.4. If the previous insurance policy has been terminated effective 1 January of a calendar year or due to a change in the conditions, the insurance policy will commence at the new insurer as per the termination date of the old insurance policy. You must then sign up with the new healthcare insurer within 1 month after the termination date of your previous insurance.

6.1.5. If the insurance contract takes effect within 4 months after the insurance obligation has arisen, the healthcare insurance starts on the day the insurance obligation arose.

**Example**

You are required to insure your child within 4 months of childbirth, ensuring that your child is insured from the date it was born.

6.1.6. The Healthcare Insurance Act includes provisions relating to mandatory insurance. It is not mandatory for us to conclude a healthcare policy with or for a person subject to mandatory insurance if that person is already insured pursuant to the Healthcare Insurance Act.

## 6.2. Termination by operation of law

The insurance policy expires automatically on the day following the day:

- The healthcare insurer is no longer permitted to offer or execute healthcare insurance policies due to a change in or suspension of its licence to operate a non-life insurance business. We will disclose any such changes at least 2 months in advance;
- The insured person dies;
- The insured person's obligation to take out insurance terminates.

You, as the policy holder, are required to inform us of the death of an insured or of the end of mandatory insurance of an insured as soon as possible. If you do not notify us of the end of mandatory insurance of an insured on time and we pay the cost of healthcare to a healthcare provider, we will claim these costs from you. If we determine that the insurance policy has terminated, we will send you a termination certificate as soon as possible.

## 6.3. When can you change or cancel your insurance policy?

6.3.1. **Change**

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

6.3.2. **Annual cancellation**

As the policy holder, you are entitled to terminate the healthcare insurance policy annually as per 1 January, subject to receiving your notice in writing latest by 31 December of the previous year. You then have until 1 February to find another insurer that will insure you retroactively from 1 January.

6.3.3. **Intermediate cancellation**

You, as the policy holder, are entitled to intermediate termination of the healthcare insurance policy in writing:

- Of another insured if this insured has taken out a different healthcare policy. If you cancel the healthcare policy before the other healthcare policy becomes effective, the termination date will coincide with the start date of the new healthcare policy. If the notice of cancellation is received later, the cancellation will take effect on the first day of the second calendar month after we have received the cancellation;
- Within 6 weeks after receiving a notification from us as referred to in Section 78c, second subsection, or Section 92, first subsection, of the Healthcare (Market Regulation) Act. The cancellation will take effect on the first day of the second calendar month following the day on which you cancelled;
- In the event of changes to the premium and/or policy conditions as set out in Article 5.2;
- If you participate in one of our group contracts with your former employer, and you are offered to participate in the group contract of your new employer. You may then cancel the healthcare insurance at any time up to 30 days after the new employment commences. In that event both the cancellation and the registration become effective on the start date of the employment at the new employer if that is the first day of the calendar month, and, if not, then on the first day of the calendar month following the start date of the employment.

**Cancellation on 18th birthday**

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

6.3.4. **Cancellation service**

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

6.3.5. **When is cancellation not possible?**

If we sent you a reminder for arrears in premium payments, you are not permitted to cancel your healthcare policy during that period until full payment of the premium, interest and collection fees has been received. You may cancel the health insurance policy if we have suspended cover or confirm your cancellation within 2 weeks.

## 6.4. When are we entitled to cancel, dissolve or suspend the insurance contract?

We can cancel, rescind or suspend healthcare insurance in writing:

- If you fail to pay amounts charged by their due date, as stated in Article 3.5;
- In the event of fraud (see Article 2.4);
- If you intentionally have not provided any, incomplete or incorrect information or documents that have or could have worked to our disadvantage;
- If you acted with the intent of misleading us, or if we had not accepted your application for healthcare insurance if we had known the actual circumstances. In such cases we reserve the right to cancel the healthcare policy within 2 months of detection and with immediate effect. In such cases, we are not liable for paying out any amounts, or we may reduce the amount to be paid out. We may offset the resulting claims with other amounts payable to you;
- If you exhibit unwelcome behaviour toward us, our staff or healthcare providers, or cause damage to our property. Inappropriate behaviour includes aggression, making threats, using force or intimidation, or other undesirable behaviour. Undesirable behaviour is defined at our discretion. We may report this to the police and register you (or have you registered) in our Incidents Register and the External Referral Registry (EVR). We observe a notice period of 2 months when terminating. If we have terminated your healthcare insurance in such circumstances, you cannot take out supplementary insurance with the insurers of Coöperatie VGZ for 8 years.

## 6.5. Evidence of termination

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

- Name, address, place of residence and citizen service number (BSN) of the insured;
- Name, address and place of residence of the policy holder;
- The day on which the healthcare policy terminates;
- Whether on that day an excess applied and if yes, the amount of this excess.

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

### 6.6. Insuring non-insured persons

If the CAK concluded this healthcare policy on your behalf pursuant to Section 9d, subsection 1 of the Healthcare Insurance Act, the following applies:

a. You may deem this healthcare policy null and void if you can demonstrate within 2 weeks to both us and the CAK that you already have healthcare insurance. The 2-week period starts on the date on which the CAK has informed you that it has started this healthcare insurance policy on your behalf;
b. We may lawfully reverse this healthcare policy due to error if you demonstrate that you are not subject to mandatory insurance;
c. You are not permitted to cancel this healthcare insurance during the first 12 months. After this 12-month period, the regular cancellation options as set out in Article 6.3 apply.

## Article 7. Statutory excess

### 7.1. Amount of statutory excess

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

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

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

- General practitioner care. The excess is applicable to medications. The excess is also applied for laboratory tests and diagnostics conducted by a different healthcare provider at the request of the general practitioner and charged to you. See Article 11, General practitioner care;
- Care due to overweight and obesity as defined in Article 13;
- Nursing and care as defined in Article 14;
- Obstetric care by an obstetrician, general practitioner or gynaecologist. Any fees associated with obstetric care, such as medication, blood tests and patient transport, are also subject to the excess. See Article 15.1, Obstetric care and Article 16, Specialist medical care;
- Insertion and removal of an IUD (coil) by a general practitioner or obstetrician. The excess does apply to the IUD (coil). See Article 34, Medications, and the Medical Devices Regulations for reimbursement of the IUD (coil);
- Maternity care. See Article 15.2, Maternity care;
- The Stop Smoking programme as set out in Article 24;
- Preferred medications as set out in the Pharmaceutical Care Regulations. Please keep in mind that pharmacy services, for example, dispensing fees, counselling on a new drug or inhalation instruction are not exempt from this excess. See Article 34, Medications;
- Our selected healthcare providers for the Blue Care pilot project in the Maastricht and Heuvelland region, to the extent that they provide the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your excess. See Article 34, Medications;
- The preferred and selected liquid nutrition products as set out in the Pharmaceutical Care Regulations. See Article 35, Dietary preparations;
- Medical aids on loan. See Article 36, Medical aids and dressings;
- Care related to a live donation, after expiration of the period set out in Article 22 point d, Tissue and organ transplants;
- Transport of a donor as set out in Article 22, items e and f, Tissue and organ transplants if the donor has concluded a healthcare insurance;
- Any personal contributions and/or personal payments.

### 7.3. The relevant healthcare providers and healthcare arrangements to which the statutory excess is not applicable

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

### 7.4. Calculation method of amount of statutory excess

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

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

The calculated amount will be rounded off to whole euros.

**Example**

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

### 7.5. Calculation of statutory excess

When calculating the excess, the costs of care or another service will be allocated to the calendar year in which the care was received. If a treatment falls in 2 calendar years and the healthcare provider may charge the costs as a single amount (for example the Diagnosis Treatment Combination), these costs will be charged to the excess of the calendar year in which the treatment started.

## Article 8. Voluntary excess

### 8.1. Variations of voluntary excess

If you are age 18 or older, you may select a healthcare policy with a voluntary excess amounting to: €0, €100, €200, €300, €400 or €500 per calendar year. The costs of healthcare are charged to you up to this amount. Depending on the selected amount of the voluntary excess, you will receive a discount on the premium basis. The selected voluntary excess and any discounts are stated on the policy schedule.

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

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

### 8.3. Calculation of voluntary excess amount

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

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

The calculated amount will be rounded off to whole euros.

**Example**

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

8.3.2. If the healthcare insurance policy does not become effective on 1 January and you had taken out a healthcare policy with us previously with a different voluntary excess amount, then the total voluntary excess is calculated as follows:

a. Each amount of voluntary excess x the number of days that the voluntary excess is applicable;
b. The sum of the amounts stated under a divided by the number of days in the relevant calendar year;
c. The result of this amount will be rounded off to the nearest whole euro.

### 8.4. Amendments to voluntary excess

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

### 8.5. Calculation of statutory and voluntary excess

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

## Article 9. Abroad

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

If you live in or are temporarily residing in an EU/EEA or treaty country outside the Netherlands, you are entitled to the following healthcare:

- Healthcare in accordance with the statutory insurance package in an EU/EEA country or treaty country, if applicable to you. This right to healthcare is set out in the EU social security regulations or a social security treaty;
- Healthcare provided by a contracted healthcare provider or healthcare institution;
- Reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the amount you would receive if you selected a non-contracted healthcare provider in the Netherlands. For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Please note**

In the event of emergency care provided by a non-contracted healthcare provider, you are entitled to reimbursement of the costs up to the Wmg rates applicable in the Netherlands or the reasonable market-level rates as applicable in the Netherlands. For foreseeable care that a contracted care provider is not expected to provide in time or at all, we may supplement the compensation for the costs of care provided by a non-contracted care provider up to a maximum of the Wmg rates applicable in the Netherlands or the reasonable market price applicable in the Netherlands.

**European Healthcare Insurance Card (EHIC)**

On the reverse of your healthcare card, you can find the EHIC. If you travel to an EU/EEA country or Switzerland, this card entitles you to necessary medical care abroad. You can use the EHIC in Australia for emergency medical care. You may only use this EHIC if you are insured with us. If you use this EHIC abroad, while you know or could reasonably know that it is no longer valid, the cost of healthcare will be charged to you. Do you not have an EHIC healthcare card? You can request one free of charge.

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

If you are living in or residing in a non-EU/EEA country or non-treaty country, you may choose healthcare in your country of residence or temporary residence and select:

- Healthcare provided by a contracted healthcare provider or healthcare institution;
- Reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the amount you would receive if you chose a non-contracted healthcare provider in the Netherlands. Please refer to Articles 1.4 and 1.6 of these policy conditions.

**Please note**

The costs of treatment abroad may be higher than the costs of the same treatment in the Netherlands. We will reimburse the costs up to the amount you would receive if you had the treatment in the Netherlands. Therefore please take into consideration that you will likely have to pay for a (large) part of the bill yourself if you are having treatments abroad.

### 9.3. Approval and/or referral

You would like to be treated abroad? If you are admitted to a hospital or other institution for 1 or more nights for this treatment, you will need our prior consent. You also need permission for receiving care abroad if this is stated in the healthcare provisions (Articles 11 to 39). These Articles also set out when you need a referral or prescription.
Do you not need our permission, but would you like to know in advance whether your treatment abroad is eligible for reimbursement? Then contact us to ask us to review it for you. For more information, please check our website.
You do not require approval if you are unexpectedly hospitalised and the treatment cannot reasonably be postponed until you have returned to your country of residence. If you are admitted for 1 or more nights, you must call, or have someone else call, our emergency centre. The phone number is available in the App, on your healthcare card and on our website.

## Article 10. Complaints and disputes

### 10.1. Do you have a complaint? Submit your complaint to the Complaints Management department

You may rest assured that we organise everything carefully relating to your healthcare insurance policy. However, one hundred percent satisfaction is not always achievable. We are open to hearing your complaints and suggestions. For more information regarding filing a complaint, please visit our website.

**Tips for submitting a complaint**

- Please indicate in as much detail as possible what happened, what you are dissatisfied with, what you think is the best solution and when you can best be reached.
- Please attach all relevant documents. Please do not send any originals with your complaint. After all, you may still need the originals yourself.
- If you are unable or unwilling to submit your complaint, you can have someone else do this on your behalf and designate a proxy. However, for privacy reasons, we will require your permission in writing to deal with such a proxy. We cannot process the complaint until we receive your permission.

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

### 10.2. Complaints about our forms

Do you find a form redundant or complicated? Then you may submit a complaint. For more information, see our website.

Alternatively, you can submit your complaint to the Dutch Healthcare Authority for the attention of the Information Line/the Notification Centre, PO Box 3017, 3502 GA Utrecht, the Netherlands, email: info@nza.nl. The website of the Dutch Healthcare Authority, www.nza.nl, sets out how to submit a complaint about forms.

# II. Healthcare Provisions

**Your insurance is an in-kind insurance policy. You are entitled to care on the basis of this insurance cover. Articles 11 through 39 list the details of the care to which you are entitled.**

## MEDICAL CARE

## Article 11. General practitioner care

1. General practitioner care is medical care as general practitioners tend to provide and the accompanying examinations and diagnostics. GP care also includes health advice, assistance in giving up smoking and preconception care (childbirth consultation). Foot care as defined in the NZa policy rule Other medical care also falls under general practitioner care.

   **Coaching for quitting smoking**
   Counselling for quitting smoking is defined as:
   - Short treatments, such as one-off short counselling sessions for quitting smoking;
   - Intensive forms of treatment aimed at behavioural change (in a group or as an individual).

   Information about the Quit Smoking Programme is set out in Article 24.

   **Preconception care**
   Pre-conception healthcare (pregnancy wish visit) is defined as:
   - Advice on healthy nutrition
   - Advice on intake of folic acid
   - Advice on intake of vitamin D
   - Advice on quitting smoking, alcohol and drugs, if necessary with active counselling to realise this
   - Advice on using medication
   - Advice on treatment of existing conditions and previous pregnancy complications
   - Advice on infectious diseases and vaccinations
   - Detecting risk based on your disease history and offering genetic counseling if you are not (yet) pregnant.

2. Specialist medical care bordering on the medical domain of the general practitioner.
   Examples of such healthcare include:
   - Regular or minor surgery interventions
   - ECG diagnostics (heart images)
   - Lung function test (spirometrics)
   - Diagnostics based on the Doppler test (testing the blood flow in the vascular system)
   - MRSA screening (screening for Meticillin Resistant Staphylococcus Aureus)
   - Audiometrics (hearing system testing)
   - IUD (pessary, diaphragm) application or removal, implantation or removal etonogestrel implantation rod. Are you age 21 or older? Then you are not entitled to reimbursement of the contraceptive, except in the context of treatment of endometriosis or menorrhagia (if there is anemia). See Article 34
   - Medically necessary circumcision (circumcision)
   - Therapeutic injections (Cyriax).

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

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

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

**Multi-disciplinary care (chain care)**

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

**Home Care Group**

The healthcare group is a partnership of healthcare providers with various disciplines, with a general practitioner in charge. Together, they provide chain healthcare. In addition to the general practitioner, healthcare is also delivered by a nurse, physician's assistant, dietician, podotherapist or pedicurist, for example.

**Excess**

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

**This is where to go**

1. For general practitioner care (items 1 and 2) and multidisciplinary care (item 3.1):
   To a primary care physician, GP, healthcare group or medically qualified third parties. Under the medical responsibility of a general practitioner, this care may also be provided by a physician's assistant, nurse, nurse practitioner (NP), physician assistant (PA) or family practice assistant (POH) (GGZ).
   You may also visit a certified obstetrician for the placement or removal of an IUD.
   Your obstetrician can inform you about this.
2. For foot care as listed under 1 at:
   - A podiatrist who is registered with the Quality Register Paramedics
   - A medical pedicurist registered in ProCert's KRP (Quality Register for Pedicures)
   - A pedicurist with the certification 'Diabetic foot'
   - A pedicurist registered in the Stipezo Register Paramedische Voetzorg (RPV or Register Paramedic Foot care)
   - A pedicurist registered in the Kwaliteitsregister Medisch Voetzorgverleners (KMV or Quality Register Medical Foot care Providers) of Nederlandse Maatschappij Medisch Voetzorgverleners (NMMV or Dutch Association of Medical Foot care Providers).

   The podiatrist draws up the treatment plan and determines what part of the treatment a (medical) pedicurist may provide. The partnerships between podotherapists and pedicurists are available from our website.
3. A contracted healthcare group contracted multidisciplinary care (item 3.2):
   From a contracted healthcare group.

You can ask your general practitioner's clinic about the possibilities for multidisciplinary care. For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions.

If you select a non-contracted healthcare group for contracted multidisciplinary care as described in item 3.2, you are not entitled to reimbursement.
Do you not use multidisciplinary care or are you unable to use it in your area? Then you are entitled to care provided by individual healthcare providers under the relevant healthcare Articles, such as general practitioner care (items 1 and 2) and dietetics (Article 29).

Would you prefer to visit a general practitioner or healthcare group with whom we have not concluded a contract for general practitioner care or multidisciplinary care as described in section 1, 2 or 3.1? Then you are entitled to reimbursement of the cost of healthcare up to a maximum of the applicable Wmg rates.
Would you prefer to visit a care provider other than a general practitioner or healthcare group with whom we have not concluded a contract for the relevant care? Then please take into consideration that you will likely have to pay part of the bill yourself. This also applies to testing requested by your general practitioner to be carried out by another non-contracted healthcare provider (for example X-rays or blood tests). For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

## Article 12. Medical care for specific patient groups

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

   The primary care provider will draw up your treatment plan and lead the multi-disciplinary team. The treatment plan sets out the care and the number of half-day sessions of care in a group.

**Excess**
This healthcare is set off against the excess.

**This is who to see**
1. For care as referred to under 1: by a geriatric specialist, a doctor for the mentally handicapped, a healthcare psychologist (GZ-psycholoog), general remedial educationalist or clinical (neuro)psychologist.
2. For care set out in 2: a multi-disciplinary team led by the primary care provider (leading treatment professional). The primary practitioner is a specialist in geriatrics or doctor of mentally handicapped. The primary practitioner for a nationally accredited multidisciplinary care programme may also be a GZ psychologist, general remedial educationalist or clinical (neuro)psychologist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
General practitioner or medical specialist. Referral for care as listed under 2 may also be issued by a specialist in geriatrics, physician for the mentally handicapped, GZ psychologist or general remedial educationalist.

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

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

# Article 13. Care due to overweight and obesity

## 13.1. Chain approach to care and support for insured up to age 18 who are overweight and obese

The chain approach to care and support due to overweight and obesity is for insured up to age 18 with a moderately increased weight-related health risk (WRH). The WRH is determined based on the standard of care for obesity. The chain approach includes at least guidance and coordination by a central healthcare provider. A central healthcare provider:

- prepares a broad anamnesis
- establishes a plan of action with child and family and ensures consistency of care and treatment, but does not provide the actual care
- coordinates the right support and care at the right time by the right professional for the child and family
- is committed to strengthening the self-management of the child and family so that they are increasingly capable of achieving sustainable behavioural change on their own.

A combined lifestyle intervention (CLI) for insured up to age 18 is part of the chain plan. A CLI is an accredited care programme on healthy eating, eating habits and increased exercise, and serves to develop and maintain a healthy lifestyle. Optionally, customised psychological interventions to support behavioural change may be part of the care programme.

The chain approach as a whole can be applied up to 3.5 years. This 3.5-year period includes a possible 6-month interim period during which activities in the social or public domain take place. The interim period may be extended in consultation with us if it can substantially contribute to achieving the goal of the care plan.

A CLI lasts for 24 consecutive months. You are not entitled to reimbursement of the costs of exercise and guidance.

**This is not insured**

Is a CLI not part of the care plan? Then the cost of coordination by a central care provider is not covered by health-care insurance.

**Excess**

No excess applies for this healthcare.

**This is who to see**

1. For guidance and coordination by a central care provider: in the case of a level 5 adolescent nurse working in Youth Healthcare
2. For an accredited combined lifestyle intervention: with a licensed child lifestyle coach. On our website, you can find accredited combined lifestyle interventions and children's lifestyle coaches.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**

General practitioner, paediatrician, adolescents physician or level 5 adolescent nurse practitioner.

## 13.2. Chain approach to care and support for insured age 16 and older/adults

A combined lifestyle intervention (CLI) is an accredited programme on healthy eating, eating habits and increased exercise to develop and maintain a healthy lifestyle. Optionally, customised psychological interventions to support behavioural change may be part of the care programme. Are you age 18 or older? Then you may qualify for an accredited programme starting with a moderately elevated weight-related health risk (WRH or WRH).
The WRH is determined on the basis of the Obesity Care Standard. Are you age 16 or 17? Then you are eligible for a CLI if you have a moderately elevated WRH and your GP estimates that you could benefit from a CLI for adults Please find the accredited programmes on our website. A programme is completed in 24 consecutive months. You are not entitled to reimbursement of the cost of exercise or assistance with exercise.

**Excess**
No excess applies for this healthcare.

**This is where to go**
1. To a lifestyle coach registered in the KABIZ register (Quality Registration and Accreditation Healthcare Professionals) and affiliated with the Beroepsvereniging Leefstijlcoaches Nederland (BLCN, Professional Association Lifestyle Coaches Netherlands)
2. A physical therapist, remedial therapist, dietician or occupational therapist who are registered lifestyle coaches.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
General practitioner.

## Article 14. Nursing and care (district nurses)

Nursing and care is care such as nurses tend to provide without the need for a stay in an institution. The care is related to the need for or a high risk of medical care as set out in
article 2.4 of the Healthcare Insurance Decree. In addition to nursing activities and care, this care also includes coordination, signaling, prevention, instruction, strengthening of the client's own control and autonomy, the client system and case management. This care also includes care such as a nurse would provide if you were to make use of an emergency call via a personal alarm (for example if you had fallen at home).

This care includes nursing day care, intensive child care in a nursing day care centre or child care home. Intensive Child Care (ICC, IKZ), also called medical child care, is care provided to children up to age 18 that involves a need or high risk of need for care as nurses tend to provide in connection with medical care. These children also have a need for permanent supervision or 24-hour care in the vicinity.

You need an indication for nursing and/or care and a care plan must be prepared. The indication is issued by a level-5 nurse or nursing specialist. The nurse consults with you to prepare a treatment plan in compliance with the guidelines of the occupational group Nursing & Caring in the Netherlands. The treatment plan describes the healthcare you need in terms of nature, scope and duration and the goals set.
The indication for nursing and care for insured persons under age 18 is prepared by a paediatric nurse, level 5, or a nursing specialist. The nurse consults with the parents and paediatrician to prepare a treatment plan. This care plan describes the care needed in nature, extent and duration, along with the goals set.

**Please note**
An increasing number of specialist medical treatments are provided in a residential setting. We do not reimburse the associated nursing and care if we pay for it as part of specialist medical care.

**Personal Budget (pgb)**
You may be entitled to reimbursement of nursing and care in the form of a personal budget (pgb). This requires our prior approval. The Nursing and Care Personal Budget Regulations set out the terms and conditions that apply to having a pgb. The Nursing and Care Personal Budget Regulations are available from our website.

**Excess**
No excess applies for this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

1. A home care or other institution relating to nursing and care with a level 5 paediatric nursing specialist or nursing specialist with a permanent contract. The level 5 paediatric nursing specialist or nursing specialist establishes the indication and remains involved in the implementation and evaluation of the care plan. Care is provided by a college/mbo
nurse, nurse specialist, level 3 caregiver or caregiver in individual health care (VIG-er).
2. For an independent level 5 college paediatric nursing specialist or nursing specialist for the indication and provision of care. The healthcare can also be provided by a level 4 or 5 nursing specialist, nurse, healthcare worker level 3 or healthcare worker in individual nursing healthcare (VIG staff). This is permitted only if this healthcare provider collaborates with the level 5 paediatric nursing specialist or nursing specialist who prepared the medical indication. The healthcare provider who prepared the medical indication remains involved in the implementation and evaluation of the care plan. The cooperation is in writing and we receive a copy of it.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

**Approval**

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

## Article 15. Obstetric care and maternity care

### 15.1. Obstetric care

Obstetric care, including pre and after care, is care as obstetricians tend to provide. Obstetric care also includes the use of the delivery room if delivery in a hospital or birth clinic is medically necessary.

**This care also comprises:**

- Pre-conception healthcare (pregnancy wish visit)
  If you wish to get pregnant, you can make use of pre-conception healthcare. Article 11, item 1 indicates the elements included in this type of care.
- Counselling
  If you are pregnant and you are considering pre-natal screening for birth defects, you will generally require an extensive consultation with your general practitioner, obstetrician or medical specialist first. This consultation visit is referred to as counselling. During this visit you will receive information on the content and scope of pre-natal screening. You can then make an informed decision as to whether you want this screening.
- The non-invasive prenatal test (NIPT) and invasive diagnostics if you have a medical indication.
- Invasive diagnostics (chorionic villus testing or amniocentesis) if an NIPT shows that you have a significant risk of having a child with a chromosomal abnormality (such as Down's syndrome).

**Excess**

No excess applies for obstetric care. Any fees associated with obstetric care, such as medication, blood tests and patient transport, are also subject to the excess. No excess applies for the placement and removal of an IUD (coil) by the obstetrician. The excess does apply to the IUD (coil). See Article 34, Medications, and the Medical Devices Regulations for reimbursement of the IUD;
For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
To an obstetrician or general practitioner who has received continuing education and has specifically focused on physiologic obstetrics.
For the NIPT, you can visit a blood collection site for NIPT. The blood test is performed by a university centre. For invasive diagnostics, visit a prenatal diagnostic centre. Integral maternity care may only be provided by an Integral Maternity Care Organisation (IGO) that has a contract with us.

**Integral maternity care**

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

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

## 15.2. Maternity care

Maternity care includes care as maternity nurses tend to provide to mother and child in connection with childbirth, for up to 6 weeks counting from the day of delivery. The number of maternity care hours is indicated using the National Indication Protocol Maternity Care (LIP) and in consultation with the maternity care organisation.
Please find this protocol on our website. After delivery and during your maternity period, the maternity care organisation will determine if the number of hours indicated needs to be adjusted. For each day of hospitalisation on which some maternity care has already been provided in the relevant hospital, we deduct the average number of hours of maternity care per day from the number of maternity care hours indicated. If several care facilities (for example, hospital and maternity care organisation) charge for the same day of maternity care, you are also entitled to maternity care on this double day.

**Please note**

Request maternity care at least 5 months prior to the expected due date via our website. Then you can be assured that your request will be processed in time.

**Personal contribution**
You are charged a statutory personal contribution amounting to:
- €5.10 per hour for maternity care at home or in a birth clinic;
- €20 per day for both mother and child in the event of delivery in a birth clinic or hospital, without a medical need. In addition to the personal contribution, you must pay the difference in costs between the rate charged by the birth clinic or hospital and the maximum reimbursement of €143 per day for both mother and child.

**Excess**
No excess applies for this healthcare.

**This is where to go**
A qualified maternity nurse who is registered with the Maternity Care Knowledge Centre or nurse. Maternity care as a part of integral birth care may be provided by an Integral Birth Care Organisation (IGO) that has a contract with us. Please find more information about integral maternity care in Article 15.1, Obstetric care.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Extra information**

Are you using a non-contracted maternity nurse or nurse? Please enclose a copy of the indication in accordance with the LIP (Landelijk Indicatie Protocol Kraamzorg - National Referral Protocol Maternity Care).

You can request a copy from your maternity care organisation and/or from the independent maternity nurse or nurse.

**Personal contribution and maximum reimbursement**

| **Delivery and maternity care at home** | |
|---|---|
| Delivery at home | No personal contribution applies. |
| Maternity care at home | Subject to a personal contribution for maternity care amounting to €5.10 per hour. |
| **Delivery and maternity care in a birth clinic or hospital with medical necessity** | |
| Delivery in a birth clinic or hospital with medical necessity | No personal contribution applies. |
| Maternity care in a birth clinic | Subject to a personal contribution for maternity care amounting to €5.10 per hour. |
| Maternity care in hospital after delivery with medical necessity | No personal contribution applies. |
| **Childbirth and maternity care in a birth clinic or hospital without medical necessity** | |
| Childbirth without medical necessity in the delivery room of a birth clinic<br>Childbirth and maternity care in a hospital without medical necessity | The maximum reimbursement for mother and child together is €246 per day.<br>This fee is calculated as follows:<br>Maximum reimbursement is 2 x €143: € 286 per day<br>Less: personal contribution is 2 x €20: € 40 per day<br>—————<br>€ 246 per day<br><br>The difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of €246 per day is charged to you personally. |
| Delivery without medical necessity in a birth clinic or hospital as part of integral maternity care by an Integral Maternity Care Organisation contracted by us | The personal contribution for mother and child combined amounts to €531.07. |
| Maternity care in a birth clinic | Subject to a personal contribution for maternity care amounting to €5.10 per hour. |

**Medical necessity**

Your obstetrician or the general practitioner providing the obstetric care determines whether childbirth in a hospital or birth clinic is medically necessary.

## Article 16. Specialist medical care

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

- Care provided by a thrombosis unit
- Second opinion by a medical specialist
  This is subject to a referral from the healthcare provider treating you. This may concern the relevant general practitioner, obstetrician or medical specialist, for example. The second opinion must relate to the medical care that you already discussed with your first healthcare provider. You are required to return to your original healthcare provider with the second opinion, as the first person will remain the leading provider in your treatment;
- Dialysis in a dialysis centre, hospital or at home. Please find more information regarding dialysis in the home situation and the allowance for additional costs (electric power) on our website.

- Chronic intermittent respiration and the required equipment. Please find more information regarding an allowance for electric power costs of mechanical breathing equipment in the home situation on our website.
- Medically necessary circumcision (circumcision).

To the extent you are participating in research testing as referred to in Article 2.2, healthcare insurance Regulations, medical specialist care also includes:

a. from 1 July 2021 to 1 August 2025, bladder instillation with bladder irrigation fluids containing chondroitin sulphate and/or hyaluronic acid for the treatment of patients with bladder pain syndrome with non-transurethral treatable Hunners lesions;
b. From 1 January 2017 to 1 January 2025, intensified, alkylating chemotherapy with stem cell transplantation for the treatment of patients age 18 to 65 with BRCA1-like, stage III breast cancer;
c. From 1 October 2017 to 1 October 2024 combination treatment of cytoreductive surgery and hyperthermic intraperitoneal chemotherapy in patients with both gastric carcinoma and synchronous peritoneal metastases or tumor-positive abdominal fluid;
d. From 1 April 2019 to 1 March 2024, CardioMEMS arteria pulmonalis monitoring in patients with chronic heart failure New York Heart Association class III with recurrent hospitalisations;
e. From 1 January 2020 to 1 January 2027, hyperthermic intraperitoneal chemotherapy added to primary debulking in patients with stage III ovarian carcinoma;
f. From 1 January 2020 to 1 January 2027, Nusinersen for the treatment of patients with 5q spinal muscular atrophy who are age 9.5 and older.

Once the research testing is completed, you are entitled to this care as described in Article 2.2 paragraph 6, health-care insurance Regulations. This does not apply in the event of intermediate suspension of the research testing.

The Minister of Health has the option of designating care as conditionally admitted care four times a year. The above list may not be up to date. It indicates the status insofar as known at the moment of preparing and printing these policy conditions. Please check Article 2.2 of the healthcare insurance Regulations on our website for the most current overview.

**This is not insured**

a. Treatments against snoring with uvuloplasty
b. Treatments aimed at sterilisations (for both male and female)
c. Treatments aimed at reversing sterilisations (for both male and female)
d. Treatment of plagiocephaly and brachycephaly without craniosynostosis with a cranial band
e. Fertility-related care if you are a woman age 43 or older, unless it concerns an in-vitro fertilisation attempt that was started before reaching age 43.

**Excess**

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

**This is where to go**

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

**Please note**

The healthcare providers were contracted based on quality criteria for good healthcare. This means that certain specialist medical healthcare is purchased only from healthcare providers who fulfil these criteria.
Would you like to know which care providers have a contract with us, and for which care? Please refer to our website to see a list of such information.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Integral birth care**
Midwives, maternity nurses and obstetricians who work together in an Integral Maternity Care Organisation (IMCO or IGO) can agree an integral rate for maternity care with us. The IGO may charge you for this care only based on a contract concluded with us.

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

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

**Which types of care are subject to prior approval?**

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

| | |
|---|---|
| **Ophthalmology:** | Refraction surgery (eye laser treatments or lens implants) and eyelid corrections |
| **Otorhinolaryngology (ENT):** | ear corrections and treatment of nasal shape deviations. |
| **Surgery:** | Gynaecomasty (breast formation in men), mammary hypertrophy (abnormal breast size), abdominal wall corrections |
| **Dermatology** | Benign (non-malignant) tumours, pigment disorders, vascular dermatosis (birthmarks) |
| **Gynaecology:** | Vulvar and vaginal abnormalities |
| **Plastic surgery:** | See Article 21 Plastic and/or reconstructive surgery |

If in doubt, we recommend contacting us to check if prior approval is required for any treatment.
Your medical specialist is required to notify you that you will be charged the cost of care if you have not received prior authorisation.

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

# Article 17. Rehabilitation

## 17.1. Rehabilitation

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

- This care is designated as the most effective for you to prevent, reduce or overcome a disability resulting from disorders or limitations of movement or a disability resulting from a central nervous system disorder that results in limitations in communication, cognition or behavior, and;
- This care enables you to achieve or maintain a degree of independence which, given your restrictions, is reasonably possible.

The rehabilitation as set out above also includes:

- The quick scan as part of early interventions for long-term a-specific complaints of the position and locomotor system. A-specific complaints refer to complaints for which no clear cause can be found;
- Cancer rehabilitation. This healthcare is aimed at functional, physical, psychological and social problems relating to cancer, including aftercare and rehabilitation that is part of the oncology healthcare. This concerns advice and counselling where necessary relating to managing the disease, recovery, improving and maintaining the health condition. Cancer rehabilitation must be aimed at all phases you may be in (diagnosis - treatment - aftercare).

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

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

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**

General practitioner, company doctor or medical specialist.

**Approval**

You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

## 17.2. Geriatric rehabilitation

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

GRZ is covered only if:

1. The care is provided within one week of a hospital stay as referred to in Article 2.12 of the Healthcare Insurance Decree (see Article 37, Stay), and this stay was not preceded by a stay as referred to in Article 3.1.1 of the Long-Term Care Act;
2. You have an acute condition that involves acute mobility impairment or decrease in self-sufficiency and you received prior specialist medical care for this condition. The assessment (geriatric assessment) is performed by a geriatrician, clinical geriatrician, geriatric internist or geriatric specialist. Geriatric rehabilitation must follow the geriatric assessment within one week, even if you were not hospitalised;
3. The initial care is accompanied by a stay as referred to in Article 2.12 of the healthcare insurance Decree.

**Geriatric rehabilitation**

Geriatric rehabilitation is aimed at vulnerable elderly people undergoing specialist medical treatment. For example due to a stroke, bone fracture or a replacement joint. Such elderly clients need a multidisciplinary rehabilitation programme adjusted to their individual rehabilitation possibilities and training pace, taking any other conditions into consideration (complex multi-morbidity). The aim is to help them return to their home situation and continued participation in society.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
A multidisciplinary team of experts in geriatric rehabilitation led by a specialist in geriatric medicine.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

## Article 18. Genetic testing

Hereditary testing is medical care as referred to in Article 16 (Specialist Medical Care) and includes testing of hereditary defects by means of genealogical tests, chromosome tests, biochemical diagnostics, ultrasound tests and DNA tests, the provision of hereditary advice and the psychological-social assistance relating to this care. If this is necessary for the advice to be prepared for you, the examination will also include testing of persons other than the insured. In that case those persons may also receive advice.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
A centre for genetic counselling. This is an accredited and licensed institution for the application of clinical genetic research and genetic counseling.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
General practitioner or medical specialist.

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

### 19.1. In vitro fertilisation (IVF)

In vitro fertilisation (IVF) is medical care as referred to in Article 16 (Specialist Medical Care) and includes a maximum of the first, second and third IVF attempts per pregnancy to be realised if you are age 42 or younger. If you have started with a first, second or third IVF attempt, you may complete this attempt after your 43rd birthday at the expense of your health insurance company. If you are under age 38, the first and second IVF attempts will only be reimbursed if one embryo is placed each time.
In this context, a realised pregnancy is defined as a continuous pregnancy of at least 10 weeks counted from the moment of follicle puncture. Fertilisation of the egg cell takes place immediately consecutive to the puncture. For cryos (cryo-preserved embryos), a term of at least 9 weeks and 3 days after the implantation date applies to define an ongoing pregnancy.

An IVF attempt, being healthcare in accordance with the in-vitro fertilisation method, comprises:
a. Promoting the maturation of oocytes in a woman's body based on hormonal treatment
b. Follicular puncture
c. Fertilisation of oocytes and cultivation of embryos in the laboratory
d. The single or multiple implantation of 1 or 2 embryos into the uterine cavity to induce pregnancy.

An IVF attempt does not count until successful follicular puncture has been performed in phase b. Only attempts subsequently aborted count toward the number of attempts. The transfer of embryos obtained in an earlier phase of treatment (whether or not cryopreserved in the meantime) is part of the IVF attempt that led to the creation of the embryos. If there are any embryos left over after an ongoing pregnancy has been established, you are entitled to have them re-placed on the grounds of Article 19.2, Other fertility-related care.

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

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
With a gynaecologist in a facility licensed for this purpose.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
Gynaecologist or urologist.

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

**IVF treatment abroad**
Your eligibility for IVF treatment depends on your personal situation, for example your age and how long you have attempted to become pregnant. Would you like to go abroad for IVF treatment? Please contact us in advance. For more information, see our website.

## 19.2. Other fertility-related care

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

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
A gynaecologist or urologist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
General practitioner or medical specialist.

## Article 20. Audiological care

Audiological care is medical care as referred to in Article 16 (Specialist Medical Care) and includes care relating to:
- Hearing tests
- Advice about the hearing aid to be purchased
- Information about the use of the equipment
- Psychosocial care if required in connection with problems with impaired hearing
- Assistance in making a diagnosis in cases of speech impediments and language or language development disorders in children.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
In a multidisciplinary team of experts associated with an audiology centre, under the responsibility of a medical specialist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

## Article 21. Plastic and/or reconstructive surgery

Plastic and/or reconstructive surgery is medical care as referred to in Article 16 (Specialist Medical Care) and includes treatments of a plastic-surgical nature, if it concerns:
1. Correction of abnormalities of appearance associated with demonstrable physical dysfunction;
2. Correct disfigurement caused by a disease, an accident or a medical procedure;
3. Correct paralysed or weakened upper eyelids if resulting in serious limitation of the visual field, or if it is a result of a congenital deformity or a chronic disorder present at birth.
4. Correct congenital deformities in connection with lip, jaw and palate clefts, deformities of the facial bones, benign proliferations of blood vessels, lymphatic vessels or connective tissue, birthmarks and deformities of the urinary tract and sexual organs;
5. Correct primary sexual characteristics where transsexuality has been established;
6. Surgically insert and replace a breast prosthesis other than after a full or partial mastectomy;
7. Surgically insert and surgically replace a breast prosthesis in the event of agenesis/aplasia of the breast (lack of breast formation) in women and in male-female transgenders, subject to the following criteria:

- Absence of an inframammary fold (fold under the breast) and;
- Gland tissue of less than 1 cm, shown by an ultrasound.

**What is the definition of plastic surgery treatments?**
Treatments of a plastic surgical nature are understood to mean: interventions to change the shape or an aspect of the appearance. These procedures are not limited to the specialist field of plastic surgery.
The ‘Reference Guide assessment plastic surgery treatments’ sets out a further explanation of when you are entitled to this care in accordance with the criteria listed. This guide was compiled by the Association of Public Health Physicians (Vereniging Artsen Volksgezondheid, VAV), the Dutch healthcare insurers (Zorgverzekeraars Nederland, ZN) and the Netherlands Healthcare Institute (Zorginstituut Nederland). You can find this reference guide on our website.

**This is not insured**
a. Treatment of paralysed or weakened upper eyelids, other than those listed in point 3 of this Article
b. Abdominal liposuction;
c. Surgical insertion and/or removal of a breast prosthesis without medical necessity or for cosmetic reasons.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
A medical specialist. Epilation (hair removal) in transgender care may also be performed by a skin therapist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
General practitioner, company doctor, medical specialist or dental surgeon.

**Approval**
You require our prior approval. The application must be accompanied by an explanation from your treating medical specialist. You do not need approval for primary or secondary breast reconstruction (initial breast repair surgery) after breast cancer. However, tertiary breast reconstruction after breast cancer is subject to approval. Tertiary breast reconstruction is a second reconstruction operation on the same breast.
More information about applying for approval is set out in Article 1.9 of these policy conditions.

## Article 22. Tissue and organ transplants

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

Care also includes reimbursement for:
a. Specialist medical care in connection with donor selection;
b. Specialist medical care in connection with the surgical removal of the transplant material from the selected donor;
c. The examination, preservation, removal and transport of the post-mortem transplant material in connection with the intended transplant;
d. The care of the donor arranged in these policy conditions for a maximum period of thirteen weeks, or in the case of a liver transplant for a maximum period of six months, after the date of discharge from the institution in which

the donor was hospitalised for selection or removal of the transplant material insofar as this care is associated with this hospitalisation;

e. The transport of the donor in the lowest class of a means of public transportation within the Netherlands or, if due to medical necessity, transport by car within the Netherlands, in connection with the selection, hospitalisation and discharge from the hospital together with the care as referred to under d;
f. The transport to and from the Netherlands of a donor residing abroad, in connection with a transplant of a kidney, a liver or bone marrow with regard to an insured person in the Netherlands plus other costs involved in the transplant which are related to the fact that the donor resides abroad. The costs of staying in the Netherlands and any loss of income are not covered.

If the donor concluded a healthcare policy, the cost of transportation referred to under e and f will be charged to the donor's healthcare insurer.

**Excess**
This healthcare is set off against the excess. The excess does not apply for:
- Care related to a living organ donation after the period referred to under d has expired.
- Transport of a donor such as set out under e and f, provided the donor has healthcare insurance.

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

**This is where to go**
A medical specialist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

## Article 23. Sensory disability care

Care for the sensory disabled is multi-disciplinary care in connection with a visual, auditory or communicative impairment resulting from a language development disorder or a combination of these impairments. This healthcare is aimed at learning how to manage, reverse or compensate for the disability, with the purpose of optimising independence in daily life.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
An institution specialised in treating people with a sensory disability, with a multidisciplinary treatment team.

Healthcare relating to a visual impairment: the ophthalmologist or healthcare psychologist has final responsibility for the healthcare delivered and the treatment plan. The clinical physician or other disciplines may also bear this responsibility. The activities of the clinical physician or other disciplines are limited in that case to the healthcare as set out in Section 2.5a of the Healthcare Insurance Decree, and the requirements and conditions imposed on sensory disability healthcare.

Healthcare relating to an auditive impairment or communicative impairment due to a language development disorder: the healthcare psychologist has final responsibility for the healthcare delivered. The orthopedagogist or other disciplines may also bear this responsibility. In that case, the activities of the remedial educationalist or other disciplines are limited to the care as described in Article 2.5a Health Insurance Decree and the requirements and conditions set out therein for sensory disability care.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
Medical specialist or general practitioner. Referral for care in connection with an auditory or communicative disability may also be made by a clinical physicist-audiologist at an audiology centre.

## Article 24. Quit Smoking programme

The quit smoking programme comprises medical care to support behavioural change with the aim of quitting smoking. Medications can also be part of this care if prescribed as part of the programme, to support behavioural change. You can attend the programme in a group or individually. The objective of the programme is for you to quit smoking. You may attend a Stop Smoking programme maximum once per calendar year.

**Excess**
No excess applies to this healthcare type. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
Healthcare providers who work in compliance with the Healthcare Module Tobacco Addiction.
The medications may only be delivered by one of our contracted online pharmacies. These are listed on our website.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? Or do you use a pharmacist or dispensing general practitioner with whom we have not concluded a contract for these medications? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

# MENTAL HEALTHCARE (GGZ)

## Article 25. Mental healthcare (GGZ) for insured age 18 and older

Mental healthcare is medical care as psychiatrists and clinical psychologists tend to provide for insured age 18 and older. The treatment (intervention) must comply with the state of art and best practice. On our website, you can find information about treatments that meet this requirement in the List of Therapies GGZ. This overview states which therapies do or do not comply and in which situations they may be applied.

**The following is not insured**
Care for which effectiveness is not, or not adequately, substantiated by evidence is not covered by basic insurance. To determine whether care is covered, we rely on DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), care standards, opinions of Zorginstituut Nederland, Zorgkompas Zorgverzekeringswet and the List of Therapies GGZ, among others.

Please find below a list of some conditions, treatments and interventions that are not covered by the GGZ mental health system. This list sums up examples and is not exhaustive:
- Treatment of adjustment disorders (for example divorce and mourning)
- Help with work and relationship problems
- Help with sleep disorders, sexual dysfunctions
- Psychosocial help/care (e.g. for stress or burnout)
- Treatment for learning disorders

- Self-help
- Directing to care
- Prevention, unless this involves indicated or care-related prevention
- Services
- Psychological help related to physical conditions
- Intelligence tests
- Neurofeedback
- Treatment that primarily addresses disorders is not included in the DSM-5 qualification. This means treatments for obesity or sex or eating addiction, for example, are not covered
- Counseling of a non-medical nature, such as training, coaching and courses
- Diagnostics without the intention of GGZ mental health treatment
- 5 or more diagnostic consultations leading to a non-insured diagnosis
- Resocialisation without GGZ mental health treatment.
- Inpatient addiction treatment admissions that are not immediately followed up with subsequent, outpatient follow-up treatment. The period after discharge is considered a vulnerable period. Only if properly embedded in an outpatient treatment regimen (proper pre and post-treatment care), inpatient treatment (abroad) can be considered effective, and be classed as in accordance with the state of science and practice.
- Admission based on a social indication (e.g. in case of lack of housing), unless it concerns Residence with justification.

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

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

**National Quality Charter GGZ**

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

**Primary care provider**

In an independent practice, the primary practitioner usually performs the treatment personally. Several care providers may be involved in the treatment in an institution. Among other things, the coordinating primary care provider determines the cooperation with these care providers. The primary care provider also ensures that you participate in the decision-making process regarding your treatment options.

1. The primary practitioner GB GGZ (generalist basic mental healthcare) may be an independent practice (section II, care performance model setting 1): clinical (neuro)psychologist, psychotherapist and healthcare psychologist (GZ psychologist).
2. The primary practitioner SGGZ (specialist mental healthcare) may be an independent practice (section II, care performance model setting 1): psychiatrist, clinical (neuro)psychologist or psychotherapist.
3. The primary practitioner GB GGZ in an institution may be (section III, care performance model setting 2 and higher): clinical (neuro)psychologist, psychotherapist, GZ psychologist and mental health nursing specialist.
   Primary care provider GB GGZ in an institution may also include:
   - Specialist geriatrics and clinical geriatrician: for patients of (biological) older age with a mental health main diagnosis
   - Addiction physician KNMG: if the main diagnosis is addiction and/or gambling problems

- Remedial educationalist-general physician: for diagnostics, treatment and medical supervision of insured persons in a (complex) personal dependency relationship with (complex) learning, behavioral or developmental problems if they are covered by the Zorgverzekeringswet (Health Insurance Act) financed medical GGZ or forensic care. This often concerns young adults or policyholders with additional mental handicap.
- Social psychiatric nurse: in the coordinating role in chronic primary mental healthcare (setting ambulatory section III monodisciplinary). The social psychiatric nurse does not make the psychiatric diagnosis and/or medical indication. The social psychiatric nurse does not prepare the initial treatment plan, but may develop the initial treatment plan at a more detailed level based on the social psychiatric nurse diagnosis and treatment.

4. The primary practitioner SGGZ in an institution may be (section III, care performance model setting 2 and above): psychiatrist, clinical (neuro)psychologist, psychotherapist, GZ psychologist and mental health nursing specialist. Primary care provider GB GGZ in an institution may also include:
   - Specialist geriatrics and clinical geriatrician: for patients of (biological) older age with a mental health main diagnosis
   - Addiction physician KNMG: if the main diagnosis is addiction and/or gambling problems
   - Physician assistant if the care is part of the physician assistant's area of expertise in mental health care. There are somatic problems that are related to psychiatric problems within a multidisciplinary setting. The physician assistant works within a collaborative setting that includes at least one psychiatrist.
   - Remedial educationalist-general physician: for diagnostics, treatment and medical supervision of insured persons in a (complex) personal dependency relationship with (complex) learning, behavioral or developmental problems if they are covered by the Zorgverzekeringswet (Health Insurance Act) financed medical GGZ or forensic care. This often concerns young adults or policyholders with additional mental handicap.
   - Social psychiatric nurse: in the coordinating role in the care delivery model setting outreach. Outreach care is multidisciplinary care for policyholders with serious psychiatric conditions, for example. Often, care is provided in or near the insured's home. The social psychiatric nurse does not make the psychiatric diagnosis and/or medical indication. The social psychiatric nurse does not prepare the initial treatment plan, but may develop the initial treatment plan at a more detailed level based on the social psychiatric nurse diagnosis and treatment.
5. The primary practitioner GGZ for treatment started under the Youth Act may be: child and youth psychologist NIP, GZ psychologist and general remedial educationalist NVO. The primary practitioner has a post-master registration in the SKJ (Stichting Kwaliteitsregister Jeugd) register or a BIG registration. They may only be the primary care provider for a maximum period of 365 days after your 18th birthday.
6. Under the final responsibility of the primary care provider, some of the care may also be provided by a care provider registered in the list of other consultation professions.
7. For highly specialised mental healthcare, you must go to a care provider contracted by us. If you make use of a healthcare provider who does not have a contract with us for this care, you are not entitled to full or partial reimbursement.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? Then look for more information about reimbursement in Articles 1.4 and 1.6 of these insurance terms and conditions.

You cannot transfer your claim for mental healthcare against us to healthcare providers or others that have no contract with us for this care. This is a clause as referred to in Section 3:83 paragraph 2 of the Dutch Civil Code. A reimbursement for the costs of care provided by a care provider with whom we do not have a contract will be transferred to the policyholder's account number.

**Referral letter required from**
General practitioner, occupational physician, medical specialist, psychiatrist, geriatrics specialist, doctor for the mentally handicapped, emergency room physician KNMG (emergency medical care physician), street doctor or your primary practitioner in case of a referral. A street doctor is a (family) doctor who provides care to homeless people. Were you receiving mental healthcare based on the Youth Act and you do not have a referral letter for this from a referrer as listed above?

Then you need a new letter of referral.
The referral must comply with the 'Mental Health Referral Agreements' as established by the Ministry of Health, Welfare and Sport.

**Approval**

- You need our prior consent for Esketamine (nasal spray)
- You need our prior approval for mental healthcare with stay (see Article 37, Stay). If the period for which you have given permission is about to expire, you must reapply for permission. Your healthcare provider can help you fill out a GGZ authorisation form. The form is available from our website. Please submit the application at least 2 months before the expiration date. Then you can be assured that your request will be processed in time. The address to send the application to is included in the first section of these conditions.

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

# PARAMEDICAL CARE

## Article 26. Physiotherapy and Remedial therapy

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

**Up to age 18**

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

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

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

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

**Remedial therapy for COPD**
Remedial therapy under the supervision of a physiotherapist or remedial therapist in COPD (Chronic Obstructive Pulmonary Disease) GOLD class II and higher. The number of treatments depends on the severity of the complaints and the risk of lung attacks according to the GOLD group A, B, C or D. Group B is then subdivided into:

- B1: moderate disease level or sufficient physical capacity
- B2: high disease level and limited physical capacity

| Group | A | B1 | B2 and C | D |
|---|---|---|---|---|
| The first 12 months<br>The maximum number of sessions in the 12-month period after start of treatment is: | 5 | 27 | 70 | 70 |

| Group | A | B1 | B2 and C | D |
|---|---|---|---|---|
| After the first 12 months<br>The maximum number of sessions in each 12-month period after the first year is: | 0 | 3 | 52 | 52 |

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

**Chronic List**
The list of conditions for physiotherapy and remedial therapy is also referred to as the 'Chronic List'. This name is not fully appropriate, as not all chronic conditions are listed. Listed conditions include certain conditions of the nervous system or the locomotor system, certain vascular and lung-related conditions, lymph oedema, soft tissue tumours and scar tissue on the skin. In some cases it also includes treatment of a condition after hospitalisation to accelerate recovery. Are you unsure if your condition is on this list? Then check with your healthcare provider beforehand. You can find the List of Physiotherapy and Remedial Therapy Disorders (Appendix 1 of the healthcare insurance Decree) on our website.

**Fall prevention exercise programme for high risk of falling**
Up to 1 exercise programme every 12 months to improve muscle strength, balance and difficulty walking.
You are entitled to an accredited programme if a fall risk assessment (also known as a fall analysis) has shown that you need guidance from a physiotherapist or remedial therapist due to physical or psychological problems. Check our website to see who may perform the fall risk assessment. Accredited fall prevention exercise programmes can also be found on our website.

**All ages**
**Arthritis physiotherapy**
Insofar as you are participating in research testing as referred to in Article 2.2 healthcare insurance Regulations, physical therapy also includes:
a. From 1 October 2019 to January 2026, long-term active physical therapy from the twenty-first session for patients with axial spondyloarthritis with severe functional limitations
b. From 1 October 2019 through 1 January 2025, long-term active physiotherapy from the twenty-first session for patients with rheumatoid arthritis with severe functional limitations.
Once the research testing is completed, you are entitled to this care as described in Article 2.2 paragraph 6, healthcare insurance Regulations. This does not apply in the event of intermediate suspension of the research testing.

**Physical and remedial therapy focused on direct recovery care of patients with severe COVID-19**
You can claim until 1 January 2025:
a. A maximum of 50 physiotherapy and/or remedial therapy sessions in a maximum period of 6 months after the first treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start physical and/or remedial therapy within one month after the referral letter has been issued.
b. A maximum of 50 physiotherapy and/or remedial therapy sessions in a period of a maximum of another 6 months following on from the period referred to under a. You will need a referral from your GP or medical specialist. You must start physical and/or remedial therapy within one month after the referral letter has been issued.
You are entitled to physiotherapy and remedial therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the testing and analysis has not yet started, you must be willing to participate in it. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research testing is defined as main care effectiveness research funded

by the Netherlands Organisation for Health Research and Care Innovation (ZonMW) and additional national observational care research testing designed and conducted in collaboration with the main research.
Once the testing or analysis is completed, you are entitled to this care as described in Article 2.2 paragraph 6 healthcare insurance Regulations.

**This is not insured**

- Arbo (occupational) curative care. This concerns healthcare aimed at healing and treating acute and chronic physical occupational conditions;
- Reintegration processes. Reintegration is the system of measures designed to ensure the occupationally disabled employee's return to the labour process;
- Treatments and treatment programmes with the aim of improving physical condition, such as medical training therapy, physio fitness, movement exercises for seniors, movement exercises for overweight persons and cardio training.

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

1. Physiotherapist, paediatric physiotherapist, pelvic physiotherapist, psychosomatic physiotherapist, geriatric physiotherapist and a manual therapist
2. To a Cesar/Mensendieck or paediatric remedial therapist
3. To an oedema (physical) therapist or skin therapist for oedema therapy
4. At a skin therapist for scar therapy
5. From a physical therapist with a Hand Therapist Certificate (CHT-NL) for a hand or finger splint for temporary use.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**ParkinsonNet**

Do you have Parkinson's syndrome and do you need physiotherapy or remedial therapy? For this type of care, we exclusively conclude contracts with physiotherapists and occupational therapists who are a ParkinsonNet member. If you go to a healthcare provider that is not on the ParkinsonNet list, you will receive a lower reimbursement. For more information, please refer to Articles 1.3 and 1.4. For more information, see our website.

**Chronisch ZorgNet for claudication**

Do you need remedial therapy (walking training) for peripheral arterial vascular conditions in the legs (intermittent claudication)? For this type of care, we exclusively conclude contracts with physiotherapists and occupational therapists who are a Chronisch ZorgNet member. If you go to a healthcare provider that is not on the Chronisch ZorgNet (chronic care net) list, you will receive a lower reimbursement. For more information, please refer to Articles 1.3 and 1.4. For more information, see our website.

**Hand and finger splint**

Do you need a hand or finger splint for temporary use? Then you can only see a physical therapist with a Hand Therapist Certificate (CHT-NL). A hand or finger splint for preventive use, such as for playing sports, is not insured.

**Chronic Care Network for COPD**

Do you need remedial therapy because of COPD? Then you can see a physiotherapist or remedial therapist who is a member of the national network Chronic CareNet. For more information, see our website.

**Referral letter required from**

General practitioner, company doctor, medical specialist, nursing specialist or physician assistant indicating that you have a condition stated in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree).

## Article 27. Speech therapy

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

**This is not insured**

Speech therapy treatments related to:
- Dyslexia
- Impaired language development in connection with a dialect or a different mother tongue
- Speaking in public
- The art of declamation.

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

You can claim until 1 January 2025:
a. Speech therapy in a maximum period of 6 months after the first treatment. You will need a referral from your GP or medical specialist. The referral letter must be issued no later than 6 months after the acute illness stage of severe COVID-19. You must start speech therapy within one month of the referral letter being issued.
b. Speech therapy in another maximum period of 6 months following the period referred to in a. You will need a referral from your GP or medical specialist. You must start speech therapy within one month of the referral letter being issued.

You are entitled to speech therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research testing is defined as main care effectiveness research funded by the Netherlands Organisation for Health Research and Care Innovation (ZonMW) and additional national observational care research testing designed and conducted in collaboration with the main research.
Once the testing or analysis is completed, you are entitled to this care as described in Article 2.2 paragraph 6 healthcare insurance Regulations.

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

A speech therapist.
Speech therapy treatments that deviate from regular treatments may only be provided by a speech therapist registered in one of the following sub-registers of the Dutch Association for Speech Therapy and Phoniatrics (NVLF):
- Aphasia
- Hanen programmes
- Integral healthcare for stuttering
- Preverbal speech therapy (eating and drinking)
- Stuttering.

Stutter therapy may also be given by a stutter therapist registered with the Nederlandse Vereniging voor Stottertherapie (NVST - Dutch Association for Stutter Therapy).
For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**ParkinsonNet**

Do you suffer from Parkinson and you require speech therapy? We only contract with speech therapists affiliated with ParkinsonNet for this care. If you go to a healthcare provider that is not on the ParkinsonNet list, you will receive a lower reimbursement. For more information, please refer to Articles 1.3 and 1.4. For more information, see our website.

## Article 28. Occupational therapy

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

**Occupational therapy focused on direct recovery care of patients with severe COVID-19**
You can claim until 1 January 2025:

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

You are entitled to occupational therapy aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research testing is defined as main care effectiveness research funded by the Netherlands Organisation for Health Research and Care Innovation (ZonMW) and additional national observational care research testing designed and conducted in collaboration with the main research.
Once the testing or analysis is completed, you are entitled to this care as described in Article 2.2 paragraph 6 healthcare insurance Regulations.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
An occupational therapist.
An occupational therapist with a Hand Therapist Certificate (CHT-NL) for a hand or finger splint for temporary use.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**ParkinsonNet**
Do you suffer from Parkinson and you require occupational therapy? We only contract with occupational therapists affiliated with ParkinsonNet for this care. If you go to a healthcare provider that is not on the ParkinsonNet list, you will receive a lower reimbursement. For more information, please refer to Articles 1.3 and 1.4. For more information, see our website.

**Hand and finger splint**
Do you need a hand or finger splint for temporary use? Then you can only see an occupational therapist with a Hand Therapist Certificate (CHT-NL). A hand or finger splint for preventive use, such as for playing sports, is not insured.

## Article 29. Dietetics

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

**Dietetics focused on direct recovery care of patients with severe COVID-19**
You can claim until 1 January 2025:

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

You are entitled to dietetics aimed at the direct recovery care of patients with severe COVID-19 exclusively if you participate in research studies and, if applicable, an additional analysis of the care provided. Or if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data based on questionnaires and additional surveys. You must also consent to the anonymised sharing of your treatment data. Research testing is defined as main care effectiveness research funded by the Netherlands Organisation for Health Research and Care Innovation (ZonMW) and additional national observational care research testing designed and conducted in collaboration with the main research.
Once the testing or analysis is completed, you are entitled to this care as described in Article 2.2 paragraph 6 healthcare insurance Regulations.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
To a dietician.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

# ORAL CARE

## Article 30. Dental care for insured under age 18

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

1. Check-up (periodic preventive dental examination); 1 time per year. If necessary, you are entitled to such check-ups more than once per year;
2. Incidental visit
3. Removing plaque
4. Fluoride treatment from the date the first element of the adult teeth has broken through: twice annually. If necessary, you are entitled to such check-ups more than twice per year;
5. Sealing (sealing pits and grooves in teeth and molars)
6. Gum treatment (periodontal treatment)
7. Anaesthesia
8. Root canal treatment (endodontic assistance)

9. Fillings (restoration of teeth with plastic materials)
10. Treatment after maxillary complaints (gnathological treatment)
11. Full dental prosthesis for upper and/or lower jaw, plate prosthesis or frame prosthesis (removable prosthetic devices)
12. Specialist dental surgery with the exception of the insertion of dental implants
13. X-ray examinations. You are not entitled to X-ray tests for orthodontics.

If you are under age 23, then you are entitled to reimbursement of the cost of crowns, bridges and implants if it concerns replacement of one or more permanent incisor or canine teeth that have not grown or are missing due to an accident. The necessity of this healthcare must be determined before reaching age 18.

**Excess**
If you are age 18 and up, then this healthcare service will be set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

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

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Approval**
You require our prior approval for:
- Crowns, bridges and implants
- Jaw overview pictures
- Autotransplants by a dental periodontist, dental implantologist or dentist
- The 11th sealing or more
- Extracting a front tooth, baby tooth or baby tooth in a difficult situation where the gums have to be pushed aside
- The surcharge for a severely shrunken jaw in the case of a dental prosthesis
- Treatments of the chewing system
- Treatments of the gums
- The cost of all other dental treatments that combined exceed €1,400 per year.

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

## Article 31. Specific dental care

Specialist dental care is for people with a specific condition. Such dental care takes more time and more expertise. You are only entitled to special dentistry if it enables you to maintain or acquire a dental function equivalent to that which you would have had if you had not had the disorder.

### 31.1. Dental care in special cases

Dental care in special cases is care as dentists tend to provide, which is necessary:
1. If you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system;
2. If you have a non-dental physical or mental condition;

3. If you must undergo a medical treatment and this treatment would have inadequate results without such special dental care. This generally concerns eliminating inflammation in the mouth. Examples of de-inflammation include treatment of the gums, pulling teeth or administering antibiotics.

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

**Personal contribution**

You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if it is not a matter of special cases requiring dental care.

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

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

**The healthcare may be provided in:**

1. Dental care practice
2. Hospital
3. Centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthesia? Then the healthcare may only be provided in a hospital or centre for specific dental care.

A centre for specific dental care is:

1. An institution for specific dental care accredited by the Nza (Netherlands Healthcare Authority)
2. A centre that complies with the following requirements:
   - A positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - The centre works with an anaesthesiologist who is an NVA member;
   - There is a contract document with an ambulance service or hospital for transport to a hospital if required;
   - There is a contract document with a hospital near the centre for taking in patients if required;
   - The centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
   - When treating children, the dentist must be an accredited dentist-paedo-dontologist.

Please refer to our website to see a list of such centres.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**

Dentist, orthodontist or a dental surgeon.

**Approval**

You require our prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

### 31.2. Dental implants

The care includes the placement of a dental implant in the context of special dental care if you:
1. Have a severe developmental disorder, growth disorder, or acquired abnormality of the dental-oral system;
2. Have an acquired defect of the jaw-mouth system in the form of a very severely shrunken toothless jaw and the implants serve to secure a removable prosthesis.

**Implants in a very severely shrunken toothless jaw**
If you have had a full dental prosthesis (dentures) for a long time, your jaw may lapse so severely that your dental prosthesis hardly has any grip. In such a case, implants can be a solution. This generally concerns 2 implants in the lower jaw with 2 buttons or a rod screwed in that serve to click on the dentures. The dentures are still removable by hand. For prosthetic devices for insured age 18 and older, see Article 33.

**Personal contribution**
You are due a statutory personal contribution if you are age 18 or older concerning healthcare that is not directly related to the indication for special dentistry. The personal contribution is equivalent to the amount that may be charged if it is not a matter of special cases requiring dental care.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
Dentists, certified oral hygienist working in a centre for specific dental care, dental surgeon or orthodontist in collaboration with a dental surgeon. In the event of implants in a very severely lapsed toothless jaw, this healthcare may also be provided by a dental implantologist.

**The healthcare may be provided in:**
1. Dental care practice
2. Hospital
3. Centre for specific dental care.

Do you need a treatment under helium or other sedation or full anaesthetics? Then the healthcare may only be provided in a hospital or centre for specific dental care.
A centre for specific dental care is:
1. An institution for specific dental care accredited by the Nza (Netherlands Healthcare Authority)
2. A centre that complies with the following requirements:
   - A positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - The centre works with an anaesthesiologist who is an NVA member;
   - There is a contract in writing with an ambulance service or hospital for transport to a hospital if required;
   - There must be a contract in writing with a hospital near the centre for intake of patients
   - The centre using (nitrous oxide) sedation is accredited accordingly by the Academic Center for Dentistry Amsterdam (ACTA)
   - When treating children, the dentist must be an accredited dentist-paedo-dontologist.

Please refer to our website to see a list of such centres.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you?
For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Referral letter required from**
Dentist, orthodontist or a dental surgeon.

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

## Article 32. Oral surgery for insured age 18 and older

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

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

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
An oral surgeon.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

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

## Article 33. Prosthetic devices for insured age 18 and older

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

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

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

**Personal contribution dental prosthesis**

You are entitled to a dental prosthesis for the upper and/or lower jaw. This is subject to a personal contribution. The personal contribution also applies to the cost of placing the fixed part of the supra structure (meso structure). A meso structure is the non-removable construction between implants and the dentures (the click system). The costs of extracting teeth do not qualify for reimbursement, but may be reimbursed if you have supplementary (dental) insurance. In addition to a personal contribution, the excess also applies.
For an implant for a full denture if you have a very severely shrunken toothless jaw, see Article 31.2.

**Excess**

This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**

A dentist, dental implantologist or dental prosthodontist.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Approval**

1. You need our prior approval for conventional (normal) dentures:
   a. If there are additional engineering costs for a metal reinforcement, softening base, non-toxic synthetic resin/monomer-free synthetic resin and/or mesh reinforcement/fibre reinforcement
   b. If you want to replace your dentures within 5 years after purchase
   c. For the supplement very severely shrunken jaw
2. You require our prior approval for:
   a. Dental prosthesis on implants
   b. Rebasing (filling) or repairing dental prosthesis on implants
   c. A bar or buttons (meso structure)

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

# PHARMACEUTICAL CARE

## Article 34. Medications

Pharmaceutical care includes the supply of medications, or advice and guidance such as pharmacists tend to provide for medication assessment and responsible use of medication and drugs.
This care also comprises:
- Issuing a drug subject to prescription
- Issuing a drug subject to prescription with an instruction talk if the drug is new to you
- Instructions for a medical aid to be used for a drug subject to prescription
- Medication assessment of chronic use of medications subject to prescription.

**Registered medications**

The care includes medications registered as preferred in the Healthcare Insurance Regulations. These are set out in Appendices 1 and 2 of the Healthcare Insurance Regulations.

**Preferred medications**

Appendix 1 of the Healthcare Insurance Scheme sets out groups of medications with the same active ingredient. We select certain active ingredients and a preferred medication. You are only entitled to such preferred medications.

Please find a list of such preferred medications in the Pharmaceutical Care Regulations on our website. We do not reimburse other medications with the same active ingredient. If treatment with a preferred medication is not medically warranted, your doctor will list 'medical necessity' on the prescription. In that case, you have the right to choose a different medication.

**Medical necessity**

Doctors may only list ‘medical necessity’ on the prescription if they can substantiate it. Does the pharmacist have any questions about the medical necessity? For example because you have not used the medication before? Then the pharmacist will contact your doctor. The pharmacist will choose which medication to give you based on the active ingredient prescribed by your doctor and your doctor's explanation. If there is no medical necessity, the pharmacist will give you the preferred medication.

**Preferred medications and your excess**

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

**Self-care products**

Care includes self-care medications if you need to use these medications for more than 6 months. You are only entitled to laxatives, remedies for allergies, remedies for diarrhoea, remedies to empty the stomach and remedies for dry eyes, which are listed in Appendix 1 of the healthcare insurance Regulations. For the first 15 days, you are not entitled to reimbursement of the cost of such medication.

**Non-registered medications**

Care includes non-registered drugs if rational pharmacotherapy is involved. Rational pharmacotherapy is the treatment, prevention or diagnosis of a condition with a medicine in a form suitable for you, the efficacy and effectiveness of which has been demonstrated in scientific literature and which is also the most economical for health insurance purposes.
You are entitled to the following non-registered medications:

- Pharmacy preparations;
- Medications that your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medications Act;
- Medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you. You are entitled to such medications only if you have a rare disorder that does not occur in the Netherlands more frequently than in 1 in 150,000 inhabitants.

**Temporary shortage of medications**

If a registered medicine cannot be supplied in the Netherlands or cannot be supplied in sufficient quantities, the care will include a replacement medicine from abroad. This drug must have been brought from abroad with permission from the Health and Youth Inspectorate or with a temporary license from the Medicines Evaluation Board.

**This is not insured**

- Pharmaceutical care for a medicine that is not covered by insurance
- Education on pharmaceutical self-management for a patient group
- Advice pharmaceutical self-care
- Advice use of medications subject to prescription during travel
- Advice risk of disease when travelling
- Pharmaceutical care in the cases indicated in the Healthcare Insurance Scheme
- Preventive travel kit of medications and vaccinations
- Medications for research as referred to in Section 40, third subsection, under b, of the Wet op de geneesmiddelen (Medications Act)
- Medications that are equivalent or virtually equivalent to a non-preferred registered medication, unless classed differently by ministerial regulation

- Medications as referred to in Section 40, third subsection, under f, of the Medicines Act

The Healthcare Insurance Scheme is available from our website.

Please note:
Pharmaceutical counselling during hospitalisation, day treatment or polyclinic visits and pharmaceutical counselling in the context of discharge from hospital are reimbursed exclusively as part of specialist medical care.

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

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

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

The calculated amount will be rounded off to whole euros.

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

**Excess**
This healthcare is set off against the excess. Do you use preferred medications as set out in the Pharmaceutical Care Regulations? Then the excess does not apply. The excess also does not apply to the healthcare providers we selected for the Blauwe Zorg experiment in the Maastricht and Heuvelland area, insofar as they supply the preferred lung medication we selected. Please find a list of such healthcare providers and preferred lung medication in the Pharmaceutical Care Regulations, Appendices D and E. You may also choose other lung medication that is not preferred by us. But this is subject to your statutory and voluntary excess.

Please take into consideration that the services of the pharmacy, for example the issue fee, the instructions for a new drug or inhaling instructions, are not exempt from your excess.
For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
Pharmacist or dispensing general practitioner.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

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

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

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

#### New medication

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

#### Medication based on repeat prescription

- 1 month for a drug that costs over €1,000. If you are well adjusted to the medication after a consecutive period of 6 months, your pharmacist may issue this medication to you for a period of 3 months.
- 1 month for sleeping drugs
- 1 month for medications that reduce anxiety and unrest (with the exception of anti-depressant class medications)
- 1 month for medications listed in the Opium Act.
- At least 3 months and maximum 12 months for a drug to treat a chronic condition.

#### Reasons to issue a drug for a shorter period

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

#### Contraceptives and insulin

For the contraceptive pill and for insulin, you only need a prescription the first time.

**Approval**

1. You require our prior approval for a number of registered medications included in Appendix 2 of the Healthcare Insurance Scheme. Please find a list of such medications in the Pharmaceutical Care Regulations. We reserve the right to amend the list of preferred medications at any time. You will receive information about it. To apply for permission, your doctor can obtain a doctor's certificate from www.znformulieren.nl or download and fill out an approval form from our website.
   If you use a pharmacist or dispensing general practitioner with whom we have concluded a contract for the relevant care, you can then hand in the form filled in by your doctor together with the prescription. Your pharmacist assesses your compliance with the conditions. If, for reasons of privacy, you do not wish to hand in this form at your pharmacy, you can also send it or have it sent to us directly.
   Do you visit a pharmacist or dispensing general practitioner with whom we have not concluded a contract for the relevant care? You can then request approval in advance by submitting the form directly to us. Look for the address on our website.
2. You require our prior approval for the following non-registered medications:
   - A number of pharmacy preparations (custom medication) supplied. These are preparations your pharmacy makes and delivers to your pharmacy;
   - Medications that your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medications Act;
   - Medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you.

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

**Contraceptives**

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

If you are age 21 and up, You are only entitled to contraceptives if these items are used to treat endometriosis or menorrhagia (if suffering from anaemia). Please note: This requires our prior approval. For information on requesting approval, see Item 1 under the Approval heading of this article.

If you are not entitled to such reimbursement, you may be reimbursed for the cost of the contraceptive if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

Irrespective of your age, you are entitled to having a contraceptive such as a diaphragm or implanon rod placed or removed by a general practitioner or by a medical specialist. For placing or removing a diaphragm, you may also choose an obstetrician certified for this service.

## Article 35. Dietary preparations

Dietary preparations are polymeric, oligomeric, monomeric and modular dietary preparations. Dietary preparations are only part of the care if you cannot manage with adapted normal food and other products of special nutrition and you are:

a. Suffering from a metabolic disorder
b. Suffering from a food allergy
c. Suffering from a resorption disorder
d. Suffering from disease-related malnutrition or risk of malnutrition as indicated based on a validated screening instrument; or
e. You are dependent on this product in accordance with the guidelines accepted by the relevant professional groups in the Netherlands.

**Dietary preparations**

Dietary preparations are medical food with a different form and formula than standard food.
There are various types, including liquid nutrition and tube feeding.
Liquid nutrition may include extra energy, protein, fat or vitamins and minerals.
Catheter-administered nutrition (tube feeding) is special nutrition directly taken into your stomach or digestive system via a thin tube (catheter).

**Dietary product**

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

**Excess**

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

**This is where to go**

A pharmacist, dispensing general practitioner or a preferred healthcare provider. For tube feeding, you can only go to a medical specialty store, also called a facility.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Please note**

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

**Prescription**

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

**Approval**

You will need our permission in advance. To apply for approval, you can use the prescription issued by your general practitioner or the Declaration of Dietary Preparations filled in by your medical specialist, dental surgeon, physician assistant, nurse or dietician (ZN Declaration of Polymeric, Oligomeric or Modular Dietary Preparations). More information about applying for approval is set out in Article 1.9 of these policy conditions.

# MEDICAL AIDS

## Article 36. Medical aids and dressings

Medical aids and dressings are functional support aids and dressings materials as referred to in the Healthcare Insurance Decree and the Healthcare Insurance Regulations. In the Medical Devices Regulations we have set out further conditions for obtaining such medical devices/aids. The Healthcare Insurance Decree, the Healthcare Insurance Scheme and the Medical Aids Regulations are available from our website. Certain groups of medical aids are included in the Healthcare Insurance Scheme with a functional description. This means that the healthcare insurer can determine which medical aids are covered in the Medical Aids Regulations. If you want a medical aid that is part of the group of functional descriptions of medical aids, but the specific medical aid is not included in the Medical Aids Regulations, you may submit an application form to us.

Most medical aids and bandaging are given to you under direct ownership. If you receive a medical aid as such, you simply own the medical aid permanently. Other medical aids are generally leased out to you. Lease means that you may use the medical aid as long as you need and as long as you remain insured with us. You conclude a loan agreement with us or the care provider that sets out your rights and obligations. Medical aids and devices on loan can be obtained only from a care provider with whom we have concluded a contract.

The following information is available from the Medical Devices Regulations:
- Whether you will lease or own the medical aid;
- The quality standards the healthcare provider must meet;
- Whether you need a referral and if so, from which party;
- Whether you need our prior approval (for (first) purchase, repeat or repair);
- Term of use of the device in question. This term of use is indicative. If required, you may ask us to deviate from it;
- Maximum number of pieces to be delivered. Such numbers are indicative. If required, you may ask us to deviate from it;
- Specific details such as maximum reimbursements or statutory personal contributions.

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

**Information relating to contracted healthcare providers**

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

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

**Excess**
This healthcare is set off against the excess. The excess does not apply to medical aids on a lease basis.
For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
A healthcare provider for medical aids. Please refer to the Medical Aids Regulations to see if the healthcare provider is required to meet certain quality requirements.
For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the care that concerns you? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

**Leased equipment**
If you go to a care provider with whom we have not concluded a contract for the relevant care and it concerns a medical aid on loan, please contact us; Then the reimbursement is up to 70% of the average cost per user per year. The amount of the average cost is equivalent to the costs we would have paid for providing a leased medical aid.

**Referral letter required from**
The Medical Aids Regulations set out which medical aids require a referral. This referral letter must include the indication.

**Approval**
The Medical Aids Regulations set out which medical aids require prior approval. Please find more information about applying for approval in Article 1.9 of these conditions.

**Extra information**
1. You are required to take good care of the medical aid. Within the normal average term of use, you will receive approval for replacement of a medical aid only if the current medical aid is no longer adequate. You may submit an application for replacement within the term of use, modification or repair to us with a motivation.
2. You may obtain approval for a second piece of the medical aid if you are reasonably dependent on it.
3. Leased medical aids may be subject to inspection. If we are of the opinion that you are not (or no longer) reasonably dependent on the medical aid, we may reclaim the aid.

# STAY IN AN INSTITUTION

## Article 37. Stay

Stay is a medically necessary stay of 24 hours or longer in the context of general practitioner care (Article 11), obstetric care (Article 15.1), medical specialist care (Articles 16 to 23), mental healthcare (Article 25) and surgical dental care of a specialist nature (oral care, Article 30, 31 and Article 32) as set out in these insurance terms and conditions, during an uninterrupted period of up to 3 years (1095 days), as defined in Article 2.12 of the healthcare insurance Decree. An interruption of up to 30 days is not considered an interruption, but these days do not count

towards the calculation of the 3 years (1095 days). Interruptions due to weekend and holiday leave do count towards the calculation of the 3 years. A stay also includes the necessary nursing, care and paramedical care.
A stay is also possible for insured under age 18 who require intensive child care as set out in Article 14, Nursing and Care.

Reimbursement for a stay in the vicinity of a hospital is possible if this is necessary in connection with specialist medical care. The maximum reimbursement is €89 per day.

**When are you entitled to an allowance for a stay in the vicinity of a hospital?**
Are you receiving CAR T-cell therapy and do you live more than 60 minutes away from the expert hospital where you are receiving the treatment? If so, we can provide a reimbursement for accommodation near the hospital at your request. Reimbursement begins on the day you leave the hospital and stops after 14 days, unless you need to stay longer due to medical complications. The maximum reimbursement is €89 per day.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
The stay may take place in a hospital, in a psychiatric ward of a hospital, in a GGZ mental healthcare institution, or in a recovery/rehabilitation institution.
First-line stay is permitted in an institution performing medical care under the responsibility of the general practitioner, geriatric medical specialist or doctor for mentally disabled.
The stay related to intensive child care may take place in a children's care home.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Are you going to a care provider that does not have a contract with us for the relevant care? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

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

**At the instructions of**
General practitioner, obstetrician, medical specialist, psychiatrist or dental surgeon. For intensive child care stays, a paediatrician or level 5 paediatric nurse practitioner may issue a prescription.
They determine whether a stay is medically necessary in connection with medical care or medically necessary in connection with surgical care of a specialist nature as referred to in Article 32 Oral Surgery for insured age 18 and older.

**Approval**
You need our prior approval for stays in connection with specialist medical care (Article 16), rehabilitation (Article 17.1), plastic and/or reconstructive surgery (Article 21), mental healthcare (Article 25) and oral care (Articles 30, 31 and 32) if this is indicated in the relevant care Article. Look for more information in the relevant healthcare Article.
You also need our permission for a stay in the vicinity of a hospital if this is necessary in connection with specialist medical care.

# TRANSPORT OF THE PATIENT

## Article 38. Ambulance and patient transport

Ambulance and patient transport includes:

1. Transport by ambulance due to medical necessity as referred to in Section 1, first subsection, of the Wet ambulancevoorzieningen (Ambulance Facilities Act), over a maximum distance of 200 km, single journey:
   a. To a healthcare provider or institution for healthcare of which the cost is fully or partially covered under the healthcare insurance policy;
   b. To an institution where you will stay with the costs fully or partially covered pursuant to the Wlz;
   c. If you are under age 18, to a healthcare provider or institution where you will receive mental healthcare, of which the cost is fully or partially covered under the competent Municipal Executive pursuant to the Youth Act;
   d. From a Wlz institution as set out in this article under item 1b, to:
      - A healthcare provider or institution for examination or treatment that is fully or partially covered by the Wlz;
      - A healthcare provider or institution for measuring and fitting a prosthesis that is fully or partially covered by the Wlz;
   e. To your home or another home, if you cannot reasonably receive the necessary care in your home if you come from one of the care providers or institutions referred to in this article in points 1a through 1d;
2. Patient transport over a distance of no more than 200 kilometres, one way. Seated transport of the patient includes transport of the patient by car, other than by ambulance, or transport in the lowest class of a means of public transport to and from a healthcare provider or institution as referred to under item 1a, 1b or 1d or a home as referred to under item 1e.
   You are exclusively entitled to such transport in the following situations:
   a. For kidney dialyses and for the visits, tests and check-ups necessary for the treatment;
   b. For oncology treatments with chemotherapy, immunotherapy or radiotherapy and for the visits, tests and check-ups necessary for the treatment;
   c. If you are only able to move about in a wheelchair;
   d. If your vision is restricted to such an extent that you are not able to move about without assistance.

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

Your visual disability must be such that you are unable to travel by public transport. This is determined, among other things, by your vision (visual acuity) and your field of vision. You are entitled to patient transport if your vision in both eyes is less than 0.1 or if you have a field of vision less than 20 degrees. You may also have a combination of poor vision and a very severely impaired field of vision. In this case, an individual assessment will be required to determine your right to transport.

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

**When can you invoke the hardship clause?**

If the outcome of the sum ‘number of consecutive months that transport is necessary X number of times per week X number of km, single journey’ exceeds or is equal to 250. For instance: you had to go to hospital twice per week for 5 months. The one-way distance was 25 kilometres (km). In this case you may apply for the hardship clause, as
5 months x 2 times per week x 25 km single journey makes 250.

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

**Lodging costs**
Are you dependent on transportation as referred to in 2a through 2g for at least three consecutive days? Then at your request, we may grant reimbursement for lodging costs up to a maximum of €89 per day. In that case, you are entitled to transport or a mileage allowance for the return journey to the treatment location and to reimbursement of two or more overnight stays in the vicinity of the treatment location. The lodging allowance therefore partly replaces the transport allowance.

**Personal contribution**
You are charged a statutory personal contribution of up to €118 per calendar year for patient transport.
This is not subject to a personal contribution for ambulance transportation and accommodation costs.

**Excess**
This healthcare is set off against the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

**This is where to go**
1. For ambulance transport: a licensed ambulance transport company.
2. For patient transport:
    - A taxi driver/transportation firm
    - A public transport company. Reimbursement is based on public transport card, second class
    - Private vehicle, self-drive or family care providers (family members, people close to you): reimbursement of €0.38 per kilometre. The distance is calculated based on the quickest route as provided by the ANWB route planner. The two single journeys (there and back) are calculated separately.

For more information about healthcare provided by a contracted healthcare provider, please refer to Article 1.3 of these policy conditions. Do you use a taxi operator that does not have a contract with us? For more information, please refer to Articles 1.4 and 1.6 of these policy conditions.

**Subject to prescription by**
General practitioner or medical specialist. For patient transport as set out in item 2e (intensive child care), you need a prescription from the paediatrician or level 5 child nurse. For patient transport as set out in item 2g (medical care specific patient groups), you need a prescription from a general practitioner, medical specialist, geriatric specialist, doctor for the mentally handicapped, healthcare psychologist or general remedial educationalist.
You do not need a prescription for emergency ambulance transport.

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

You can request permission from the transportation desk via our website for:
- Patient transport for kidney dialysis and oncology treatments
- Patient transport to and from a nursing home or children's home in the case of intensive child care
- Reimbursement of lodging expenses.

**Additional information**
1. If we grant you approval to go to a certain healthcare provider or institution, the 200-km limitation does not apply.
2. In cases where transport of the patient by ambulance, car or a public means of transport is not possible, we may allow the transport of the patient to take place by another means of transport to be designated by us.

# HEALTHCARE MEDIATION

## Article 39. Healthcare advice and mediation

You are entitled to mediation for care if there is an unacceptably long waiting list for treatment by a care provider that may provide this care in accordance with the health insurance policy. You may use the services of our Healthcare Advice and Mediation department for such mediation services. You can reach this department through our website.
You may also approach this department for general questions on care, such as relating to looking for a healthcare provider with a certain area of expertise or help in navigating through the care sector. Together with you, we will look into the possibilities.

If no solution can be offered or if the care cannot be provided on time as a result of this solution, you may use a care provider with whom we have not concluded a contract for the relevant care. We will reimburse the costs of this non-contracted care provider up to the maximum of the rates applicable in the Netherlands under the Wmg rates. If no Wmg rates apply, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands.

# III. Definitions

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

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

**Sworn translator:** This is a translator authorised to provide certified translations. This is necessary when translating official documents such as medical certificates and civil status documents. Certified translators are listed in the Register of Certified Translators and Interpreters (Rbtv), www.bureauwbtv.nl.

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

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

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

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

**Excess**

1. Statutory excess: an amount towards the costs of care or other services as set out in or pursuant to Section 11 of the Healthcare Insurance Act, which is payable by you.
2. Voluntary excess: an amount towards the costs of healthcare or other services as agreed between you, as the policy holder, and the healthcare insurer, as set out in or pursuant to Section 11 of the Zvw (Healthcare Insurance Act), which is payable by you.

**European Union and EEA Member State:** This includes the following countries within the European Union in addition to the Netherlands: Austria, Belgium, Bulgaria, Croatia, Cyprus (the Greek area), the Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Germany, Martinique, St. Barthélemy, St. Martin and La Réunion), Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal (including Madeira and the Azores), Romania, Slovenia, Slovakia, Spain (including Ceuta, Melilla and the Canary Islands), Czech Republic and Sweden. On the basis of treaty provisions, Switzerland is classed as equivalent to the above countries in this context. EEA countries (Member States who are a party to the Agreement on the European Economic Area) are also included: Liechtenstein, Norway and Iceland.

**Fraud:** The intentional commission or attempted commission of forgery, deception, injuring the rights of debt collectors or beneficiaries and/or misappropriation or embezzlement in the process of entering into and/or performing an insurance contract or healthcare insurance contract, with the objective of obtaining a benefit, reimbursement or performance to which the party is not entitled, or obtaining insurance cover under false pretences.

**Birth clinic:** Primary birth clinic to facilitate natal care (care during delivery) and postnatal care (care after delivery), the management and operation of which is carried out by primary maternity care providers. The management and operation of the primary birth clinic can also be carried out by healthcare providers other than primary obstetricians, such as maternity care providers.

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

**GGZ:** Mental healthcare.

**GGZ Institution:** Institution that provides medical care in connection with a psychiatric disorder.

**Institution**

1. An institution within the meaning of the Accreditation of Healthcare Providers Act.
2. A legal entity established abroad providing healthcare in the relevant country in the legal framework of the social security system applicable in that country, or focusing on providing care to specific groups of public officers.

**KNMG:** The Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG) is a federation of professional associations of doctors and the association De Geneeskundestudent and represents the interests of doctors in the Netherlands.

**NZa:** Nederlandse zorgautoriteit - Dutch Healthcare Authorities.

**Policy:** The healthcare policy as set out in Article 1, paragraph 1 under i of the healthcare insurance Act, i.e., the deed recording the healthcare insurance policy concluded between the policyholder and a healthcare insurer. The (healthcare) policy consists of a policy schedule and these insurance terms and conditions.

**In writing:** wherever reference is made in these insurance terms and conditions to ‘in writing’ it shall also mean ‘by email’.

**Approval (consent, authorisation):** Approval in writing for receiving certain care provided to you by or on behalf of the healthcare insurer, prior to receiving the relevant healthcare service.

**You:** Policy holder and/or insured.

**Stay:** A stay of 24 hours or longer.

**Treaty country:** A country that is not a member state of the European Union or EEA, with which the Netherlands has concluded a treaty on social security and which includes a regulation on the provision of medical care. This includes the following countries: Australia (for holiday/temporary stay), Bosnia-Herzegovina, Cape Verde, Macedonia, Morocco, Serbia-Montenegro, Tunisia, Turkey and the countries of the United Kingdom (England, Northern Ireland, Scotland and Wales).

**Insured:** The person for whom the risk of needing medical care, as referred to in the healthcare insurance Act, is covered by healthcare insurance and who is listed as such on the healthcare insurer's policy schedule.

**Policyholder:** The person who has contracted health insurance with the health insurance company. These policy conditions refer to the policy holder and the insured as ‘you’. Provisions referring only to the policy holder specifically specify this accordingly in the relevant Article.

**Person subject to statutory insurance:** A person who is subject to statutory insurance pursuant to the Healthcare Insurance Act; the person must take out a healthcare insurance or have this taken out.

**Policy Conditions VGZ Basis Keuze /policy conditions:** The healthcare insurer's model contract referred to in Article 1j of the healthcare insurance Act.

**VGZ Basis Keuze:** A healthcare insurance policy concluded between the healthcare insurer and the policyholder for an insured person. These policy conditions refer to the VGZ Basis Keuze as ‘the healthcare policy’.

**Wlz:** Long-Term Care Act.

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

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

**Healthcare:** Care and/or other services.

**Care Provider:** A person or legal entity who provides care professionally or commercially as defined in Article 1, opening words and sub c, part 1 of the Wmg. The term 'Care provider' also includes all practitioners engaged for the delivery of care at the risk and expense of the healthcare provider.

**Healthcare provision:** Article relating to certain care. See Section II, Healthcare Provisions.

**Healthcare insurer/VGZ:** VGZ Zorgverzekeraar N.V., having its registered office in Arnhem, the Netherlands Chamber of Commerce number: 09156723. The healthcare insurer is registered in the Insurers Register of AFM (Financial Markets Authorities Netherlands) and DNB (the Dutch Central Bank), licence number: 12000666. The healthcare insurer is part of Coöperatie VGZ U.A. The healthcare insurer is referred to as ‘we’ and ‘our’ in these policy conditions.

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

Visit

**www.vgz.nl**

**for more information and contact details**

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