Nationale-Nederlanden Zorg terms and conditions of health insurance and additional insurance packages

from 1 January 2022

nationale nederlanden

Terms and conditions of insurance

Health Insurance

and

Additional Insurance Packages

valid from 1 January 2022

The previous terms and conditions of insurance are hereby superseded

How your insurance works

In this introduction, you will find general information about what you need to do to receive healthcare (and get your expenses reimbursed). The information is concise and does not include rights and obligations. The full text of the clauses is presented in this booklet of terms and conditions of insurance, and starts from clause A.1.

1. Terms and conditions of insurance

This booklet of terms and conditions of insurance is divided into four sections:

- section A details the general terms and conditions for health insurance and additional insurance packages;
- section B details the healthcare covered under your health insurance;
- section C details non-standard and additional terms and conditions that only apply to additional insurance packages and private medical expenses insurance;
- section D details the healthcare under your additional insurance packages. Your Reimbursements Overview specifies what you are insured for, along with the level of reimbursement (if any).

Sections A and B therefore apply to all health insurance (general insurance policies), while sections A, C and D apply to additional insurance packages.

Your and our rights and obligations are detailed:

- on the policy document: this specifies which insurance package you have taken out; and
- in your Reimbursements Overview: this specifies your reimbursement entitlements; and
- in the Terms and Conditions of Insurance for Health Insurance and Additional Insurance Packages, appendices and various regulations. All these documents are available on our website or on request.

Where we use the masculine form in these terms and conditions of insurance, the feminine form may also be meant and vice versa.

Under point 2 below, we will use ‘occupational therapy’ as an example to demonstrate how you can use this booklet to check what your insurance covers. While this booklet applies to everyone insured by us, not all of the clauses will apply in all cases.

2. Reimbursements

Please note! Please check your Reimbursements Overview to see which reimbursements you are insured for before consulting these Terms and Conditions of Insurance

Your Reimbursements Overview specifies what you are insured for. It also specifies whether a maximum limit applies to reimbursement. The Reimbursements Overview specifies the clause in the Terms and Conditions of Insurance in which the description and terms and conditions for each reimbursement can be found.

Your Reimbursements Overview shows whether occupational therapy is included in your additional insurance package and, if so, the level of reimbursement.
If occupational therapy, clause D.17.1. does not appear on your Reimbursements Overview, you will not be able to claim additional reimbursement, only the reimbursement provided under the health insurance.

You are only insured in accordance with the clauses listed in your Reimbursements Overview. The exclusions (see ‘Please note!’) and terms and conditions of the entire clause apply, even if you are only insured in respect of part of the clause.

The Reimbursements Overview specifies exactly which healthcare you are insured for, along with details of the level of reimbursement. An example excerpt from the Reimbursements Overview is shown below. This overview may show that you are insured for occupational therapy. The number in the Terms and conditions column refers to the clause number in this booklet.

What is reimbursed	Amount reimbursed	Terms and conditions
Occupational therapy		**D.17.**
Occupational therapy for insured persons up to the age of 18	up to 2 hours a year, in addition to the reimbursement provided by the health insurance policy	D.17.1.
Training and supervision for carers of insured persons who receive occupational therapy	up to 2 hours a year	D.17.2.

3. How we process your invoice

We have an agreement with contracted healthcare providers, whereby they can send us their invoices directly. This is also occasionally the case for oral care by healthcare providers who do not have a contract with us. Upon receipt of an invoice, we will reimburse it in full to your healthcare provider. If we pay your healthcare provider more than the amount you are covered for under your insurance, (for example if a personal contribution — statutory or otherwise — applies, or you have not yet paid all of your deductible), we will send you a message informing you that we have paid too much (see the explanation under 'When healthcare costs are not reimbursed in full'). We will then send you an invoice for this amount.

Healthcare providers who do not have a contract with us will send the invoice to you and you will initially pay the healthcare provider yourself. You will then need to send us the original invoice (not a copy) by post or by email. As soon as we have processed the invoice, we will send you a statement of the amount to be reimbursed.

4. When healthcare costs are not reimbursed in full

There may be various reasons why we will not reimburse your healthcare costs in full:

Deductible

This is an amount set by law that you are required to pay every year. You can choose to increase your deductible by adding a voluntary deductible. A deductible applies only to healthcare covered by your health insurance. Reimbursements under your additional insurance package will not be set off against your deductible.

Personal contribution

Personal contributions payable under your health insurance are also set by law. A personal contribution is a fixed amount or percentage that you must pay yourself. Personal contribution amounts are specified in your Reimbursements Overview. A statutory personal contribution, if applicable, applies only to healthcare covered by your health insurance and does not apply to reimbursements made under your additional insurance package. Your Reimbursements Overview will also specify if your additional insurance package provides reimbursement of personal contributions.

Partial reimbursement

In case of partial reimbursement, your Reimbursements Overview will state, for example, that we will cover 80% of the costs, up to a maximum amount of €500 per year. This means that we will reimburse 80% of the amount due on each invoice, until we have reached the upper limit of €500 for that year.

Reimbursement for as long as you are insured with us

Certain types of healthcare are reimbursed only once per insured person and only up to a maximum amount. In this case, your Reimbursements Overview will state, for example, that we will reimburse up to €1,000 over the entire period you are insured with us. To find out more about the maximum reimbursements we pay out, please see clause C.9.2.

Rates

Your Reimbursements Overview details the extent of the reimbursement you will receive. This will often be a percentage (e.g. 100%), but this does not mean we will always cover your bill in full. Please see clause A.20 for more information.

5. Conditions for reimbursement

The clause for the healthcare you need specifies the terms and conditions we have set for that type of healthcare. Some common terms and conditions are:

- the healthcare provider treating you must be competent:
  Healthcare providers must be suitably qualified and have sufficient expertise in their field. Other than that, healthcare providers also need to have, for example, a clear complaints procedure in place for patients. Such healthcare providers can sometimes be identified from their title (medical specialist), or by virtue of the fact that they have been recognised either by the government or by us. You can ask us about this or check for yourself on our website.

- you must seek our approval prior to commencement of the treatment:
  For certain kinds of healthcare, it can be difficult to determine whether or not you are insured for reimbursement. In such cases, you must seek our prior approval. Your insurance will only cover the costs of the requested healthcare once you have obtained our approval (see clause A.18).

6. Internet

Your terms and conditions of insurance, regulations and other relevant appendices are available on our website. You can also request copies from us.
Our website also provides other information, such as:

- information about healthcare providers, such as where you should go for specific healthcare, and details of which healthcare providers are contracted;
- the list of conditions for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). This document states whether physiotherapy and/or exercise therapy are covered under your health insurance (and, if so, the amount reimbursed). If you are not entitled to reimbursement under your health insurance, the treatment may be reimbursed under your additional insurance package;
- a range of appendices that form part of your insurance, such as various regulations;
- your personal page. You can log on using your password or DigiD to view your policy document, submitted invoices and/or reimbursements and inform us of any changes.

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Types of health insurance and additional insurance packages

You can take out one or more of the following types of health insurance:

- a 'Restitutie' health insurance policy;
- a 'Natura' health insurance policy;
- a 'Natura JUST' health insurance policy;
- a 'Natura Select' health insurance policy;
- a 'Natura Direct' health insurance policy;
- a 'Combinatie' health insurance policy; or
- a different health insurance policy, based on one of the above types of health insurance.

You can also choose from our various additional insurance packages.

Your health insurance is a health insurance policy as defined in the Dutch Health Insurance Act ('Zorgverzekeringswet').
If you select the 'Natura', 'Natura JUST', 'Natura Select' or 'Natura Direct' health insurance policy, you are insured for healthcare (they are 'in-kind policies').
The 'Restitutie' health insurance policy is a 'refund policy' that entitles you to reimbursement of the costs of covered healthcare.
With the 'Combinatie' health insurance policy, you are either insured for healthcare ('in kind') or entitled to reimbursement of the costs of covered healthcare ('refund'). Your premium schedule shows which healthcare is provided 'in kind'; for other covered healthcare not listed on this schedule you are reimbursed for the costs of this healthcare. You can also find this information on your Reimbursements Overview.

Your policy document states the type of health insurance and additional insurance packages that you hold.

SECTION A

GENERAL TERMS AND CONDITIONS FOR HEALTH INSURANCE AND ADDITIONAL INSURANCE PACKAGES

A.1. Definitions

This clause defines the terms used in the terms and conditions of insurance.

Abroad
Any country other than the Netherlands. If you do not live in the Netherlands, 'abroad' means any country other than your country of residence.

Accident
A sudden, unexpected, involuntary and external event that directly results in bodily injury that can be detected objectively by a medical professional. An accident is also deemed to include a situation where you suddenly and involuntarily end up in circumstances that you did not foresee and could not reasonably have foreseen and that results in bodily injury that can be detected objectively by a medical professional.

Some examples of such a situation or circumstances include:
- an infected wound or blood poisoning;
- sprains, dislocations and tears of the muscles and ligaments;
- involuntary ingestion of or poisoning with gases, vapours, liquid or solid substances or objects, unless this is through the use of alcohol, medicine or drugs;
- infection by exposure to pathogens or due to poisoning during an involuntary fall into water or any other substance (liquid or otherwise), or if you enter it yourself to save a person, animal or object;
- drowning, suffocation, frostbite, hypothermia, sunstroke, burning (except as the result of sunbathing), lightning strike or other electrical discharge, or coming into contact with a corrosive substance;
- natural violence such as an earthquake, flood, tsunami (tidal wave), hurricane, or volcanic eruption;
- starvation, dehydration and exhaustion;
- complications or aggravation of injuries as the result of medically required treatment after an accident;
- becoming infected with HIV through a blood transfusion or injection with a contaminated needle while being treated in a hospital.

We consider an acute, serious illness to be equivalent to an accident. An acute, serious illness exists if:
- medical care is required immediately on medical grounds and cannot be postponed, or an

illness or condition is life-threatening; and
- the healthcare required is covered by the general insurance policy; and
- based on objective medical standards, no recovery can be expected within the next six months.

Additional insurance package
An insurance agreement for reimbursement of the costs of healthcare that runs alongside and in addition to a health insurance policy. You can take out one or a combination of additional insurance packages with us. Whenever we refer to 'additional insurance package', this also includes a combination of additional insurance packages.

Admission
A period of nursing and treatment (including at least one overnight stay) in a facility for specialist medical healthcare in a ward set up for nursing. The admission must be a medical necessity in terms of medical healthcare.
However, this does not include a stay in an outpatient clinic, nor day care or urgent medical care, nor a facility for rehabilitation.

Your health insurance covers admissions of up to 1095 (3 x 365) consecutive days. Days are counted using the following rules:
- if your admission is interrupted for a period of fewer than 31 days, the number of days of interruption do not count towards the total number of days. We continue counting after the interruption;
- if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning and you are again entitled to healthcare and reimbursement of such for the total number of days (again up to a maximum of 1095 days);
- if your admission is interrupted for weekend/holiday leave, the number of days of interruption count towards the total number of days.

AGB code
This code is an administrative code assigned to healthcare providers in the Netherlands, identifying each one individually. Each healthcare provider is listed with its unique AGB code in a national register (Vectis) containing all information necessary to submit claims for the healthcare, to purchase and contract the healthcare and to help guide insured persons to the right healthcare.

Approval
A written statement stating that:
- we consider the healthcare to be covered by your insurance policy/health insurance policy/additional insurance package; and
- your situation indicates reasonable medical grounds for this; and
- you are entitled to the healthcare in accordance with the terms and conditions of insurance.

The statement is issued by our 'Medische Beoordelingen' (Medical Assessments) department.

At home
The place where you live, i.e. your fixed place of abode.

Birth centre
A facility for first-line midwifery care (also known as a birth clinic or childbirth centre) located in a hospital that also offers urgent midwifery care as part of its healthcare services. This is a place where you can give birth and, if necessary, stay for a period of time afterwards.

Birth clinic
A facility where a woman can stay after giving birth and receive obstetric care. Childbirth does not take place in a birth clinic.

CAK
The Dutch Central Administration Office ('Centraal Administratie Kantoor', CAK), as defined in Article 6.1.1, first paragraph, of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

Centre for dental care in exceptional circumstances
A centre that provides dental care in exceptional circumstances in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as a centre for dental care in exceptional circumstances.

Cesar/Mensendieck exercise therapist
A Cesar or Mensendieck exercise therapist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Clinical psychologist
A healthcare psychologist registered as a clinical psychologist under the terms of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet Beroepen in de Individuele Gezondheidszorg', also referred to as 'Wet BIG').

Company doctor

A doctor listed as a company doctor on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Consultation
A consultation with a healthcare provider. This can involve a referral, a discussion of a patient's medical history, a physical examination, diagnosis and/or additional tests/diagnostics where such is deemed medically necessary.

Day treatment
Healthcare of a few hours' duration, provided in a facility for specialist medical healthcare, in a department set up for day nursing, or in a rehabilitation centre intended for medical tests and/or medical treatment, without the need for admission. The healthcare involved must be generally foreseeable.

DBC healthcare product (Diagnosis-Treatment-Combination)
A Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC), also referred to as a DBC healthcare product, is a 9-digit code that describes the entire process of treatment under specialist medical healthcare, i.e. all the steps required to treat a particular condition or illness. The start date of a DBC healthcare product is the date on which the first healthcare activity took place. This date is significant for the reimbursement given that the bill is settled on the DBC start date. The rate for a DBC healthcare product is based on an average of the costs incurred and the healthcare provided for a particular course of treatment.
In addition to a DBC healthcare product, a hospital can charge other costs in a specialist medical healthcare course of treatment. These costs come under 'other healthcare products' ('overige zorgproducten', OZP). These are often stand-alone activities that do not involve an entire course of treatment, such as when a general practitioner requests a diagnostic test (like an ultrasound or X-ray) or in the case of dental surgery. Specific types of expensive healthcare (like intensive care, expensive medicines and blood products) are claimed as 'other healthcare products' as well.

Deductible
The costs of healthcare covered by the health insurance policy, but which you must pay yourself. The deductible is set by law. A deductible is not the same as a personal contribution. Deductibles and personal contributions may apply simultaneously to the insured healthcare. To find out more about the deductible, please see clauses A.12. and A.13.

Dental hygienist
An independent dental hygienist who practices at his/her own expense and on his/her own responsibility.

Dentist
A person who is qualified as a dentist and is registered as a dentist under the terms of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

Diagnostics
Determination of the medical cause of the patient's problem, illness or condition.

Dietician
A dietician with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Dispensary
A general practitioner or pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').

Doctor of Public Health
A doctor listed as a Doctor of Public Health ('arts Maatschappij en Gezondheid') in the registers administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Doctor for the mentally disabled
A doctor listed as a doctor for the mentally disabled on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

EU/EEA member state
The EU (European Union) member states are:
Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek part), Czech Republic, Denmark, Estonia, Finland, France (including - French Guyana, Guadeloupe, Martinique, Réunion, Saint Barthélemy and Saint Martin), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal (including the Azores and Madeira), Romania, Slovakia, Slovenia, Spain (including the Canary Islands, Ceuta and Melilla) and Sweden. Under international treaties, Switzerland is considered to be on a par with the above. The following are not part of the EU (this list is not exhaustive): Andorra, the Channel Islands, the Isle of Man, Monaco, San Marino and Vatican City.

The EEA (European Economic Area) states are: the aforementioned EU states, Iceland, Liechtenstein and Norway.

Facility for specialist medical healthcare
A facility as defined in the Dutch Healthcare Institutions (Accreditation) Act ('Wet toelating zorginstellingen', WTZi), such as a hospital or an independent treatment centre, for example. The facility must have a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.

- where we mean to refer only to a hospital, this is written as: hospital (facility for specialist medical healthcare). In this case we mean a general hospital, a specialist hospital (i.e. a hospital that provides healthcare for just one or a limited number of specialist fields such as a burns unit or psychiatric hospital) or a university hospital.
- where we mean to refer only to an independent treatment centre, this is written as: independent treatment centre (facility for specialist medical healthcare).
- where we mean to refer to both, we write 'facility for specialist medical healthcare' and nothing else.

Family or family members
We define family or family members as the person who would be considered to be your sole life partner and with whom you reside and run a joint household. We also include as family members:

- children up to the age of 18 (including adopted children and foster children);
- children between the age of 18 and 30 years who are students, even if those children do not live at the same address as you (the policyholder) and so do not form a joint household with you;
- any individual the company or organisation that has concluded the group insurance agreement with us deems to be a family member.

A family member may have his/her own policy or may be co-insured on the policy of another family member.

General insurance policy
An insurance agreement taken out for reimbursement of the costs of healthcare. The insurance agreement provides independent cover, i.e. it does not constitute an addition to any other insurance policy. A general insurance policy is the same as a health insurance policy. These terms can be used interchangeably.
An exception to this is the 'Verdragspolis' as referred to in C.11.2, which is not a general insurance policy.

General practitioner
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Geriatric specialist
A doctor listed as a geriatric specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Healthcare group
A partnership of healthcare providers, registered as a legal entity. Also see clause A.17.

Health insurance
Health insurance as defined in the Dutch Health Insurance Act ('Zorgverzekeringswet') for the provision of healthcare or reimbursement of healthcare. Health insurance is the same as a general insurance policy. These terms can be used interchangeably.

Health insurer
An authorised insurance company that provides health insurance. The insurance company to which these terms and conditions of insurance apply is the insurance company specified in that capacity on the policy document. In these terms and conditions of insurance, we refer to the insurance company as 'we' and 'us'.

Hospital
Please refer to 'Facility for specialist medical healthcare'.

Independent treatment centre (ZBC)
Please refer to 'Facility for specialist medical healthcare'.

Insurance
An insurance agreement consisting of one or more of the following types of insurance:

- health insurance;
- private medical expenses insurance;
- additional insurance package.

If the insurance consists of a combination of two or more of the aforementioned insurance agreements, it can only include one health insurance policy or one private medical expenses insurance policy.

Insured person
An individual who is insured for healthcare and/or the costs of healthcare. In the terms and conditions

of insurance, we refer to the insured person and the policyholder using 'you' and 'your'. Where we refer only to the insured person, and not the policyholder, we use 'you (the insured person)' and 'your (the insured person's)'.

Laboratory tests
Tests performed by a legally authorised laboratory that has an official rates decision, allowing costs of tests to be claimed up to a specified maximum price.

(Medical) adviser
A doctor, pharmacist, dentist, physiotherapist or other expert who provides us with advice on medical, pharmacotherapy-related, dental or physiotherapy-related healthcare or healthcare that relates to his/her own field of healthcare expertise.

Medical indication/grounds
In medicine, an 'indication' is a condition or illness that makes a particular treatment or procedure advisable; i.e. a doctor has established or suspects that there are medical grounds for you to receive certain healthcare.

Medical specialist
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism.

Medicine/medication
Medicine.

Month
A calendar month.

Nursing specialist
A nurse listed on the register of nursing specialists administered by the Nursing Specialisms Registration Committee ('Registratiecommissie Specialismen Verpleegkunde', RSV).

Explanation: the limits of authority of the nursing specialist are determined by the level of education, competence, field of expertise and specified limitations in relation to the designated treatments. For a more detailed explanation of the field of expertise and authority of a nursing specialist, please refer to the Regulation on the Independent Authority of Nursing Specialists ('Regeling zelfstandige bevoegdheid verpleegkundig specialisten'). For a more detailed explanation of the authority of a nursing specialist in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).

Obstetric care
Healthcare during the period after giving birth, provided by an obstetric nurse qualified to nursing or obstetric nursing level 3 or equivalent, and who is listed in the Quality Register of Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg', KCKZ).

Obstetrician
An individual listed as an obstetrician on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

Obstetric nurse
An individual listed as an obstetric nurse in the Quality Register of Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg', KCKZ).

Occupational therapist
An occupational therapist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Orthodontist
A dental specialist listed on the specialist register for odontomaxillary surgery administered by the Royal Dutch Dental Organisation ('Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde').

Out-of-hours general practitioner surgery
An association of general practitioners. The association has legal personality, as defined in Article 29c of the Dutch Decree on the expansion and limitation of scope of the Healthcare (Market Regulation) Act ('Besluit uitbreiding en beperking werkingssfeer Wet marktordening gezondheidszorg'). The association was established in order to provide urgent general practitioner care in the evenings, at night, at weekends and on public holidays at a designated after-hours general practice

('huisartsenpost') and has a legally valid rate.

Pedicurist
- individuals listed on the Quality Register for Pedicurists ('Kwaliteitsregister Pedicure') or listed as a pedicurist on the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg') with the DV (diabetes) specialism may treat insured persons suffering from diabetes mellitus.
- individuals listed on the Quality Register for Pedicurists ('Kwaliteitsregister Pedicure') or listed as a pedicurist on the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg') with the RV (rheumatoid arthritis) specialism may treat insured persons suffering from rheumatoid arthritis.
- individuals listed on the Quality Register for Medical Foot Care Providers ('Kwaliteitsregister Medisch Voetzorgverlener') as a medical foot care provider may treat insured persons suffering from rheumatoid arthritis.
- individuals listed on the Quality Register for Pedicurists ('Kwaliteitsregister Pedicure') or listed as a medical pedicurist on the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg'). A medical pedicurist is a pedicurist who specialises in a range of complex foot problems. This type of pedicurist may treat insured persons suffering from diabetes mellitus or rheumatoid arthritis.
- individuals listed as an allied chiropodist in the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg'). An allied chiropodist is a pedicurist who specialises in a range of complex foot problems. This type of pedicurist may treat insured persons suffering from diabetes mellitus or rheumatoid arthritis.

The clauses that describe healthcare also specify which of the types of pedicurist referred to above can provide the healthcare.

Personal contribution
The costs of healthcare covered by the health insurance policy, but which you must pay yourself in full or in part. Personal contributions are set by law. This statutory personal contribution may be a fixed amount per treatment or a set percentage of the costs of the healthcare. A personal contribution is not the same as a deductible. Deductibles and personal contributions may apply simultaneously to the insured healthcare.

Physician assistant
An individual listed on the Quality Register of the Dutch Association of Physician Assistants ('Nederlandse Associatie Physician Assistants', NAPA).

Explanation: The field of expertise of a physician assistant includes the performance of tasks within the subfield of medicine in which the physician assistant is qualified. These tasks include the examination, treatment and support of patients suffering from common conditions within the specific subfield of medicine. For a more detailed explanation of the field of expertise and authority of a physician assistant, please refer to the Decree on the Field of Expertise and Qualifications of Physician Assistants ('Besluit deskundigheidsgebied en opleidingseisen physician assistants'). For a more detailed explanation of the authority of a physician assistant in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).

Physiotherapist
An individual listed as a general physiotherapist in the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland') and/or any register(s) designated by us.

Podiatrist
A podiatrist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') who is a member of the Dutch Association of Podiatrists ('Nederlandse Vereniging van Podotherapeuten', NVvP).

Policy document
Proof of insurance.

Policyholder
The person who takes out the insurance agreement with us, and in whose name the policy is written. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using 'you' and 'your'. Where we refer only to the policyholder, and not the insured person, we use 'you (the policyholder)' and 'your (the policyholder's)'.

Prevention
A set of individual or group activities aimed at improving or maintaining your physical and/or mental health.

Private medical expenses insurance
This type of insurance is not a health insurance policy as defined in the Dutch Health Insurance Act ('Zorgverzekeringswet') and is therefore also not insurance as defined in Article 1, Paragraph f, of the Dutch Healthcare (Market Regulation) Act ('Wet Marktordening Gezondheidszorg', Wmg). It is a non-statutory general insurance policy. Private medical expenses insurance can only be taken out and is only in effect where there is no insurance obligation under the Dutch Health Insurance Act ('Zorgverzekeringswet'). This insurance offers independent cover without this being supplemental to the cover under another insurance policy.

Psychiatrist
A doctor listed as a psychiatrist on the specialist register administered by the Royal Dutch Medical Association ('Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunst') who specialises in the diagnosis and treatment of disorders of the cognitive functions, the emotional functions, the psychomotor system, motivation and behaviour.

Psychotherapist
A healthcare provider who is qualified as a psychotherapist and is registered as a psychotherapist under the terms of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

Primary healthcare
First point of contact for people who need healthcare.

Prosthodontist
An individual who holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

Referral
For certain types of healthcare, you need to have a referral before you start receiving the healthcare. The healthcare provider who issues this referral must be one of the healthcare providers we specify under 'Referral' in these terms and conditions.

Rehabilitation
Tests, advice and treatment of a specialist medical, allied health, behavioural science and rehabilitation nature.
Rehabilitation consists of specialist medical rehabilitation or geriatric rehabilitation.
Rehabilitation doctors have ultimate medical responsibility for the content and quality of specialist medical rehabilitation.
Geriatric specialists have ultimate medical responsibility for the content and quality of geriatric rehabilitation.
Rehabilitation healthcare is provided by a coherent, interdisciplinary team, in which all members cooperate closely in working towards the same treatment goal for the patient. The team is associated with a facility for rehabilitation.

Royal Dutch Medical Association youth healthcare doctor
A doctor listed as a Royal Dutch Medical Association youth healthcare doctor on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Skin therapist
A skin therapist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and who has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.

Sonographer
An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV) or the register administered by the Dutch Professional Association of Sonographers ('Beroepsvereniging Echoscopisten Nederland', BEN).

Speech and language therapist
A speech and language therapist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Sports doctor
A doctor listed as a sports doctor on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

Stay
A period during which you either permanently or temporarily (with or without an overnight stay) stay or live somewhere other than in your home without this necessarily involving the nursing or treatment you would receive during an admission for example.

Treatment
Contact, physical or online, with one or more healthcare providers, involving the provision of healthcare and/or advice. Treatment does not include courses or training.

Treatment proposal
A treatment proposal states which healthcare (examination, treatment or therapy) you need; for medicine you are given a prescription.

Treaty country
Treaty country means:
- the following states with which the Netherlands has a treaty for social security, including arrangements for the provision of medical healthcare: Australia, Bosnia and Herzegovina, Cape Verde, Macedonia, Montenegro, Morocco, Serbia, Tunisia and Turkey;
- European Union (EU) member states other than the Netherlands;
- states that are party to the Agreement on the European Economic Area (EEA);
- Switzerland;
- the United Kingdom.

Urgent medical care
Healthcare that is a medical necessity and that cannot reasonably be postponed. This concerns medical care that can reasonably be described as urgent in the general opinion of the group of relevant professional practitioners.

Written
A physical or electronic means of conveying information, whereby the information itself can be understood, stored and reproduced. An electronic means of conveying information includes the internet and emails. Written communication includes by letter, email and through the 'Mijn' environment on our website.

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

Wmo
The Dutch Social Support Act ('Wet maatschappelijke ondersteuning').

Year
A calendar year. However, when referring to someone's age, we do not mean a calendar year. We simply mean a year in the person's life.

A.2. Fundamentals of your insurance

A.2.1. General

You have taken out insurance with us. We record the agreement on the policy document, which we send to you each year.

A.2.2. Insurance obligation

You are able to take out health insurance with us if you are obliged to do so under the Dutch Health Insurance Act ('Zorgverzekeringswet').

A.2.3. Basis of your insurance

Your insurance is based on:
- the present terms and conditions of insurance;
- the registration form and the details entered on it by you or by a third party on your behalf;
- the information and statements received by us when you took out the insurance, as provided by you or by a third party;
- the policy document, regulations, protocols and policy appendices;
- any associated or group agreements.

A.2.4. Basis of your health insurance

In addition to clause A.2.3., your health insurance is also based on:
- the Dutch Health Insurance Act ('Zorgverzekeringswet');
- the Dutch Health Insurance Decree ('Besluit zorgverzekering');
- the Dutch Health Insurance Regulations ('Regeling zorgverzekering');
- the explanatory notes to the above Acts and Regulations;
- the interpretations of 'Zorginstituut Nederland' (known in Dutch as 'standpunten').

A.2.5. Membership

When taking out a general insurance policy, you also request membership of the mutual insurance company 'Onderlinge Waarborg Maatschappij CZ Groep u.a.' for each insured person. The board of 'Onderlinge Waarborg Maatschappij CZ Groep u.a.' automatically accepts your request. From the moment your general insurance policy commences, every insured person you register also automatically becomes a member of this mutual insurance company.

A.2.6. Information from third parties

We assume that you are familiar with the

information provided to us by third parties in relation to your insurance registration and we consider this information to have been supplied by you.

A.2.7. Contract party

We regard you (the policyholder) to be our sole contract party for the insurance. The policyholder alone is able to cancel or change the insurance.

A.2.8. Verification of the policy document

We assume that the details provided on your registration apply to you. If the details on the policy document are incorrect or incomplete, you must notify us within 30 days of receiving the policy document. If you do not contact us about this within the specified period, we will assume that the details provided are complete and accurate.

A.2.9. Your card

Once you have registered with us, we will send you an insurance card in addition to the policy document for your health insurance. You can show this card to obtain insured healthcare from healthcare providers who have a healthcare agreement with us and/or to whose healthcare you are entitled under your terms and conditions of insurance.

Please note!
You will not be issued an insurance card:

- if you have private medical expenses insurance rather than health insurance; or
- if you only have an additional insurance package.

A.2.10. Applicable terms and conditions of insurance

Your policy document specifies the applicable terms and conditions of insurance. If you believe that a different version of the terms and conditions of insurance, the Reimbursements Overview and/or any addition applies, or that a different text is in effect, only the text and contents of the versions in effect and in our possession at that time are valid.

A.2.11. Other languages

Besides Dutch, we can also issue terms and conditions of insurance, Reimbursements Overviews, regulations and/or appendices in one or more other languages. In the event of any discrepancies in the content or interpretation of such documents between the Dutch version and the version in another language, only the text and content of the Dutch versions in our possession at that time are valid.

A.2.12. Terms and conditions of insurance that deviate from the law

We endeavour to ensure that the terms and conditions of insurance, Reimbursements Overviews, regulations, schedules and appendices are in keeping with current legislation. This ensures that the scope and content of the cover of your general insurance always aligns with the provisions set out by law and that your general insurance policy is a model agreement within the meaning of the Dutch Health Insurance Act. However, if new or amended legislation takes effect late or in the interim, one or more parts of the terms and conditions of insurance, Reimbursements Overviews, regulations, schedules and appendices may deviate from the law. In the event of a discrepancy between, on the one hand, the terms and conditions of insurance, Reimbursements Overviews, regulations, schedules and appendices and, on the other hand, one or more legal provisions, explanatory memoranda or interpretations thereof, the relevant law, explanatory memorandum or interpretation will take precedence.

A.2.13. What we will send you

When you take out insurance with us for the first time, or when the terms and conditions of insurance, the premium, the premium base and/or your entitlement to healthcare and/or reimbursement changes, we will send you:

- a new policy document. When we do this, we will also specify the date on which the new policy document takes effect. Your old policy document will cease to be valid from that date.
- the new terms and conditions of insurance and Reimbursements Overview, if you request these. We will specify the date on which the new terms and conditions of insurance and Reimbursements Overview take effect. This nearly always coincides with the date on which your new insurance takes effect. Your old terms and conditions of insurance and Reimbursements Overview will cease to be valid from that date.
- any addition to your existing terms and conditions of insurance and Reimbursements Overview, if you request this. We will specify the date on which the addition takes effect. This nearly always coincides with the date on which your new insurance takes effect. Additions will take effect on that date, alongside your existing terms and conditions of insurance and Reimbursements Overview.

Your terms and conditions of insurance and Reimbursements Overview are available on our website.

A.3. Content and scope of your insurance

A.3.1. Healthcare mediation

You are entitled to healthcare recommendations and mediation. This includes instances where the required healthcare cannot be provided, or cannot be provided in good time. The inability to provide healthcare, or provide it in good time, also includes instances where the healthcare can only be provided far from your place of residence or where the healthcare provided near to the insured person's place of residence is of inadequate quality.

A.3.2. Content and scope of healthcare

Who determines the content and scope of the healthcare?

- the content and scope of your health insurance is set by the government.
- we determine the content and scope of our private medical expenses insurance and additional insurance packages.

These terms and conditions of insurance describe what you are insured for. All healthcare must meet the requirements set out below:

- it is healthcare that healthcare providers in the relevant profession provide in accordance with their standards and norms and deem accepted.
  Explanation:
  - to determine whether certain healthcare is included in the healthcare that a particular professional group provides, we look at the symptoms/conditions that a particular professional group treats and the forms of healthcare they generally provide for such. In other words, the healthcare must be within the domain of a certain professional group and this professional group must consider that the healthcare is within its area of expertise.
  - the healthcare is insured healthcare under the general insurance policy in accordance with the Dutch Health Insurance Act ('Zorgverzekeringswet') and is listed on your Reimbursements Overview and is specified in detail in section B of these terms and conditions of insurance; or
  - the healthcare is insured healthcare under your additional insurance package(s) and is listed on your Reimbursements Overview and is specified in detail in section D of these terms and conditions of insurance.
- the content and scope of healthcare is determined by the latest practical and theoretical standards and/or by what is deemed to constitute responsible and adequate healthcare and services in the field in question.
  Explanation:
  - there must be sufficient (substantive) evidence that the healthcare is effective and safe (in the long term). In assessing this, we consider all of the available scientific information.
  - the scope of healthcare is specified in the Reimbursements Overview and other forms of communication. Where an amount, number or period is specified for a particular type of healthcare, you will be entitled to that healthcare up to a maximum of the amount, number or period specified. Payment of invoices for a lower amount, lower number or shorter period will never exceed the amount claimed.
- in light of your indication, there are reasonable medical grounds for you being provided with the healthcare. The healthcare provided must be appropriate to the condition.
  Explanation:
  The healthcare must be both effective and suited to your situation. For example, there must be medical grounds for you receiving the healthcare and it must neither be unnecessarily expensive nor unnecessarily extensive. Healthcare that is disproportionately expensive and/or extensive in your situation is not deemed adequate healthcare and is therefore not covered by your insurance, not even if you pay for part of it yourself.
  Example:
  If there are medical grounds for you having a hearing aid in category X and a device costing €1500 is sufficient and suitable for you, that hearing aid is deemed to be effective healthcare. In this case, your statutory personal contribution is 25% of €1500, which may be reimbursed in part under your additional insurance package if you are insured for this.
  If you choose an equally suitable device from the same category X that costs €2000, we will not provide any reimbursement since that device is not deemed 'effective'; if there are two hearing aids within a category (e.g. X) that are equally suitable and satisfactory for you, we will reimburse the €1500 hearing aid on the basis of this being 'effective', while we will not reimburse any of the costs of the €2000 hearing aid.
- insured healthcare can also include healthcare other than that described in this section B.
  The following conditions apply to this 'other healthcare':

  - the generally held opinion must be that the other healthcare will lead to a comparable result; and
  - the other healthcare is not barred for legal reasons; and
  - we have given you our prior approval for the 'other healthcare'.
- the costs of healthcare you receive can only be reimbursed under one of the provisions of the general insurance, though your additional insurance package may possibly provide an additional reimbursement for this healthcare.

These general criteria apply in addition to the other criteria specified in these terms and conditions of insurance for the entitlement to healthcare or the reimbursement of the costs of healthcare. If you are already in receipt of healthcare that no longer satisfies amended terms and conditions of insurance, of which you have now been notified, entitlement to this healthcare and reimbursement of the costs of this healthcare will cease. If you are receiving treatment for which we have provided approval, you may complete this treatment.

A.3.3. Conditional healthcare

Contrary to the provisions of clause A.3.2., bullet points 2 and 3, cover also includes healthcare and services designated for a limited time in the Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Such healthcare is governed by the applicable terms and conditions (see clause B.22.). The Dutch Health Insurance Regulations ('Regeling zorgverzekering') are available on the government website
at wetten.overheid.nl (in Dutch).

A.3.4. Area of cover

Your insurance has worldwide cover.

Example:
While on holiday in France, you purchase prescription glasses. You hold an additional insurance package that includes reimbursement of the costs of vision aids up to €100 every two years. Reimbursement applies also to glasses purchased abroad.
The terms and conditions that apply to a particular clause also apply abroad. The healthcare provider must comply with the criteria, laws and regulations applicable in the country concerned.

A.3.5. Customised terms and conditions

Your reimbursements and terms and conditions presented online are customised to your situation. You may notice at some point that different terms and conditions and/or reimbursements now apply to you, because you have turned 18 or 22 for example.
In these instances, we have not changed the terms and conditions or reimbursements (as specified in clause A.5.3.), but rather other terms and conditions and/or reimbursements now apply to you due to your age.

A.4. Commencement and term of your insurance

A.4.1. Commencement date

The insurance commences on the date we receive your request for insurance with us. Your request must include the address that you used to register in the Persons Database ('Basisregistratie Personen', BRP). We can also register you for insurance without the (correct) address listed in the Persons Database ('Basisregistratie Personen', BRP), if:

- you send us a statement or payslip from your employer, no more than one month old, which states your date of commencement of employment. This must show that you are liable for income tax in relation to work performed in the Netherlands or on the continental shelf (as defined in Article 1.1.1 of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz); or
- you send us a statement from the 'Sociale Verzekeringsbank', which shows that you are insured under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz); or
- there is nothing that you could reasonably have done to avoid the address provided by you being different from the address in the Persons Database ('Basisregistratie Personen', BRP).

If you are currently insured with a different health insurer and you state in your request that you would like your insurance to commence on a later date, your insurance will commence on that later date. Your policy document will specify the commencement date of insurance.

A.4.2. Request for change

We regard any request for insurance that you submit to us to also be a request to cancel any similar types of insurance that you already hold with us.
If you submit a request for health insurance to another health insurer, we regard that request to be a request to cancel any health insurance that you hold with us, with effect from the date we receive a copy of any such request.

A.4.3. Insured with retrospective effect

We will register you with retrospective effect:

- if your health insurance takes effect within 4 months of your insurance obligation arising. In this case, the commencement date will be the date on which your insurance obligation arose.
- if you take out insurance with us within one month of cancelling your insurance with another health insurer as a result of the terms and conditions of insurance being changed, or because it was the end of the year. Your insurance/health insurance/additional insurance package will take effect with us on the day after the date of cancellation of your old insurance.

A.4.4. Insurance term

The insurance term will be one whole year, except where your insurance with us commences part-way through the year. If the latter applies, your insurance will run until 1 January of the following year. After that, we will renew your insurance each year for one year. We will send you a reminder about this before renewal, along with details of any changes. You will have the opportunity at this point to change or cancel your insurance.

A.4.5. Start and end of entitlement to healthcare

You are only entitled to healthcare for which you are covered in accordance with the terms and conditions of insurance, and which you receive during the term of this health insurance policy. If you claim for a DBC healthcare product code that commenced before the end date of your health insurance, we assume that the associated costs were incurred while you were insured.

A.5. Cancellation and changes made by you

A.5.1. Withdrawal from your new insurance contract

When you (the policyholder) take out an insurance policy or change your existing insurance policy, under your right of withdrawal you may terminate that insurance policy free of charge and without having to provide a reason. The following terms and conditions apply:

- you must notify us about the withdrawal in writing, clearly stating your name, address, place of residence and details of the insurance policy from which you wish to withdraw.
- you have the right to withdraw from the insurance policy within 14 days of your new insurance policy taking effect with us. If the insurance policy has not yet taken effect, we must receive your notice of withdrawal within 14 days of your receipt of the policy document.

If you do not comply with these conditions, you cannot withdraw from your new insurance policy.

We will cancel the new insurance policy with retrospective effect, from the date on which the policy took effect. We will repay any premiums that you have already paid us for this insurance, within 30 days of receiving your notice of withdrawal.
If you have been reimbursed for costs incurred between the commencement date of insurance and the date of withdrawal, you must repay these to us within 30 days of receiving a breakdown from us.

A.5.2. At the start of a new year

You (the policyholder) are entitled to cancel or change your insurance each year. If you do so, we must receive written notification of your cancellation or change by 31 December at the latest. If we receive notification after this date, your existing insurance will continue for a further year, ending on 1 January of the following year. This clause does not apply to health insurance taken out by the Dutch Central Administration Office (CAK) on your behalf; see clause A.5.8.
In the case of a change, you will take out replacement insurance with us, once we have approved this. Your existing insurance will then end on 1 January.

A.5.3. In the event of changes to the terms and conditions of insurance

We reserve the right to change the terms and conditions of insurance. If the change is to your disadvantage (and it affects the insurance you have taken out), you (the policyholder) will be entitled to cancel or change the insurance. You must notify us of your decision to cancel your insurance in writing within 30 days of our notification to you of the change. Your insurance will end or change on the date the change takes effect.
Your right to cancel or change the insurance does not apply in the event that the change to the terms and conditions of insurance is the result of a change in the law.

A.5.4. In the event of changes to the premium base

We will notify you of any changes to the premium base at least 7 weeks in advance. If we increase the premium base, you (the policyholder) will be entitled to cancel or change your insurance at any time from the date on which we notify you of the change up to the date on which the increase takes effect. You must notify us of your decision to cancel

your insurance in writing. Your insurance will end or change on the date the premium increase takes effect.

A.5.5. In the event of changing to a different group insurance scheme

If you (the policyholder) are insured through a group insurance scheme with an employer, and you subsequently start working for a different employer who operates a different group insurance scheme, you (the policyholder) will be entitled to cancel your group insurance with your old employer part-way through the year. You (the policyholder) will be able to cancel your old group insurance in writing, at any time from the date on which your previous employment ends, up to 30 days after the date on which you commence your new employment. Your new group insurance will take effect on the date on which you commence employment with your employer, where this is the first day of the calendar month; otherwise it will take effect on the first day of the month following commencement of employment. Your old group insurance will end on the same day as your new insurance takes effect, as will the premium discount and any other group agreements under the old group insurance scheme.

A.5.6. In the event of changing from group insurance to personal insurance

If you are no longer eligible to participate in the group agreement that includes the group insurance scheme, we will convert the group insurance held by you (the policyholder) and your family members into a personal insurance policy. This applies in the following cases, for example:

- you (the policyholder) have taken out group insurance through your employer, and you are no longer considered an employee of that employer. If you notify us within 30 days of ceasing to be an employee, you will be entitled to remain a member of the group insurance scheme until 1 January of the following year. If you notify us later than this, we will decide when your membership ends.
- you (the policyholder) have taken out group insurance through a legal entity who represents your interests. We will do this on the date on which you are no longer considered an individual whose interests are represented by that legal entity.
- the group agreement (concluded between the employer or representative and us) under which your group insurance was taken out, ends for any reason.

In the cases above, you will no longer be entitled to receive the group discount. Should a situation as described above occur, the group insurance policy or policies will continue without interruption on the basis of the terms and conditions that apply to a personal insurance policy and that come closest to those of the former terms and conditions that applied under the group insurance scheme. From then on, you will need to start paying the premium for personal insurance.

A.5.7. In the event of insurance for someone else ending

If you (the policyholder) have insured someone else, you will be entitled to cancel insurance for that individual or take out different insurance with us part-way through the year, if the person concerned is insured under different insurance:

- if you (the policyholder) cancel the insurance in writing **before** the new insurance takes effect, the insurance will end on the date on which the new insurance takes effect;
- if you (the policyholder) cancel the insurance in writing **after** the new insurance has taken effect, the insurance will end one full month after we receive your notice of cancellation.

A.5.8. In the event of health insurance taken out by CAK ending

If you are obliged under the Dutch Health Insurance Act (‘Zorgverzekeringswet’) to take out health insurance, it may be the case that you were nevertheless not insured and that the Dutch Central Administration Office (CAK) took out health insurance for you with us.

- you are entitled to cancel this health insurance with retrospective effect, within two weeks of CAK notifying you, if you can demonstrate to CAK and to us that you have already taken out alternative health insurance within three months of CAK notifying you that you were wrongly not insured.
- you cannot cancel this health insurance during the first 12 months that it is in effect.

A.5.9. Instances when you cannot cancel or make changes

The opportunities for cancellation and making changes, as set out in clauses A.5.2., A.5.4., A.5.5. and A.5.7. above, do not apply in the following situations:

- you (the policyholder) have failed to pay us the premium and costs due (administrative or

otherwise) on time; and
- we have sent you a reminder about this (see clause A.9.1.), requesting that you pay us the premium due within 14 days; and
- we have not (yet) suspended the insurance cover; and
- we have not agreed to the cancellation within 14 days.

You (the policyholder) will be able to make use once again of the opportunities for cancellation and making changes, as soon as you (the policyholder) have paid us the premium and costs due (administrative or otherwise), and any collection fees due.

A.5.10. Statement of cancellation

If insurance ends as a result of cancellation, you (the policyholder) will be entitled to a statement of cancellation. We will send this to you automatically, in the form of a 'policy cancellation'. Among other things, this will state the names of the insured persons, the types of insurance concerned and the applicable premium, along with the date of cancellation.

A.6. Cancellation of the insurance by us

A.6.1. Statutory cancellation of your insurance

We are required by law to cancel your insurance in certain situations. If this is the case, we will notify you (the policyholder) as soon as possible. Cancellation will take effect the day after:
- our permit to operate a non-life insurance business changes or is revoked, and we are consequently no longer able to provide insurance. We will notify you of this at least two months in advance;
- you (the insured person) die. We must be informed of this within 30 days of the date of death.

A.6.2. Statutory cancellation of your health insurance

In addition to the provisions of clause A.6.1., we are required by law to cancel your health insurance in certain other circumstances. If this is the case, we will notify you (the policyholder) accordingly. Cancellation will take effect the day after:
- we change the area within which we offer health insurance (i.e. the operating area) and, as a result of this change, you (the insured person) now live outside our operating area. We will notify you of this at least two months in advance;
- your (the insured person's) insurance obligation ceases to exist because you are no longer insured under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), or you commence military service. You (the policyholder) must inform us of this as soon as possible.

A.6.3. Unlawfully registered

If it turns out that you (the policyholder) have taken out health insurance with us without having an insurance obligation, we will cancel the health insurance with retrospective effect from the date on which you took it out. We will offset any premiums you have paid against any healthcare that we have reimbursed, and repay or invoice you for the difference, accordingly.

A.6.4. Criminal activity

If you are involved in a criminal offence, violation, deception, fraud, coercion or threats (or attempts at such) in respect of us or a contracted healthcare provider, we will be entitled to:
- cancel all your insurance policies with us with immediate effect;
- suspend any claims for healthcare and/or reimbursement of the costs of healthcare;
- reclaim any reimbursements already paid to you;
- claim from you the costs of the investigation;
- report the matter to the police;
- record your details in the usual warning system used by financial institutions.

A.6.5. Error

If the Dutch Central Administration Office (CAK) has taken out insurance with us for you because it believed that you had an insurance obligation under the Dutch Health Insurance Act ('Zorgverzekeringswet'), but it turns out that you did not have an insurance obligation at that time, we will invoke error. We will then cancel your health insurance with retrospective effect.

A.6.5.1. No longer offering a particular policy

If we stop offering and administering a particular type of insurance policy that you have taken out, we may terminate the relevant policy, in which case we will inform you of this at least six months in advance. If we replace the insurance with another insurance policy, we will inform you at least three months before this change.

A.6.6. Statement of cancellation

If we cancel the insurance, you (the policyholder)

will be entitled to a statement of cancellation. We will send this to you automatically, in the form of a 'policy cancellation'. Among other things, this will state the names of the insured persons, the types of insurance concerned and the applicable premium, along with the date of cancellation.

A.7. Amount of the premium and costs

A.7.1. Costs

You (the policyholder) must pay us the following costs in relation to the insurance:

- the premium for all insured persons on your policy;
- any amounts that the law requires you (the insured person and the policyholder) to pay (e.g. deductible, personal contributions, amounts in excess of the maximum reimbursement);
- amounts for insured healthcare that we have paid for you (the insured person and policyholder), in advance and direct to your healthcare provider;
- any surcharges, payments that were not due and other costs. This includes any additional amount that we charge you (the policyholder) for opting not to pay the amounts due to us by direct debit from your account.

Costs do not include statutory interest, default interest and collection fees incurred in the event that you fail to pay or fail to pay on time.
The premium base and discounts that arise from a voluntary deductible are stated in the premium schedule.

A.7.2. Setting the costs

We set the costs in the legal tender used in the Netherlands (i.e. the euro), and establish the criteria for in which situations and when you (the policyholder) have to pay them. Your age and the type of insurance you (the policyholder) have taken out are contributing factors.

A.7.3. Amount of the premium

The premium referred to in the first bullet point of clause A.7.1., which you (the policyholder) must pay to us, is equal to the premium base (i.e. the gross premium) less the following discounts, where applicable:

- discount if you have opted for a voluntary deductible;
- group discount;
- discount if you pay your premium more than one month in advance (payment term discount).

A.7.4. Up to the age 18

The premium for an insured person who has health insurance is €0, up until the first day of the month following the month in which he/she reaches the age of 18.

A.7.5. While in custody or serving a custodial sentence

If you are in custody or serving a custodial sentence, you will not need to pay us any costs in relation to your insurance.

A.7.6. If your insurance changes

If your insurance changes part-way through a month, we will recalculate the costs. The new amounts will take effect on the same date as the change takes effect. In the event of an insured person dying, we will repay the amounts on a pro rata basis from the day after the date of death, or we will offset the amounts on a pro rata basis.

A.7.7. Registration of a new insured person

If you (the policyholder) register a new insured person part-way through a payment period, you will only pay for the new insured person for the remainder of that payment period.

A.7.8. If you are wrongly not insured

If you have not (yet) taken out insurance, but are required to do so under the Dutch Health Insurance Act ('Zorgverzekeringswet'), we must have received all documents within four months of your insurance obligation arising, or within one month of cancellation of your previous health insurance. If we do not receive the documents on time, the health insurance will take effect as soon as we have received the required details and/or documents.

A.8. Payment of premium and costs

A.8.1. Responsibility for paying the premium and costs

You (the policyholder) are responsible for paying the costs due on time and in full.

A.8.2. Advance payment

You (the policyholder) must pay the costs due in advance. We have agreed with you (the policyholder) the period for which you will pay these costs in advance. We call this the 'payment period'. The

payment period can be one month, a quarter, six months or a year. You (the policyholder) will have fulfilled your payment obligation on time if the total amount due for the agreed payment period is in our possession:

- no later than the date specified on the giro payment form or premium invoice, if you pay by means of a giro payment form or on the basis of a premium invoice;
- by direct debit. Direct debit payments are collected within the first 7 days of the agreed payment period. You are free to agree a different direct debit payment date with us;
- before the first day of the agreed payment period, if you pay by any means other than giro payment form, premium invoice or direct debit.

A.8.3. Payment method

You (the policyholder) have agreed with us the payment method to be used for costs due. This may be by direct debit, giro payment form (on paper or by email), internet banking transfer or a premium invoice. If you have opted for electronic communications, direct debit, giro payment form by email or, in certain circumstances, an internet banking transfer are the only payment methods allowed. In the case of 'Natura JUST' and 'Natura Direct' health insurance, direct debit is the only payment method allowed.
If we collect the costs due by direct debit from your bank account, you retain responsibility for the payment being made on time and in full. We will notify you in advance of the amount being collected from your bank account.

A.8.4. Settlement

- you (the policyholder) cannot offset debts against any amounts that we still owe you (the policyholder and insured person).
- we, however, can offset your (the policyholder's) debt against any amounts to which you (the policyholder and insured person) are entitled in relation to the insurance you have with us. We cannot offset debt against payments due under the Personal Care Budget ('Persoonsgebonden Budget', PGB).

A.9. Payment arrears

A.9.1. Reminder and suspension

If you (the policyholder) fail to fulfil your payment obligation or fail to fulfil it on time, you will be in payment arrears and we will send you a reminder. If you fail to pay within a further 14 days, we will take the following steps, in sequence:

- we will offset your (the policyholder's) debt against any amounts to which you (the policyholder and insured person) are entitled. If, after doing this, debt still remains, you must pay this. Entitlement to cover under your additional insurance package will only resume from the day after we have received all amounts owed to us.
- we will engage the services of a process server (see clause A.9.2.).
- we will cancel your additional insurance package(s).
- after six months, we will report your health insurance payment arrears to the Dutch Central Administration Office (CAK). You will then have to pay CAK an administrative premium each month for your health insurance, instead of the premium you would normally pay us. The government sets the amount of the administrative premium for your health insurance. CAK will continue to collect the administrative premium until such time as you have paid all of the amounts owed in respect of your health insurance. This is a statutory requirement.
- your obligation to pay the administrative premium to CAK will cease on the first day of the month following the month in which:
  - your payment arrears are cleared; or
  - a court declares that you (the policyholder) are subject to the debt management scheme for natural persons set out in the Dutch Bankruptcy Act ('Faillissementswet'); or
  - you (the policyholder) decide to participate in a debt/debt management scheme and this is the result of discussions with a professional debt counsellor, which also involve us; or
  - we have agreed a payment arrangement with you.

Your (the policyholder's) obligation to pay the normal costs to us will resume on the first day of the month following the month in which one of the above situations applies.

We will report you to CAK again, bringing with it a fresh obligation to pay the administrative premium from the first day of the month following the month in which:

- the debt management scheme for natural persons ceases to apply on the grounds of Article 350, paragraph 3, part c, d, e, f or g of the Dutch Bankruptcy Act ('Faillissementswet'); or
- you, according to a report to CAK, have withdrawn from participation in an agreement or scheme that applied to you as described above, before you fulfilled the agreements in respect of us, as set out in the applicable agreement or scheme.

We will share data with your municipality in order to avoid debts increasing further. We will contact your municipality as soon as you have premium arrears of 2 months or more. We will do this before reporting you to CAK. The municipality may work with us in devising arrangements for your payment arrears. If you comply with the terms and conditions, your debt with us and CAK will be cleared.

A.9.2. Interest and collection fees

If you (the policyholder) are in payment arrears, you will also have to pay us statutory/default interest on the costs that are due and payable. You will also have to pay any collection fees.

A.9.3. Expiry of payment term discount

If you (the policyholder) have agreed to pay us costs in advance for a payment period of longer than one month, you will receive a payment term discount. If you are in payment arrears, we will convert the payment period for all insurance for which you are the policyholder back to one month, and you will lose your payment term discount. The loss of your right to this discount will not entitle you to cancel your insurance.

A.9.4. Debt repayment

If you (the policyholder) are in payment arrears, each amount we receive from you will be used to repay your debt or part thereof in the following order:

- first, you repay any interest and collection fees (see clause A.9.2.);
- then you repay the costs of your health insurance, followed by the costs of your additional insurance package(s). Please see clause A.7.1. for an explanation of 'costs'. Your debt will be repaid, starting with the oldest parts first.

If the outstanding debt consists of amounts from more than one period, as a result of you not having paid over an extended period of time, you cannot split the debt up by, for example, first paying only the premium due, followed by any other debts. The debt must be settled in full for each period.

A.10. Premium and costs upon cancellation

A.10.1. Debt on cancelled insurance

If you still owe us premiums and costs, as defined in clause A.7.1., in relation to insurance that has been cancelled, and you take out new insurance with us, we reserve the right to:

- offset the costs of healthcare due for reimbursement under your new insurance policy against the old outstanding debt;
- postpone our obligations until such time as you (the policyholder) have paid all premiums and costs that are due and payable. We will not reimburse any invoices until such time as you (the policyholder) have paid all unpaid premiums and costs to us, including those from the old cancelled insurance.

A.10.2. Overpaid premium

- if your insurance ends part-way through a payment period that you (the policyholder) have paid for in advance, you (the policyholder) will be repaid the part of the premium for the number of days remaining in that payment period.
- if your insurance changes part-way through a payment period that you (the policyholder) have paid for in advance, we will offset any overpaid premium for the number of days remaining in the payment period, against the premium that you must pay for the new insurance.
- we reserve the right to cancel your insurance part-way through a payment period that you (the policyholder) have paid for in advance, in the event that you are involved in a criminal offence, violation, deception, fraud, coercion or threats (or attempts at such) in respect of us. In this case, you (the policyholder) will not be repaid any paid amount in respect of the remaining part of the payment period.

A.11. Changes to the premium base

We reserve the right to change the premium base, in which case, the premium will also change. We will notify you (the policyholder) of any such change at least 7 weeks before it takes effect. Clause A.5.4. explains your cancellation rights under these circumstances.

A.12. Compulsory deductible

A.12.1. Amount of deductible

If you are aged 18 or above, a compulsory deductible of €385 will apply to your health insurance for a full year. If the insurance commences or ends after 1 January, or if you reach the age of 18 after 1 January, the compulsory deductible for that year will be less. Please also see clauses A.12.6. and A.12.7.

The compulsory deductible means that you pay the

first €385 of costs that are eligible for reimbursement under your general insurance policy yourself. Only after you have done this will we reimburse the other costs covered by your health insurance.
A deductible is not the same as a personal contribution (statutory or otherwise). Deductibles and statutory or other personal contributions may apply simultaneously to the insured healthcare.

A.12.2. Offsetting of deductible

- the costs of healthcare are offset against the compulsory deductible for the year in which the healthcare is provided.
  If healthcare is received in two consecutive years and invoiced as a single amount on one invoice, the costs of this healthcare are offset against the compulsory deductible from the first year.
- invoiced amounts are offset against the deductible if we receive the invoice no later than 31 December of the year after treatment or after the DBC was opened. A treatment on 1 April 2021, for example, can therefore no longer be offset against the deductible if we receive the invoice after 31 December 2022.

Please note!
The costs of a DBC healthcare product code (with the exception of the primary DBC healthcare product codes) only count towards the compulsory deductible for the year in which a DBC healthcare product code commenced (i.e. the opening of the DBC healthcare product code). This does not apply, however, to Other Healthcare Products ('Overige Zorg Producten', OZP) for specialist medical or specialist psychiatric healthcare.

A.12.3. No deductible

Some costs do not count towards the compulsory deductible. This means that we will reimburse these costs, even if you have not yet used all of your compulsory deductible of €385. The following costs do not count towards the compulsory deductible:

1. The costs of general practitioner care. The compulsory deductible will apply, however, to costs of healthcare related to general practitioner care, where that healthcare is performed elsewhere and is invoiced separately. This healthcare must be carried out by a person or facility that is able to request a rate set by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa).

   Example:

   In a particular year, you incur costs of €75 that are covered by your health insurance. The costs include €30 for a consultation with a general practitioner. These costs do not count towards the compulsory deductible. The costs also include €45 for collecting blood for a blood test upon referral by the general practitioner. The blood collection and the laboratory costs for the blood test do count towards the compulsory deductible. In this case, you will have to pay €45 yourself. We will reimburse the €30 for the general practitioner consultation.

2. The costs of midwifery care and obstetric care, as detailed in clauses B.5., B.6 and B.7.

   Please note!
   The compulsory deductible does, however, apply to:
   - the noninvasive prenatal test (NIPT) under clause B.5.3;
   - admission to a facility after childbirth (e.g. if you, as a healthy mother, stay in hospital during your child's medically necessary admission);
   - costs that are related to this type of care, but that are listed in other clauses in our terms and conditions of insurance, for example IVF, transport by ambulance, medicines, medical aids and laboratory and diagnostic tests that are neither performed by, nor invoiced by, a general practitioner.

3. The costs of healthcare for you as a donor, from 13 weeks onwards (six months onwards in the case of a liver transplant) following admission for the selection or removal of the organ(s)/tissue to be transplanted (see clause B.4.7.2.). This concerns healthcare relating to the organ transplant.
4. The costs of transport for the donor in relation to organ transplants, if these transport costs are covered by the individual's health insurance (see clause B.4.7.2);
5. The costs of registering with a general practitioner or a facility that offers general practitioner healthcare. Costs of registration include:
   - an amount for registering as a patient. We will reimburse an amount up to a maximum of the rate set under the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg') (taking into account tax legislation);
   - costs that are related to:
     - the way in which the medical healthcare is provided in the general practice or

facility;
- the characteristics of the patient file;
- the location of the practice or facility.

We must have a contract in place with the general practitioner or facility for this. This contract must also include an agreement that the general practitioner or facility can invoice the costs of your registration;

6. The costs of multidisciplinary care;
7. The costs of district nursing (also see clause B.26.);
8. Medical aids that we lend to you. There will be no charge for this, which is why the compulsory deductible will not apply. The compulsory deductible will apply, however, to the costs of consumer goods and usage associated with the medical aid that we lend you.
9. All or part of the costs of healthcare and other services if you have attended a programme designated by us for diabetes, depression, cardiovascular disease, chronic obstructive pulmonary disease, being overweight, dementia, thrombosis care, incontinence care or a quit smoking course.
   In the case of a quit smoking course, this refers to the costs of the course, including the medicines or nicotine replacement products (pharmacotherapy) that are part of the quit smoking course (see clause B.21.2.) and that are prescribed by a contracted quit smoking healthcare provider.
   However, these costs *are* set off against the voluntary deductible.
10. The costs of the SkinVision app (see clause B.4.3.). However, these costs *are* set off against the voluntary deductible.
11. The costs of healthcare we have designated if you use the services of a healthcare provider who has a contract with us for this healthcare.
    In the 'Natura Select' health insurance only, we have designated the following healthcare:
    - physiotherapy for intermittent claudication (see clause B.8.4);
    - pelvic therapy for urinary incontinence (see clause B.8.2);

    The additional terms and conditions that apply to the specific healthcare are explained in the related clauses. Your policy document states whether you have taken out 'Natura Select' health insurance with us.
    However, these costs *are* set off against the voluntary deductible.

Furthermore, neither a compulsory deductible nor a voluntary deductible will apply to healthcare eligible for reimbursement under your additional insurance package(s).
For specialist medical healthcare covered by the additional insurance package (clause D.1.), the compulsory deductible does, however, apply to preliminary examinations, check-ups, laboratory tests, etc. if these are not included in the Diagnosis-Treatment Combination ('DBC') for the procedure.

A.12.4. Costs that you have to pay yourself

Costs that, in accordance with the terms and conditions of insurance, you must pay yourself, do not count towards the compulsory deductible you have to pay. These include, for example, personal contributions, statutory or otherwise.

A.12.5. Payment to healthcare providers and deductible

If a contracted healthcare provider submits a claim directly to us, we can reimburse the healthcare provider directly in respect of your costs. If any of your deductible is still outstanding, we will claim the amount paid on such an invoice back from you or offset it against your outstanding deductible.
If you send us the invoice yourself or if the healthcare provider does not have a contract with us for the healthcare concerned, we will pay you if any of your deductible is still outstanding. We will pay you the amount you are insured for, less the outstanding deductible. You will be responsible for paying the healthcare provider on time and in full.

A.12.6. If the health insurance commences, ends or changes part-way through the year

If your health insurance commences or ends part-way through the year, you will pay a proportion of the compulsory deductible for the part of the year that the health insurance is active, rounded off to the nearest euro.
We count the number of days in the year that the health insurance is active and divide this by the total number of days in that year, i.e. 365 (or 366 in the case of a leap year). We multiply this result by €385, and round the answer off to the nearest euro.

Example of compulsory deductible:
Your health insurance commences on 23 September 2022. There are 100 days between 23 September 2022 and 31 December 2022. Because 2022 is not a leap year it only has 365 days. Your compulsory deductible is calculated as:

- €385/ 365 = €1.0547 deductible per day
- €1.0547 x 100 days = €105.47 deductible for the year (not yet rounded off)

- rounding €105.47 off to the nearest euro, the end result is €105. This will be your compulsory deductible for that year.

Please note!
If, in a particular year, you take out different consecutive health insurance policies with us, each with a different voluntary deductible, the total deductible for the year is calculated by adding together the pro rata deductibles for each part of the year.

Example of compulsory and voluntary deductible:
Your first health insurance policy runs from 1 January 2022 to 30 June 2022, i.e. 181 days. In this case, you only have the compulsory deductible of €385.

Your second health insurance policy runs from 1 July 2022 to 31 December 2022, i.e. 184 days. In this case, you opt for a voluntary deductible of €300, alongside the compulsory deductible.

Your compulsory deductible for the first health insurance policy is calculated as:
- €385/ 365 = €1.0547 deductible per day
- €1.0547 x 181 days = €190.90 deductible for the year, i.e. €191 when rounded off to the nearest euro.

Your deductible (compulsory and voluntary) for the second health insurance policy is calculated as:
- €385+ €300 = €685
- €685/ 365 = €1.8767 deductible per day
- €1.8767 x 184 days = €345.31 deductible for the year, i.e. €345 when rounded off to the nearest euro.

We add up the deductible amounts for these two periods: €191 + €345 = €536. This is your deductible (compulsory + voluntary) for the whole year.

A.12.7. When you reach the age of 18

If you are not yet 18 years old, the compulsory deductible is €0. If you are aged 18 or above, the compulsory deductible is €385 for a whole year. If your compulsory deductible changes part-way through a year, and you had health insurance with us immediately prior to the change, your compulsory deductible will be calculated proportionately and rounded off to the nearest whole euro.

The compulsory deductible will be calculated as follows:
- we multiply the compulsory deductible amount by the number of days in the year for which this compulsory deductible applies;
- we divide the result by the total number of days in that year, i.e. 365 (or 366 in the case of a leap year);
- we round the result off to the nearest whole euro.

Example:
You have taken out health insurance for you and your son. Your son reaches the age of 18 on 5 November 2022. Before 5 November 2022, he did not have a compulsory deductible (€0). From 5 November 2022, his compulsory deductible is €385. There are 57 days from 5 November to the end of the year. So the deductible for your son for that year is calculated as:
- €385/ 365 days = €1.0547 deductible per day
- €1.0547 x 57 days = €60.12 deductible for the year, i.e. €60 when rounded off to the nearest euro. This is the remaining part of the deductible, and will apply from the time your son turned 18.

A.12.8. First compulsory, then voluntary deductible

The costs covered under the health insurance are first offset against the compulsory deductible. Once this has been paid in full, the costs are offset against your voluntary deductible, if you opted for one. When the latter reaches €0 too, we will reimburse any further costs incurred by you, as long as your health insurance provides cover for these.

A.12.9. Payment in instalments

You (the policyholder) also have the option of paying the compulsory deductible in instalments.

Criteria for exercising this option
- you have health insurance with us on 1 January;
- you have health insurance with us with a compulsory deductible only, i.e. you have not opted for a voluntary deductible;
- you are 18 years old or above;
- your request for payment in instalments reached us before 1 February of the year to which the compulsory deductible applies;
- you decide which of the insured persons specified on your policy document you want to register for this scheme. You register the participants at the same time as submitting your request;
- you pay in 10 instalments from the first quarter of the participation year.

Terms and conditions during participation

- participation in the payment scheme will be renewed annually, unless you notify us before 1 February of the following year that you no longer wish to participate, and for which of the insured persons this applies.
- we will send you a final account in the first quarter of the following year. If you have paid too much for the compulsory deductible, we will repay the (remaining) amount no later than during that same quarter. If we receive invoices after this, which then have to be offset against your compulsory deductible for the previous year, we will reclaim the necessary amounts from you.

Cancellation of participation

- you must let us know if you no longer wish to participate.
- we can cancel participation if:
  - the above terms and conditions are no longer satisfied;
  - you fail to make a payment on time;
  - your insurance situation changes insofar as the policyholder or number of participants changes.
- if participation in the payment scheme ends part-way through the year, we will send you a final account immediately. If you have paid too much for the compulsory deductible, we will repay the excess. If you still owe us an amount for the compulsory deductible, you will have to pay us the shortfall immediately and in full. If we receive invoices after this, which then have to be offset against your compulsory deductible, we will reclaim the necessary amounts from you.

A.13. Voluntary deductible

A.13.1. Terms and conditions for the voluntary deductible

The provisions of clauses A.12.2., A.12.3.(1) to A.12.3.(8), and A.12.4. to A.12.8 relating to the compulsory deductible also apply to the voluntary deductible for your health insurance. The following terms and conditions of insurance also apply to the voluntary deductible.

A.13.2. Lower premium

If you are 18 years old or above, you can opt for a voluntary deductible alongside the compulsory deductible for your health insurance. The greater the voluntary deductible, the lower the premium you (the policyholder) will pay for your health insurance.

You can choose a voluntary deductible of €100, €200, €300, €400 or €500 per year.

If you have a 'Natura JUST' health insurance policy, you can only choose a voluntary deductible of €300 or €500 per year.
If you have a 'Natura Select' health insurance policy, you can only choose a voluntary deductible of €500 per year.

Additional insurance packages do not have deductibles.

A.13.3. When you reach the age of 18

We will ask you no later than the month before your 18th birthday how much voluntary deductible you wish to apply from your 18th birthday. If you do not respond or do not respond on time, we will calculate the premium for your health insurance based on no voluntary deductible.

A.14. General obligations

A.14.1. Failure to comply with your obligations

You have certain general obligations towards us. These obligations are described in this clause. If you harm our interests as a result of failing to comply with your obligations, you will lose your right to healthcare cover. We also reserve the right to reclaim any reimbursements you have already received from us for healthcare, and you will lose your right to healthcare and/or reimbursement of any invoices you have already submitted.

A.14.2. General obligations

You must:

- be able to prove your identity if you request healthcare in a facility for specialist medical healthcare or an outpatient clinic;
- ask the doctor or medical specialist in attendance to tell our medical adviser about the reason for admission, if requested;
- assist us, our medical adviser, consultant dentist, auditor and/or the healthcare provider with whom we have an agreement, in obtaining all the necessary information;
- inform us within 30 days if you are taken into custody, put in prison or given a prison sentence;
- inform us within 30 days of leaving custody or prison;
- inform us who the new policyholder(s) is (are) within 30 days of the policyholder dying or losing

the entitlement to dispose of his/her assets independently.

A.14.3. Holding a third party liable

Assignment: transferring receivables to us
Sometimes we may be able to hold third parties liable for costs or healthcare that we have reimbursed under your insurance. From the time your insurance takes effect, you transfer any receivables due to you from third parties to us. This involves receivables related to healthcare that may qualify as being covered by the insurance.

Cooperation in the event of liability of third parties
Circumstances, events or accidents may occur, for which you immediately or later need healthcare, the costs of which are covered by one or more of your insurance policies. If we may be able to hold third parties liable for these costs, you must notify us of this within 14 days. You must cooperate fully with our efforts to recover any such costs.

No agreements with third parties
You must not come to any agreements with third parties (not even insurers) who we could hold liable. This does not apply where we have given prior written approval.

Consequences of failure to cooperate
We may hold you liable for all losses and costs arising from your failure to assist us in our recourse against third parties.

A.15. Provision of information

A.15.1. Provision of correct information

You are obliged to provide us with correct information and help us acquire all of the necessary information. If you misrepresent the facts, give us false or misleading documents, make false statements or refuse to cooperate with us in any way, we can:

- cancel your insurance and you will cease to have any further entitlement whatsoever to healthcare cover;
- recover from you all amounts you received from us, going back to the date on which you misled us;
- recover from you the costs of investigating the intentional deceit;
- list you on our incident register;
- record your details in the designated warning systems used by insurers;
- report the matter to the police;
- refuse any new request from you for insurance, for a period of five years.

This will also apply if someone else has performed the aforementioned actions on your behalf.

A.15.2. Significant events

You must notify us within 30 days of any events that could be significant in allowing us to provide adequate health insurance. Significant events include:

- moving house or a change of address as registered in the Persons Database (‘Basisregistratie Personen’, BRP);
- a change of postal address or other means of communication (e.g. email address);
- birth or adoption;
- death;
- divorce;
- start and end of a period of custody/prison sentence;
- start and end of participation in a group agreement;
- change to the family composition.

If you notify us within the specified timescale, any changes to your insurance will apply from the date of the significant event. If you fail to notify us within the specified timescale, we will decide the date on which any changes to your insurance will apply.

A.15.3. Sharing information

We share the necessary information concerning the package, package participation, premium, discount and personal data only where this is material to the correct execution of your insurance policy/policies and the associated terms and conditions. The purpose of sharing this information is to (among other things):

- verify the group entity in which you participate;
- recover the costs we have paid out for insured healthcare from third parties, such as from a travel insurer for healthcare provided abroad.

A.15.4. Current address

We assume that you receive any correspondence sent to the latest postal address or email address that we have on record for you. We cannot accept liability for any losses incurred by you if you do not receive correspondence or do not receive it on time, where this results from your failure to notify us of your current postal or email address.

A.16. Privacy and checks

A.16.1. Privacy

For any insurance you take out with us, we process

only the data required to execute your insurance agreement(s). If the data concerned is personal data, we process this in compliance with the provisions of the Implementation Act of the General Data Protection Regulation ('Uitvoeringswet Algemene verordening gegevensbescherming') and the General Data Protection Regulation (EU Regulation 2016/679).
The privacy statement on our website tells you more about privacy and your rights and obligations concerning the data (including personal data) we store and process.

A.16.2.

DELETED

A.16.3.

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A.16.4. Substantive checks

We are entitled to verify details and perform checks in relation to fraud when executing your insurance agreement and in regard to your details (including personal data) that we record and process in our database. We do this in accordance with the Dutch Health Insurance Act ('Zorgverzekeringswet'), the national Protocol on Substantive Checks ('Protocol materiële controle') and the national Protocol on Incident Warning Systems for Financial Institutions ('Protocol Incidentenwaarschuwingssystemen Financiële Instellingen'). You must cooperate with us fully in this respect.

A.17. Healthcare providers

A.17.1. Definition of healthcare provider

Under the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg), a healthcare provider is a natural person or legal entity providing healthcare in a professional or commercial capacity, or a natural person or legal entity charging rates on behalf of, for or in connection with the provision of healthcare by an authorised healthcare provider.
The term healthcare provider may occasionally also refer to a natural person who provides healthcare insured with us in a non-professional or non-commercial capacity. This mainly involves healthcare purchased directly by an insured person using a Personal Care Budget ('Persoonsgebonden Budget', PGB) under the Dutch Regulations on PGBs for Nursing and Other Care ('Reglement PGB Verpleging en Verzorging').

A healthcare provider can be:

- a person; or
- a facility for the provision of healthcare; or
- a healthcare group (see clause A.17.3.).

A healthcare provider provides healthcare or supplies products and/or aids. Supply refers to the provision of medicines, medical aids and any associated services.

A.17.2. Terms and conditions for healthcare and healthcare providers

Healthcare is covered by the insurance if:

- a type of healthcare provider for the healthcare concerned is specified in the terms and conditions of insurance or the Reimbursements Overview under the heading 'healthcare provider'. Types of healthcare provider not mentioned for the healthcare concerned are not authorised to provide healthcare at our expense, nor can they claim it from us. Consequently, you are not covered for healthcare provided by any type of healthcare provider not mentioned, even if you are insured for the healthcare concerned; and
- the healthcare provider provides the healthcare themselves. Healthcare can also be provided by another healthcare provider, including a type of healthcare provider not mentioned, as long as this healthcare provider operates under the responsibility of a healthcare provider who is expressly mentioned in the applicable clause, and unless stated otherwise in that clause; and
- the healthcare provider claims the healthcare under their own name. It is also possible for a facility, a different healthcare provider or a third party to submit a claim for the healthcare under the name of the responsible healthcare provider; and
- a healthcare provider in the Netherlands complies with the rules and regulations laid down in and/or pursuant to legislation for the applicable profession and business, and the operation thereof, and, in doing so, provides authorised healthcare. For instance, healthcare providers based in the Netherlands must comply with the requirements laid down in and/or pursuant to the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) and the Dutch Healthcare Quality, Complaints and Disputes Act ('Wet kwaliteit, klachten en geschillen zorg', Wkkgz). Healthcare providers based in the Netherlands must also comply with the provisions of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG):
  - doctors, dentists, pharmacists, healthcare psychologists, psychotherapists,

physiotherapists, obstetricians and nurses must be listed on the national BIG registers or another register that we consider to be equivalent (for example, registration as a clinical chemistry laboratory specialist with the Dutch Association of Clinical Chemistry and Laboratory Medicine ('Nederlandse Vereniging voor Klinische Chemie en Laboratoriumgeneeskunde', NVCK));
    - we will only reimburse healthcare provided by other healthcare providers where such healthcare providers, under Article 34 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG), have gained a designated qualification and lawfully use the title and/or designation conferred upon them by that qualification; and
- the healthcare provider supplying the care must also have an AGB code (administrative code assigned to healthcare professionals in the Netherlands); and
- a healthcare provider in a foreign country complies with the requirements, laws and regulations set out for their profession in the country concerned.

A.17.3. Principal contractor

A principal contractor (like a healthcare group, healthcare centre or a podiatrist, for example) is a healthcare provider as defined in clause A.17.1. A principal contractor also has the following characteristics:

- the principal contractor has legal personality and enters into contracts in partnership with several healthcare providers of different disciplines, for example a general practitioner and a dietician, who provide the actual healthcare.
- the principal contractor can provide various forms of healthcare (see clauses B.3.1., B.11. and B.23.).
- the principal contractor is responsible for monitoring compliance with the quality requirements for the affiliated healthcare providers and the provision of healthcare in accordance with healthcare standards. When written from the patient's perspective, healthcare standards specify what constitutes good quality healthcare in terms of healthcare content, its organisation and the support of self-management. A healthcare standard therefore acts as an aid to the healthcare provider, insurer and patient alike.

A.17.4. Contract, payment agreement and recognition

a. Contracted healthcare providers

We have entered into contracts for the provision of healthcare and/or resources by healthcare providers. These contracts set out the agreements we have made in relation to the price, quality and effectiveness of the healthcare, and the terms and conditions under which healthcare providers provide healthcare and can claim costs from us. We have a list of all the contracted healthcare providers, which is available on our website.

If we have entered into a contract with a healthcare provider, the contract might not cover all of the provider's services, healthcare-related or otherwise. We might only contract a healthcare provider for certain specific healthcare services, for example, or within a certain budget (revenue ceiling, volume agreements). This may result in the healthcare provider no longer accepting you for treatment due to these volume agreements or because of having reached, or nearly reached, the applicable revenue ceiling.
If you have a 'Natura' (in-kind) health insurance policy, our Healthcare Team ('Zorgteam') can help you find another healthcare provider who can accept you as a patient.

If you have a 'Restitutie' (refund) health insurance policy, our Healthcare Team ('Zorgteam') can contact the healthcare provider to ask that you be accepted for treatment all the same. Our Healthcare Team can also help you find another healthcare provider.

If you have a 'Combinatie' health insurance policy, our Healthcare Team ('Zorgteam') can help you find another healthcare provider for the insured ('in kind') healthcare. For healthcare for which the costs are reimbursed, the Healthcare Team can contact the healthcare provider to ask that you be accepted for treatment all the same. Our Healthcare Team can also help you find another healthcare provider.

If you were already being treated by this healthcare provider, you are free to complete your course of treatment with him or her. If a budget (revenue ceiling) has been agreed with a healthcare provider or volume agreements have been made, we will state this under the information on the particular healthcare provider on our website.

The rates we agree with healthcare providers are nearly always lower than those invoiced by non-contracted healthcare providers. Even though you are insured for reimbursement in full, you still have a vested interest in a lower rate because of

offsetting against your deductible. After all, you will have to pay the deductible yourself. You will also benefit from the lower rates for healthcare that we negotiate with healthcare providers. To find out more about the rates of reimbursement we apply, please see clause A.20.

b. Non-contracted healthcare providers
If you go to a non-contracted healthcare provider, we will reimburse part or all of the costs of healthcare, providing that the terms and conditions of clause A.17.2. and the terms and conditions of the applicable healthcare have been satisfied. To find out more about the rates of reimbursement we apply, please see clause A.20.

c. Healthcare provider with a payment agreement
If you use a healthcare provider with whom we have a payment agreement, the costs of healthcare provided will be claimed directly from us, not you. We will then pay the healthcare provider directly for the costs of insured healthcare. Please see clauses A.19.3. and A.19.4.

d. Recognition of healthcare providers
We have recognised groups of healthcare providers and/or professionals. Although we have not made agreements with them, we have imposed additional terms and conditions on healthcare providers within the groups of healthcare providers and/or professionals, as a means of assuring quality.
The additional terms and conditions for recognition can be found in:

- clause A.1. or C.1. in the definition of the healthcare provider concerned. For example, a podiatrist must be a member of the Dutch Association of Podiatrists ('Nederlandse Vereniging van Podotherapeuten', NVvP); or
- the applicable clause in section B or D, where the healthcare is defined. For example, a provider of alternative healthcare must be a registered member of one of the professional associations for alternative treatment methods. The list of professional associations is available on our website.

In conclusion
Healthcare providers may have entered into more than one of the specified agreements with us.

All contracted healthcare providers have a payment agreement with us. Recognised healthcare providers may also have a payment agreement with us. The reverse does not apply. Healthcare providers who have a payment agreement with us do not necessarily have a contract with us for particular healthcare or resources.

A.17.5. Contract with healthcare provider ends

- if the contract we have entered into with your healthcare provider ends after you have started to receive treatment, we will continue to reimburse this healthcare under your health insurance for the duration of your treatment.
- if you switch to us from a different health insurer part-way through your treatment, you will continue to be entitled to insured healthcare and reimbursement thereof under your health insurance with the same healthcare provider with whom your previous health insurer had a contract. This also applies in instances where we do not have a contract with the healthcare provider concerned, or where we are unable to take out a contract in time, or we are unable to guarantee that healthcare under your health insurance will be provided in time.

In this case, healthcare will be reimbursed under your health insurance as if it had been provided by a healthcare provider with whom we do have a contract.

A.17.6. Location where the healthcare is provided

The healthcare is provided at a location that is reasonably fit to purpose and medically appropriate. This can be a location concerning which agreements have been made between us or between the healthcare provider and you, or which has been designated by law or by the Dutch Health and Youth Care Inspectorate ('Inspectie Gezondheidszorg en Jeugd') as a location where healthcare can be provided.
The healthcare can also be provided online where appropriate.
In special situations or for special healthcare the location where the healthcare is provided is specified in the relevant clauses.

Explanation:
The healthcare providers listed below provide the healthcare at:

- general practitioner: the practice of the general practitioner, a designated after-hours general practice ('huisartsenpost'), the general practitioner's laboratory, or your home or temporary place of residence (though not at a facility for specialist medical healthcare or a nursing home);

- pharmacy: the practice of a dispensing general practitioner or a government-recognised pharmacy (local or in a hospital) or your home or temporary place of residence;
- medical specialist: in a facility for specialist medical healthcare or the medical specialist's practice. The healthcare can also be provided at another facility that we have recognised as a location where the relevant healthcare can be provided, as specified in the conditions for the healthcare concerned;
- sonographer: an ultrasound centre or antenatal screening centre;
- obstetrician: a birth centre or birth clinic, your home or your temporary place of residence.

For other healthcare providers, the healthcare is provided at the practice of the healthcare provider or at your home or your temporary place of residence. If the provision of the healthcare at your home or temporary place of residence is subject to this being medically necessary, this will be stated in the clause for the relevant healthcare, in which case you will need a referral stating why this is medically necessary.

Healthcare that forms part of multidisciplinary care can, depending on the type of care, also be provided at the location where a healthcare provider (affiliated with a principal contractor or working in a regional partnership with several healthcare providers of different disciplines) works.

A.18. Approval

A.18.1.1. Approval

For all healthcare, in the clause relating to this healthcare we state whether our approval is required. If it is, you are obliged to get our approval before receiving the healthcare. Before we give our approval, we first check to ensure that the healthcare meets the requirements under the terms and conditions and that it will be effective and suited to your situation. We may need to receive additional information before we can determine this. When we provide approval, you know to what extent the healthcare you need is insured, and you know from which healthcare provider(s) you can receive this healthcare.

A.18.1.2. Contracted healthcare provider and approval

When you go to a contracted healthcare provider, this healthcare provider can do the following on our behalf (assuming such is set out in the agreement):

- assess whether you meet the conditions for receiving the healthcare (or reimbursement of the costs);
- assess which healthcare is recommended in your situation;
- provide approval if that is required.

If the healthcare provider is unable to assess whether approval should be given, he/she will send us the request for approval.
It is therefore not necessary for you to inform us about any of this. Also see clause A.17.4.a.

A.18.1.3. Non-contracted healthcare provider and approval

If you go to a non-contracted healthcare provider, you must request approval from us (or the non-contracted healthcare provider must do so on your behalf) if this requirement is stated in the clause with the provisions for the healthcare concerned. To this end, you must send the following to our 'Medische Beoordelingen' (Medical assessments) department:

- an application detailing your healthcare provider's reasons for the treatment, as specified in the clause covering the healthcare concerned;
- if possible, a cost estimate and/or treatment plan for the healthcare requested;
- additional information we occasionally ask you to provide when we are determining whether we should give our approval for particular healthcare;
- requests and additional information must be provided in one of the commonly spoken languages (Dutch, English, German, French or Spanish). If the document is not in one of these languages, we will ask that you include a translation of the document. Alternatively, you can have us arrange the translation and repay us for the costs charged by the translation agency.

Also see clause A.17.4.b.

A.18.2. Approvals, referrals and prescriptions when you change health insurer

If you switch to us from a different health insurer part-way through your treatment (see clause A.17.5., bullet point 2), any approvals, referrals and prescriptions under the health insurance will remain valid as if you were still insured by the other health insurer.

A.18.3. Statements and promises

Any statements and promises that we make to you will only be binding on us if we confirm them in writing. We assume that you receive any correspondence sent to the most recent postal or email

address we have on record for you. We cannot accept liability for any losses incurred by you if you do not receive correspondence or do not receive it on time, where this results from your failure to notify us of your current postal or email address.

A.18.4. Period of validity

Approval is valid:

- for a maximum of 365 days, unless expressly stated otherwise; and
- based on the laws and regulations and the terms and conditions of insurance that apply at the time the approval is issued.

The approval is no longer valid if:

- the relevant laws and/or regulations change; or
- your insurance changes or is cancelled (unless the commencement date of the DBC healthcare product code falls within the term of your insurance).

A.19. Invoices

A.19.1. Invoices in general

- if you are entitled to reimbursement, we will pay the amount to you (the policyholder) through the bank account number (IBAN) known to us.
- healthcare providers who have an agreement with us can submit their invoices to us directly, and we will pay these healthcare providers directly (see clause A.19.3.).
- if you go to healthcare providers with whom we do not have an agreement, they will send you the invoice, which you can then submit to us.
- with regard to non-contracted healthcare providers or any other third party, you may not:
  - transfer your claim against us or another right to them;
  - provide them with a security interest, such as a pledge;
  - give them permission, an order, instruction or similar to submit a claim on your behalf, to receive a payment for you, or to accept a payment that fulfils an obligation of yours to that third party.

A.19.2. Submitting invoices

You can submit invoices in a variety of ways:

- by smartphone, using our dedicated app to send us a digital photograph of the invoices;
- online through your personal page (in the 'Mijn' environment on our website), by sending us a scan or digital photograph of the invoices;
- by post, by sending us your original invoices. Copies can only be sent in exceptional cases, with our agreement.

Your healthcare provider can submit invoices to us through Vecozo or Cryptshare.

Invoices from foreign countries

If you have received healthcare while abroad, you may be entitled to reimbursement of some or all of the invoices you submitted earlier in your country of residence.
If that is the case, we will be able to process copies of the original, foreign invoices. You send us the copies, along with a statement from the implementing body of the social or statutory insurance in your country of residence, stating:

- that some or all of the costs did not qualify for reimbursement; and
- the amount outstanding that you have to pay.

Criteria for invoices

Invoices must:

- relate to treatment, healthcare, medicines and/or medical aids that were actually provided or supplied;
- be received by us within 36 months of the date on which the healthcare was provided. Invoices received later than this will no longer qualify for reimbursement;
- be provided in one of the commonly spoken languages (Dutch, English, German, French or Spanish). The same applies to your treatment reports. If the document is not in one of these languages, we will ask that you include a translation of the bill. Alternatively, you can have us arrange the translation and repay us for the costs charged by the translation agency.
- be sent by you, or by/on behalf of the healthcare provider or the healthcare facility;
- be written in such a way that we can process them in accordance with the terms and conditions of insurance, without further query or investigation. We use the same specification for invoices as that used by the Dutch tax authorities.

  The healthcare provider must include at least the following on the invoice:
  - the name of the healthcare provider;
  - the address of the healthcare provider;
  - your name;
  - a breakdown of the treatment;
  - the date on which, or the period over which, treatment took place;
  - the amount claimed for the healthcare that was provided;
  - the name, strength, quantity and method of administration of any medicines you

received abroad.
The invoice must also include the following, if applicable:
  - the number under which the healthcare provider is listed on a register under the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', BIG);
  - the AGB code (administrative code assigned to healthcare professionals in the Netherlands);
- meet the criteria specified by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). These criteria take precedence over those of the Dutch tax authorities;
- in the case of specialist medical healthcare, include costs along with the correct DBC healthcare product code.

For reimbursement purposes, we use the date of treatment or supply, not the order date or invoice date.

Please note!
- we will not reimburse costs on the basis of quotes, advance bills, reminders or demands.
- we will not return invoices, enclosures and documents that you send us, not even if you have only been partly reimbursed, an amount has been offset against your deductible or you have received no reimbursement at all. You can, however, request a certified copy from us.
- invoices for medicines obtained abroad must be legible (where handwritten) and complete. If the name, strength, quantity and method of administration of the medicine are not stated in full on the invoice, you must send us the patient information leaflet, box and/or labels.

A.19.3. Direct payment to the healthcare provider

When your insurance commenced, you gave us permission to enter into a contract with healthcare providers. We can agree, for example, for healthcare providers to send some or all of their invoices directly to us, and for us to pay them directly to the healthcare providers. You must cooperate with us in this respect. If we receive an invoice from a healthcare provider with whom we have a payment agreement, and the invoice qualifies for reimbursement, you are deemed to have given us permission to pay this invoice directly to the healthcare provider. By paying the invoice to the healthcare provider, our obligation to reimburse you for the costs ceases to exist. Payment of the invoice to the healthcare provider/healthcare facility can also be achieved by offsetting the amount against any advance payments we have already made to the healthcare provider/healthcare facility.

A.19.4. Healthcare provider reimbursed too much

If we pay the healthcare provider more than we have to under your insurance, we assume that you authorise us to collect the amount overpaid to the healthcare provider. If, in accordance with these terms and conditions of insurance, you are not entitled to the healthcare, or you are entitled to less healthcare, or to less reimbursement than the amount we paid to the healthcare provider, you will be required to repay us the difference. This can happen if, for example, you have a deductible or personal contribution (statutory or otherwise), or a maximum reimbursement (statutory or otherwise) applies.

A.19.5. Verification of original invoices

If you send us invoices over the internet, you must keep the original, paper invoices for at least 2 years, as we can request them for verification purposes.

A.19.6. Priority of reimbursement

We process invoices in the order in which we receive them. We apply a sequence of priority to determine whether an invoice may be reimbursed and, if so, how much will be reimbursed. This sequence is as follows:
- firstly, a current national insurance or social security scheme, such as the Dutch Long-Term Care Act (Wlz; formerly the AWBZ); the Dutch Youth Act ('Jeugdwet') or the Dutch Social Support Act (Wmo);
- secondly, the health insurance;
- thirdly, a group additional insurance package that can only be taken out by employees of a company or organisation that has entered into a group agreement with us;
- fourthly, an individual additional insurance package, i.e. an additional insurance package that provides reimbursement for various different types of healthcare; and
- finally, a specific additional insurance package, i.e. an additional insurance package that provides reimbursement for only one or a few different types of healthcare,
  such as for oral care, or for a luxury package in a hospital.

A.20. Rates

A.20.1. Specification of rates

Your Reimbursements Overview, in conjunction with the clauses in section B, specifies the type of healthcare and amount of reimbursement to which you are entitled. This will often be a percentage, such as 100%, but this does not mean we will always reimburse your invoice in full. We use various rates:

1. Agreed rate
This is the rate or average rate we have agreed for the healthcare/treatment concerned in the contracts we have made with contracted healthcare providers. The rates for different types of healthcare are available on our website.

If you use a non-contracted healthcare provider, one of the following situations can apply:

a. We have agreed identical rates with other healthcare providers for the same healthcare/treatment (as you are receiving). In this case, this rate is the agreed rate.
b. We have agreed different rates with other healthcare providers for the same healthcare/treatment (as that you are receiving). In this case, the average of these rates is the agreed rate.

2. Fixed (set-point) rate set by law
This is the fixed rate set by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg). The rate used by a healthcare provider must be exactly the same as this rate. These rates are also known as set-point rates.

3. Statutory maximum rate
This is the maximum rate set by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg). The rate applied by a healthcare provider may be lower but may not be higher than this rate.

4. Market rate applicable in the Netherlands
This is the market rate based on current market conditions in the Netherlands, as referred to in Article 2.2., clause 2, paragraph b, of the Dutch Health Insurance Decree ('Besluit zorgverzekering').

Explanation:
The costs of the healthcare claimed must be reasonable in comparison with the price of similar healthcare claimed by similar healthcare providers in the Netherlands. In principle, we will reimburse the invoice in full. However, in isolated cases where the invoice submitted is unreasonably high, and therefore differs excessively from invoices for similar healthcare from similar healthcare providers, we will pay up to the market rate applicable in the Netherlands, and refuse to pay extremely high costs to the extent that they exceed this market rate.

5. Claimed rate
The amount stated on the invoice.
Reimbursement will never exceed the costs of healthcare actually incurred, and that you were invoiced for.

A.20.2. Amount of the rates

Check your policy document to see which type of insurance you have:

1. 'Natura' health insurance policy (see A.20.2.1.)
2. 'Natura Select' health insurance policy (see A.20.2.1.)
3. 'Natura JUST' health insurance policy (see A.20.2.1.)
4. 'Natura Direct' health insurance policy (see A.20.2.1.)
5. 'Restitutie' health insurance policy (see A.20.2.2.)
6. 'Combinatie' health insurance policy (see clause A.20.2.1. for 'in-kind' healthcare and clause A.20.2.2. for the reimbursement of the costs of covered healthcare)

Other insurance:

7. Additional insurance package and private medical expenses insurance (see A.20.2.2.)
8. Additional mixed insurance package (see A.20.2.1. and A.20.2.2.)

You have a 'Natura', 'Natura Select', 'Natura JUST' or 'Natura Direct' health insurance policy
If you have one of these policies, you are entitled to receive ('in-kind') healthcare from a contracted healthcare provider. With these 'in-kind' health insurance policies you are also entitled to reimbursement of the costs of healthcare from non-contracted healthcare providers; the costs will not be reimbursed in full, however (see clause A.20.2.1. for details).

You have a 'Restitutie' health insurance policy
If you have a 'Restitutie' health insurance policy, this entitles you to reimbursement (i.e. a refund) of the costs of healthcare. See clause A.20.2.2 for details.

You have a 'Combinatie' health insurance policy
If you have a 'Combinatie' health insurance policy, you are entitled to receive healthcare from a contracted healthcare provider ('in kind'). With this policy, you are also entitled to reimbursement of the costs of healthcare from non-contracted healthcare providers; the costs will not be reimbursed in full, however (see clause A.20.2.1. for details). You can see which healthcare is covered 'in kind' on your premium schedule and your Reimbursements Overview;
for other covered healthcare not listed on these documents you are reimbursed for the costs of this healthcare (i.e. a refund). See clause A.20.2.2.

A.20.2.1. How health insurance/additional insurance with 'in-kind' cover for healthcare works

If you have a health insurance policy or additional insurance package with 'in-kind' cover, the situations below apply to healthcare provided under a:
- 'Natura' health insurance policy;
- 'Natura Select' health insurance policy;
- 'Natura JUST' health insurance policy;
- 'Natura Direct' health insurance policy.

And for the healthcare provided under 'in-kind' cover, they also apply to:
- the 'Combinatie' health insurance policy; and
- the additional insurance package.

Situation 1:
a. You use a contracted healthcare provider, or
b. You want to go to a contracted healthcare provider, but you cannot reasonably do so, because it is not available, or cannot be deemed to be 'timely healthcare', or because there is a need for urgent care in the Netherlands or abroad. What constitutes timely healthcare depends on a combination of reasonable waiting periods, based on medical grounds, and what is generally accepted by society. You are therefore forced to go to a non-contracted healthcare provider instead.

You are entitled to insured healthcare from this healthcare provider, at the following rates:
- the fixed (set-point) rate set by law; or
- if no statutory rate applies, the agreed rate, or (in situation b) the average agreed rate; or
- if this cannot be determined, the claimed rate up to the statutory maximum rate in the Netherlands; or
- if this cannot be determined either, the claimed rate up to a maximum of the market rate applicable in the Netherlands; or
- a percentage or an amount (reimbursement) as stated in the Reimbursements Overview for your additional insurance package.

If you have a health insurance policy or additional insurance package with 'in-kind' cover, the situations below apply to healthcare provided under a:
- 'Natura' health insurance policy;
- 'Natura Select' health insurance policy;
- 'Natura JUST' health insurance policy;
- 'Natura Direct' health insurance policy.

And for the healthcare provided under 'in-kind' cover, they also apply to:
- the 'Combinatie' health insurance policy; and
- the additional insurance package.

Situation 2:
You can go to a contracted healthcare provider, but you prefer (and opt to) go to a non-contracted healthcare provider.

In this situation, we reduce the reimbursement and in our calculations use a percentage *) of:
a. the fixed (set-point) rate set by law; or
b. if no fixed rate has been set, the average agreed rate; or
c. if this cannot be determined, the claimed rate up to the statutory maximum rate in the Netherlands; or
d. if this cannot be determined either, the claimed rate up to a maximum of the market rates applicable in the Netherlands; or
e. a percentage or an amount (reimbursement) as stated in the Reimbursements Overview for your additional insurance package, assuming no statutory maximum rate has been set for this.

Percentage *)
This percentage *) is:
- 75% for the 'Natura' health insurance policy;
- 75% for the 'Combinatie' health insurance policy for the covered healthcare provided under 'in-kind' cover;
- 70% for the 'Natura Select' health insurance policy;
- 65% for the 'Natura Direct' health insurance policy;
- 60% for the 'Natura JUST' health insurance policy.

The hardship clause applies for an insured person with a 'Natura Select', 'Natura Direct' or 'Natura JUST' health insurance policy.
You can request the application of this clause if the

lower reimbursement (70% of the agreed rate in the case of the 'Natura Select' policy, 65% for the 'Natura Direct' policy, and 60% with the 'Natura JUST' policy) impedes your choice in finding a healthcare provider suitable for your situation. If this applies to you, you must inform us in writing why this lower reimbursement impedes your choice and ask us to reimburse 75% of the agreed rate despite your policy terms and conditions. We will let you know our decision within four weeks.

Examples for different types of insurance:

- under 'in-kind' cover, when will you receive reimbursement at a rate lower than the fixed or agreed rate for healthcare provided?

Example 1
You visit a physiotherapist. You found the healthcare provider on our website and noticed that the physiotherapist you want to use is not contracted. Even though our website lists other physiotherapists who are contracted, you prefer to use the physiotherapist you have chosen. There is no fixed rate set by law for physiotherapy. However, there is an agreed rate, since we have agreed rates with other physiotherapists. We will reimburse 75% of the agreed rate.

Example 2
Your physiotherapist charges €28.50 for a session. We do not have a contract with this physiotherapist and, in accordance with your health insurance, we will reimburse 75% of the agreed rate. Our agreed rate with physiotherapists is €28.50. You will be reimbursed: 75% of €28.50, i.e. €21.38.

- under 'in-kind' cover, when will you receive reimbursement of 100% of the agreed rate for healthcare provided?

Example 3
You need treatment for an inguinal hernia. In the Netherlands, you would be placed on an unacceptably long waiting list. The healthcare you require is not available locally within a reasonable timeframe. Consequently, you ask us for permission for treatment abroad. We assess your request and give our approval, but the healthcare provider who is treating you does not have a contract with us for this healthcare. There is no fixed rate set by law for this type of treatment. However, we do have agreements in place for this type of treatment with other healthcare providers in the Netherlands. Let us say the agreed rate is, for example, €100. The healthcare provider you use charges €150 for the treatment. We will reimburse 100% of the agreed rate. In other words, you will be reimbursed 100% of €100, i.e. €100.

'Natura JUST' health insurance policy
The situation below applies exclusively to the 'Natura JUST' health insurance policy for the use of certain medical aids. For this health insurance policy, we have selected specific suppliers for certain medical aids. You can see which healthcare this concerns and the details of the selected suppliers on the JUST website and in the Regulations on Medical Aids ('Reglement Hulpmiddelen').

Situation 3:
You can use a selected supplier, but you prefer to use a non-contracted supplier or a regular contracted supplier that has not been specifically selected for the 'Natura JUST' health insurance policy.

In this situation, we reduce the reimbursement and in our calculations use a percentage (60%) of:
a. the fixed statutory rate; or
b. if no fixed statutory rate applies, the average agreed rate; or
c. the amount charged if this is less than the average agreed rate; or
d. the charged rate (up to the statutory maximum rate in the Netherlands) if there is no agreed rate/average rate; or
e. a percentage or an amount (reimbursement) as stated in the Reimbursements Overview for your additional insurance package.

A.20.2.2. How 'refund policies', i.e. health insurance, additional insurance and private medical expenses insurance under which healthcare costs are reimbursed, work

If you have a:
- 'Restitutie' health insurance policy; or
- 'Combinatie' health insurance policy, for the part that concerns reimbursement of healthcare costs; or
- additional insurance package, for the part that concerns reimbursement of healthcare costs; or
- private medical expenses insurance,

we will only reimburse the following:
- the fixed (set-point) rate set by law; or
- if your Reimbursements Overview includes an amount, number, percentage, hours and/or

periods, the maximum amount, number, percentage, hours and/or periods; or
- if we have not specified the above, the claimed rate up to the statutory maximum rate in the Netherlands; or
- if there is no statutory maximum rate, the claimed rate up to a maximum of the market rate applicable in the Netherlands.

Tip:
If you go to a contracted healthcare provider to receive the healthcare, we will reimburse the agreed rate. The rates we agree with our contracted healthcare providers are nearly always lower than those invoiced by non-contracted healthcare providers. Since the amount offset against your deductible for this healthcare under the general insurance is also lower, you also benefit from the lower rates we have agreed with our contracted healthcare providers.

- when will you receive reimbursement of the claimed rate, up to a maximum amount, under an additional insurance package?

Example:
You visit an acupuncturist. The treatment costs €60. The acupuncturist is recognised in accordance with the terms and conditions. We have not entered into any contracts with providers of alternative healthcare. Providers of alternative healthcare are free to set their own treatment costs. Consequently, there is no fixed rate set by law, nor can the market rates applicable in the Netherlands be ascertained (or they cannot be ascertained accurately). You will therefore be reimbursed up to the claimed rate. If you have an additional insurance package, which reimburses up to €40 per day of treatment, for example, you will be reimbursed €40 (providing you have not yet used your annual maximum reimbursement).

A.20.2.3. Deleted

A.20.3. Personal Care Budget ('Persoonsgebonden Budget', PGB)

The provisions of clause A.20.2., regarding rates, do not apply to district nursing (clause B.26.), if this healthcare is paid for by means of a Personal Care Budget ('Persoonsgebonden Budget', PGB) under the Dutch Regulations on PGBs for Nursing and Other Care ('Reglement PGB Verpleging en Verzorging').

A.20.4. VAT

If the law requires that a healthcare provider charges you VAT on the costs of the healthcare provided, the VAT charged will be included in the reimbursement.

A.21. General exclusions

A.21.1. General

You are not entitled to the following treatment (costs):
1. Costs of appointments with healthcare providers that you fail to attend.
2. Costs associated with obtaining copies of, or access to, medical details.
3. Treatments for medical pedagogical issues, dyslexia, language development disorders relating to dialect and/or being a non-native speaker, language testing, spelling testing, intelligence testing or treatments that have an educational aim.
4. Costs of foreign currency exchange and payments.
5. Charges (made by a bank or other organisation) for payments to or from a foreign country.
6. Costs associated with the late payment of invoices sent by the healthcare provider directly to you.
7. Costs charged by means of an advance payment invoice.
8. Costs that come under the claims, cover and/or funding provided under the Dutch Youth Act ('Jeugdwet'), the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and/or the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo). This includes any amounts that you have to pay yourself under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and/or the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo), unless these terms and conditions and reimbursements overviews state explicitly that these statutory personal contributions are reimbursed in part or in full.
9. Certificates, vaccinations and tests (e.g. pre-employment and occupational screening, or tests in relation to your study, driving licence or pilot's licence). We will, however, pay these costs where this is provided for by or pursuant to the Dutch Health Insurance Act ('Zorgverzekeringswet').
10. Additional costs, e.g. administrative, invoicing and postage costs.
11. More than one treatment of the same type on the same day, except where this is expressly permitted in these terms and conditions of

insurance or on your reimbursements overview. A 'type of treatment' refers to the healthcare described in a clause, i.e. one clause deals with one type of healthcare.

12. Treatment that is not generally recognised in accordance with prevailing medical standards in the Netherlands, or that is still at a scientific or experimental stage.
13. Treatment that, in our opinion, does not address the illness or its symptoms, or prevent the illness from worsening.
14. Treatment that cannot be considered to constitute responsible and suitable healthcare.
15. Treatment that is not substantiated on medical or dental grounds.
16. Healthcare given in any period during which your insurance does not provide cover, e.g. before the insurance commences or after it has ended. The determining factor here is the date of treatment, not the date of the invoice.
    If the invoice relates to a DBC healthcare product code, and the commencement date for the DBC healthcare product code is outside of the term of insurance, none of the costs associated with this entire DBC healthcare product code are covered.
17. Healthcare that is not listed or specified in your insurance.
18. Treatment that did not involve personal (physical) contact, but that was provided by telephone or by email and/or the internet. In such cases, non-physical treatment cannot reasonably be considered feasible, nor is it expected to yield the desired results.
    For example, while manual therapy or performing a filling under oral care is impossible by telephone, mental healthcare is indeed feasible by electronic means of communication (e.g. over the internet). This will be indicated, where necessary, in the terms and conditions for the healthcare concerned.
19. Population screening.
20. Costs that are related to:
    a. sports massage;
    b. work-related and/or recreational therapy;
    c. company emergency responder courses.
21. Self-administered healthcare.
22. Costs of healthcare that exceed the maximum insured amount of reimbursement or the maximum number of insured treatments. Consequently, in any year, we will not reimburse more than the maximum amount insured, even if you did not use any or all of the maximum amount in a previous year.
23. Healthcare you receive through, or medicine/products prescribed by, a healthcare provider who is your partner or a first or second-degree family member and/or relative, unless we give you prior permission.

A.21.2. Acts of war and terrorism

You are not entitled to the following treatment (costs):

- damage or losses in connection with acts of war caused by, or resulting from, armed conflict, civil war, insurrection, domestic civil commotion, riots and mutiny taking place in the Netherlands, as specified in Article 3:38 of the Dutch Financial Supervision Act ('Wet op het financieel toezicht'). In this context, we use the definitions drawn up by the Dutch Association of Insurers ('Verbond van Verzekeraars'). Please also refer to clause C.10.4. for other types of insurance besides health insurance.
- terrorism risk: terrorism, malicious contamination, preventive measures or preparatory actions and behaviour (jointly referred to as 'terrorism risk'). In this context, we use the definitions drawn up by the Dutch Terrorism Risk Reinsurance Company ('Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden', NHT) in the most recent terrorism cover clause sheet ('clausuleblad terrorismedekking').
  Costs resulting from these events (both in the Netherlands and abroad) will, however, be reimbursed insofar as we are able to pay them from the amount we receive under reinsurance from the NHT in Amsterdam.
  Insured persons who live outside of the Netherlands are not covered by this reinsurance, and are therefore not entitled to reimbursement.
  If, following a terrorist attack, an additional contribution is made available under Article 33 of the Dutch Health Insurance Act ('Zorgverzekeringswet'), you will be insured for an additional reimbursement to the extent to be specified under that article.

Terrorism:
'acts of violence or aggression – falling outside the scope of any of the six acts of war specified in Article 3:38 of the Dutch Financial Supervision Act ('Wet op het financieel toezicht') – in the form of an attack or series of attacks related in time and intention, that result in injury or ill health, whether or not this results in death, and/or damage to items or other harm to economic interests, whereby it can be reasonably assumed that the attack or series of attacks - whether or not there is an organisational connection - were planned and carried out with the intention of achieving certain political and/or

religious and/or ideological goals.'

Malicious contamination:
'- falling outside the scope of any of the six acts of war specified in Article 3:38 of the Dutch Financial Supervision Act ('Wet op het financieel toezicht') – the distribution of pathogens and/or chemicals that, as a consequence of their direct or indirect physical, biological, radioactive or chemical effects, may cause injury and/or ill health, whether or not this results in death, to people or animals and/or damage to items or other harm to economic interests, whereby it can be reasonably assumed that the distribution – whether or not there is an organisational connection – was planned and carried out with the intention of achieving certain political and/or religious and/or ideological goals.'

Preventive measures:
'measures taken by the government and/or insured persons and/or third parties to avoid an imminent threat of terrorism and/or malicious contamination, or to mitigate the consequences thereof where such acts have manifested themselves.'

Reinsurance provided by the NHT
Reinsurance provided by the NHT covers the costs of terrorism risk up to a maximum of 1 billion euros per year. This amount may vary from year to year and applies jointly to all insurers affiliated with the NHT. In the event of any changes, the NHT will announce this in three national newspapers.

Terrorism clause sheet
Nearly all insurers use the reinsurance provided by the NHT. A national terrorism clause sheet ('Clausuleblad Terrorisme' published by the NHT) has also been published. You can find out more about this at nht.vereende.nl/en/.

A.21.3. Nuclear reactions

You are not insured for treatment (costs) arising as a result of nuclear reactions.
You will be insured, however, if the costs arise as a result of radioactive material outside of a nuclear power plant, and the following terms and conditions are satisfied:

- the Dutch government has granted a permit for the installation of the nuclides;
- the location of this material does not contravene the Dutch Nuclear Incidents (Third Party Liability) Act ('Wet aansprakelijkheid kernongevallen');
- a third party is not liable for the losses incurred, under Dutch law or that of a foreign country.

A.21.4. Custody or imprisonment

You are not entitled to healthcare or reimbursement of the costs of such at any time when you are held in custody or in prison, even if the healthcare you receive is covered by the insurance. This applies to custody/imprisonment both in the Netherlands and abroad. In this case, you will have to rely on the medical healthcare provided by, or on behalf of, the institution where you are being detained. In the Netherlands, this is the responsibility of the Dutch Ministry of Justice ('Ministerie van Justitie').

A.22. Disputes

A.22.1. Requests for reconsideration

If you do not agree with a decision we have made in relation to the insurance, you can submit a written request for the decision to be reconsidered.

A.22.2. Court or disputes committee

If you do not agree with the outcome of the reconsideration, you will have the option of:

- referring the matter to the competent court if we fail to respond to your request for reconsideration within four weeks. You can also do this if we state that we stand by our original decision (and state the reasons why);
- referring the dispute to the 'Geschillencommissie Zorgverzekeringen' (Health Insurance Disputes Committee) of the 'Stichting Klachten en Geschillen Zorgverzekeringen' (SKGZ, the Health insurance Complaints and Disputes Committee), Postbus 291, 3700 AG Zeist, Netherlands (www.skgz.nl (in Dutch)). The Dutch Health Insurance Ombudsman ('Ombudsman Zorgverzekeringen') works for this organisation. The ombudsman will try to resolve the complaint through a process of mediation. If this proves unsuccessful, the SKGZ can issue a final and binding recommendation.

Once you have chosen one of the options above, you cannot, in principle, resort to the other.

A.23. Complaints

A.23.1. Complaint

You can also complain to us about issues that are not directly related to the implementation of your health insurance. You can do so in writing or by telephone. We will come to a decision about your complaint and inform you of the outcome.

A.23.2. If you do not agree with the decision

If you do not agree with our decision and/or your complaint has not been resolved satisfactorily, you will have the option of:

- referring your complaint to the competent court;
- referring your complaint to the 'Stichting Klachten en Geschillen Zorgverzekeringen' (SKGZ, the Health insurance Complaints and Disputes Committee). The Dutch Health Insurance Ombudsman ('Ombudsman Zorgverzekeringen') works for this organisation. The ombudsman will try to resolve the complaint through a process of mediation. If this proves unsuccessful, the SKGZ can issue a final and binding recommendation.

Once you have chosen one of the options above, you cannot, in principle, resort to the other.

A.23.3. Complaints about standard forms

In the event that you, healthcare providers or other health insurers find our forms unnecessarily complex or superfluous, you can complain about this to the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). The NZa will make a ruling in this respect, and the ruling will be binding.

A.24. Dutch law

Your insurance is subject to Dutch law.

A.25. Situations not covered

The Executive Board and/or management will decide how to proceed in situations that are not covered in these terms and conditions of insurance.

SECTION B

HEALTHCARE COVERED BY HEALTH INSURANCE

B.1. Deleted

B.2. Foreign healthcare

B.2.1. Living or staying in a treaty country, and healthcare in a (different) treaty country

Healthcare: what you are insured for

If you live or stay in a treaty country and receive healthcare there, or you stay temporarily in a different treaty country (which can also be the Netherlands!) and receive healthcare there, you can choose between:

- healthcare in accordance with the statutory arrangements that apply in that treaty country, under the provisions of the EU social security regulations or the applicable treaty; or
- insured healthcare (or reimbursement thereof) in accordance with the health insurance you have taken out, as described in clause B.2.2.

Approval

Approval (see clause A.18.) is required for all non-urgent medical care that can be scheduled in advance:

- for which you will be admitted for at least 1 night (inpatient care);
- that is included on the comprehensive list with mandate requirements for healthcare provided outside the Netherlands ('Limitatieve lijst met machtigingsvereisten voor zorg in het buitenland') (outpatient care). This list is available on our website;
- for which approval would also be required if you were receiving this medical care in the Netherlands. You can see whether approval is required in the clause relating to that particular healthcare.

B.2.2. Healthcare outside of your country of residence

Healthcare: what you are insured for

If you use a healthcare provider outside of your country of residence with whom we do not have an agreement, we will provide the same reimbursement as we would have done if you had used a healthcare provider in the Netherlands with whom we do not have an agreement. Please refer to clause A.20. for more details.

The healthcare in question will be subject to the same terms and conditions as in the Netherlands.

We advise you to first request a healthcare recommendation through our customer services team so that you know the financial implications of using the foreign healthcare provider. In order to be able to assess your request properly, we will need more information than is normally provided on a referral or treatment proposal. This can vary, depending on the condition and treatment.

Example:
You wish to consult a medical specialist in a foreign country. If you request a healthcare recommendation from us beforehand, we will be able to tell you:
- whether the healthcare involved is covered by your insurance;
- whether your situation gives reasonable medical grounds for this healthcare;
- whether there are healthcare providers in the Netherlands or abroad with whom we do have an agreement for this healthcare;
- whether you will need to pay extra for the healthcare. You may have to pay a higher rate for the treatment abroad than you would for comparable treatment in the Netherlands, or you may have to pay an amount yourself under the social security system in the country concerned.

Tip:
If you are temporarily abroad, but still in Europe or in Australia, you can request the European Health Insurance Card (EHIC). On presentation of this card, you will be able to receive healthcare in countries in the EU, Macedonia, Norway, Iceland, Liechtenstein, Switzerland and Australia. In most cases, you will not need to pay anything in advance. Healthcare providers in foreign countries know that we will pay their invoice. However, you may still have to pay a certain amount yourself under the social security system in the country concerned. You may be able to claim reimbursement of this under your additional insurance package.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare is subject to the deductible.
- this healthcare may be covered to a greater extent under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- hospitals in foreign countries are familiar with the EHIC, but the same cannot be said of all general practitioners, pharmacists and other healthcare providers. The card is intended for healthcare that is a medical necessity and that cannot reasonably be postponed until you return to your country of residence, for insured persons who are on holiday or temporarily abroad (e.g. in connection with work or study). You can request the card, free of charge, online at www.zorgwijzer.nl (in Dutch), even if you live abroad. If you live abroad with co-insured family members, you can request cards for them on the 'Zorginstituut Nederland' website at www.zorginstituutnederland.nl.

Approval
Approval (see clause A.18.) is required for all non-urgent medical care that can be scheduled in advance:
- for which you will be admitted for at least 1 night (inpatient care);
- that is included on the comprehensive list with mandate requirements for healthcare provided outside the Netherlands ('Limitatieve lijst met machtigingsvereisten voor zorg in het buitenland') (outpatient care). This list is available on our website;
- for which approval would also be required if you were receiving this medical care in the Netherlands. You can see whether approval is required in the clause relating to that particular healthcare.

B.3. General practitioner

B.3.1. Advice, examination and supervision

Healthcare: what you are insured for

General practitioner care includes, among other things:
- health advice and preventive healthcare in areas such as quitting smoking (see clause B.21.2.), problematic alcohol consumption, depression, and being overweight;
- treatment;
- diagnostic tests carried out by and at the general practice;
- request for an MRI scan for indications specified in NHG ('Nederlands Huisartsen Genootschap', Dutch College of General Practitioners) guidelines and standards;
- preconception care; this concerns a preconception consultation at the request of the insured person. During such a consultation, you are provided information and advice to promote a healthy start to an intended pregnancy. The focus is on the medical history, lifestyle factors (alcohol, smoking, drugs and weight), taking folic acid, hereditary factors, environmental factors (working conditions, infection risk, socio-economic factors), any previous pregnancy complications, and general health-related matters like

current use of medication, and any childhood diseases and/or vaccinations you have had;
- multidisciplinary care, for the following conditions:
  - diabetes mellitus type II (DM Type II) in insured persons who are aged 18 or above;
  - cardiovascular/vascular risk management to manage cardiovascular disease for insured persons aged 18 and above;
  - chronic obstructive pulmonary disease (COPD);
  - asthma suffered by insured persons from the age of 16;

  The healthcare is provided in accordance with the healthcare standards that apply for these conditions. For more information, please refer to clause A.17.3.

Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances. Consultations may also be provided online if the healthcare programme has made arrangements for such.

Please note!
- the healthcare does not include:
  - medical screening or check-ups, solely at the request of the insured person, and where they are not a medical necessity;
  - advice on and vaccinations and tablets for travel abroad. The provisions of clause D.2.3. apply to this healthcare.
- the costs of an MRI or lab tests performed by a facility for specialist medical healthcare or an independent laboratory are subject to the deductible, even if the MRI or lab tests are performed at the request of the general practitioner.
- consultations and treatments performed by or under the responsibility of the general practitioner are not subject to the deductible. However, other costs (like vaccinations and vaccines, for example) are set off against your deductible.
- refer to clause A.21. for the general exclusions.

Terms and conditions

General
In the case of multidisciplinary care, the healthcare is claimed through the principal contractor in accordance with the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg).

Healthcare provider
Healthcare is provided by a general practitioner or a healthcare provider within the general practice, out-of-hours general practitioner surgery or healthcare group (e.g. a practice assistant, nurse, nursing specialist or physician assistant).
The general practitioner has ultimate responsibility for the work of the healthcare provider within the general practice, out-of-hours general practitioner surgery or healthcare group.

In the case of multidisciplinary care, the healthcare is provided by:
- a general practitioner or other healthcare provider affiliated with a contracted principal contractor in the case of asthma or increased vascular risk.
- a general practitioner or other healthcare provider specified in the policy rule stated above in the case of COPD, DM type II or cardiovascular risk management for cardiovascular disease.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.3.2. Other general practitioner care

Healthcare: what you are insured for

This involves medical healthcare that borders on general practitioner medicine, for which we have a contract with your general practitioner, or for which the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) has given performance descriptions in its Policy Rule on Other Medical Care ('Beleidsregel Overige Geneeskundige Zorg').

This type of healthcare includes:
- (minor) surgical procedures;
- injection therapy (Cyriax);
- insertion of IUD/implants and/or removal of an Implanon rod;
- compression therapy for open wounds;
- removal of a foreign object from the eye;
- audiometry (hearing tests);
- ECG tests (electrocardiograph);
- Doppler tests (for blood vessels);
- spirometry (pulmonary function test);

- cow's milk allergy test;
- provision of individual healthcare for tuberculosis and infectious diseases.

Please note!
- refer to clause A.21. for the general exclusions.
- consultations and treatments performed by or under the responsibility of the general practitioner are not subject to the deductible; other costs (e.g. vaccinations, vaccines, laboratory costs and diagnostic tests) are subject to the deductible.
- a Mantoux test, within the scope of prevention before a trip abroad, comes under clause D.2.3., not under the present clause.

Terms and conditions

General
- see clause B.3.1.
- the cow's milk allergy test is a double-blind food challenge test, in accordance with the applicable youth healthcare guidelines on food allergies. Under medical supervision, test food containing cow's milk and not containing cow's milk is administered during 2 sessions. Neither the healthcare providers, nor you, nor your child knows which sample contains cow's milk.
- a Mantoux test can be performed within the scope of providing individual healthcare for tuberculosis and infectious diseases. This may require referral, diagnosis, treatment and supervision. The Mantoux test can only be claimed on a consultation basis by a contracted 'GGD' (regional health authority).

Healthcare provider
- cow's milk allergy testing is performed by a healthcare provider working under the responsibility of a youth healthcare doctor, and with whom we have written agreements on how the test is to be performed.
- individual healthcare for tuberculosis and infectious diseases is provided by qualified doctors, who are registered in the Netherlands with the Royal Dutch Medical Association's Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). This might be, for example, a doctor for the control of infectious diseases, employed by a 'GGD' (regional health authority).
- insertion of IUD/implants and/or removal of an Implanon rod can be done by the general practitioner or, alternatively, by an obstetrician who is registered on the proficiency register of the Royal Dutch Organisation of Obstetricians (KNOV) kept for this purpose. See clause B.5.1. Midwifery care.
- the other general practitioner care is provided by or under the responsibility of a general practitioner.

Referral
A general practitioner or medical specialist needs to provide a referral before healthcare commences.

Approval
Approval is not required.

B.3.3. General practitioner for mental healthcare

Healthcare: what you are insured for

General practitioner care also includes healthcare in the field of mental healthcare, and covers:
- healthcare for minor psychological complaints (such as depression), whereby you do not (yet) have a psychological disorder that requires treatment under basic mental healthcare (see clause B.19.1.) or general specialist mental healthcare (see clause B.19.2.);
- preventive healthcare for complaints in the field of depressive disorders, panic disorders or problematic alcohol consumption;
- healthcare for a suspected minor psychiatric disorder. The disorder is non-complex, has a low risk and shows short-term symptoms;
- healthcare and supervision in a stable, chronic situation for a mental health issue that has a low risk and is not crisis-sensitive.

Please note!
- healthcare does not cover a psychological or psychiatric disorder that requires treatment under basic mental healthcare (see clause B.19.1.) or general specialist mental healthcare (see clause B.19.2.). The general practitioner can issue a referral in these cases.
- the healthcare is not subject to a deductible.

Terms and conditions

General
See clause B.3.1. The following additional terms and conditions apply:
- the healthcare can also be provided online through a programme recognised by us.
- the results of a targeted questionnaire and diagnostic consultation are required in order to be able to determine whether you can be treated by a general practitioner.

Healthcare provider
Preferably, a general practitioner is supported by a primary care practice assistant specifically trained for mental healthcare ('POH GGZ') when providing healthcare for minor psychological complaints.

Approval
Approval is not required.

B.3.4. General practitioner and combined lifestyle intervention from the age of 18

Healthcare: what you are insured for

If you are 18 or older, you are insured for general practitioner care in the form of a combined lifestyle intervention if you have a moderately elevated weight-related health risk. This care is aimed at bringing about a change in behaviour in order to achieve and maintain a healthy lifestyle.

The healthcare provided is a combination of:
- advice and guidance on nutrition and eating habits;
- advice and guidance on healthy exercise (encouraging exercise and keeping you motivated, monitoring progress and directing you to exercise opportunities in the social sphere);
- advice on and guidance towards establishing permanent behavioural change to create and maintain a healthy lifestyle;
- healthcare-related feedback to the referring healthcare provider about the progress;
- an evaluation, with a review of your wishes for a possible maintenance phase.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare referred to in this clause does not include:
  - the actual exercise programme or sport (or guidance during this);
  - day treatment and/or admission;
  - a healthcare programme for children.
- the healthcare is not subject to a deductible.
- you are not entitled to dietetics or reimbursement of the costs of dietetics (see clause B.11) in combination with the combined lifestyle intervention healthcare programme for the same indication without an additional healthcare need based on a separate, specific indication.
- if the healthcare programme starts while you are insured with us, you will be entitled to the healthcare or reimbursement of the costs of the healthcare for the duration of the programme, even if you switch to another health insurer before the programme is complete. If you switch, you can continue the healthcare programme that you started at our expense at the expense of your new health insurer.

Terms and conditions

General
- an insured person aged 16 or 17 is entitled to this healthcare if the general practitioner considers the healthcare also appropriate for this insured person.
- you may only take part in the maintenance phase of the programme after completing the treatment phase.
- you have at least a moderately elevated weight-related health risk as expressed by your Body Mass Index (BMI). You have an indication for this healthcare if you have:
  - a BMI of 30 (i.e. 30kg/m2); or
  - a BMI of 25 (i.e. 25kg/m2) with an increased risk of cardiovascular disorders and DM type II based on the cardiovascular risk, obesity and diabetes healthcare standards; or
  - a BMI of 25 and you have been diagnosed with osteoarthritis or sleep apnea.
- the healthcare is provided in the form of a healthcare programme recognised by us; you can find a list of these programmes on our website.

Healthcare provider
The healthcare is provided by a healthcare provider registered as a lifestyle coach with the professional association of lifestyle coaches in the Netherlands ('Beroepsvereniging Leefstijl Coaches Nederland', BLCN). This lifestyle coach works in consultation with and provides feedback to the referring healthcare provider.

Referral
A general practitioner, possibly in consultation with a geriatric specialist, doctor for the mentally disabled and/or medical specialist, needs to provide a referral before the combined lifestyle intervention programme commences.

Approval
Approval is only required if you have already made use of this healthcare and you again wish to take part in such a healthcare programme.

Rates
We use a variety of rates. The rate will depend on which healthcare provider you use. For more information, please refer to clause A.20.

B.4. Specialist medical healthcare

B.4.1. General specialist medical healthcare

Clause B.4. covers specialist medical healthcare. You are insured for:

- medical care;
- preventive healthcare;
- specialist mental healthcare (see clauses B.19.2. and B.19.3.);
- oral care by a dental surgeon. The other terms and conditions that apply to this healthcare are specified in clauses B.12., B.13. and B.14.

Within specialist medical healthcare, we distinguish between the following in this clause:
- specialist medical healthcare with admission (see clause B.4.2.);
- specialist medical healthcare without admission (non-clinical) (see clause B.4.3.);
- plastic surgery (see clause B.4.5.);
- medical rehabilitation and geriatric rehabilitation (see clause B.4.6.);
- organ transplants (see clause B.4.7.);
- dialysis without admission (see clause B.4.8.);
- mechanical ventilation (see clause B.4.9.);
- tests for cancer in children (see clause B.4.10.);
- thrombosis service (see clause B.4.11.);
- genetic testing and advice (see clause B.4.12.);
- audiology care (see clause B.4.13.);
- fertility treatment (see clause B.4.14.);
- second opinion (see clause B.4.15.);
- sonography (see clause B.5.2.);
- antenatal screening (see clause B.5.3.);
- conditional healthcare (see clause B.22).

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the following healthcare is not classified as specialist medical healthcare under clause B.4.:
  - abdominal liposuction;
  - the insertion or replacement of a breast prosthesis by way of an operation, where you have not had a partial or total mastectomy, and it does not involve agenesis/aplasia of the breast in women, nor a comparable situation in transgender women in whom transsexuality has been established (also known as man-to-woman transgender people);
  - removal of a breast prosthesis by way of an operation, without this being medically necessary;
  - treatments for snoring by way of uvuloplasty;
  - sterilisation treatments;
  - treatments to reverse sterilisation;
  - circumcision that is not medically necessary;
  - correction of the position of the ears (protruding ears);
  - periodontal surgical healthcare as part of dental surgery that is carried out outside of a hospital (facility for specialist medical healthcare);
  - treatment using a cranial orthosis in case of plagiocefaly and brachycefaly without craniosynostosis.

Please note!
The following excluded healthcare may be insured under an additional insurance package. Your Reimbursements Overview will show whether or not this is the case. This applies to:
- sterilisation;
- sterilisation reversal;
- correction of the position of the ears;
- eyesight correction (laser eye treatment);
- cosmetic treatments;
- treatment for snoring;
- replacement of breast prostheses;
- treatment using a cranial orthosis.

B.4.2. Specialist medical healthcare with admission

Healthcare: what you are insured for

The healthcare includes:
- specialist medical treatment;
- admission in the lowest nursing care category of a facility for specialist medical healthcare for up to 1095 (3 x 365) days;
- admission, nursing and other care;
- allied healthcare (e.g. physiotherapy, exercise therapy, occupational therapy, and speech and language therapy), including medicines, medical aids and dressings associated with the treatment;
- laboratory tests.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.
- treatments that involve plastic surgery are not covered under this clause, but under clause B.4.5.
- laboratory tests requested by a provider of alternative healthcare are not covered by your health insurance.
- in the event that you are admitted to a hospital (facility for specialist medical healthcare) abroad that has two or more categories of nursing care the rate for nursing care that applies to patients admitted to Dutch hospitals will serve as a basis for determining the amount of cover.

Terms and conditions

General
- admission to the facility is medically necessary in connection with medical care (including specialist medical healthcare).
- your health insurance covers admissions of up to 1095 (3 x 365 consecutive days. Days are counted using the following rules:
  - if your admission is interrupted for a period of fewer than 31 days, the number of days of interruption do not count towards the total number of days. We continue counting after the interruption;
  - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning and you are again entitled to healthcare and reimbursement of such for the total number of days;
  - if your admission is interrupted for weekend/holiday leave, the number of days of interruption count towards the total number of days.

Healthcare provider
The healthcare is provided by a facility for specialist medical healthcare, a medical specialist or a dental surgeon.

Referral
- a general practitioner, doctor for the mentally disabled, geriatric specialist, medical specialist, nursing specialist, physician assistant, sports doctor, youth healthcare doctor or company doctor needs to provide a referral before treatment commences.
- in the case of fitting dental implants, a dentist needs to provide a referral before treatment commences.
- in the case of healthcare related to pregnancy and/or childbirth, an obstetrician may also provide a referral before treatment commences.
- in the case of eye conditions, an optometrist may also provide a referral.
- for healthcare relating to a cleft (cleft lip and/or jaw and/or palate) a referral may also be made by a cleft team.

Approval
Approval (see clause A.18.) is required for specialist medical healthcare involving dental surgery, comprising the fitting of dental implants, osteotomy, and the removal of teeth under anaesthetic. You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.3. Specialist medical healthcare without admission

Healthcare: what you are insured for

The healthcare comprises specialist medical healthcare, without admission. Examples of this type of healthcare include:
- treatment that is carried out without admission, such as ophthalmology healthcare;
- application of a plaster cast;
- ECG tests.

Healthcare and aids that may constitute part of the treatment include:
- nursing;
- medicines;
- medical aids;
- dressings;
- laboratory tests.

Healthcare and/or aids required after the treatment, or associated with continued treatment, are not covered here.

Insured persons can also access this healthcare using digital applications that we have designated. One of these is the SkinVision app, which you can use to take a photo of a spot on your skin and have this assessed to see whether it presents a risk of skin cancer. If a high risk is detected, you will receive medical advice.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare you receive through the SkinVision app is not subject to the compulsory deductible.
- other healthcare is subject to the deductible.
- clause B.4.1. also applies here.
- treatments that involve plastic surgery are not covered under this clause, but under clause B.4.5.
- laboratory tests requested by a provider of alternative healthcare are not covered by your health insurance.

Terms and conditions

General
Conditions for healthcare through the SkinVision app:
- the app account must be linked to your customer number.
- you must be 18 years or older.

Healthcare provider
The healthcare is provided by a medical specialist.

Referral
- a general practitioner, obstetrician, medical

specialist, doctor for the mentally disabled, geriatric specialist, nursing specialist, physician assistant, sports doctor, youth healthcare doctor, company doctor or, in the case of general infectious disease control or an STD, a doctor from a 'GGD' (regional health authority) needs to provide a referral before treatment commences.
- in the case of a hearing disorder, you may also be referred to an ENT doctor by a triage hearing care professional before treatment commences.
- in the case of an eye condition, you may also be referred to an ophthalmologist by an optometrist or orthoptist before treatment commences.
- for healthcare relating to a cleft (cleft lip and/or jaw and/or palate) a referral may also be made by a cleft team.
- no referral is required for healthcare provided through the SkinVision app.

Approval
Approval is not required.
Rates
We use a variety of rates. The rate will depend on which healthcare provider you use. For more information, please refer to clause A.20.

B.4.4. Deleted

B.4.5. Plastic surgery

Healthcare: what you are insured for

The healthcare includes treatment of a cosmetic surgery nature. The healthcare may or may not involve admission. It involves correction of:
- abnormalities in your appearance that result in demonstrable disorders of physical function. This relates to physical complaints, which objective tests have shown to be caused by the physical abnormality to be corrected. An example of this is the untreatable, constantly-present blemishes in the folds of skin associated with a severely overhanging abdomen;
- disfigurements that have arisen as the result of illness, an accident or a medical procedure (such as an operation). This is the case where a severe disfigurement is immediately obvious in daily life, for example disfigurement resulting from burns, or amputated legs, arms or breasts;
- paralysed or drooping upper eyelids, where the paralysis or drooping has led to severe limitations to the field of vision, or is the result of a congenital defect or the existence of a chronic condition at birth;
- agenesis/aplasia of the breasts (failure of the breasts to develop) in women and man-to-woman transgender people, by way of a surgical procedure for the insertion or replacement of breast prostheses in women and a comparable situation in transgender women in whom transsexuality has been established (also known as man-to-woman transgender people);
- primary sexual characteristics in the event of transsexuality being established;
- the following congenital disfigurements:
  - cleft lip, jaw or palate;
  - disfigurement of the facial bones;
  - benign, uncontrolled growth of blood vessels, lymphatic vessels or connective tissue;
  - birthmarks;
  - disfigurement of the urinary tract and genitalia.

Examples of instances when plastic surgery comes under insured healthcare:
- breast reduction:
  you are insured for a breast reduction if your cup size is DD/E or greater (or cup size D if you are less than 1.60m in height), and you suffer from a demonstrable physical complaint. The complaint must be the direct consequence of the weight of your breasts and must cause severe restriction. Other treatments and therapies must have been unsuccessful in relieving your complaint. Additionally, your weight must be stable and not excessive. The reason for this is that the risk of complications arising during operations increases significantly in people who are overweight, with the likelihood of success decreasing accordingly.
- laser treatment:
  your health insurance may cover laser treatment of blood vessels, skin pigment discolouration and other abnormalities and skin conditions. Your condition must involve (immediately noticeable) disfigurement or demonstrable disorders of physical function. Most disfigurements do not meet these criteria.
- nose correction:
  you are only insured for a nose correction where this involves a severe restrictive obstruction that cannot be treated in any other way. Entitlement to correction in connection with deformity or congenital disfigurement is rare.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

- an additional insurance package may cover a similar type of healthcare. Your Reimbursements Overview will show whether this is the case.
- we will not reimburse the costs of any photos we may require as a result of a request for approval.

Terms and conditions

General

- the 'VAGZ Werkwijzer' (Manual published by the Dutch Association of Medical Consultants Employed by Health Insurance Funds ['Vereniging van Adviserend Geneeskundigen bij Ziekenfondsen']) will be used for all plastic surgery procedures.
- when admission is medically necessary, the conditions for admission (see clause B.4.2.) apply.

Healthcare provider

The healthcare is provided by a medical specialist, who is also responsible for any healthcare provided by other, authorised healthcare providers.

Referral

A general practitioner, doctor for the mentally disabled, geriatric specialist, medical specialist, nursing specialist, physician assistant, youth healthcare doctor or company doctor needs to provide a referral before treatment commences.

Approval

- approval (see clause A.18.) is required in cases of treatment that appears on the latest national list of surgical procedures. You can request a copy of the 'Limitatieve lijst machtigingen medisch specialistische zorg ZN' ('Zorgautoriteit Nederland' restrictive list of authorisations for specialist medical healthcare) or download a copy from our website.
- in the case of correction of the upper eyelids, a healthcare provider who has a contract with us for this care will assess, on our behalf, whether your indication meets the requirements of the Dutch Health Insurance Act ('Zorgverzekeringswet'). Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
  our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.4.6. Rehabilitation healthcare

B.4.6.1. Rehabilitation

Healthcare: what you are insured for

Specialist medical rehabilitation involves the most suitable healthcare for preventing, mitigating and/or overcoming your handicap. This type of healthcare includes:

- admission: in cases of rehabilitation where you are admitted for several days. Such admission happens when it is expected that this will achieve better results than rehabilitation without admission;
- part-time or day treatment: this is rehabilitation without admission.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

General

This involves complex, interrelated problems with movement, feeling, intellectual capacity, speech, language and/or behaviour caused by:

- mobility disorders or restrictions;
- a disorder of the central nervous system that results in limitations in communication, mental capacity and/or behaviour.

Rehabilitation focuses on improving and/or preventing problems in daily life and social functioning that arise as a result of an accident, operation or serious illness. The aim is to allow you to function as independently as possible given your limitations.

Healthcare provider

A coherent, interdisciplinary team in a rehabilitation centre that works together closely in order to achieve the common goal of the patient's treatment, under the ultimate responsibility of the rehabilitation doctor.

Referral

A general practitioner, doctor for the mentally disabled, geriatric specialist, company doctor, medical specialist, nursing specialist, physician assistant or sports doctor needs to provide a referral before treatment commences.

Approval

Approval (see clause A.18.) is required for a rehabilitation treatment without admission.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.4.6.2. Geriatric rehabilitation

Your Reimbursements Overview will show whether or not you are entitled to this healthcare (or reimbursement of this healthcare).

Healthcare: what you are insured for

Geriatric rehabilitation comprises integrated, multidisciplinary rehabilitation healthcare relating to:

- vulnerability;
- complex multimorbidity; and
- reduced learning and training capacity.

The healthcare is intended to reduce your functional limitations, so you can return home. The duration of the healthcare may not be more than 6 months.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

General

- the geriatric rehabilitation takes place within one week of admission to, and treatment in, a facility for specialist medical healthcare, as referred to in clause B.4.2 and, upon commencement, involves admission, as referred to in clause B.4.2; it does not involve a prior stay, as referred to in Article 3.1.1 of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).
- entitlement to geriatric rehabilitation also applies in the event of sudden mobility disorders or a decrease in independence due to a condition for which you have already received specialist medical care. In this case, it must have been established that you are part of the target group for geriatric rehabilitation. The required assessment can be made by a geriatrician in the accident and emergencies department, or by means of an emergency consultation at the geriatric outpatient clinic.

Healthcare provider

A coherent, interdisciplinary team in a rehabilitation centre that works together closely in order to achieve the common goal of the patient's treatment, under the ultimate responsibility of the geriatric specialist.

Referral

- a doctor for the mentally disabled, geriatrician, medical specialist, physician assistant, or nursing specialist needs to provide a referral before treatment commences.
- if you receive treatment as a result of a condition with sudden onset or a trauma, the geriatric assessment must have been conducted by a multidisciplinary team, under the ultimate responsibility of a geriatric internist and/or clinical geriatrician.

Approval

Approval (see clause A.18.) is required if (in special cases) the geriatric rehabilitation will last longer than six months.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.4.7. Organ transplants

B.4.7.1. Healthcare for you as the recipient

Healthcare: what you are insured for

As the insured person and recipient of an organ, your healthcare consists of:

- organ and tissue transplants;
- specialist medical healthcare associated with the transplant of the organ(s)/tissue from the donor to you (the recipient);
- testing, removal, storage and transport of the organ(s)/tissue to be transplanted following death, in connection with the transplant. Live donation may also be involved.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

General

- the transplant takes place on the basis of an indication that is accepted for the form of transplant in question, in accordance with the latest practical and theoretical standards.
- the organ and tissue transplants are performed in:
  - a member state of the European Union;
  - a state that is party to the Agreement on the European Economic Area;
  - a different state, if the donor lives in that state, and the donor is the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative of the insured person.

Healthcare provider

The healthcare provider must:

- comply with the statutory minimum requirements for organ and tissue transplants; and
- be affiliated with a transplant centre that has been authorised and recognised by law.

Referral
A medical specialist, nursing specialist or physician assistant needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.7.2. Healthcare for you as the donor

Healthcare: what you are insured for

Healthcare for the donor involved in an organ transplant (i.e. the person who donates an organ/tissue to you, the recipient), consists of:

- admission and specialist medical healthcare in relation to the selection or removal of the organ(s)/tissue to be translated, for up to 13 weeks from the end of such admission. In the case of liver donors, the maximum period increases to six months.
- transport within the Netherlands, on the basis of the lowest class of public transport. The donor must need this in relation to the selection process and subsequent admission and discharge from a hospital (facility for specialist medical healthcare). The entitlement to transport will last for up to 13 weeks from the end of the admission. In the case of liver donors, the maximum period increases to six months.
- if transport is a medical necessity, a private car or taxi may be used instead of public transport.
- transport to and from the Netherlands, if the donor lives in a foreign country, in cases of a kidney, liver or bone marrow transplant for an insured person in the Netherlands.
- costs incurred by the donor in connection with the transplant, where the costs relate to the fact that the donor lives abroad. This refers to costs that are incurred in relation to the fact that the screening and selection of donors takes place abroad. This includes, for example, travel costs to and from a facility in the foreign country where the screening takes place, and the costs associated with the selection and transport of blood samples. The accommodation costs and any loss of income incurred by a donor who lives in a foreign country are not covered.

The healthcare available to the donor under this clause, is covered by the insurance taken out by you, as the recipient of the organs transplanted or to be transplanted, for up to 13 weeks (or six months in the case of a liver transplant) from the end of the admission. The donor is also regarded as an insured person under your insurance, solely in respect of this healthcare.

However, if the donor has taken out his/her own health insurance or health insurance has been taken out on his/her behalf, the donor's transport and associated costs, as referred to in the 2nd, 3rd and 4th bullet points of this clause, will be reimbursed under the donor's health insurance. The donor's transport and the healthcare relating to the organ transplant from 13 weeks (or six months in the case of a liver transplant) after the end of the admission are not subject to the deductible. Also see clause A.12.3.

Please note!

- refer to clause A.21. for the general exclusions. the healthcare does not include:
  - accommodation costs in the Netherlands for a donor who lives abroad;
  - any loss of income incurred by a donor.
- clause B.4.1. also applies here.

Terms and conditions

See clause B.4.7.1.

B.4.8. Dialysis

Healthcare: what you are insured for

The healthcare includes:

- dialysis in connection with kidney problems (haemodialysis) and peritoneal dialysis, without admission;
- associated specialist medical healthcare, comprising:
  - tests, treatment and nursing involved in the dialysis;
  - medicines that are required for the treatment;
  - any psychosocial support you may require.

If the dialysis takes place in your home, you will also be insured for:

- training, provided by the dialysis centre, of individuals who perform or assist with the home dialysis;
- the loan, routine inspection and maintenance (including replacement) of the dialysis equipment and accessories;
- the chemicals and fluids needed in relation to performing the dialysis;
- the necessary expert assistance with the dialysis, provided by the dialysis centre;
- psychosocial support for individuals who help perform the dialysis at home;

- any other consumer items that are reasonably required for dialysis.

In accordance with clause B.17. Medical aids, you are also insured for the following healthcare. Please also refer to our regulations on medical aids ('Reglement Hulpmiddelen'):

- reasonable modifications to the home, and its subsequent return to the original condition, insofar as these are not covered under different statutory regulations;
- other reasonable costs directly associated with home dialysis, insofar as these are not covered under different legislation.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

Healthcare provider
The healthcare is carried out by or under the ultimate responsibility of a medical specialist.
Referral
A medical specialist needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.9. Mechanical ventilation

Healthcare: what you are insured for

The healthcare includes:

- provision of necessary mechanical ventilation or provision of the required equipment, so this is available to you for immediate use during each treatment;
- related specialist medical healthcare;
- medicines that are related to mechanical ventilation;
- the costs of electricity for mechanical ventilation when this is provided in your home.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.
- the healthcare does not include nursing in connection with ventilation at home that is required in connection with the specialist medical healthcare covered in this clause.

Terms and conditions

Healthcare provider
The healthcare is provided by, or under the responsibility of, a ventilation centre.
Treatment proposal
A medical specialist must have determined that the healthcare is medically necessary.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.10. Tests for cancer in children

Healthcare: what you are insured for

Your child's healthcare includes the centralised (reference) diagnostics, coordination and registration of biopsy samples submitted.

Please note!

- refer to clause A.21. for the general exclusions.
- clause B.4.1. also applies here.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The healthcare is provided by the Dutch foundation for children's oncology, 'Stichting Kinderoncologie Nederland' (SKION).
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.11. Thrombosis service

Healthcare: what you are insured for

Healthcare provided by the thrombosis service comprises:

- taking regular blood samples from you;
- laboratory tests required to establish the clotting time of your blood. The tests are performed by, or under the responsibility of, the thrombosis service;
- any equipment and accessories you need in order to determine your blood clotting time. The thrombosis service will provide you with this equipment;
- training in how to use the equipment for measuring blood clotting time, and assistance in

performing the actual measurements;
- advice from the thrombosis service in relation to the use of medicines for controlling blood clotting.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

Healthcare provider
The healthcare is provided by a recognised and authorised thrombosis service.
Referral
A physician assistant needs to provide a referral before treatment commences.
Treatment proposal
A general practitioner, a doctor for the mentally disabled, a geriatric specialist, your attending medical specialist or nursing specialist or a thrombosis doctor affiliated with a recognised thrombosis service must have determined that the healthcare is medically necessary.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.12. Genetic testing

Healthcare: what you are insured for

The healthcare consists of genetic testing and advice, comprising the centralised (reference) diagnostics, coordination and registration of blood and bone marrow preparations submitted. This type of healthcare includes:
- testing for genetic abnormalities through genealogy, chromosome testing, biochemical diagnostics, ultrasound imaging and DNA testing;
- advice in relation to genetics;
- psychosocial support appropriate to the healthcare;
- testing of others, where this is required in order to be able to advise you. The others will also be able to obtain advice.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

Healthcare provider
The healthcare is provided by a clinical geneticist in a clinical genetics centre that has been authorised and recognised by law.
Referral
A general practitioner, medical specialist or nursing specialist needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.13. Audiology care

Healthcare: what you are insured for

Audiology care involves healthcare that is related to problems with hearing/the auditory function. You are insured for:
- auditory function tests;
- advice on purchasing hearing aids;
- information on the use of hearing aids;
- psychosocial healthcare in connection with problems associated with impaired auditory function, where this is necessary;
- assistance with the diagnosis of speech and language disorders in children.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

Healthcare provider
The healthcare is provided by a healthcare provider who complies with the statutory minimum requirements for this type of healthcare, and who is affiliated with a facility for specialist medical healthcare or an audiology centre.
Referral
A general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, medical specialist, nursing specialist, physician assistant, clinical physicist in audiology, triage hearing care professional or company doctor needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.14. Fertility treatment

Healthcare: what you are insured for

The healthcare comprises fertility-related healthcare for women under the age of 43.
This healthcare includes the 1st, 2nd and 3rd attempts at in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) treatment, and the medicines used for this in accordance with the Medicines Reimbursement System (GVS) (see clause B.15.), for each desired pregnancy, if you:

- are younger than 38, and no more than one embryo is transferred in each of the 1st and 2nd IVF attempts (up to 2 embryos in the 3rd attempt);
- are between 38 and 42 years old, and no more than 2 embryos are transferred in each attempt;
- are 43 or older, but were younger than 43 when the treatment commenced: you will be entitled to conclude the current attempt.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.
- the healthcare does not include:
  treatment for the egg cell donor and donation of the egg cell in the case of egg cell donation treatment. National criteria apply to the reimbursement of egg cell donation.
- following a successful pregnancy, you will again be entitled to this healthcare, in accordance with the applicable terms and conditions.
  A successful pregnancy means:
  - a term of pregnancy of at least 9 weeks and 3 days, calculated from the date of implantation in the case of transfer of cryopreserved (frozen) embryos; or
  - a term of pregnancy of at least 10 weeks, calculated from the date of follicular aspiration; or
  - a term of pregnancy of at least 12 weeks, calculated from the first day of the last period, in the case of a spontaneous (physiological) pregnancy.
- in vitro fertilisation has four consecutive stages:
  - stage 1: hormone treatment to stimulate egg cell maturation;
  - stage 2: follicular aspiration (retrieval of mature egg cells);
  - stage 3: fertilisation of the egg cells and embryo culture in the laboratory;
  - stage 4: one or more implants of 1 or 2 embryos into the uterus.

  In vitro fertilisation is deemed to have occurred if stage 2 (i.e. follicular aspiration) is successful. The transfer of previously cultured (frozen) embryos forms part of the in vitro fertilisation during which the embryos were cultured.

Examples:

- you are undergoing your 3rd attempt. Although the follicular aspiration is successful, it does not result in pregnancy. A subsequent (4th) attempt is not covered by your health insurance.
- you are undergoing your 3rd attempt. You did not become pregnant as a result of embryo transfer, but a few frozen embryos remain. All of the remaining frozen embryos can be transferred, up to a maximum of two at a time. This applies even if you have reached the age of 43: this is still considered to be part of the 3rd attempt which started when you were not yet 43.
  If it were the 1st or 2nd attempt, and you were younger than 38, only one embryo at a time could be transferred.
- you are undergoing your 3rd attempt. An embryo is transferred, but the pregnancy ends 14 weeks after the date of follicular aspiration. You will again be entitled to three attempts (if you are younger than 43), since you had a successful pregnancy.
- you have had three attempts without success. After a period of time you become pregnant naturally. Assuming you are younger than 43, you are then entitled to three more attempts.

Terms and conditions

Healthcare provider
The treatment is carried out by a gynaecologist in an appropriately licensed facility.
Referral
A general practitioner, medical specialist, physician assistant or nursing specialist needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.4.15. Second opinion

Healthcare: what you are insured for

The healthcare consists of a second opinion. This involves a consultation about an existing diagnosis or treatment proposal with a second, independent medical specialist who works in the same field of expertise as the healthcare provider first consulted.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- clause B.4.1. also applies here.

Terms and conditions

General

- the second opinion relates to your medical healthcare.
- you return with the second opinion to the original healthcare provider, who retains control of your treatment.

Healthcare provider

The healthcare is provided by a medical specialist or dental surgeon.

Referral

In order to obtain a second opinion, the general practitioner or medical specialist who is treating you must issue a separate referral before the treatment commences.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.5. Healthcare before childbirth

B.5.1. Midwifery care

Healthcare: what you are insured for

The healthcare includes:

- insertion of IUD/implants and/or removal of an Implanon rod;
- preconception care; this concerns a preconception consultation at your request. During such a consultation, you are provided information and advice to promote a healthy start to an intended pregnancy. The focus is on the medical history, lifestyle factors (alcohol, smoking, drugs and weight), taking folic acid, hereditary factors, environmental factors (working conditions, infection risk, socio-economic factors), any previous pregnancy complications, and general health-related matters like current use of medication, and any childhood diseases and/or vaccinations you have had;
- preventive care during pregnancy to promote good health for yourself and your unborn baby;
- midwifery care.

Please note!

- refer to clause A.21. for the general exclusions.
- the healthcare is not subject to a deductible.
- a deductible does apply for the actual IUD or Implanon rod (but not to insertion or removal by the obstetrician or general practitioner).

Terms and conditions

Healthcare provider

Support during pregnancy where there are no medical grounds is provided by an obstetrician or general practitioner. Support during pregnancy on medical grounds is provided by a gynaecologist.

Referral

In cases where a gynaecologist provides the healthcare, a general practitioner, physician assistant, nursing assistant or obstetrician needs to provide a referral before treatment commences.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.5.2. Ultrasound scans

Healthcare: what you are insured for

The healthcare consists of general, routine ultrasound scans and specific, diagnostic ultrasound scans, providing there are medical grounds for the latter.

Please note!

- refer to clause A.21. for the general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider

The ultrasound scans are performed by a medical specialist, general practitioner, obstetrician or sonographer.

Referral

In cases where a medical specialist or sonographer provides the healthcare, a general practitioner, physician assistant or obstetrician needs to provide a referral before treatment commences. If you are already being treated by a medical specialist for midwifery care, a referral for an ultrasound scan is not required.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.5.3. Antenatal screening

Healthcare: what you are insured for

Antenatal screening includes:

- counselling for pregnant women. During

counselling, you are provided with information about the antenatal screening;
- the structural ultrasound scan for pregnant women of all ages (also known as the '20-week ultrasound');
- the non-invasive prenatal test (NIPT) and the invasive diagnostic test, for pregnant women who require these on medical grounds:

in the case of an invasive diagnostic test, medical grounds also means instances where an NIPT shows a significant risk of a foetus having a chromosome aberration.

Please note!
- refer to clause A.21. for the general exclusions.
- the NIPT and follow-up diagnostic tests are subject to the deductible. Please refer to clause A.12.3. for more information.
- a non-medically necessary screening may be covered under an additional insurance package. Your Reimbursements Overview will show whether this is the case.

Terms and conditions

Healthcare provider
The antenatal screening is performed by a medical specialist, general practitioner, obstetrician or sonographer, who:
- is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO); or
- works in partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).

The non-invasive prenatal test (NIPT) is carried out as part of scientific research (the TRIDENT study). The blood will need to be collected at a blood lab that is recognised under the TRIDENT study.

Referral
In cases where a medical specialist or sonographer provides the healthcare, a general practitioner or obstetrician needs to provide a referral before treatment commences. A referral is not required if the midwifery care is provided by a specialist.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.5.4. Initial interview and registration for obstetric care

Healthcare: what you are insured for

The healthcare consists of registration and the initial interview for obstetric care. The initial interview involves discussion about the obstetric care (the type and number of hours) you will receive after childbirth. The number of hours of obstetric care is indicated on the basis of the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). You can view the protocol on our website or we can provide a copy on request.

Please note!
- refer to clause A.21. for the general exclusions.
- the registration and initial interview are covered by your health insurance once only per pregnancy.
- the registration costs for a birth centre or birth clinic are not reimbursed unless you stay at that facility for the entire period after giving birth and, accordingly, do not receive any obstetric care at home.
- the healthcare is not subject to a deductible.

Terms and conditions

General
The registration and initial interview may be performed at your home, or over the telephone.
Healthcare provider
The registration and initial interview are performed by:
- a facility that provides obstetric care; or
- an obstetric nurse working independently.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.6. Healthcare during childbirth

Healthcare: what you are insured for

Midwifery care during childbirth (including care immediately preceding and after childbirth) can be provided with or without medical grounds for this care and comprises the assistance of an obstetric nurse or other nurse during the birth (partus assistance). This is provided on the basis of the Detailed Partus Assistance Framework ('Inhoudelijk Kader Partusassistentie') up to the maximum number of hours specified by the obstetrician in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').

Please ask us for a copy of this framework and indication protocol, or download a copy (in Dutch) from our website.
Childbirth means the end of pregnancy, at any time after week 16.

Please note!

- refer to clause A.21. for the general exclusions.
- you will need to pay a statutory personal contribution. In cases of childbirth as an outpatient or in a birth centre without medical grounds, you will have to pay €19 per person, for the mother and child/children, yourself. The personal contribution is not higher if more than one child is born.
- if more than €134 per person is charged, you will also have to pay any amount in excess of €134 yourself.
- the maximum reimbursement and the statutory personal contribution will remain the same, regardless of whether the birth involves one child or several children.
- the statutory personal contribution for this healthcare and/or additional healthcare relating to the childbirth may possibly be covered under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- the healthcare is not subject to a deductible.

Example:
Say, for example, you give birth in a hospital or birth centre without medical grounds and without admission:

- we will reimburse 2 x €134 for mother and child, meaning the total reimbursement for this childbirth is €268.
- however, from this we will deduct, for mother and child, the statutory personal contribution of €19, i.e. a total of €38.
- you will therefore receive €268 - €38 = €230 from us.

Terms and conditions

General
Childbirth means the end of pregnancy, at any time after week 16.
Healthcare provider
Childbirth with medical grounds takes place under the care of a medical specialist.
Such healthcare can also be performed by an obstetrician or general practitioner where there are no medical grounds.
Referral
For healthcare in relation to childbirth on medical grounds, a general practitioner or obstetrician needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.7. Healthcare after childbirth

Healthcare: what you are insured for

Healthcare after childbirth comprises:

- obstetric care for mother and child/children;
- midwifery care for mother and child and admission to a facility when required;
- any medicines, medical aids and dressings required for the specialist medical healthcare during a period of admission.

The obstetric care is given immediately after childbirth and is exclusively intended for:

- the birth mother, or
- the person caring for the newborn(s) (if the birth mother is not present); and
- the newborn(s).

The number of days you receive obstetric care and the number of hours per day are determined during the initial interview for obstetric care (see B.5.4.). After delivery, the obstetrician or medical specialist will once again determine how much obstetric care is required. The agreements are specified in the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’). Please ask us for a copy of this indication protocol, or download a copy from our website.

Obstetric care for mother and child at home normally lasts eight days. A further two days can be added if there are medical grounds for doing this. The additional number of hours/days and the number of hours/days of obstetric care elsewhere will depend on the assessment made by the obstetrician or medical specialist, who will discuss this with the facility that or person who is to provide the obstetric care.

Where there are medical grounds, you will also be insured for admission to a facility for specialist medical healthcare, and obstetric and specialist medical healthcare there, from the day of childbirth. Your obstetric care is included in this admission. The number of days of admission are used to calculate the number of hours/days of obstetric care that remain.

Please note!

- refer to clause A.21. for the general exclusions.
- a statutory personal contribution for obstetric care will apply in the following situations:
  - a statutory personal contribution of €4.70 per hour, in the birth clinic or at home;
  - a statutory personal contribution of €19 per person per day, for mother and child/children, for obstetric care that is not medically necessary, and that is provided in a facility for specialist medical healthcare, a birth centre or a birth clinic;
  - if the facility charges more than €134 per person per day, you will also have to pay any amount in excess of €134 yourself;
  - this means that the maximum reimbursement for mother and one child is €230 (i.e. 2 x max. €134 minus 2 x €19).
- this healthcare may also be covered (to a greater extent) under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- the healthcare is not subject to a deductible.

Terms and conditions

General

You arrange the obstetric care yourself by no later than your 20th week of pregnancy. If you need help or advice on arranging obstetric care, please contact us.

Healthcare provider

An obstetrician or a medical specialist provides the postnatal midwifery care (postnatal checks) in the period after childbirth; the postnatal checks may only be carried out by a medical specialist if this is medically necessary.

Obstetric care is provided by:

- a facility that provides obstetric care; or;
- an obstetric nurse working independently.

During admission to a facility for specialist medical healthcare on medical grounds, the obstetric care is covered under nursing and other care. Specialist medical healthcare is provided by a medical specialist or an obstetrician.

Referral

In cases of admission to the facility for specialist medical healthcare and nursing of mother and/or child/children on medical grounds, the obstetrician, general practitioner, medical specialist, physician assistant or nursing assistant needs to provide a referral before treatment commences.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.8. Physiotherapy and/or Cesar/Mensendieck exercise therapy

B.8.1. Physiotherapy and/or exercise therapy from the age of 18

Healthcare: what you are insured for

If you are aged 18 or above, you are insured for physiotherapy and/or exercise therapy if you experience limitations that are caused by a condition specified on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie').
You can ask us for a copy of this list (Appendix 1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering') or download a copy (in Dutch) from our website.

For each condition (specified on the list), the required treatments include physiotherapy and/or exercise therapy from the 21st session onwards (i.e. not session 1 to 20).
If you are treated for a condition for which the list specifies a maximum term, you are insured for sessions up to the end of this term.

Pelvic physiotherapy is described in clause B.8.2., physiotherapy in the form of supervised walking therapy to treat intermittent claudication in clause B.8.4., physiotherapy in the form of supervised exercise therapy to treat osteoarthritis in the hip or knee joint in clause B.8.5. and physiotherapy in the form of supervised exercise therapy for COPD in clause B.8.6.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- this healthcare may be covered to a greater extent under an additional insurance package. This means that, if you are entitled to reimbursement under this clause, some or all of the first

20 sessions may be insured under your additional insurance package. Your Reimbursements Overview will show whether this is the case.
- please refer to clause B.8.3. for the terms and conditions.

B.8.2. Pelvic physiotherapy from the age of 18

Healthcare: what you are insured for

If you are aged 18 or above, the healthcare will consist of up to 9 pelvic physiotherapy sessions for urinary incontinence for as long as you are insured with us.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare is not subject to the compulsory deductible if:
  - you have 'Natura Select' health insurance with us; and
  - you see a healthcare provider who has a contract with us for this healthcare.

  Your policy document states whether you have taken out 'Natura Select' health insurance with us.
- in all other cases, the healthcare is subject to the deductible.
- under an additional insurance package, this healthcare may also be covered to a greater extent as normal physiotherapy. Your Reimbursements Overview will show whether this is the case.
- please refer to clause B.8.3. for the terms and conditions.

B.8.3. Physiotherapy and/or exercise therapy up to the age of 18

Healthcare: what you are insured for

If you are younger than 18, the healthcare will include physiotherapy and/or exercise therapy if you experience limitations that are caused by a condition:
- specified on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie').

  You can ask us for a copy of this list (Appendix 1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering') or download a copy (in Dutch) from our website.

  You are insured for the required sessions, starting from the first session. If you are treated for a condition for which the list specifies a maximum term, you are insured for sessions up to the end of this term;
- not specified on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie').

  You are insured for 9 sessions per year for each condition. If, after these 9 sessions, you still suffer from the condition, you are insured for up to 9 additional sessions for the same condition, i.e. up to 18 sessions in total.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare may be covered to a greater extent under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- the healthcare is not subject to a deductible.

Terms and conditions (B.8.1., B.8.2. and B.8.3.)

General
- these terms and conditions apply to insured persons of all ages.
- other therapies, for example those provided by a physiotherapist or exercise therapist specialising in children, a manual therapist, a pelvic physiotherapist, a geriatric physiotherapist and an oedema physiotherapist, also come under the heading of physiotherapy and/or exercise therapy.
- the number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required for your condition.
- if the sessions are group sessions, the group may not have more than 10 participants.
- the healthcare may be provided at your home if this is medically necessary. This must be stated in the referral.

Healthcare provider
- physiotherapy is provided by a physiotherapist.
- manual therapy is provided by a manual therapist. This means a physiotherapist listed as a manual therapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us.
- pelvic physiotherapy is provided by a pelvic physiotherapist. This means a physiotherapist listed as a pelvic physiotherapist on the Dutch

Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us.
- physiotherapy for children is provided by a physiotherapist specialising in children. This means a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us.
- geriatric physiotherapy is provided by a geriatric physiotherapist. This means a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us.
- oedema therapy is provided by an oedema physiotherapist or skin therapist. This means a physiotherapist listed as an oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us.
- exercise therapy is provided by a Cesar/Mensendieck exercise therapist.
- exercise therapy for children is provided by a Cesar/Mensendieck exercise therapist specialising in children. This means an exercise therapist listed as an exercise therapist specialising in children on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Referral

A general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, dentist, company doctor, nursing specialist, or medical specialist needs to provide a statement before treatment commences in cases of:
- a condition listed in Appendix 1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering'); or
- pelvic physiotherapy for urinary incontinence; or
- the treatment being provided at your home.

Approval
- the healthcare provider who has a contract with us for this healthcare will check on our behalf whether your condition is on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie') or whether it is a case of pelvic physiotherapy for urinary incontinence. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
  our approval is required, however, if the treatment is provided by a non-contracted healthcare provider (see clause A.18.).
- please ask us for a healthcare recommendation in advance if you are in any doubt as to whether or not your condition comes under any of these conditions.
- approval is required if more than one treatment (other than intake and examination) is required in one day.
- if, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will also need approval (see clause A.18.).

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.8.4. Physiotherapy for intermittent claudication from the age of 18

Healthcare: what you are insured for

You are insured for physiotherapy in the form of supervised walking therapy to treat intermittent claudication with peripheral artery disease at Fontaine stage 2. The healthcare consists of up to 37 sessions over a maximum period of 12 months. During the therapy, you will be encouraged to adopt a self-management approach, with the ultimate aim of being able to continue exercising independently.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare is not subject to the compulsory deductible if:
  - you have 'Natura Select' health insurance with us; and
  - you use a physiotherapist who is affiliated with Chronisch ZorgNet; and
  - you see a healthcare provider who has a contract with us for this healthcare.

  Your policy document states whether you have taken out 'Natura Select' health insurance with us.
- in all other cases, the healthcare is subject to the deductible.
- if the sessions are group sessions, the group may not have more than 10 participants.

Terms and conditions

General
- you are 18 years old or above.
- the healthcare may be provided at your home if this is medically necessary. This must be stated in the referral.

Healthcare provider

The healthcare is provided by a physiotherapist.

Referral
A general practitioner, nursing specialist or medical specialist needs to provide a statement before treatment commences.
Approval
- a healthcare provider who has a contract with us for this healthcare and who is affiliated with Chronisch ZorgNet will check the referral on our behalf to establish whether it is a case of peripheral artery disease at Fontaine stage 2. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
  our approval is required, however, if the treatment is provided by a non-contracted healthcare provider (see clause A.18.).
- approval is required if more than one treatment (other than intake and examination) is required in one day.
- if, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists, you will also need approval (see clause A.18.1).

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.8.5. Physiotherapy and exercise therapy for osteoarthritis in the hip or knee joint from the age of 18

Healthcare: what you are insured for

You are insured for physiotherapy in the form of supervised exercise therapy in cases of osteoarthritis in the hip or knee joint. The healthcare consists of up to 12 sessions over a maximum period of 12 months. During the therapy, you will be encouraged to adopt a self-management approach, with the ultimate aim of being able to continue exercising independently.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- if the sessions are group sessions, the group may not have more than 10 participants.

Terms and conditions
General
- you are 18 years old or above.
- the healthcare may be provided at your home if this is medically necessary. This must be stated in the referral.

Healthcare provider
The healthcare is provided by a physiotherapist or a Cesar/Mensendieck exercise therapist.
Referral
A general practitioner, nursing specialist or medical specialist needs to provide a referral before treatment commences.
Approval
- the healthcare provider who has a contract with us for this healthcare will assess the referral on our behalf to establish whether it involves osteoarthritis in the hip or knee joint. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
  our approval is required, however, if the treatment is provided by a non-contracted healthcare provider (see clause A.18.).
- approval is required if more than one treatment (other than intake and examination) is required in one day.
- if, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists, you will also need approval (see clause A.18).

Rates
We use a variety of rates. The rate will depend on which healthcare provider you use. For more information, please refer to clause A.20.

B.8.6. Physiotherapy and/or exercise therapy for COPD from the age of 18

Healthcare: what you are insured for

You are insured for physiotherapy and/or exercise therapy in the form of supervised exercise therapy in cases of chronic obstructive pulmonary disease (COPD) stage II or higher of the GOLD classification of COPD severity by spirometry. This type of healthcare includes:
- for GOLD classification class A, for symptoms and risk of exacerbations: 5 sessions over a maximum period of 12 months;
- for GOLD classification class B1, for symptoms and risk of exacerbations: 27 sessions over a maximum period of 12 months after the start of the treatment, and 3 sessions per 12 months in the following years;
- for GOLD classification class B2, C or D, for symptoms and risk of exacerbations: 70 sessions over a maximum period of 12 months after the start of the treatment, and 52 sessions per 12 months in the following years.

You can read more about the GOLD classification

and its classes on our website.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- if the sessions are group sessions, the group may not have more than 10 participants.

Terms and conditions
General
- you are 18 years old or above.
- the healthcare may be provided at your home if this is medically necessary. This must be stated in the referral.

Healthcare provider
The healthcare is provided by a physiotherapist or a Cesar/Mensendieck exercise therapist.
Referral
a general practitioner, medical specialist or a respiratory nurse specialist needs to provide a referral before treatment commences.
Approval
- a healthcare provider who has a contract with us for this healthcare will check the referral on our behalf to establish whether it is a case of COPD stage II or higher and, if so, which class you belong to. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
- our approval is required, however, if you are treated by a non-contracted healthcare provider (see clause A.18.).
- approval is also required if more than one treatment (other than the intake and examination) is required in one day.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.9. Occupational therapy

Healthcare: what you are insured for

Occupational therapy comprises no more than ten hours of treatment per year and includes the provision of advice, instruction, training and/or treatment, all aimed at helping you achieve, or regain, your independence.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- if the sessions are group sessions, the group may not have more than 10 participants.
- this healthcare may also be covered (to a greater extent) under an additional insurance package. Your Reimbursements Overview will show whether this is the case.

Terms and conditions

General
The healthcare may be provided at your home if this is medically necessary.
Healthcare provider
An occupational therapist provides the healthcare.
Referral
- a referral is not required when the treatment is provided by a contracted healthcare provider.
- if the treatment is provided by a non-contracted healthcare provider, a general practitioner, nurse (level 5), doctor for the mentally disabled, geriatric specialist, company doctor, nursing specialist, or medical specialist needs to provide a referral before treatment commences.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.10. Speech and language therapy

Healthcare: what you are insured for

The healthcare comprises speech and language therapy that is provided on medical grounds and improves or restores the ability to speak.
This healthcare also covers stammer therapy.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the healthcare does not include:
  - treatments that have an educational aim;
  - treatment of a language disorder and/or articulation problems relating to dialect and/or being a non-native speaker;
  - treatment of dyslexia;
  - stammer therapy using the Del Ferro, BOMA or INS methodologies (see clause D.5. for more information).

Terms and conditions

General
The healthcare may be provided at your home if this is medically necessary.
Healthcare provider
A speech and language therapist provides the healthcare.

Referral
- a referral is not required when the treatment is provided by a contracted healthcare provider to insured persons aged 18 or older.
- if the treatment is provided by a non-contracted healthcare provider, a general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, company doctor, dentist, medical specialist, clinical physicist in audiology at an audiology centre, or nursing specialist needs to provide a referral before treatment commences.

Approval
Approval is required if more than one treatment is required in one day.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.11. Dietetics

Healthcare: what you are insured for

The healthcare comprises dietetics provided on medical grounds:
- up to a maximum of three hours of treatment per year; or
- 100% if the healthcare is provided in the context of multidisciplinary care. The multidisciplinary care must be for the treatment of:
  - diabetes mellitus type II (DM Type II) in insured persons who are aged 18 or above; or
  - increased vascular risk (VRM); or
  - the chronic lung condition chronic obstructive pulmonary disease (COPD); or
  - asthma.

  This healthcare is provided in accordance with the healthcare standards that apply for these conditions. For more information, please refer to clause A.17.3.

  Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare is subject to the deductible, unless it is provided as part of multidisciplinary care.
- an additional insurance package may cover a similar type of healthcare to a greater extent. Your Reimbursements Overview will show whether this is the case.
- you are not entitled to reimbursement of the costs of dietetics outside of multidisciplinary care if you are already receiving dietetics provided by a healthcare group as part of multidisciplinary care for the same condition. The costs of dietetics will only be reimbursed for an additional healthcare need based on a separate, specific indication.
- you are not entitled to reimbursement of the costs of dietetics if there are no medical grounds for this. This includes, for example, dietary advice in connection with sport or losing weight, if this is not considered medically necessary.
- you are not entitled to dietetics (or to reimbursement of the costs of dietetics) in combination with the combined lifestyle intervention programme (see clause B.3.4.) for the same indication without there being an additional healthcare need based on a separate, specific indication.
- if the sessions are group sessions, the group may not have more than 10 participants.

Terms and conditions

General
- in the case of multidisciplinary care, the healthcare is claimed through the principal contractor using one integrated rate. In this case, the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) applies.
- the healthcare may be provided at your home if this is medically necessary.

Healthcare provider
A dietician provides the healthcare.
In the case of multidisciplinary care, the healthcare is provided by a dietician who:
- is affiliated with or contracted by a principal contractor;
- is affiliated with a contracted principal contractor in the case of asthma.

Referral
- a referral is not required when the treatment is provided by a contracted healthcare provider.
- if the treatment is provided by a non-contracted healthcare provider, a general practitioner, doctor for the mentally disabled, geriatric specialist,

youth healthcare doctor, dentist, company doctor, nursing specialist, or medical specialist needs to provide a referral before treatment commences.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.12. Oral care for all age groups

B.12.1. Oral care in exceptional circumstances

Healthcare: what you are insured for

The healthcare includes oral care in exceptional circumstances that is required because:

- you suffer from a severe developmental or growth disorder, or have an acquired disorder of the teeth/jaw/mouth; and/or
- you suffer from a non-dental physical or mental condition; and/or
- you receive medical treatment that has demonstrably inadequate results without dental care. This type of dental care generally involves ensuring that the mouth is kept free of infection through, for example, the use of a periodontal treatments, the extraction of teeth and/or the administration of antibiotics.

Without this oral care, your teeth are unable to achieve or sustain the normal function that they would have had if you did not suffer from the condition.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the costs of a mandibular repositioning device (MRD) including diagnostics and aftercare (codes G71*, G72 and G73*) are not reimbursed as oral care. A mandibular repositioning device is a medical aid used to treat snoring.
- please refer to clause B.12.3. for the terms and conditions.

B.12.2. Implant

Healthcare: what you are insured for

This healthcare involves the insertion of a dental implant:

- in the case of a severely shrunken, toothless jaw, to which the removable denture can be attached; and
- if you suffer from a severe developmental or growth disorder, or have an acquired disorder of the teeth/jaw/mouth, as referred to in clause B.12.1., and, without this type of dental care, your teeth are unable to achieve or sustain the normal function that they would have had if you did not suffer from the condition.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- a statutory personal contribution applies to the full denture attached to a dental implant. For more information, please refer to clause B.14.
- this healthcare may also be covered (to a greater extent) under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- please refer to clause B.12.3. for the terms and conditions.

B.12.3. Orthodontic care in exceptional circumstances

Healthcare: what you are insured for

Orthodontic care will be covered by your health insurance if:

- you satisfy the criteria specified in clause B.12.1.; and
- you suffer from a severe developmental or growth disorder of the teeth/jaw/mouth, which requires the involvement of other disciplines besides dental care for treatment.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- we do not reimburse the following:
- repair or replacement of braces damaged through intentional acts or negligence (codes F811B* and F811C**)**.

Terms and conditions (B.12.1., B.12.2. and B.12.3.)

General

- if, in the case of combined orthodontic treatment and dental surgery, prosthetic follow-up treatment is required, a multidisciplinary treatment plan will need to be devised by all of the healthcare providers involved.
- the care may be provided at your place of residence; you will need a written recommendation from the general practitioner or specialist for this.

Healthcare provider

- the healthcare available under clause B.12.1. is provided by a dentist, dental hygienist, dental surgeon, orthodontist or an authorised healthcare provider who is affiliated with a centre for oral care or a centre for dental care in exceptional circumstances.
- the healthcare available under clause B.12.2. is provided by a dentist or dental surgeon.
- the healthcare under clause B.12.3. is provided by an orthodontist or at a centre for dental care in exceptional circumstances;
- dental treatment performed under a general anaesthetic or sedation will be provided by an authorised healthcare provider:
  - in a centre for dental care in exceptional circumstances that has been recognised by the Dutch Central Consultative Body for Dental Care in Exceptional Circumstances ('Centraal Overleg Bijzondere Tandheelkunde', COBIJT); or
  - with whom we have agreements in place for this treatment.

Referral

In the case of insertion of dental implants, a dentist, orthodontist or dental implantologist needs to provide a referral before treatment commences.

Approval

- approval (see clause A.18.) is required for the healthcare specified in clause B.12.1.
  The request for approval must be supported by a written statement of the reasons from your dentist, along with a written treatment plan. We reserve the right to withdraw approval if:
  - the oral care is no longer necessary;
  - you seriously neglect your oral hygiene;
  - you fail to follow the advice given by the healthcare provider.
- approval (see clause A.18.) is required for the insertion of a dental implant (see clause B.12.2.). You must also have a severely shrunken, toothless jaw. The request for approval must be supported by a written statement of the reasons from your dentist or dental surgeon, along with a written treatment plan. You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.
- approval (see clause A.18.) is required for orthodontic care in exceptional circumstances (see clause B.12.3.). The request for approval must be supported by a written statement of the reasons from your orthodontist, along with a written treatment plan.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.13. Oral care up to the age of 18

Healthcare: what you are insured for

As well as the healthcare described in clause B.12., oral care up to the age of 18 comprises:

a. one routine preventive dental examination per year. Examinations may take place more frequently, where there are good dental grounds for this;
b. incidental dental consultations;
c. removal of tartar;
d. up to 2 fluoride treatments per year for children, once the permanent teeth have started to come through (i.e. not for the milk teeth);
e. application of protective enamel to the crests of molars (i.e. cavity-sealing enamel);
f. treatment of the teeth's supporting tissue, e.g. the gums (i.e. periodontal assistance);
g. anaesthesia (i.e. a local anaesthetic);
h. root canal treatment (i.e. endodontic care);
i. filling of teeth with plastic materials;
j. treatment of the masticatory (chewing) system (gnathology);
k. removable full dentures (conventional dentures), which may also involve implants, or a partial set of dentures;
l. replacement of one or more missing permanent incisors or canines (with non-plastic materials) and the insertion of dental implants. This is necessary when one or more of these permanent incisors or canines have not developed, or these teeth are missing as a direct result of an accident;
m. dental surgery, with the exception of the insertion of dental implants;
n. X-ray examination, with the exception of X-ray examination in connection with orthodontics;
o. New patient intake.

Please note!

- refer to clause A.21. for the general exclusions.
- an additional insurance package may cover this or a similar type of healthcare to a greater extent. Your Reimbursements Overview will show whether this is the case.
- the healthcare does not include:
  - crowns, bridges, implants, except in the case

of oral care in exceptional circumstances (see clause B.12.1.), or if the front teeth (i.e. incisors or canines) are missing as a direct result of an accident or because they have not developed;
  - orthodontic assistance and associated X-rays, except in cases of oral care in exceptional circumstances (see clause B.12.1.);
  - gum shields (code M61), except in cases of oral care in exceptional circumstances (see clause B.12.1.);
  - external whitening (code E97);
  - shaping and/or treatment of milk teeth (code M05);
  - a mandibular repositioning device (MRD) including diagnostics and aftercare (codes G71*, G72 and G73*). A mandibular repositioning device is a medical aid used to treat snoring;
  - simple bacteriological examination (code M32);
  - treatment of white spots (codes M80* and M81*);
  - insertion of skeletal anchorage devices in the context of orthodontic care, except in cases of orthodontic care in exceptional circumstances (see clause B.12.3).
  - orthodontic care required as a result of the insertion of autografts (code J39).
- the healthcare is not subject to a deductible.

Terms and conditions

General

- you are younger than 18.
- the care may be provided at your place of residence; you will need a written recommendation from the general practitioner or specialist for this.

Healthcare provider

The healthcare is provided by:

- a dentist;
- an authorised healthcare provider who is affiliated with a centre for oral care;
- an authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances;
- an authorised healthcare provider affiliated with a facility for youth dental care;
- an authorised healthcare provider affiliated with a facility for specialist medical healthcare;
- an authorised prosthodontist (with a referral from a dentist if the care concerns full implant-retained dentures or a partial set of dentures).
- the head of a team who has followed the specific training programme and has demonstrable specific expertise in the case of inserting autografts (autologous implants), code J39.

  Healthcare available under clause B.13.a to f inclusive, and i, may also be provided by a dental hygienist (insofar as he/she is appropriately qualified).

Approval

- approval (see clause A.18.) is required in cases of:
  - the replacement and/or filling of teeth with non-plastic materials;
  - the insertion of dental implants that are required in order to replace one or more permanent incisors or canines that are missing as a direct result of an accident or because they have not developed;
  - the insertion of dental implants for teeth that have not developed in the case of oligodontia, for the purpose of re-establishing the dental function;
  - the total costs (including technical costs) for the full upper or lower denture to be made and inserted by a dentist amounting to more than €650 per jaw;
  - the total costs (including technical costs) for the full upper or lower denture to be made and inserted by a prosthodontist amounting to more than €600 per jaw;
  - a panoramic dental X-ray (OPT, indicated by code X21);
  - - insertion of autografts (autologous implants) (code J39). The application is submitted by the head of the treatment team using the special application form for this treatment.

- your healthcare request must be supported by a written statement of the reasons from the dentist, along with a written treatment plan.
  We reserve the right to withdraw approval if:
  - the oral care is no longer necessary;
  - you fail to follow the advice given by the healthcare provider; or
  - you seriously neglect your oral hygiene.
- you will also need our approval for the following types of healthcare provided by a specialist dentist for oral disease, and dental surgeon:
  - treatment of the teeth's supporting tissue, e.g. the gums (i.e. periodontal care);
  - extraction of teeth under general anaesthetic or sedation;
  - jaw surgery (osteotomy);
  - insertion of a dental implant.

  You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list

of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.
- you will also need our approval for oral care provided in a centre for dental care in exceptional circumstances.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.14. Oral care from the age of 18

Healthcare: what you are insured for

In addition to the healthcare described in clause B.12., the healthcare also includes:

a. dental surgeon (specialist medical healthcare), i.e. oral care for surgery of the mouth, jaw and face, including:
   - specialist surgical oral care;
   - associated X-ray examination;
   - admission to a hospital (facility for specialist medical healthcare) in the lowest nursing care category for up to 1095 (3 x 365) days and, during the period of admission, the provision of specialist medical treatment, nursing and other care, allied healthcare, medicines, medical aids and dressings associated with the treatment.

b. removable full dentures: this consists of oral care in accordance with dentistry standards and includes:
   - reimbursement of 75% of the costs of making and inserting:
     - a removable full denture; or
     - a temporary removable full (immediate) denture; or
     - a removable full replacement denture; or
     - a removable full implant overdenture fitted to one or more natural teeth, for the upper and/or lower jaw;
   - reimbursement of 90% of the costs of repair and/or rebasing of:
     - an existing removable full denture; or
     - an existing removable full implant overdenture, whether or not this is fitted to dental implants.

c. implant-retained denture (full denture, attached to a dental implant). This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth. This involves oral care in accordance with dentistry standards and includes:
   - a reimbursement of 90% for the overdenture for the lower jaw; or
   - a reimbursement of 92% for the overdenture for the upper jaw.

d. denture on own upper or lower jaw (conventional removable full denture) together with implant-retained dentures on the other jaw (removable full denture attached to a dental implant), jointly declared using code J50. This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth. This comprises oral care in accordance with dentistry standards and includes reimbursement of 83% of the costs for both dentures. For the related mesostructure, the reimbursement is 90% if this is inserted in the lower jaw, and 92% if this is inserted in the upper jaw.

e. implant with crown for insured persons up to and including the age of 22: replacement of incisors or canines (with non-plastic materials) and the insertion of dental implants. This is necessary when one or more of the permanent incisors or canines have not developed, or the teeth are missing as a direct result of an accident that occurred before you reached the age of 18.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the healthcare does not include:
  - periodontal surgery by a dental surgeon (i.e. surgery on the teeth's supporting tissue, e.g. the gums);
  - insertion of a dental implant;
  - extractions, where there are no complications;
  - a mandibular repositioning device (MRD) including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid to alleviate sleep apnea.
  - orthodontic care covered under front tooth replacement (see clause B.14.e) if it is needed as a result of the insertion of autografts.
- you will only be entitled to what we have granted approval for.
- under this clause, we do not reimburse:
  - the statutory personal contribution of 25% for a full denture, immediate denture, replacement denture or overdenture;
  - the statutory personal contribution of 10% for the repair and/or rebasing of your full denture;
  - the statutory personal contribution of 10% for an implant overdenture for the lower jaw, of 8% for an implant overdenture for the upper jaw, or of 17% for a removable denture in

combination with an implant-retained denture.

This healthcare may be covered under an additional insurance package. Your Reimbursements Overview will show whether this is the case.

Terms and conditions

General

An admission must be considered a medical necessity in connection with the specialist surgical oral care.

Healthcare provider

- the specialist medical oral care, as described in clause B.14.a., is provided by a dental surgeon.
- the oral care related to the removable full denture, as described in clause B.14.b., is provided by:
  - a dentist; or
  - a prosthodontist; or
  - an authorised healthcare provider who is affiliated with a centre for oral care or a centre for dental care in exceptional circumstances; or
- a prosthodontist in the case of:
  - the manufacture and supply of a new, removable full denture for the upper and/or lower jaw, not fitted to implants or natural teeth (i.e. own teeth);
  - the refitting (rebasing) or repair of a removable full denture for the upper and/or lower jaw (whether or not this involves dental implants), not fitted to natural teeth (i.e. own teeth).
- the oral care related to the full denture attached to a dental implant, as described in clause B.14.c., is provided by:
  - a dentist; or
  - an authorised healthcare provider who is affiliated with a centre for oral care or a centre for dental care in exceptional circumstances; or
  - a prosthodontist if your dentist has referred you to a prosthodontist.
- oral care for insured persons up to the age of 22 needing replacement of teeth and insertion of dental implants, as specified in clause B.14.e., is provided by:
  - a dentist; or
  - a dental surgeon in the case of insertion of implants.

Referral

In cases where you need oral care from a dental surgeon, a centre for oral care, or a centre for dental care in exceptional circumstances, a dentist, orthodontist or general practitioner needs to provide a referral before treatment commences.

Approval

Approval (see clause A.18.) is required in cases of:

- the following healthcare provided by a dental surgeon:
  - treatment of the teeth's supporting tissue, e.g. the gums (i.e. periodontal care);
  - extraction of teeth under general anaesthetic or sedation;
  - jaw surgery (osteotomy);

  You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.
- insured persons up to the age of 22 needing replacement of teeth (with non-plastic materials) and insertion of dental implants. This is necessary when one or more of the permanent incisors or canines have not developed, or the teeth are missing as a direct result of an accident that occurred before you reached the age of 18. This also applies to situations in which:
  - as the result of an accident, a tooth has broken to such an extent that only a small part of the root remains. The remaining part of the root needs to be left in place so as not to disrupt the development of the jaw, but will need to be removed later because it will not be able to support a prosthetic device.
  - a tooth that has been knocked out in an accident has been put back in the socket and secured so as not to disrupt the development of the jaw, even though there is little chance that the tooth can ultimately be saved.

  The treatment history must show that the accident occurred and was recorded before the patient turned 18 and the remaining part of the root or the reinserted front tooth needs to be removed before the age of 23, right before the insertion of an implant;
- the total costs (including technical costs) for the full upper or lower denture to be made and inserted by a dentist or prosthodontist amounting to more than €650 per jaw;
- the full upper and/or lower denture (whether or not this involves dental implants) being replaced within five years of purchase. This does not apply to temporary full dentures or converting partial dentures made of synthetic resin or frame dentures with one or more elements into complete dentures.

If you use a non-contracted healthcare provider, you will also need to have requested approval from us beforehand where the following is involved:

- a fixed part of the suprastructure (for fastening the removable denture to the implants) and the removable denture (the implant-retained denture). You must also have a severely shrunken, toothless jaw.
- repair and/or rebasing of a removable denture fitted to implants (implant-retained dentures);
- repair or replacement of the fixed part of the suprastructure fitted to the implants and/or the part of the suprastructure in the denture.

Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.15. Medicines

B.15.1. Medicines, general

Healthcare: what you are insured for

The healthcare consists of the supply of, and provision of advice in relation to, medicines that are listed in the Medicines Reimbursement System (GVS). This relates to Appendices 1 and 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), the text of which is available on the government website at wetten.overheid.nl (in Dutch).
To find the relevant appendices in Dutch, type 'Regeling zorgverzekering' in the 'In de titel' box. You can scroll to the appendices ('bijlagen') using the sidebar.

The Pharmacy Regulations ('Reglement Farmacie') form part of these terms and conditions and include the list of medicines specified in Appendix 2 of the Dutch Health Insurance Regulations.
You can download a copy of the Pharmacy Regulations and/or the list of preferred medicines ('Lijst voorkeursmedicijnen'), or you can call us to request a copy of these.

B.15.1.a. Medicines

The Dutch Ministry of Health, Welfare and Sport has developed the Medicines Reimbursement System (GVS). This is a list of all registered medicines (Appendix 1) and registered medicines with further terms and conditions (Appendix 2) for which you are insured. Appendices 1 and 2 are available in the Dutch Health Insurance Regulations ('Regeling zorgverzekering') at wetten.overheid.nl (in Dutch).
The Medicines Reimbursement System (GVS) specifies whether a medicine will be reimbursed in full, or whether a statutory personal contribution applies.

Sometimes further terms and conditions apply to certain medicines, regarding the medical grounds for prescribing these for example. This applies to registered medicines with further terms and conditions (Appendix 2) and to non-registered medicines. You can read more about this in the Pharmacy Regulations ('Reglement Farmacie').
Non-registered medicines are pharmacy preparations (prepared through pharmaceutical compounding) for example, or medicines imported from abroad. The healthcare must involve rational pharmacotherapy, i.e. the treatment, prevention or diagnosis of a condition using medicine in a form that is suitable for you. Scientific research must have demonstrated that the medicine is efficient and effective. The medicine must also be the most economical available for the health insurance.

Please note!

- refer to clause A.21. for the general exclusions.
- some medicines are not reimbursed in full under the Medicines Reimbursement System (GVS); the part that is not reimbursed is the statutory personal contribution. you must pay a statutory personal contribution of €250 (maximum) per year.

  Example:
  Your medicine costs €100, €25 of which you have to pay yourself (personal contribution). The remaining €75 is set off against your deductible. Assuming you do not take any other medicines subject to a personal contribution, you have a personal contribution ten times: 10 x €25 = €250. After receiving that particular medicine ten times, the full amount for the medicine (€100) will be set off against any outstanding deductible.

  If the health insurance starts or ends during the course of the year, the bills already submitted will be recalculated proportionally and rounded off to whole euros. In that case, you only pay a proportional part of the statutory personal contribution for the part of the year that the health insurance policy was in effect.

  Recalculation example:
  You were insured with us on 1 January and your

policy ended on 1 March. During that period, you paid a total of €50 by way of your personal contribution for medicine under the Medicines Reimbursement System.
  - 2022 has 365 days. The period 1 January to 1 March 2022 has 60 days.
  - €250/ 365 = €0.6849 personal contribution per day
  - €0.6849 x 60 days = €41.09. We round this amount off, meaning your personal contribution for the period 1 January to 1 March is €41.
  - you have already paid €50. €50 minus €41 is €9, so we repay you €9.

- the healthcare does not include:
  1. alternative (homoeopathic and anthroposophic) medicines;
  2. medicines that are precautionary, or aimed at preventing illness in relation to trips abroad;
  3. medicines that are equivalent or almost equivalent to a registered medicine not included in the Medicines Reimbursement System (GVS), unless stipulated otherwise in a ministerial regulation (see clause B.15.4.);
  4. over-the-counter medicines and medicines used in a hospital, insofar as they are not covered by your health insurance, in accordance with Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Moisturising eye drops (artificial tears) are included under clause B.17.11. of our regulations on medical aids ('Reglement Hulpmiddelen');
  5. medicines for research or experimental use;
  6. medicines, as referred to in Article 40, clause 3, paragraph f of the Dutch Medicines Act ('Geneesmiddelenwet');
  7. medicines that are financed in another way, e.g. through a national insurance scheme, government funding or a subsidy;
  8. a medicine for which we do not have a preference, while we do have a preference policy for that medicine. For more information, see the explanation of preferred medicines in the Pharmacy Regulations ('Reglement Farmacie') and our list of preferred medicines ('Lijst voorkeursmedicijnen');
  9. medicines that are used for indications other than those specified in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'). This also applies if the additional terms and conditions are not met. See the explanation in this clause under 'Terms and conditions', 'Approval'. Further terms and conditions;
  10. personal care and cosmetic products, such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses, sun-care products, etc.;
  11. additional costs, e.g. administrative, import and/or postage costs;
  12. vitamins and dietary supplements;
  13. medicines whereby a claim can be made under a manufacturer's warranty or other compensation scheme, following the failure of the method of administration, related to a medical aid or consumer item where applicable;
  14. non-registered medicines, including nonregistered allergens. A pharmacy preparation or a medicine that is registered abroad may, under certain conditions, be eligible for reimbursement;
  15. medicines prescribed by an alternative doctor, or another type of healthcare provider not mentioned in this clause.
  16. esketamine nasal spray; this is covered under clause B.19.

Please note!
An additional insurance package may cover (to a greater extent) a similar type of healthcare and/or the statutory personal contribution. Your Reimbursements Overview will show whether this is the case.

B.15.1.b. Supply of medicines and advice
The healthcare includes the supply of medicines and the relevant advice and guidance provided when dispensing these medicines.

The following rules apply to the supply of medicines:
- the medicine may only be supplied to the insured person for whom it is intended, or to his/her carer, or to the healthcare provider responsible for administering the medicine;
- only where it is medically necessary, where a medicine is prescribed over a longer period of time it can be supplied in the form of medication rolls (also referred to as 'Baxter rolls') with a one, two or three-week supply. The medication roll consists of sachets which are linked together, with each sachet containing all the medication for a specific date and time.

The related advice consists of the following, as a minimum:
- guidance in relation to the use of a new medicine (first issue) or, if you have not used a

medicine for more than 12 months, additional guidance in relation to the second issue of a medicine;
- instruction in relation to a medicine that also requires the use of a medical aid;
- pharmacological support during visits to an outpatient clinic, hospitalisation and/or discharge from a hospital.

Please note!
- refer to clause A.21. for the general exclusions.
- the healthcare is not subject to the deductible if it concerns:
  - supplying and giving advice on preferred medicines. Our preferred medicines are specified on the list of preferred medicines ('Lijst voorkeursmedicijnen') on our website.
  - supplying and giving advice on medicines or nicotine replacement products that are part of a quit smoking course if these are prescribed by a contracted quit smoking healthcare provider;
- in all other cases, the healthcare is subject to the deductible.

This healthcare does not include:
- information and advice in relation to:
  - over-the-counter medicines (that are not reimbursed under clause B.15.3.); and
  - medicines aimed at preventing illness/disease while travelling abroad;
- provision of and instruction in the use of medical aids, where the associated medicines are paid for by the hospital;
- instruction in the use of medical aids that are required for medicines, if the medical aids are provided by someone other than a pharmacist or a dispensing general practitioner;
- the additional costs of submitting prescriptions and collecting medicines outside of normal opening hours. These are only covered under your health insurance in an emergency.

Terms and conditions

Preferred medicines
Within a group of interchangeable medicines, we designate one or more medicines as preferred medicines, on the basis of the lowest price; we called this 'product preference'. Within this group, you are only insured for the preferred medicine.
There will always be at least one medicine available to you containing the prescribed active ingredient in the appropriate strength and with the appropriate method of administration.
To find out which are preferred medicines, please see the list of preferred medicines ('Lijst voorkeursmedicijnen'). We may amend the list from time to time, in which case we will tell you about it on our website.
We also have what we refer to as a 'Lowest Price Guarantee' or 'price preference'.
You can read more about our preference policy in clause 1 of our Pharmacy Regulations ('Reglement Farmacie').

Healthcare provider
The medicines are supplied by or under the supervision of a pharmacist or a dispensing general practitioner.
This can also be in a foreign country, in which case:
- the active ingredient, dosage and method of administration of the medicine must be listed in the Dutch Medicines Reimbursement System (GVS);
- the reimbursement is in line with the reimbursement limit that has been set in the Netherlands (see clause 1.1 of the Pharmacy Regulations ('Reglement Farmacie'));
- the additional terms and conditions as specified in this clause (B.15.1.) apply.

Medicines from foreign countries
Invoices for medicines purchased abroad must be legible and complete. If the name, strength, quantity and method of administration of the medicine are not stated in full on the invoice, you must send us the patient information leaflet, box and/or labels (or a photo of these) along with your invoice.

Treatment proposal
General
The medicines must be prescribed by a general practitioner, doctor for the mentally disabled, geriatric specialist, doctor specialising in infectious diseases affiliated with a 'GGD' (regional health authority), medical specialist, dentist, dental surgeon, physician assistant, nursing specialist or obstetrician (taking into account their authority in relation to writing prescriptions and their field of expertise). All the information relating to this is provided in Article 36 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', 'Wet BIG'), which you will find (in Dutch) at wetten.overheid.nl.
For the additional conditions relating to the authority of a physician assistant and nursing specialist in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch

Society for the Promotion of Pharmacy (KNMP). Also see the definition in clause A.1.

Medicine supply periods
The healthcare only includes the supply of medicines on prescription (treatment proposal). A prescription is always given for a certain period only and the length of this period can differ for each type of medicine. The following supply periods apply to prescriptions (treatment proposal):

- 15 days or the smallest consumer package for a medicine that you are taking for the first time;
- 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy;
- 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics);
- a maximum of 30 days for medicines listed in the Dutch Opium Act ('Opiumwet'), with the exception of medicines for the treatment of ADHD, for which up to a 3-month supply may be provided;
- 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy;
- 12 months for 'the pill' (oral contraceptives);
- 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.

If a medicine comes under several of these categories, the shortest period applies.

No repeat prescriptions
Prescriptions for the following medicines do not have a maximum validity:

- 'the pill' (oral contraceptives); and
- insulin to treat diabetes ('diabetes mellitus')

You only need to have these medicines prescribed once and no repeat prescriptions are required. Your health insurance covers no more per year than the amount required for a 12-month period. A new prescription will be required if the medicine, dosage and/or the use of the medicine changes.

Approval
For some medicines listed in the Medicines Reimbursement System (GVS), further terms and conditions apply or approval is required (see clause A.18.). You will find these terms and conditions in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), the text of which is available on the government website at wetten.overheid.nl (in Dutch).

Clause 4 of our Pharmacy Regulations ('Reglement Farmacie') contains the list of medicines (active ingredients) requiring prior assessment, meaning we must determine in advance whether you satisfy the conditions for being prescribed this medicine, or the healthcare provider must do this on our behalf. The government may change the list in the Dutch Health Insurance Regulations ('Regeling zorgverzekering') over the course of a year, in which case we will post new regulations with the amended list online.

Medicines imported from foreign countries and not registered in the Netherlands
In accordance with Article 2.8, clause 1, paragraph b of the Dutch Health Insurance Decree ('Besluit zorgverzekering'), the prescriber must request approval from us in advance for the medicines specified in the header above, subject to the following conditions:

- the medicine must be intended for a patient who has an illness that does not occur more frequently in the Netherlands than in 1 in 150,000 inhabitants; and
- no treatment is possible with a medicine registered in the Netherlands or one prepared in the Netherlands through pharmaceutical compounding; and
- the treatment, prevention or diagnostics are in a form that is suitable for you; and
- the efficacy and effectiveness must have been proven in scientific literature; and
- the treatment is the most economical for you and the health insurance.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.15.2. Medication assessment in the event of chronic use of medicine

Healthcare: what you are insured for

In the case of chronic use of multiple medicines, the healthcare comprises a periodic medication assessment (at least once every 12 months) when required from a medical and pharmaceutical perspective. Please see the Pharmacy Regulations ('Reglement Farmacie') for more information.

Please note!

- refer to clause A.21. for the general exclusions.

- this healthcare is subject to the deductible.

Terms and conditions

General
The terms and conditions specified in clause 2 of the Pharmacy Regulations ('Reglement Farmacie') must be fulfilled.

Healthcare provider
The healthcare is provided exclusively by a pharmacist or dispensing general practitioner who has successfully completed a supplementary training course that we consider sufficient for carrying out a medication assessment.

Treatment proposal
A pharmacist, general practitioner (dispensing or otherwise), doctor for the mentally disabled, geriatric specialist or medical specialist must have determined that the medication assessment is required from a medical and pharmaceutical perspective.

Approval
Approval (see clause A.18.) is only required if you need a medication assessment for a different medical or pharmaceutical reason and the general terms and conditions specified above are not fulfilled.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.15.3. Over-the-counter medicines and proton-pump inhibitors

Healthcare: what you are insured for

The healthcare comprises the medicines listed below in the case of chronic use. Certain types of these medicines are also available without a prescription.

Over-the-counter medicines and proton-pump inhibitors
These are medicines that come under one of the following categories:

- laxatives;
- medicines to treat allergies;
- medicines to treat diarrhoea;
- medicines to evacuate the stomach;
- artificial tears;
- proton-pump inhibitors, including medicines that have a proton-pump inhibitor as an ingredient.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- this healthcare does not include medicines (prescription-only or over-the-counter) and proton-pump inhibitors that you take during the first 15 days.

Terms and conditions

General

- medicines (over-the-counter and prescription-only) are subject to the terms and conditions set out in clause B.15.1;
- the medicine (prescription-only or over-the-counter) and proton-pump inhibitor must be listed in Appendices 1 and 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering') and in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index';
- the prescriber expects that you will be needing the medicine (prescription-only or over-the-counter) for longer than 6 months to treat a chronic illness. The prescriber must state on the prescription that the medicine being prescribed is for chronic use.

Treatment proposal
A general practitioner, doctor for the mentally disabled, geriatric specialist, medical specialist, dentist, dental surgeon, obstetrician, nursing specialist or physician assistant must have determined that the medicines (prescription-only or over-the-counter) are medically necessary for chronic use.

Approval
Approval may be required because medicines (prescription-only and over-the-counter) and proton-pump inhibitors are subject to additional terms and conditions (see clause B.15.1. under 'Approval').

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.15.4. Medicines prepared by the pharmacy

Healthcare: what you are insured for

This healthcare comprises medicine prepared for a specific prescription by or on the instructions of a pharmacist (pharmaceutical compounding).

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- compounded medicines that are equivalent or almost equivalent to a registered medicine not included in the Medicines Reimbursement System (GVS) are only reimbursed if stipulated in a ministerial regulation, The government can designate a medicine if it is:

  - is a compound for use during a 'bridging period', i.e. an application for the medicine to be included in the Medicines Reimbursement System (GVS) has been submitted, but a decision has not yet been made;
  - is one that has not been included in the Medicines Reimbursement System (GVS) because it is too expensive, while the price of the compounded medicine would be acceptable.
- compounded medicines that are equivalent or almost equivalent to a medicine that is neither registered nor included in the Medicines Reimbursement System (GVS) are not reimbursed.
- a statutory personal contribution applies to compounded medicines that include a medicinal ingredient for which a statutory personal contribution applies.

Terms and conditions

General

- medicines are subject to the terms and conditions set out in clause B.15.1.
- rational pharmacotherapy must be involved. See clause B.15.1.a. 'Medicines'.
- for certain preparations, we will need additional information in order to assess whether they qualify as rational pharmacotherapy. For more information, please see clause 3 of the Pharmacy Regulations ('Reglement Farmacie') on the reimbursement of compounded medicines.
- the compounded medicine is not a product within the definition of the Dutch Commodities Act ('Warenwet').

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.16. Dietary preparations

Healthcare: what you are insured for

The healthcare comprises the provision of polymer, oligomer, monomer and modular dietary preparations as liquids and/or for tube feeding.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the healthcare does not include:
  - dietary supplements and vitamin preparations that are available without a prescription;
  - slimming products, not even if they are registered as a dietary preparation;
  - special dietary products such as lactose-free cheese, gluten-free bread, goat's or horse's milk, etc.;
  - thickening powders;
  - nutrients administered directly into the bloodstream; these are reimbursed under clause B.15.1.

Terms and conditions

General

The following terms and conditions apply to dietary preparations:

- the dietary preparation you have been prescribed must be registered as a dietary preparation and included as such in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index';
- the terms and conditions for dietary preparations as set out in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering') (see clause B.15.1.: 'Approval, Further terms and conditions') must be fulfilled;
  - special dietary products (normal but adapted food) have not proven effective for you;
  - other special food products have not proven effective for you and you are suffering from a metabolic disorder and/or a food allergy and/or a resorption disorder and/or illness-related malnutrition, or are at risk of such (as determined using a formally established method);
  - you are reliant on dietary preparations in accordance with the relevant professional group's guidelines that apply in the Netherlands.

  The text of the Dutch Health Insurance Regulations ('Regeling zorgverzekering') is available on the government website at wetten.overheid.nl (in Dutch).

In the case of an allergy, the costs of the dietary preparations are only reimbursed from the moment that it is proven that the insured person has the allergy.
For example, it is suspected that you have a cow's milk protein allergy and so a double-blind, placebo-controlled food challenge is conducted. Only after it has been established, based on the results of this test, that you have a milk allergy are you entitled to reimbursement. Costs incurred during the testing period prior to the double-blind, placebo-controlled food challenge are not reimbursed.

Treatment proposal

A youth healthcare doctor, doctor for the mentally disabled, geriatric specialist, medical specialist, nursing specialist, or dietician must have

determined that the dietary preparations are medically necessary.

Approval

Approval (see clause A.18.) in the form of a doctor's statement is required. The healthcare provider prescribing the dietary preparation must complete the national doctor's statement. On the basis of this doctor's statement, we or a healthcare provider with whom we have an agreement will assess whether you or the prescription satisfy the terms and conditions.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.17. Medical aids

Healthcare: what you are insured for

B.17.1. General

The healthcare comprises the provision of functioning medical aids, for ownership or on loan, and the replacement, adjustment and repair of these medical aids, as well as instruction and guidance in their use. 'Functioning' is taken to mean that the medical aids are ready for use on delivery.

'Medical aids' are those referred to and/or specified in the Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Certain medical aids are named specifically in the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), while others are not. The text of the Dutch Health Insurance Regulations ('Regeling zorgverzekering') is available on the government website at wetten.overheid.nl (in Dutch).

Entitlement to the medical aid is specified in accordance with its function — you are insured for a functioning medical aid to compensate for the specified functional impairment.

The medical aid must comply with the latest practical and theoretical standards, i.e. it must have been shown to be effective for its intended purpose. An exception applies to conditionally authorised healthcare. Please see clauses A.3.3. and B.22. for more information.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- the healthcare does not include:
  - costs for the normal use of the medical aid, such as costs of energy consumption and replacing batteries. However, these costs are covered by your health insurance if this is stated in the regulations on medical aids ('Reglement Hulpmiddelen');
  - medical aids that come under the claims provided under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo);
  - medical aids and dressings supplied as part of and during admission or a specialist medical treatment (see clause B.4. for more information);
  - medical aids that do not comply with the latest practical and theoretical standards, unless they come under clause B.22.;
  - medical aids or modifications to medical aids if they are used exclusively or predominantly in the working or teaching environment, unless stated otherwise in the regulations on medical aids ('Reglement Hulpmiddelen');
  - commonly used aids, i.e. aids that do not have a direct relationship to a limitation or disorder you have, such as computers and mobile phones for example, and/or permanent medical aids that are not excessively expensive, like caps, scarves, turbans, walking frames and adapted eating utensils;
  - inexpensive aids for activities of daily living, such as a jar opener or a reacher/grabber.
- the following medical aids are, in general, not covered by your health insurance, or are only covered under certain terms and conditions. However, they may be covered under your additional insurance. This applies to:
  - bedwetting alarm;
  - vision aids;
  - orthotic insoles;
  - medical aids for foot care;
  - home monitor;
  - medical aids for ADLs;
  - home care items;
  - support pessary;
  - test strips for non-insulin-dependent diabetes patients;
  - personal alarm (social alarm);
  - condoms;
  - braces and bandages;
  - epileptic seizure alarm;
  - cranial orthosis.

  For more information, please see clause D.4.
  some medical aids covered by your health insurance are not reimbursed in full and are subject to, for instance, a statutory personal contribution or a statutory maximum reimbursement. Where this applies, this is stated under the relevant medical aid in our regulations on medical aids ('Reglement Hulpmiddelen'). You can also find information under clause D.4.

Tip:
Additional insurance packages also provide reimbursement for certain medical aids. Your Reimbursements Overview will show whether this is the case.

B.17.2. 'Reglement Hulpmiddelen'
The medical aids referred to in clause B.17.1. are included in our regulations on medical aids ('Reglement Hulpmiddelen'), which form part of this health insurance. The regulations on medical aids ('Reglement Hulpmiddelen') also specify:

- the terms and conditions for entitlement to these medical aids;
- whether or not approval from us is required;
- the requirements we stipulate for the medical aid and/or the healthcare provider;
- the amount of the statutory personal contribution or maximum reimbursement, where applicable.

You can view the regulations on medical aids ('Reglement Hulpmiddelen') on our website or we can provide a copy on request.

B.17.3. Personal contribution or maximum reimbursement
A statutory personal contribution or statutory maximum reimbursement applies to certain medical aids. Please see the regulations on medical aids ('Reglement Hulpmiddelen') to find out which medical aids these are. If you obtain the medical aid from a healthcare provider who has a contract with us for this care, we will pay the healthcare provider and subsequently settle the statutory personal contribution with you, unless the regulations on medical aids ('Reglement Hulpmiddelen') stipulate otherwise.

If you obtain the medical aid from a non-contracted healthcare provider, you pay the healthcare provider and send us the bill. When we settle the bill with you, we will immediately take into account the statutory personal contribution or maximum reimbursement.

Please note!
This statutory personal contribution and/or an additional reimbursement on top of maximum amounts may be covered through an additional insurance package; Your Reimbursements Overview will show whether this is the case.

B.17.4. Care for the medical aid
You are responsible for the medical aid you own or have on loan. You must, in any case, observe the guidelines and/or warranty conditions of the manufacturer and/or healthcare provider.
If a medical aid we have provided for you (either permanently or on loan) is damaged as the result of negligence on your part, costs relating to this damage (including the costs of repair and replacement) are not covered under your health insurance. If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.

Terms and conditions

General

- you must satisfy the terms and conditions we have stipulated for the medical aid in question in the terms and conditions of insurance and the regulations on medical aids ('Reglement Hulpmiddelen').
- the medical aid must meet the requirements that apply to that medical aid in the regulations on medical aids ('Reglement Hulpmiddelen').
- given your needs and taking into account the provision of effective healthcare, you are reasonably reliant on a medical aid of that nature and to that extent.
- the medical aid is, for you, necessary and fit-to-purpose, and it is not excessive, unnecessarily expensive or unnecessarily complicated. We and/or the healthcare provider with a contract for this healthcare will determine whether these requirements have been met.
- there must be specific medical grounds for requiring the medical aid. If these medical grounds are stipulated by law, this will be listed along with the relevant medical aid in the regulations on medical aids ('Reglement Hulpmiddelen').

Healthcare provider
The regulations on medical aids ('Reglement Hulpmiddelen') will state whether, for a particular medical aid, we have specific requirements that apply to a certain healthcare provider.

Prescription
Prior to the start of the treatment, you need a referral and/or prescription for the use of the medical aid from a doctor or another healthcare provider authorised to issue this. The regulations on medical aids ('Reglement Hulpmiddelen') specify, for each medical aid, who is authorised to write the referral letter or prescription for that medical aid.

Approval

- approval (see clause A.18.) is required if this is stated for that particular aid in the regulations on medical aids ('Reglement Hulpmiddelen').
- we may amend our approval policy for a particular medical aid, in which case the terms and conditions set out in our regulations on medical aids ('Reglement Hulpmiddelen') will change as

well. We will also tell you about it on our website. If you request approval for the provision of a medical aid, the terms and conditions in effect at the time we receive your request will apply.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.17.5.
Deleted.

B.18. Transport

B.18.1. Ambulance

Healthcare: what you are insured for

The healthcare includes:

- patient transport by ambulance as referred to in Article 1, Paragraph 1 of the Dutch Ambulance Facilities and Services Act ('Wet ambulancevoorzieningen') over a maximum distance of 200 kilometres for a one-way journey, unless you have approval from us for journeys over a longer distance, or in the case of urgent ambulance transport;
- patient transport by another means if transport by ambulance is not possible and if you have received prior approval from us for transport by the other means;
- the operating costs directly linked to the use of an Automated External Defibrillator (AED) that are charged to the ambulance service (i.e. the costs of the electrode pads).

Under the Dutch Ambulance Facilities and Services Act ('Wet ambulancevoorzieningen'), an ambulance is defined as 'a motor vehicle, boat or helicopter equipped to transport sick or injured people'.

Example 1:
You are at sea (either within or outside Dutch territorial waters) and you have an accident, with the result that you need to be transported by helicopter. This helicopter transport is also covered by your health insurance if you are transported to the nearest land (in the Netherlands or another country). In such a case, your reason for being at sea – as a professional diver, sports diver, oil rig worker, fisherman, etc. – is irrelevant.

Example 2:
You are in a foreign country and become sick. Given your medical situation, transport by aeroplane is the most suitable way to transport you to the nearest hospital. In this case, the cost of your aeroplane ticket is covered by your health insurance. However, once you have recovered and fly back to where you came from in the foreign country, given that you are no longer sick, the cost of the return aeroplane ticket is not covered by your health insurance.

In an emergency, always contact the Helpline/emergency service.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- this healthcare is not covered if the costs can be reimbursed under the Dutch Long-Term Care Act (Wlz) or the Dutch Social Support Act (Wmo).

Terms and conditions

General

- in this context, patient transport means:
  - patient transport in the Netherlands, or in your country of residence if you live in a foreign country, i.e.:
    transport of an insured person by ambulance:
    - between the insured person's home address (temporary or permanent) or the location of the accident or sudden illness; and
    - the nearest location for treatment, nursing and/or healthcare or, if suitable healthcare is not available there, to a location further away; or
    - between the location for treatment, nursing and/or healthcare; and
    - the home or another residence where the insured person will be staying if this person will not be able to, within reason, receive the care needed at his or her own home;
  - patient transport during a temporary stay in a foreign country.
- at the location of treatment, nursing and/ healthcare, you receive the healthcare that is covered under your health insurance policy, the Dutch Youth Act ('Jeugdwet') in the case of mental healthcare, or the Dutch Long-Term Care Act (Wlz), as referred to in Article 3.1.1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering').
- the patient transport by ambulance is medically necessary because any other type of transport (by car, public transport or taxi) would not be responsible for medical reasons.

Healthcare provider
The ambulance service has a recognised permit.
Treatment proposal

A general practitioner, doctor for the mentally disabled, geriatric specialist, medical specialist, physician assistant or nursing specialist must have determined that the patient transport by ambulance is medically necessary. This does not apply if the event of urgent ambulance transport.

Approval

Approval (see clause A.18.) is required if:

- you are being transported more than 200 kilometres on a one-way journey; or
- you want to use a different type of transport, because transport by ambulance is not possible.

Please ask us for a healthcare recommendation in advance if you are in any doubt about the insurance.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.18.2. Transport (patient transport by car, public transport or taxi) or accommodation costs

Healthcare: what you are insured for

The healthcare includes:

- patient transport:
  - by car;
  - in the lowest class of public transport; or
  - by taxi;

  over a maximum distance of 200 kilometres for a one-way journey, unless you have approval from us for journeys over a longer distance;
- patient transport by another means if patient transport by car, public transport (in the lowest class) or taxi is not possible and if you have received prior approval from us for transport by the other means;
- transport of an escort and, in exceptional cases, two escorts. Having an escort must be required or the insured person being escorted must be under the age of 16. In this context, a guide/assistance dog is also considered to be an escort.

A reimbursement of €0.32 per kilometre applies to patient transport using a private or rental car.

The distance of the journey is determined using the latest version of the Routenet route planner (which can be consulted for free online), by entering the postcode for the starting point and for the destination to determine the quickest route. The reimbursement is based on full kilometres, with rounding off being done in the usual way.

- reimbursement of the costs of accommodation up to a maximum of €77.50 per night instead of patient transport or the reimbursement of costs for such.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- a statutory personal contribution or exclusions apply to the healthcare:
  - you must pay a statutory personal contribution of €111 per year for patient transport;
  - you are not insured for patient transport to and from the location where you receive the healthcare if the healthcare you are receiving is reimbursed under your additional insurance package;
  - you are not insured for patient transport if this concerns transport to and/or from organised daytime activities and/or day treatment in a facility providing care under the Dutch Long-term Care Act (‘Wet langdurige Zorg, Wlz).
  - rental costs for a rental car are not covered by your health insurance.
- for reasons of efficiency, you may have to travel with several insured persons if you are transported by taxi;
- a statutory personal contribution does not apply to the costs of accommodation;
- if you request and receive approval from us for reimbursement of the costs of accommodation, you are not entitled to patient transport or the reimbursement of the costs of such during the treatment;
- transport to and from the place you are staying during treatment is covered under patient transport. Transport from the place you are staying to the hospital and back to the place you are staying is not covered under the patient transport clause;
- the statutory personal contribution for this healthcare and/or additional healthcare may possibly be covered under an additional insurance package. Your Reimbursements Overview will show whether this is the case.

Terms and conditions

General

Patient transport

In this context, patient transport means:

- patient transport in the Netherlands, or in your country of residence if you live in a foreign country;
- the transport of an insured person by car, public transport or taxi to:
  - a healthcare provider or facility where you will be treated and/or provided nursing care; and
  - back to your home (temporary and/or

permanent), or to another place of residence if you will not be able to receive the necessary care at your own home;
- patient transport for treatment, nursing or healthcare during a temporary stay abroad.

The patient transport is required because:
a. you will be undergoing kidney dialysis;
b. you are being treated for cancer and will be undergoing chemotherapy, radiotherapy or immunotherapy;
c. you are only able to get around in a wheelchair. The healthcare you receive at the healthcare provider or facility to which you are being transported must come under the cover of this health insurance or the Dutch Youth Act ('Jeugdwet') in the case of mental healthcare, or the Dutch Long-Term Care Act (Wlz), as referred to in Article 3.1.1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering');
d. your sight is impaired to such an extent that you are unable to travel without an escort. The healthcare you receive at the healthcare provider or facility to which you are being transported must come under the cover of this health insurance or the Dutch Youth Act ('Jeugdwet') in the case of mental healthcare, or the Dutch Long-Term Care Act (Wlz), as referred to in Article 3.1.1 of the Dutch Health Insurance Decree ('Besluit zorgverzekering');
e. you are under the age of 18 and require nursing and care due to complex somatic symptoms or a physical disability. In this case, the insured person requires permanent supervision or needs to have healthcare available nearby 24 hours a day;
f. you have been referred for geriatric rehabilitation in accordance with clause B.4.6.2.;
g. you have been prescribed day treatment that is provided in a group and is part of a healthcare programme for people with chronically progressive degenerative disorders, acquired brain injury or intellectual disability, as referred to in clause B.28.1.

In the case of kidney dialysis, and for chemotherapy, radiotherapy or immunotherapy for the treatment of cancer, patient transport also includes transport to attend consultations, tests and check-ups that are necessary as part of the treatment.

If you are using patient transport because you are undergoing kidney dialysis or being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy, you are only insured for patient transport to and from the location where you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy.

Hardship clause
The 'hardship clause' applies in certain cases i.e. where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and checks that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.

Explanation:
We use a formula and other information to determine whether you are entitled to patient transport under the hardship clause. Your request for this transport must be accompanied by a statement from your attending doctor. The healthcare you receive at the healthcare provider or facility to which you are being transported must come under the cover of this health insurance or the Dutch Long-Term Care Act (Wlz).
To determine whether you qualify for patient transport under the hardship clause, we use the following formula:
number of months' treatment x number of treatments per week x 52/12 (i.e. number of weeks in a year) x (number of kilometres in a one-way journey) x 0.25 (this is the weighting factor).
If the result is 250 or higher, you are also insured for patient transport. The distance of the journey is determined using the latest version of the Routenet route planner (which can be consulted for free online), based on the quickest route. The reimbursement is based on full kilometres, with rounding off being done in the usual way.

Example:
5 (number of months' treatment) x 2 (number of treatments per week) x 52/12 x 26 (distance in kilometres) x 0.25 (weighting factor) = 281.67. The result is higher than 250, meaning you are entitled to reimbursement for patient transport.
If your situation relating to this transport changes, you must notify us as soon as possible.

Accommodation costs
You are entitled to a reimbursement of accommodation costs if a stay outside the hospital is medically necessary in connection with specialist medical care as provided by medical specialists, without allied healthcare, nursing or other care (not including informal care).
An example of a medical necessity is needing to be at an expert hospital within 60 minutes of receiving CAR-T cell therapy. If your home address is more than 60 minutes from an expert hospital, you are entitled to reimbursement of accommodation costs

for as long as this medical necessity exists.

You are also entitled to reimbursement of accommodation costs if:
- on the basis of your medical indication or the hardship clause, you qualify for patient transport under the provisions of this clause; and
- you would require the patient transport on at least three consecutive days; and
- you have submitted an application for reimbursement of the costs of accommodation instead of being provided patient transport or being reimbursed for the costs of such, and have received our approval for this.

Healthcare provider
If the patient transport is by taxi, the taxi operator must be a recognised operator (with the 'TX Keur' quality mark for taxis) and must be properly licensed.
Approval
Approval (see clause A.18.) is required. This also applies when:
- you are being transported more than 200 kilometres on a one-way journey; or
- you are being transported by means other than by car, public transport (in the lowest class) or taxi – if you are transported by boat, for example.

Given that the healthcare involved must be effective, we will assess whether you can use public transport, private transport or a taxi.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.19. Mental healthcare

Clause B.19. covers mental healthcare. The Mental Healthcare Regulations ('Reglement GGZ') form part of this clause. These regulations provide additional information about mental healthcare and specify the further terms and conditions that need to be fulfilled for each aspect of care.
You can view the Mental Healthcare Regulations ('Reglement GGZ') on our website or we can provide a copy on request.

B.19.1. Outpatient mental healthcare

Healthcare: what you are insured for

You are insured for psychological, psychotherapeutic and psychiatric consultations. This applies to:
- diagnostics (i.e. identification of a suspected condition) with the intention of starting
- treatment of a psychological disorder.

Evidence-based e-Health can also be used as part of a blended care programme, by which we mean a complete programme of treatment initiated and completed under the responsibility of a healthcare provider. During such a programme, rather than just receiving treatment in person (face-to-face), you also receive some of the treatment online (digital contact) using a special treatment module.

Please note!
- this healthcare is subject to the deductible.
- the main exclusions are listed in the Mental Healthcare Regulations ('Reglement GGZ').
- refer to clause A.21. for the general exclusions.

Terms and conditions

General
- section 2.2 of the Mental Healthcare Regulations ('Reglement GGZ') provides additional information and more details on the matters covered below.
- the healthcare can be provided on an individual basis or in a group.
- the healthcare takes place at the practice of the attending healthcare provider or at a facility permitted to operate in the Netherlands under the Dutch Healthcare Institutions (Accreditation) Act ('Wet toelating zorginstellingen', WTZi).

Healthcare provider
- every healthcare provider has approved and valid quality regulations that have been assessed based on the latest valid national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ') as included in the Register for Quality Standards and Measuring Instruments ('Register voor kwaliteitsstandaarden en Meetinstrumenten') of 'Zorginstituut Nederland' (ZiNI). The healthcare providers can be found at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.
- the coordinating practitioner (responsible for drawing up the care needs assessment and coordinating) as referred to and designated in the latest valid national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'), holds final responsibility for the healthcare provided.
- an insured person whose treatment started while they were still covered by the Dutch Youth

Act ('Jeugdwet') and whose treatment continues after they reach the age of 18 can continue this treatment under their existing coordinating practitioner, as long as this coordinating practitioner is specified in the transitional arrangement as described in the latest national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.
- highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare. This concerns very serious or uncommon problems or a combination of complaints that are difficult to treat. This healthcare is very specialised and provided in a facility.

Referral
A general practitioner, company doctor, emergency care doctor, medical specialist, coordinating practitioner or doctor specialising in care for the homeless needs to provide a referral before treatment commences.
You can find information on further terms and conditions and exceptions relating to referrals in clause 2.2 of the Mental Healthcare Regulations ('Reglement GGZ').
Treatment proposal
The coordinating practitioner has established that the healthcare is medically required, assesses whether the healthcare is suited for the mental healthcare need and subsequently records the prescription in a treatment plan. This treatment plan is discussed with you and then finalised.
Approval
- the healthcare provider who has a contract with us for this healthcare will assess on our behalf whether your condition comes under your insured healthcare. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
- however, if the treatment is provided by a non-contracted healthcare provider our approval is required prior to treatment commencing (see clause A.18.).
- you always need approval for treatment using esketamine nasal spray.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.19.2. Deleted

B.19.3. Inpatient mental healthcare

Healthcare: what you are insured for

You are insured for medically required inpatient treatment of complex to very complex psychological disorders. This concerns admission to a facility:
- for an uninterrupted period of a maximum of 1095 (3 x 365) days. Additional terms and conditions regarding admission and reimbursement are specified in the Mental Healthcare Regulations ('Reglement GGZ');
- including daytime activities and expressive therapy (e.g. music therapy or psychomotor therapy).

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.

Terms and conditions

General
- the inpatient mental healthcare can be provided on an individual basis or in a group.
- section 3 of the Mental Healthcare Regulations ('Reglement GGZ') provides additional information and more details on the matters covered below.
- the healthcare is provided in a facility permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza), specifically:
  - the psychiatric ward of a hospital that provides healthcare covered by the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw);
  - a facility for specialist mental healthcare that provides healthcare covered by the Dutch Health Insurance Act (Zvw) and/or the Dutch Long-Term Care Act (Wlz).

Healthcare provider
- every healthcare provider has approved and valid quality regulations that have been assessed based on the latest valid national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ') as included in the Register for Quality Standards and Measuring Instruments ('Register voor kwaliteitsstandaarden en Meetinstrumenten') of 'Zorginstituut Nederland' (ZiNl). The healthcare providers can be found at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.
- the coordinating practitioner (responsible for drawing up the care needs assessment and

coordinating) as referred to and designated in the latest valid national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'), holds final responsibility for the healthcare provided. A coordinating practitioner with final responsibility is commonly a psychiatrist, clinical psychologist or clinical neuropsychologist, for example.

- an insured person whose treatment started while they were still covered by the Dutch Youth Act ('Jeugdwet') and whose treatment continues after they reach the age of 18 can continue this treatment under their existing coordinating practitioner, as long as this coordinating practitioner is specified in the transitional arrangement as described in the latest national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.
- highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare. This concerns very specialised inpatient healthcare to treat very serious or uncommon problems or a combination of complaints that are difficult to treat.

Referral
A general practitioner, company doctor, emergency care doctor, medical specialist, coordinating practitioner or doctor specialising in care for the homeless needs to provide a referral before treatment commences. You can find information on further terms and conditions and exceptions relating to referrals in clause 3 of the Mental Healthcare Regulations ('Reglement GGZ').

Treatment proposal
The coordinating practitioner has established that the healthcare is medically required, assesses whether the healthcare is suited for the mental healthcare need and subsequently records the prescription in a treatment plan.
This treatment plan is discussed with you and then finalised.

Approval

- the healthcare provider who has a contract with us for this healthcare will assess on our behalf whether your condition comes under your insured healthcare. Our prior approval is not required in this case. A list of these healthcare providers is available on our website.
- however, if the treatment is provided by a non-contracted healthcare provider our approval is required prior to admission (see clause A.18.).
- you always need approval for treatment using esketamine nasal spray.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.20. Deleted

B.21. Prevention

B.21.1. Deleted

B.21.2. Quitting smoking

Healthcare: what you are insured for

You are insured for coaching to help you quit smoking once in a calendar year. Medicines or nicotine substitutes (pharmacotherapy) are only reimbursed in combination with behavioural support in the form of individual (in person, by telephone, online) or group coaching and support with a quit smoking coach in accordance with an accredited quit smoking course. Medicines or nicotine substitutes are reimbursed under this clause, unless the medicine or nicotine substitute is registered in the Medicines Reimbursement System (GVS), in which case it will be reimbursed under the terms of clause B.15.1.

Please note!

- refer to clause A.21. for the general exclusions.
- you are only insured for the cost of medicines or nicotine substitutes if these are part of the quit smoking coaching.
- the quit smoking course is not subject to the compulsory deductible if the healthcare is provided by a contracted quit smoking healthcare provider.
- the medicines or nicotine substitutes are not subject to the compulsory deductible if:
  - they are prescribed by a contracted quit smoking healthcare provider; and
  - they are part of the quit smoking course.
- in all other cases, the healthcare and the quit smoking medicines/aids are subject to the deductible.

Terms and conditions

General
Quit smoking coaching consists of interventions aimed at a change in behaviour, if necessary with the help of 'proven effective' pharmacotherapy

(medicines or nicotine substitutes). Such pharmacotherapy can never be used without behavioural support.
The actual healthcare and support during the quit smoking course are tailored to you and, if necessary, adjusted by the healthcare provider gradually during the care process.

Healthcare provider

- the behaviour-changing support is provided by a general practitioner, medical specialist, healthcare psychologist or quit smoking coach.
- the general practitioner, medical specialist or a quit-smoking coach must be listed on the Quality Register for Quit Smoking Coaches ('Kwaliteitsregister Stoppen met Roken') and have been trained to provide intensive counselling for those trying to quit smoking.
- if medicines or nicotine substitutes are required in addition to the behavioural support, they must be provided by a supplier contracted by us for quit smoking services, or by a pharmacy.

Please note!

- if you have a policy that provides 'in-kind' cover, it is likely that your local pharmacy is not contracted for the quit smoking medicines or nicotine substitutes. Please see our website to find out which suppliers have a contract with us — simply enter 'Stoppen met roken' in the search box.
- if you have a policy that provides 'in-kind' cover, a healthcare psychologist can provide the healthcare, but might not have a contract with us for quit smoking interventions. Please see our website to find out which other healthcare providers are contracted for this healthcare — simply enter 'Stoppen met roken' in the search box.
- if you are being treated for another addiction as part of mental healthcare, the quit smoking course will also come under the mental healthcare programme for the other addiction.

Treatment proposal

- if the pharmacotherapy for the quit smoking coaching is prescribed by your general practitioner, a prescription with the letters SMR (initialisation for the Dutch term for quit smoking) is sufficient.
- healthcare providers who do not have a contract with us for quit smoking interventions will need to refer you to your general practitioner for the pharmacotherapy.
- assuming they have the authority to write such prescriptions (see clause B.15.1.b under 'Treatment proposal'), healthcare providers who have a contract with us for quit smoking interventions must prescribe the pharmacotherapy using the quit smoking medicines application form ('Geneesmiddelen bij het stoppen met roken'). This form, which can be downloaded from our website, includes a description of the prescribed procedure.
- you do not need a treatment proposal or referral for the behavioural support during a quit smoking course.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.22. Conditional healthcare

Healthcare: what you are insured for

Conditional healthcare comprises the following healthcare and services designated for a limited time under the Dutch Health Insurance Regulations ('Regeling zorgverzekering'):

a. until 1 October 2022, autologous fat transfer (AFT) to the breast as a new breast reconstruction procedure;
b. until 1 July 2022, treatment of unresectable (stage 3C) or distant metastatic (stage 4) melanoma with tumour-infiltrating lymphocytes;
c. until 1 August 2022, dendritic cell therapy for patients with stage 3B or stage 3C melanoma (a specific form of skin cancer) after complete surgical excision (removal);
d. until 1 October 2022, the treatment of patients with gastric cancer with peritoneal metastases is an experimental treatment, consisting of an operation (partial or total removal of the stomach, and removal of the peritoneal metastases) in combination with hyperthermic intraperitoneal chemotherapy (HIPEC);
e. until 1 January 2023, treatment of patients aged 18 to 65 with BRCA1-like, stage 3 hereditary breast cancer, whereby the patient is treated using high-dose chemotherapy and stem-cell transplant;
f. until 1 April 2023, the use of CardioMEMS pulmonary artery pressure monitoring for patients with chronic heart failure, New York Heart Association class III, with repeated hospital admissions;
g. until 1 October 2023, long-term, active physiotherapy for patients with axial spondyloarthritis (axSpA) with severe functional limitations, and for patients with rheumatoid arthritis (RA) with severe functional limitations;
h. until 1 October 2023, medical clothing using

silver-plated textiles, and antibacterial chitosan coated dressings for children and adults with moderate to severe atopic eczema;

i. until 1 August 2025, bladder instillations with bladder irrigation fluids in patients with interstitial cystitis (painful bladder syndrome) and Hunner's ulcers;
j. until 1 January 2027, adding hyperthermic intraperitoneal chemotherapy (HIPEC) to primary debulking (the standard treatment) in patients with stage 3 ovarian carcinoma;
k. until 1 January 2027, the drug nusinersen (Spinraza®) in the treatment of patients with 5q spinal muscular atrophy (SMA) aged 9 years and 6 months or older;
l. until 1 August 2022, primary recovery care provided by allied healthcare providers for four groups of patients who have suffered severe COVID-19, i.e.:
    1. patients admitted to hospital for severe COVID-19 and who received intensive care treatment there;
    2. patients admitted to hospital for severe COVID-19 but who did not receive intensive care treatment there;
    3. patients who were referred to hospital due to a confirmed or suspected case of COVID-19 but who remained in their own home or place of residence;
    4. patients who have been seriously ill in their own home or place of residence due to a confirmed or suspected case of COVID-19, who were not referred to hospital, and who are experiencing serious long-term effects of the disease.

    From the first session, the care consists of:
    - a maximum of 50 sessions of physiotherapy or exercise therapy;
    - a maximum of 10 hours of occupational therapy;
    - a maximum of 7 hours of dietetics;
    - all necessary speech and language therapy with no maximum number of sessions.

    Patients as described above are entitled to this recovery care for a period of six months. The healthcare must be prescribed by the general practitioner or medical specialist and within a period of six months from the acute stage of the severe case of COVID-19. The recovery care must start within a month of the prescription being issued. The care can be extended by a period of six months if required; this will also require a prescription from the general practitioner or medical specialist; and furthermore
m. any forms of specialist medical healthcare, medicines or medical aids the government designates, over the course of the year, as conditional healthcare for a set period of time. These forms of conditional healthcare can be found on our website and under Article 2.2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering').

Admission to a hospital may be required for medical reasons.

Please note!
- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.

Terms and conditions

General

You are participating in a study, by which we mean:
- a main study to determine the effectiveness of the healthcare financed by the Netherlands Organisation for Health Research and Development (ZonMw); and
- an additional national observational study of the healthcare, set up and conducted in cooperation with the main study, if:
    - the insured person, although meeting the criteria for receiving the healthcare, does not meet the criteria for participation in the main study; or
    - the insured person did not participate in the main study and the period for inclusion in the main study has expired; or
    - the insured person took part in the main study without having received the healthcare, and the insured person's participation in the main study has been completed.

    This additional observational study does not apply to the conditional healthcare specified under (a) and (f).

    For the healthcare specified under (l), where applicable, an additional analysis of the provision of the healthcare also applies or, if the study and analysis have not yet started, a check into the insured person's willingness to participate in such.

Healthcare provider

The healthcare is provided by a healthcare provider who selects patients for the study.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.23. Foot care

Healthcare: what you are insured for

The healthcare comprises foot care for insured persons with diabetes mellitus type I (type 1 diabetes) or diabetes mellitus type II (type 2 diabetes):

- for patients with healthcare profile 1: the annual targeted foot examination;
- for patients with health care profile 2 or higher: the foot care as described below.

The foot care comprises all the activities specified in the healthcare profiles, insofar as 'Zorginstituut Nederland' has designated them as medical care that can be covered under the health insurance, and it is healthcare as provided by general practitioners or medical specialists.

Once a year, a foot examination is carried out and advice is given. The aim of the examination is to determine the risk of diabetic foot ulcers (a skin defect/infection below the ankle) using 'Simm's classifications'. The healthcare profile, as described in the 2014 Dutch guidelines on the prevention of diabetic foot ulcers ('Zorgmodule Preventie Diabetische Voetulcera 2014'), will be determined using this classification system while also taking into account other non-casual factors:

- healthcare profile 2: where there is a high risk of wound/amputation but no increased pressure, foot examination including diagnostics and treatment to prevent foot ulcers;
- healthcare profile 3: where there is a high risk of wound/amputation and increased pressure, foot examination, podiatrist therapy/measures, monitoring, preventive foot care, and treatment using podiatry instruments.
- healthcare profile 4: where there is a very high risk of wound/amputation, foot examination, podiatrist therapy/measures, monitoring, preventive foot care, and treatment using podiatry instruments.

The number of treatments, examinations, and the use of diagnostics are set out in an individual treatment plan.

The healthcare for type 2 diabetes can also be provided in the form of multidisciplinary care, in accordance with the healthcare standards for type 2 diabetes. For more information, please refer to clause A.17.3.

Please note!

- refer to clause A.21. for the general exclusions.
- unless the healthcare is provided by a medical specialist in a hospital and claimed under a DBC code, the healthcare is not subject to a deductible.
- this healthcare may be covered to a greater extent under an additional insurance package. Your Reimbursements Overview will show whether this is the case.
- the healthcare does not include personal foot care such as the removal of calluses for cosmetic reasons or general toenail care.
- you are not entitled to reimbursement of the costs of foot care outside of multidisciplinary care if you are already receiving foot care as part of multidisciplinary care for the same condition (and vice versa).

Terms and conditions

General

- in cases of multidisciplinary care, the claim for this healthcare is submitted by:
  - the principal contractor (possibly a podiatrist) in accordance with the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg).
  - the individual, affiliated healthcare providers with what is known as 'costs for organisation and infrastructure', i.e. the overhead costs claimed by the principal contractor.
- the healthcare can be provided at your home if this is medically necessary.

Healthcare provider

The healthcare is provided by:

- a medical specialist;
- a general practitioner or a healthcare provider within the general practice or out-of-hours general practitioner surgery (e.g. a practice assistant, nurse or physician assistant). The general practitioner has ultimate responsibility for the work of the healthcare provider within the general practice or out-of-hours general practitioner surgery;
- a podiatrist, who may delegate (sub-contract) the care to a medical pedicurist or a pedicurist with the DV (diabetes) certificate;
- if the healthcare is part of a programme of multidisciplinary care, the insured healthcare is provided by a general practitioner and/or other healthcare provider affiliated with or contracted by a principal contractor.

Referral

No referral is needed unless the healthcare is provided by a podiatrist or pedicurist, in which case you need to have a referral from a general practitioner, medical specialist, physician assistant, or nursing specialist.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.24. Deleted

B.25. Sensory impairment care

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

Sensory impairment care involves multidisciplinary medical care provided in relation to:

- a visual impairment (sight);
- an auditory impairment (hearing);
- a communication impairment (speech) resulting from a language development disorder in children and young adults up to the age of 23 who are not autistic.

The healthcare is aimed at having the insured person learn to cope with, overcome or compensate for the impairment, with the aim of allowing the person to function as independently as possible.

The healthcare does not involve admission to and/or a stay at a healthcare facility. If medically necessary and if the terms and conditions set out in the indication protocol have been met, this healthcare also covers a stay at a healthcare facility.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.

Terms and conditions

General

- based on the diagnostics guidelines of the Netherlands Ophthalmology Society (‘Nederlands Oogheelkundig Gezelschap’, NOG), a visual impairment exists. This is the case if:
  - the visual acuity is less than 0.3 logMAR in the better eye; or
  - the field of vision is less than 30 degrees;
  - the visual acuity is between 0.3 and 0.5 logMAR in the better eye, with serious problems with day-to-day functioning as a result.
- based on the diagnostics guidelines of the Federation of Dutch Audiology Centres (‘Federatie van Nederlandse Audiologische Centra’, FENAC), an auditory impairment exists. This is the case if:
  - hearing loss on the audiogram is at least 35 dB; or
  - hearing loss is more than 25 dB.
- based on the multidisciplinary diagnostics guidelines of the Federation of Dutch Audiology Centres (‘Federatie van Nederlandse Audiologische Centra’, FENAC), a communication impairment resulting from a language development disorder exists. This is the case if:
  - the disorder can be traced back to neurobiological and/or neuropsychological factors;
  - the language development disorder is the primary condition, meaning that other problems (of a psychiatric, physiological or neurological nature) are subordinate to the language development disorder.
- the healthcare can be provided in your own home.

Healthcare provider

The healthcare is provided on a multidisciplinary basis by healthcare providers operating in a facility for the treatment of persons with sensory impairment. The activities performed by the healthcare providers are restricted to the healthcare as described in Article 2.5(a) of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’) and the requirements and terms and conditions set out in this decree regarding healthcare for persons with sensory impairment.

- a healthcare psychologist holds final responsibility for the healthcare plan and the audiological and communicative healthcare provided. Special education generalists or other specialists may also provide this care.
- an ophthalmologist or a healthcare psychologist holds final responsibility for the healthcare plan and the visual healthcare provided. Clinical physicists or other specialists may also provide this care.

Referral

A medical specialist refers the patient on the basis of the national Netherlands Ophthalmology Society (‘Nederlands Oogheelkundig Gezelschap’, NOG) referral guideline for visual healthcare. Prior to the start of extramural treatment, a referral is required from:

- a medical specialist or clinical physicist from an audiology centre if the disorder/impairment has not been diagnosed before or if the disorder/impairment has changed;

- a general practitioner or youth healthcare doctor if the disorder/impairment has been diagnosed before but an additional need for related healthcare has arisen since. A referral from a general practitioner or youth healthcare doctor is not required if the healthcare being provided is simple rehabilitation by a contracted healthcare facility for insured persons with a visual impairment. Your healthcare facility can tell you whether the care is simple rehabilitation.

Approval
Approval (see clause A.18.) is required if the stay at a facility will last longer than one year. Healthcare facilities offering these stays will know whether you qualify for the stay and when approval is required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.26. District nursing

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

The healthcare comprises nursing and care and is related to the medical care needs as referred to in Article 2.4 of the Dutch Health Insurance Decree ('Besluit zorgverzekering') or to a high risk of requiring this healthcare.

District nursing care is available to all age groups and includes nursing, care, coordination, observing and monitoring, prevention, and providing support for self-management and case management.

Integrated care
We have made agreements with municipalities on the provision of integrated care so that we can coordinate the performance of both parties' statutory duties under the Dutch Health Insurance Act ('Zorgverzekeringswet') and the Dutch Social Support Act (Wmo). The agreements that are relevant to your health insurance can be found in the terms and conditions of insurance. If you are receiving integrated care (i.e. care provided on the basis of various acts simultaneously, such as the Dutch Health Insurance Act ('Zorgverzekeringswet'), the Dutch Youth Act ('Jeugdwet'), the Dutch Social Support Act (Wmo) and the Dutch Long-Term Care Act (Wlz), we recommend that you contact us about this.

Please note!
- refer to clause A.21. for the general exclusions.
- the care may not be provided in combination with a stay in a facility, with the exception of intensive care for children. Where intensive care for children is provided in combination with a stay in a facility, this care may not be purchased using a Personal Care Budget ('Persoonsgebonden Budget' or 'PGB').
- the care is not obstetric care (see clause B.7. for more information on obstetric care).
- this care is not care for which the costs can be reimbursed under the Dutch Long-Term Care Act (Wlz).
- in the case of care for children under the age of 18 aimed at increasing independence in carrying out activities of daily living (ADL), that care comes under the Dutch Youth Act ('Jeugdwet'): the care does not take place in a medical context.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- to qualify for the healthcare, you must be, in all reasonableness, reliant on care of that nature and to that extent. The healthcare that is to be provided (and this includes the care needs assessment) must be effective.
- nursing activities and care activities will be provided during one and the same visit to you wherever possible. If the healthcare you will be receiving primarily consists of care activities, you will be in regular contact with the nurse who assessed your care needs so that the nurse can check whether your situation has changed and adjust the care needs assessment and the care plan as necessary. We expect you to cooperate with the healthcare providers to the best of your ability so that they can carry out their work safely and to the standard expected.
- certain types of healthcare must be provided by specialist nurses (for certain nursing procedures, for example, or case management for people suffering from dementia). Our Healthcare Team ('Zorgteam') can help you find a suitable healthcare provider.
- the care is provided in your own surroundings. Intensive care for children can also be provided in a medical day care centre or a children's hospice.

Personal Care Budget
In certain cases, you may also apply to us for a Personal Care Budget ('Persoonsgebonden Budget', PGB) for district nursing. You can read more about this in the Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care ('Reglement Zvw-pgb in het kader

van Verpleging & Verzorging').

Healthcare provider
General
The district nursing care is provided by healthcare providers (professional staff) who are authorised and competent to perform the activities and can demonstrate this upon request. The nurses (levels 4 and 5) are also registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG). Reserved activities are carried out in accordance with the applicable frameworks and standards. The nursing specialist or level-5 nurse who assessed the care needs is affiliated with the network (e.g. a district social support & care team or a consortium of home-care organisations, general practitioners and the hospital) that organises the healthcare and support in the district where the insured person lives, and this nursing specialist or level-5 nurse is continuously involved in the healthcare provided and in monitoring whether the care needs assessment and the care plan, and thus the care provided, are still appropriate to the patient's care needs. If you have any doubt as to whether a care worker's activities are legitimate, you can contact our Healthcare Team ('Zorgteam').

The healthcare provider supplying the care and claiming the costs must have an AGB code for district nursing and qualified staff, i.e. the healthcare provider has access to at least one nurse with an AGB code for 'Nursing level 5' who is permanently affiliated with the healthcare provider. Whether more than one level-5 nurse needs to be available depends on the nature of the healthcare being provided. You can ask us whether the healthcare provider meets these conditions.

Care needs assessment
The need for nursing care is assessed by the nursing specialist (Article 14, Dutch Individual Healthcare Professions Act ('Wet BIG'), Master's degree at higher professional level) or a level-5 nurse (Article 3, Dutch Individual Healthcare Professions Act ('Wet BIG'), Bachelor's degree at higher professional level). A digital classification system is used for the care needs assessment.
The care needs assessment describes the type of nursing and other care you need and how often you need this. It also provides support for the assessment. The nursing specialist or nurse carrying out the care needs assessment must then set this all out in a care plan. The care plan and the care needs assessment must comply with the 'Standards framework for care needs assessment and nursing and other care organisation in the home environment' ('Normenkader voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving') drawn up by the Dutch Professional Organisation for Nurses and Professional Carers Verpleegkundigen & Verzorgenden Nederland (V&VN). We assess whether the nursing process is clear from the care needs assessment report.

Based on the conditions set for this and the care needs assessment drawn up for you, we determine whether you are eligible for care in kind or for a personal care budget for nursing and other care ('pgb-verpleging en verzorging').

Approval
You do not need our approval if you use a healthcare provider who has a contract with us for this healthcare. The healthcare provider will assess on our behalf whether your condition comes under your insured healthcare. A list of these healthcare providers is available on our website.
Our approval is required, however, if the healthcare is provided by a non-contracted healthcare provider (see clause A.18.).

You can have your care needs reassessed by another nurse. The costs of this reassessment will only be reimbursed if we have given permission for this reassessment in advance. We may also appoint a different nurse for this reassessment. We may refuse such permission if, for example, you have already received a care needs assessment from several healthcare providers for the same period prior to requesting a reassessment.

If we, on our part, have any doubts about the care needs identified by the first nurse, we can have your care needs reassessed on our own initiative.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

B.27. Short-term stays in a facility

Healthcare: what you are insured for

This healthcare involves a short-term stay at a facility while receiving healthcare from a general practitioner
to promote recovery and facilitate a return home. It is expected that this will make a return to your home and recovery, in terms of healthcare, possible in the short term (except in cases of palliative

care).

It must have been established that:
- there is an immediate and demonstrable risk of a deterioration in health. Your general practitioner will take your personal situation (such as your home situation) into consideration; and
- hospitalisation is not necessary; and
- you do not need to stay for an indeterminate period of time.

The healthcare includes:
- a stay in the facility to receive medically necessary healthcare;
- 24-hour availability and provision of nursing and/or care;
- medical care, which also includes first-line diagnostics;
- allied healthcare (physiotherapy, Mensendieck/Cesar exercise therapy, speech and language therapy, dietetics and occupational therapy) relating to the indication for this short-term stay.

Explanation:
It is not always possible to receive the healthcare you need at home. This could be the case, for example, when you need continuous observation (for medical or other reasons), when specialist diagnostics or recovery care is required, or when healthcare is suddenly and unexpectedly needed. In the case of palliative care too, it is sometimes not feasible to provide this at home, in which case a hospice might be a better solution. In these situations, you may be entitled to a short-term stay away from home, as described above.
The healthcare is, in principle, aimed at you returning home within three months (except in cases of palliative care). In general, in-patient care for this length of time will be sufficient. If a longer stay is required, the care plan must justify this and explain the purpose of the extended stay.

Please note!
- refer to clause A.21. for the general exclusions.
- you are insured for medicines during your short-term stay; however, in that case the provisions of clauses B.15. and B.16. apply rather than those of B.27.
- this healthcare is subject to the deductible.
- you are not insured for a short-term stay in a facility if:
  - with a care needs assessment under the Dutch Long-Term Care Act (Wlz), you draw on a full home care package (VPT), a modular home care package (MPT) or a Personal Care Budget (PGB) to arrange care at home, or if you receive your care in a form of clustered accommodation. In these cases, the stay is paid for under the Dutch Long-Term Care Act (Wlz);
  - respite care services are involved, i.e. temporary and full substitute care at home in the event that the regular carer is temporarily unable to provide the care, or can only continue to provide the care if he or she can take a break. These care services fall under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning'). Please contact your municipality to find out about the possibilities;
  - you are younger than 18, in which case the care comes under the Dutch Youth Act ('Jeugdwet'). Please contact your municipality to find out about the possibilities.

Terms and conditions

General
The healthcare is provided in a facility in the Netherlands permitted to provide nursing and personal care under the Dutch Healthcare Institutions (Accreditation) Act ('Wet toelating zorginstellingen', WTZi), where the healthcare provider has, depending on the care being provided, at least one staff member with an AGB-code 'Nurse - level 4 or 5'.

Healthcare provider
The medical care is provided by a geriatric specialist and/or doctor for the mentally disabled, in collaboration and/or consultation with the general practitioner.
The professional carer or nurse provides the healthcare in consultation with the general practitioner and the geriatric specialist/doctor for the mentally disabled. The general practitioner can also provide the healthcare personally.
In the case of allied healthcare, the allied health professional provides the healthcare. In clauses B.8. to B.11. inclusive, the healthcare provider permitted to provide each type of allied healthcare is listed under the heading 'Healthcare provider'.

Referral
A general practitioner, possibly in consultation with a geriatric specialist, doctor for the mentally disabled, medical specialist and/or a nurse, needs to provide a referral before healthcare commences.

Treatment proposal
Together with the district nurse and in consultation with the geriatric specialist, doctor for the mentally disabled and/or medical specialist, the general practitioner assesses the need for a short-term stay.

Approval
Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.28. Medical care for specific patient groups

B.28.1. Medical care for specific patient groups in general

Healthcare: what you are insured for

Medical care for specific patient groups as referred to throughout this clause comprises a collection of forms of primary healthcare for vulnerable people living at home who have complex or highly complex problems, as a result of which they are limited/increasingly limited in their self-reliance and ability to organise their own lives and who, to a reasonable degree, are dependent on this healthcare. The focus of the healthcare is on somatic, psychological and/or behavioural aspects. Some of the specific groups referred to include:

- older people with complex conditions (somatic and/or psychological);
- people with chronically progressive degenerative disorders, such as Parkinson's disease, Huntington's disease or multiple sclerosis;
- people with acquired brain injury; or
- people with an intellectual disability.

The healthcare provider can also provide the healthcare at a location other than his or her normal place of work.

Please note!

- refer to clause A.21. for the general exclusions.
- this healthcare is subject to the deductible.
- we do not reimburse the costs of the following healthcare:
  - healthcare that is covered under the Dutch Long-Term Care Act ('Wet langdurige zorg');
  - healthcare that is covered under another provision or provisions of the general insurance policy (such as that provided by a general practitioner, physiotherapist, exercise therapist, dietician, speech and language therapist, occupational therapist or mental healthcare specialist);
  - consultation of a multidisciplinary team except with the attending doctor on the specific problems;
  - healthcare provided in the group setting is an integral course of treatment ('prestatie') and may not be charged as an individual course of treatment at the same time.

Terms and conditions

Healthcare provider

In the case of multidisciplinary healthcare, the coordinating practitioner is responsible for this healthcare. The coordinating practitioner is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

Referral

Either a general practitioner – advised by the coordinating practitioner (geriatric specialist, doctor for the mentally disabled or behavioural scientist) – or a medical specialist needs to provide a referral before healthcare commences.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

B.28.2. Individual healthcare from a geriatric specialist and doctor for the mentally disabled

Healthcare: what you are insured for

The healthcare comprises medical care for specific patient groups provided by the geriatric specialist and doctor for the mentally disabled.

Terms and conditions

See clause B.28.1. The following terms and conditions are in deviation of the terms and conditions of that clause.

Healthcare provider

The healthcare is provided by a geriatric specialist and/or doctor for the mentally disabled.

B.28.3. Individual healthcare provided by behavioural scientists

Healthcare: what you are insured for

The healthcare comprises medical care for specific

patient groups provided by behavioural scientists and is aimed at recovery and/or learning new skills or behaviour.

Terms and conditions

See clause B.28.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The healthcare is intended for patients with:

- a confirmed or suspected chronic and/or complex disease or condition that has an impact on the patient's psychiatric and cognitive functioning such as dementia, multiple sclerosis, Parkinson's disease, an intellectual disability or an acquired brain injury; or
- multiple morbidities that are often degenerative and progressive in nature (people at a very advanced age with an accumulation of somatic symptoms and experiencing, for example, a lack of meaning and purpose).

Healthcare provider

The treatment is carried out under the guidance and responsibility of a behavioural scientist with expertise in specific disorders and treatments.

B.28.4. Individual allied healthcare

Healthcare: what you are insured for

The healthcare comprises primary allied healthcare (physiotherapy, exercise therapy, occupational therapy, speech and language therapy and/or dietetics) for specific patient groups.

Terms and conditions

See clause B.28.1. The following terms and conditions are in deviation of the terms and conditions of that clause.

Healthcare provider

The healthcare is provided by a physiotherapist, exercise therapist, occupational therapist, speech and language therapist, or dietician.

B.28.5. Healthcare in a group of vulnerable patients

Healthcare: what you are insured for

The healthcare comprises care for vulnerable patients with somatic or cognitive issues (including of a psychogeriatric nature) and an intensive need for care, and is aimed at recovery and/or learning skills, or stabilising the functioning and preventing the limitations from worsening and/or the patient learning to deal with physical and/or cognitive limitations.

Terms and conditions

See clause B.28.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- the healthcare is provided in a group setting.
- the concrete and feasible treatment goals are set out in an individual treatment plan.

Healthcare provider

The healthcare is provided by a physiotherapist, exercise therapist, occupational therapist, speech and language therapist, or dietician.

B.28.6. Healthcare in a group of people with a physical disability or an acquired brain injury

Healthcare: what you are insured for

The healthcare comprises multidisciplinary care in a group setting based on an individual treatment plan. The aim of the treatment plan is for the patient to learn, as well as possible, how to deal physically and psychologically with the disorder and limitations that arise from the disorder and limitations. The treatment is aimed at maintaining and promoting the patient's functional independence. The healthcare is intended to prevent deterioration and escalation, to make behaviour manageable, and to improve physical and psychological functioning. The healthcare does not replace specialist medical rehabilitation or geriatric rehabilitation.

Terms and conditions

See clause B.28.1. The following terms and conditions are in addition to the terms and conditions of that clause.

General

- the healthcare is provided in a group setting.
- the concrete and feasible treatment goals are set out in an individual treatment plan.
- this concerns multidisciplinary treatment in a group setting.

Healthcare provider

The healthcare is provided by the coordinating practitioner in collaboration with the behavioural scientists, expressive therapists and allied healthcare providers.

B.28.7. Healthcare in a group setting for patients with Huntington's disease

Healthcare: what you are insured for

Healthcare in a group setting for patients with Huntington's disease.

Terms and conditions

See clause B.28.1. The following terms and conditions are in addition to the terms and conditions of that clause.

General

- the healthcare is provided in a group setting.
- the healthcare is provided in the form of day treatment.
- the concrete and feasible treatment goals are set out in an individual treatment plan.

Healthcare provider

The healthcare is provided by a multidisciplinary team with expertise in the field of Huntington's disease under the guidance and responsibility of a coordinating practitioner. If medically necessary, nursing care can also form part of the treatment in a group setting.

B.28.8. Healthcare for patients with severely disturbed behaviour and mild intellectual disabilities

Healthcare: what you are insured for

The course of treatment ('prestatie') comprises the following healthcare:

- integrated, multidisciplinary diagnosis of behavioural problems;
- multidisciplinary treatment of behavioural problems based on an individual treatment plan.

The healthcare is aimed at increasing your competencies, your support system and your professional network with regard to you learning to deal with your impairments in intellectual and adaptive functioning. The stepped care approach is used for the provision of this healthcare.

Terms and conditions

See clause B.28.1. The following terms and conditions are in addition to the terms and conditions of that clause.

General

- the healthcare is provided in a group setting.
- the concrete and feasible treatment goals are set out in an individual treatment plan.
- this concerns treatment of patients with an intellectual disability combined with one or more psychiatric disorders and serious behavioural problems. The behavioural problems arose in connection with the intellectual disability and the psychiatric disorder(s).

SECTION C

GENERAL TERMS AND CONDITIONS FOR ADDITIONAL INSURANCE PACKAGES

C.1. Definitions

This clause defines the terms used in sections C and D (Terms and Conditions of Insurance for Additional Insurance Packages) that were not defined previously in section A.

Carer
A person who provides informal care.

Chiropodist/registered chiropodist
A person listed on the appropriate register administered by an association for chiropodists that we have recognised and who runs a practice as a registered chiropodist.

Country of residence
The country where you live, other than the Netherlands. We also take country of residence to mean the country where you are seconded for your work and where you and your family members are living, even when this is for less than one year.

Exercise programme
An exercise programme is aimed at influencing and activating exercise behaviour and developing an active and healthy lifestyle. The duration of the exercise programme is set in advance. The programme is aimed at achieving a change in behaviour. This expressly does not include general programmes aimed at improving fitness.

Health course
A complete learning programme of a certain duration. The main focus of the learning programme is to increase your understanding of a healthy lifestyle. Within a framework of personal contact, the course or programme teaches skills aimed at changing behaviour and/or provides information to this end. The objective is for you to learn how you are personally capable of maintaining and/or improving your physical or mental health.

Home care organisation
An organisation that is able to provide the nursing and care of an insured person in the insured person's own home.

Informal care
This is care that is provided, on a voluntary basis and without monetary compensation or compensation of an equivalent nature, to a person who, due to his or her long-term and/or chronic illness or condition and/or deteriorating health, would be unable to function independently at home without this informal care. This care is available every day at (virtually) any hour of the day and can be provided

immediately. One partner caring for the other partner at home can also be seen as a carer.

Live/reside
The situation in which you have one place or country completely, or virtually completely, as the central point of your life and your social activities.
If this is not the case but you live in one place for an uninterrupted period of 365 days or more, we deem this to be the place where you live/reside. However, if you stay at that place for a period of less than 365 days, we deem this to be a temporary stay and not a case of living/residing there.

Patients' association
An association that represents the interests of patients and consumers in regard to healthcare and which is affiliated as a member or candidate member to:
- the Dutch Patients and Consumers Federation ('Nederlandse Patiënten Consumenten Federatie', NPCF);
- the Dutch Council of the Chronically Ill and the Disabled ('Chronisch zieken en Gehandicapten Raad Nederland', CG-Raad);
- the Platform for People with a Mental Disability ('Platform Verstandelijk Gehandicapten', Platform VG);
- the National Platform for Mental Healthcare ('Landelijk Platform Geestelijke Gezondheidszorg', LPGGz).

Vaccination
The administration of vaccines and/or medicines by means of injection.
The total package of healthcare comprises:
- supply of the vaccine and/or medicines;
- the injection materials;
- administration through one or more injections;
- the required registration/administration;
- any additional diagnostic tests (such as a blood test) required to determine which vaccine to use; and
- the invoiced consultation.

Z-Index
Z-Index is the organisation that collects, verifies, manages and distributes the details of all products available through public pharmacies and dispensing general practitioners. It makes this information available through the 'G-Standaard' database, which we use to see whether a medicine is registered, for example, or to check the price for that medicine.

C.2. Fundamentals of your additional insurance packages and private medical expenses insurance

C.2.1. General

Further to the provisions of clause A.2, the additional insurance package and/or the private medical expenses insurance can be based on:
- a Reimbursements Overview for your insurance packages;
- the health statement filled in by you or a third party (a healthcare provider, for example);
- a completed medical report, where applicable.

C.2.2. Nature of your additional insurance package and private medical expenses insurance

The private medical expenses insurance is a 'refund policy', meaning you are entitled to reimbursement of the costs of healthcare.

Unless stated in the introduction to your Reimbursements Overview that your additional insurance package is a mixed policy, you can assume that this is a refund policy. A mixed policy is one in which, in accordance with the provisions of at least one clause, you are insured for the reimbursement of the costs of the healthcare (refund) and, again in accordance with the provisions of at least one clause, you are insured for the healthcare directly ('in kind').

C.2.3. Content of your private medical expenses insurance

The terms and conditions for cover under your private medical expenses insurance are the same as those for the health insurance. However, the content and scope of the cover provided by the private medical expenses insurance can differ from that of the health insurance. The Reimbursements Overview specifies which healthcare you are insured for, along with details of the level of reimbursement.

C.2.4. Different provisions may apply

The following may have provisions that differ to one or more of the clauses in these terms and conditions of insurance:
- the Reimbursements Overview;
- an additional or group agreement;
- the non-standard terms and conditions set out in clause C.11.

C.2.5. References in the Reimbursements Overview

You are only insured for healthcare or reimbursement of healthcare as specified in the clauses listed on your Reimbursements Overview. Even if only a part of the reimbursement clause is specified (and not the entire clause), the description of that healthcare, the exclusions (see: 'Please note!') and the terms and conditions described in that clause or a clause from section A apply in full.

C.3. Nature, content and scope of your additional insurance package

C.3.1. Several additional insurance packages

You (the policyholder) may take out several types of additional insurance, both for yourself and for others. However, some additional insurance packages may not be combined with certain others. You can check with us to find out which.

C.3.2. Per family member

You (the policyholder) may choose from our various additional insurance packages for the people listed as insured persons on your policy — they do not all need to have the same insurance.

C.3.3. Children under the age of 18 in one family

a. The additional insurance package or combination of additional insurance packages must be the same for a child as that of one or both of the parents.
b. It is also possible, contrary to the provisions of point a. above, to take out one or more additional insurance packages for your child that are different to those of the parents, in which case the additional insurance package(s) for your child will no longer be free of charge, nor will the additional insurance package that is the same as that of one or both of the parents. The premium for the additional insurance package that applies to insured persons above the age of 18 will apply to your child in this case.

C.4. Commencement and term of your additional insurance

C.4.1. Commencement and term

If the additional insurance package commences on 1 January, this package will be in effect for one full year. If the additional insurance package commences after 1 January, this package will be in effect for the rest of the current year and the full following year.

C.4.2. Addition of family members

The additional insurance for any family members who are added to your insurance during the term of your additional insurance will be in effect for the same period as your additional insurance.

C.5. Concealment

C.5.1. Deleted

C.5.2. Cancellation by us

If the answers provided prove to be inaccurate or incomplete, we will draw this to your attention and you will have 14 days to respond. We can cancel the additional insurance package or the private medical expenses insurance immediately within 60 days of discovery of the inaccurate or incomplete information.

C.5.3. Cancellation by the policyholder

From the moment we have notified you of the inaccuracy or incompleteness of the information provided, you have 60 days in which you may cancel your additional insurance package or the private medical expenses insurance with immediate effect.

C.6. Cancellation or change

C.6.1. Cancellation for all insured persons

- if the information you provided when taking out an additional insurance package and/or private medical expenses insurance policy turns out to be inaccurate or incomplete, we can cancel the insurance concerned with immediate effect within 60 days of this discovery. We will claim back all reimbursements that we have paid you from the day that we were misled.
- if you are more than two months in payment arrears for the private medical expenses insurance, we may cancel the private medical expenses insurance policy in question.

C.6.2. Cancellation for one insured person

We will cancel the additional insurance package and private medical expenses insurance for one insured person when any of the following situations arise:

- the insured person is no longer a member of your (the policyholder's) family as defined herein;
- your (the insured person's) stay abroad can no longer be considered temporary under these terms and conditions of insurance and we have not given you express permission to keep your additional insurance.

You must notify us in writing if one or both of the situations listed above arises, and we must receive this notification within 30 days of the situation in question arising.

C.6.3. No cancellation

You are not entitled to cancel your additional insurance package in the case that we:

- reduce the premium;
- make a change to the terms and conditions of insurance that gives you more rights or fewer obligations;
- change the premium because you have reached a certain age and therefore come under a different age category;
- make a change to the terms and conditions of insurance or the premium that is not related to the additional insurance you (the policyholder) have taken out;
- change the terms and conditions of insurance as a result of a government policy or statutory regulations.

C.7. Amount of the premium and costs

In addition to the costs specified in section A, you (the policyholder) must also pay:

- a surcharge on the premium for each child younger than 18 years for whom you have taken out additional insurance. This surcharge only applies if the parents or guardians have not also taken out one or more additional insurance packages with us or if they have taken out different additional insurance packages. We will invoice this surcharge to you (the policyholder);
- a surcharge on the premium for every insured person for whom you have taken out an additional insurance package with us, but for whom no health insurance has been taken out. We will invoice this surcharge to you (the policyholder);
- a surcharge on the premium due to you having reached a certain age during the term of your additional insurance package;
- taxes that we are required to pay, by law or under a treaty, to particular bodies or authorities.

Any surcharges that apply have been included in the premium shown on your policy document.

C.8. Premium and costs upon cancellation

It is possible that you may still owe us premium and costs for an additional insurance package or a private medical expenses insurance policy that has been cancelled. If you take out a new insurance policy with us, we are entitled to:

- offset the costs of healthcare due for reimbursement under your new additional insurance package or new private medical expenses insurance policy against the old outstanding debt;
- postpone our obligations until such time as you (the policyholder) have paid all premiums and costs that are due and payable.

C.9. Reimbursement

C.9.1. Maximum reimbursement if you are not insured for the full year

We reimburse certain treatments up to a certain maximum amount per year. If your insurance starts or ends during the course of the year, we will not reduce this maximum amount.

C.9.2. Maximum reimbursement when switching additional insurance packages

You might be receiving healthcare that is partly reimbursed under your additional insurance package, but not in full. A maximum amount for costs may apply, for example, or you may be entitled to only a certain number of treatments. Let's say you later take out one or more additional insurance packages with us that reimburse this healthcare but not in full, and let's also say that this/these new additional insurance packages also reimburse the same healthcare up to a certain amount or up to a certain number of treatments over a period we specify. In this case:

- the amount you have already been reimbursed through your previous additional insurance package with us counts towards the maximum amount of your new additional insurance package;
- the number of treatments that you obtained

under your previous additional insurance with us counts towards the maximum number of treatments under your new additional insurance package;
- the period in which you are entitled to limited reimbursement continues, uninterrupted, in your new additional insurance package, on the understanding that this period starts at the moment you first incurred costs.

Certain types of healthcare are reimbursed only once per insured person and only up to a maximum amount. In that case too, the reimbursements you received from us in previous years or periods also count towards the maximum. This applies even if you have been insured elsewhere in the meantime.

Previously approved reimbursements provided also continue to count towards the maximum if we change the number of treatments and/or the amount of the reimbursement(s) in your additional insurance package.

Please note!
This clause does not apply to the reimbursement of orthodontics as specified in clause D.8.5.

C.9.3. Consecutive reimbursements

The national insurance and social security schemes, such as the Dutch Long-Term Care Act (Wlz; formerly the AWBZ), the Dutch Youth Act ('Jeugdwet') or the Dutch Social Support Act (Wmo), and your health insurance do not reimburse all healthcare (or not in full). The healthcare costs that you are not reimbursed, might, under certain conditions, be covered by your additional insurance package. This applies when:
- the costs relate to treatments that are included in your health insurance or are covered under the national insurance or social security schemes; and
- the healthcare is reimbursed in part under a national insurance or social security scheme, or through your health insurance; and
- the reimbursement is included in your additional insurance package; and
- you meet the terms and conditions set for the treatments concerned, as specified in these Terms and Conditions of Insurance for Additional Insurance Packages; and
- we have received an original, written statement from the implementing bodies for the relevant national insurance and social security schemes or from the insurer for the health insurance. This statement must specify that the invoice you submit to us for an additional reimbursement has already been submitted and processed there, as well as how it was processed and why it was not reimbursed.

C.10. General exclusions

C.10.1. Pre-existing illness

When you register with us, we may ask you about any pre-existing illnesses, conditions or impairments. If you withhold or conceal any information about this, we will not reimburse any healthcare relating to the illness, condition or impairment that you knew to exist or that already was causing symptoms at the time you applied for the insurance. We will, however, reimburse other healthcare unrelated to the illness, condition or impairment that you concealed, as long as this is covered under your insurance.

C.10.2. Other schemes or insurance

There are some costs of healthcare that we do not reimburse.
- we do not reimburse costs you could have been reimbursed for, or treatments you would have been entitled to (if you had not been insured under the additional insurance package) under:
  - a Dutch or foreign national insurance scheme, social security act or other statutory scheme, such as the Dutch Health Insurance Act ('Zorgverzekeringswet'), Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act (Wlz) or the Dutch Social Support Act (Wmo); or
  - a Dutch or foreign government scheme or a subsidy scheme such as a national immunisation programme; or
  - an EU regulation, EU treaty, EEA treaty or a bilateral social security treaty that the Netherlands has signed; or
  - another agreement, regardless of whether this was in effect at the time you took out your additional insurance or came into effect after.
- nor do we reimburse costs:
  - related to urgent treatment abroad; and
  - which a travel insurer or other insurer claims from us if you have taken out a separate travel or other insurance policy with them; and
  - which, if you had not taken out insurance with us, would be covered by that separate travel or other insurance policy (including cover for medical expenses abroad) or that have been paid or advanced by the travel or other insurer on other grounds; and
  - which are excluded by this travel or other

insurer if you have a health insurance policy or an additional insurance package.

The travel insurance provider/insurer has not signed the covenant on overlap of insurance policies ('Convenant Samenloop'), which regulates the division of the costs reimbursed to the insured person. It does not matter whether your separate travel or other insurance policy took effect before or after your insurance with us — your insurance with us does not reimburse urgent treatment abroad that comes under the separate travel or other insurance policy. Our insurance serves as a 'top-up', i.e. we only reimburse costs that exceed the cover offered by this separate travel or other insurance policy.

- we do not reimburse costs for healthcare for which you could possibly have also been reimbursed under another scheme or insurance policy but where you have not informed us of the name of the insurer concerned.

C.10.3. Personal contribution, deductible and reduced rate

We do not reimburse the following costs, unless we explicitly state that we will reimburse these costs in these terms and conditions of insurance or the reimbursements overview that applies to you:

- the personal contributions (statutory or otherwise) that you must pay under the provisions of the Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act (Wlz), Dutch Social Support Act (Wmo) or the Dutch Health Insurance Act ('Zorgverzekeringswet');
- costs offset against the compulsory deductible or your voluntary deductible under the health insurance;
- the costs you are required to pay yourself for the insured healthcare because you have claimed costs at a rate higher than the rate reimbursed under your insurance. You can read more about these rates in clause A.20.;
- costs for treatment relating to psychoanalysis;
- costs for treatment of a cosmetic-surgery nature.

If you visit a non-contracted healthcare provider for healthcare that is covered on an 'in-kind' basis, we reimburse the costs at a reduced rate. We do this in the case of a 'Natura' or 'Natura Select' health insurance policy and for the healthcare covered on an 'in-kind' basis in a 'Combinatie' health insurance policy or an additional insurance package (see clauses A.20.1. and A.20.2.). We will never reimburse costs that you are responsible for paying due to the application of the reduced rate.

C.10.4. Intentional acts, negligence, criminal offences, violations and fraud

We do not reimburse treatments and the costs thereof if you cause the condition or injury intentionally, or if it arises from your negligence or your recklessness, which, in any case, will be deemed to be the case if the condition or injury arises:

- through you operating a vehicle, vessel or aircraft (which includes a plane, helicopter, parachute, hot-air/gas balloon, and hang-glider) without complying with the legal requirements;
- through your participation in races or a speed contest involving a vehicle, vessel or aircraft as stated above;
- as a result of a sports event in which you participated in a professional capacity;
- from you taking part in a brawl, assault or other violent act;
- through you voluntarily participating in actual armed activities in foreign armed forces, except if you exclusively provide humanitarian aid or care or exclusively perform medical activities as an aid worker;
- through you not cooperating in the healing process or hindering or obstructing it.
- by travelling to and/or staying at a destination abroad for which the Dutch government has issued negative travel advice prior to your departure. This exclusion applies if:
  - the negative travel advice states:
    - avoid non-essential travel (code orange);
    - avoid all travel (code red).
  - the negative travel advice has been issued because of:
    - current or imminent war, riots or other similar disturbances where a threatening situation may arise;
    - a threat that is posed by infectious pathogens such as viruses, bacteria, fungi or other forms or combinations of these.
  - the treatment or healthcare you receive has a causal relationship with the reason for which the negative travel advice was issued.

Lifesaving, rescue and self-defence

These exclusions do not apply if the costs have arisen due to you using legal self-defence, or rescuing yourself, other people, or animals. Nor do these exclusions apply if you rescue your own property or that of others if this rescue reasonably justifies the act or behaviour mentioned in the exclusion, or is based on a statutory duty of care.

Criminal offences, violations and fraud

We do not reimburse the costs that occur as the

result of a criminal offence, violation or fraud either, i.e. costs that relate to or are the result of you committing, attempting to commit, participating in, or being an accessory to a criminal offence, violation or fraud, or you being involved in an accident in any of these circumstances. This condition applies not only if you personally commit a criminal offence, violation or fraud, but also if such is committed by someone else who has an interest in the reimbursement or the insurance contract (a healthcare provider, for example).
In the event of fraud, we may also:

- report this to the police;
- cancel the insurance contract(s);
- make a record in the warning systems used by insurers;
- claim back reimbursements that have been made and costs incurred (including costs of investigation).

C.11. Non-standard terms and conditions

Terms and conditions may apply to your additional insurance package that differ from, or are in addition to the terms and conditions of insurance described above. These non-standard terms and conditions may also apply to your private medical expenses insurance.
Your Reimbursements Overview shows whether one or more of the following non-standard or additional terms and conditions applies to your insurance.

C.11.1. Private medical expenses insurance

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

C.11.1.1. Description

You can only take out private medical expenses insurance if you are not obliged to take out health insurance under the Dutch Health Insurance Act (‘Zorgverzekeringswet’).

For healthcare in your country of residence or abroad (other than in the Netherlands) with a healthcare provider with whom we have not concluded an agreement, the healthcare provider must comply with the requirements, laws and regulations that apply in that country. For the other terms and conditions, we will check whether, if possible, these meet the terms and conditions under the relevant clause for that healthcare. Where this is not possible, we will base our assessment on what is customary in the country concerned.

C.11.1.2. End of the private medical expenses insurance

Please notify us if you are obliged to take out health insurance under the Dutch Health Insurance Act (‘Zorgverzekeringswet’) and we will end your private medical expenses insurance.

C.11.1.3. Deductible

Clause A.12.9. Payment in instalments does not apply to you.

C.11.1.4. Rate for invoices from your country of residence

a. For healthcare under your general insurance policy, if you live abroad, we use the market rate applicable in your country of residence for the reimbursement of invoices, i.e. a rate that is reasonable given the market conditions in your country of residence.
b. For healthcare under your general insurance policy or private medical expenses insurance, if the market rates applicable in your country of residence for similar healthcare differ from the market rates applicable in the Netherlands, we reimburse the costs of insured healthcare up to the higher of the two rates, but never more than the claimed rate.
c. For healthcare under your additional insurance package, if you have an additional insurance package that provides a maximum reimbursement for certain types of healthcare, this maximum reimbursement amount will be doubled on the basis of this clause. However, we never reimburse more than the amount stated on the bill.

Example 1 for a. and b.:

You are undergoing physiotherapy in your country of residence Malaysia and you receive an invoice amounting to the equivalent of €36 for a session there. A similar physiotherapy session would cost €28.50 in the Netherlands. In this case, we reimburse €36.

Example 2 for a. and b.:

Let’s say you live in Greece and you receive 5 sessions of physiotherapy there. In Greece, the average charge for such healthcare is €22 per session, while in the Netherlands this costs €28.50. You receive an invoice for €120 for all five sessions, which works out at €24 per session. In this case, we

reimburse the entire invoice of €120.

Example 3 for c.:

You have had six alternative healthcare sessions in your country of residence Malaysia. You receive an invoice for €70 per session, amounting to a total of €420. You have an additional insurance package that covers a maximum of €30 per session up to a maximum of €250 per year. Your reimbursement per session is doubled to €60 (based on 2 x €30). You will need to cover the remaining €10 (based on €70 minus €60) yourself. Since the maximum reimbursement per year is also doubled (to €500), the reimbursement for the six sessions will be €360 (based on 6 x €60).

C.11.1.5.

DELETED.

C.11.1.6. Premium for private medical expenses insurance

You must notify us if you move to another country, as a different premium may apply to your private medical expenses insurance in this case.

C.11.2. 'Verdragspolis'

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

C.11.2.1. When are you entitled to a 'Verdragspolis'?

You may only register yourself and your family members for the 'Verdragspolis' if you are entitled to be insured under treaty, i.e. you are a Dutch resident entitled to receive medical care in one of the treaty countries.
We define family member as the spouse or partner, and any child (including adopted and foster children) under the age of 18 of the person insured under treaty.
This spouse, partner or child furthermore does not earn or receive income in the Netherlands — if he or she does you must notify us.
The 'Verdragspolis' and your additional insurance end when you or your co-insured family member:

- are no longer entitled to medical care at the expense of an EU/EEA member state in accordance with Regulation (EEC) No. 1408/71 or No. 883/04; or
- are no longer entitled to medical care at the expense of Switzerland in accordance with Regulation (EEC) No. 1408/71 or No. 883/04; or
- are no longer entitled to medical care at the expense of a country with which the Netherlands has entered into a bilateral treaty on social security that includes a medical expenses clause.

C.11.2.2. No reimbursement

The 'Verdragspolis' does not entitle you to reimbursement of healthcare costs which, in accordance with statutory regulations, are covered by the healthcare, social security scheme or statutory insurance of the country in which you receive income.

C.11.3. Commencement, term and end of additional insurance packages

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

C.11.3.1.

DELETED

C.11.3.2.

DELETED.

C.11.3.3.

Your additional insurance ends when you move back to the Netherlands.

C.11.3.4.

You may only take out this additional insurance if:

- you are obliged to take out health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet'); and
- you are a member of a group agreement on the basis of which you were able to take out this additional insurance.

This additional insurance package ends if you no longer fulfil both of these conditions.

C.11.3.5.

You may only take out this additional insurance if:

- you and your family members are obliged to take out health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet'); and
- you are registered with or known to a municipal social service ('Gemeentelijke Sociale Dienst', GSD) of the Dutch Municipalities that have concluded a group agreement with us. This registration is based on an entitlement to benefits, where the entitlement is either specified in the group agreement or can be deemed equivalent to it on the grounds of that group agreement.

This additional insurance package ends if you no longer fulfil both of these conditions.

C.11.3.6.

You may only take out this additional insurance if:

- you and your family members are obliged to take out health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet'); and
- the collective labour agreement for the hospital sector and residential and nursing homes for the elderly ('Collectieve arbeidsovereenkomst voor het Ziekenhuiswezen of de Bejaardenoorden') applies to you (the policyholder).

This additional insurance package ends if you no longer fulfil both of these conditions.

C.11.3.7.

You can only take out this additional insurance package if you are admitted to a facility for the disabled with which we have entered into a group agreement for a private medical expenses insurance policy and the costs of the admission are covered under the Dutch Long-Term Care Act (Wlz).
This additional insurance package ends if you no longer fulfil this condition.

C.11.3.8. 'Meegroeiservice'

There are a number of circumstances under which you can change your additional insurance package, such as pregnancy, adoption, divorce, marriage, moving in together, loss of employment, death, moving house, retiring or when your children leave home. You can call us to request a change, which will only be granted up to once a year. The new additional insurance will come into effect on the first day of the month following the month in which you requested the change, or later if preferred.

C.11.4. Healthcare and (no) cost reimbursement

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

C.11.4.1.

DELETED

C.11.4.2.

If you live outside the Netherlands but within Europe, your additional insurance package will provide the same reimbursement as it does to insured persons who live in the Netherlands. In this context, Europe is defined as the collectivity of countries with national sovereignty that are part of the European continent, including the Russian Federation (up to the Urals) and the countries in or bordering the Mediterranean Sea.

C.11.4.3.

DELETED.

C.11.4.4.

DELETED.

C.11.4.5. Rate for invoices from your country of residence

a. For healthcare under your general insurance policy or your private medical expenses insurance, if you live abroad, we use the market rate applicable in your country of residence for the reimbursement of invoices, i.e. a rate that is reasonable given the market conditions in your country of residence.
b. For healthcare under your general insurance policy or private medical expenses insurance, if the market rates applicable in your country of residence for similar healthcare differ from the market rates applicable in the Netherlands, we reimburse the costs of insured healthcare up to the higher of the two rates, but never more than the claimed rate.
c. For healthcare under your additional insurance package, if you have an additional insurance package that provides a maximum reimbursement for certain types of healthcare, this maximum reimbursement amount will be doubled on the basis of this clause.

Example for point c.:

You have had six alternative healthcare sessions in your country of residence Malaysia. You receive an invoice for €70 per session, amounting to a total of €420. You have an additional insurance package that covers a maximum of €30 per session up to a maximum of €250 per year. Your reimbursement per session is doubled to €60 (based on 2 x €30). You will need to cover the remaining €10 (based on €70 minus €60) yourself. Since the maximum reimbursement per year is also doubled (to €500), the reimbursement for the six sessions will be €360 (based on 6 x €60).

C.11.4.6. Non-urgent medical care in an EU/EEA member state

You are insured for reimbursement of healthcare outside of your country of residence as long as this

healthcare is provided in an EU or EEA member state. This reimbursement amounts to a maximum of 200% of the market rate to which you are entitled in the Netherlands or in your country of residence. We will never reimburse more than the claimed rate.
The healthcare provided must be healthcare that would also be reimbursed under your additional insurance package if it had been provided in the Netherlands or in your country of residence. You are only insured for healthcare and the costs of healthcare stated in the Reimbursements Overview for your additional insurance package(s) and/or your dental insurance. The terms and conditions that are stipulated for the individual reimbursements (clauses) under the additional insurance package remain in force.

C.11.5. Premium adjustment

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

We will adjust the premium for your additional insurance package and/or private medical expenses insurance when you are or reach a certain age. Your Reimbursements Overview shows which ages are concerned.

a. The premium adjustment takes effect on the first day of the month following the month in which you reach the specified age.
b. The premium adjustment takes effect on 1 January of the year following the year in which you reach the specified age.

C.11.6. Additional provisions

Check your Reimbursements Overview to see whether one of the following non-standard terms and conditions applies to your insurance.

C.11.6.1. Country of residence

Contrary to the definition of the term country of residence, if you are staying in the Caribbean and the healthcare you require is not available there, you can obtain this healthcare in the United States; this healthcare will still be deemed to be healthcare in your country of residence.

C.11.6.2. Medicines

Further to the provisions of clause B.15.1, your insurance also reimburses the provision of medicines recognised and supplied in the country where you live and advice on their use. This concerns medicines that by their nature are covered under the general insurance in the Netherlands but are not included in the Medicines Reimbursement System (GVS).
This also includes:

- vaccinations under a national immunisation programme and accompanying consultations for children where they would also have been entitled to these if they were living in the Netherlands;
- vaccinations under a national immunisation programme and accompanying consultations for people in a high-risk group where you would also have been entitled to these if you were living in the Netherlands.

We do not reimburse the costs of:

- medicines, vaccinations, preparations and such that are covered under another general insurance policy or additional insurance package;
- medicines for which no prescription from a doctor is required in the Netherlands.

C.12. Accident care

C.12.1. General

'Accident' within the meaning of these terms and conditions is defined in clause A.1.
'Accident care' applies:

- to healthcare that is covered as 'accident care' under your private medical expenses insurance and/or additional insurance package;
- to the extent that your private medical expenses insurance and/or additional insurance package includes cover for accident care. This is stated on the Reimbursements Overview; and
- this healthcare is required based on the standards and norms that apply to the profession of the relevant healthcare providers; and
- this healthcare is provided as a direct consequence of an accident; and
- this healthcare is not urgent care; and
- to the extent and for as long as this healthcare is necessary to restore your medical condition or dental condition to the status immediately prior to the accident. If full recovery is not possible, this accident care comprises healthcare that brings you reasonably close to this state of recovery in accordance with the latest practical and theoretical standards. We do not reimburse healthcare required due to a lack of maintenance or care of your teeth or other body parts, or healthcare relating to a bodily function,

condition, teeth, or body parts that were already missing at the time of the accident.

C.12.2. Abroad

We do not reimburse the costs of accident care if this accident care is provided outside the Netherlands (or, if you live in another country, outside your country of residence).

C.12.3. More than one policy

If you have taken out two or more insurance policies with us, each of which reimburses costs for the same accident care, costs will only be reimbursed under the policy with the highest reimbursement for accident care. If both insurance policies offer the same level of reimbursement for these costs, the costs will be reimbursed through only one of these insurance policies.

C.12.4. Conditions for reimbursement

You are insured for certain types of accident care:

- if the accident took place when you were insured with us for the particular type of accident care; and
- from the moment we receive the notification or a statement from you or from a healthcare provider on your behalf:
  - that you have been injured in an accident; and
  - specifying when the accident occurred; and
  - stating that the particular type of healthcare is required as a direct result of the accident.

  This notification must be provided as soon as possible; no later than when the treatment under the accident care starts; or
- if you have such, you send us the official police report showing the date and the circumstances of the accident.

C.13. Deleted

SECTION D

HEALTHCARE COVERED BY THE ADDITIONAL INSURANCE PACKAGES

D.1. Specialist medical healthcare

D.1.1. Sterilisation

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of sterilisation.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

Healthcare provider

- in the case of an insured male, the treatment is carried out by or under the responsibility of a medical specialist or general practitioner.
- in the case of an insured female, the treatment is carried out by or under the responsibility of a medical specialist (gynaecologist).

Referral

A doctor or doctor for the mentally disabled needs to provide a referral before treatment commences.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.1.2. Sterilisation reversal

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse sterilisation reversal.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other

healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

Healthcare provider
The treatment is carried out by or under the responsibility of a medical specialist.
Referral
A doctor or doctor for the mentally disabled needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.1.3. Ear position correction surgery

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse correction of the position of the ears (protruding ears).
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The treatment is carried out by or under the responsibility of a medical specialist.
Referral
A doctor, doctor for the mentally disabled or youth healthcare doctor needs to provide a referral before treatment commences.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.1.4. Laser eye surgery or lens implant

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse eyesight correction by means of laser eye treatment or lens implant such as that done by medical specialists. A maximum reimbursement for a specified period applies.
The amount of the reimbursement and the length of the period are shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

General
- the treatment is not reimbursed through the health insurance.
- you have not yet reached the maximum level of reimbursement within the specified period.

Healthcare provider
The treatment is carried out by a medical specialist (ophthalmologist).
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.1.5. Deleted

D.1.6. Deleted

D.1.7. Cosmetic treatment

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse cosmetic treatments solely aimed at improving a person's appearance.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- reimbursement of laser eye treatment comes under clause D.1.4. (eyesight correction), not under the present clause. Check your

Reimbursements Overview to see whether you are entitled to reimbursement.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

General
- the maximum reimbursement applies over the entire period that you have an additional insurance package with us that includes this reimbursement.
- the maximum reimbursement applies for all cosmetic treatments together.

Healthcare provider
The healthcare is provided by a medical specialist.
Approval
Approval (see clause A.18.) is required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.1.8. Treatment for snoring

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse treatment for snoring. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of medical aids (prescribed or otherwise) to prevent snoring.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

Healthcare provider
The healthcare is provided by a medical specialist.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.1.9. Breast prosthesis

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse medical specialist care (plastic surgery) where one or both breast prostheses are replaced.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.
- the deductible does apply, however, to other healthcare like preliminary examinations, follow-up checks or laboratory tests if these do not come under the DBC healthcare product code for the procedure.

Terms and conditions

General
- the treatment concerned involves the replacement of one or more breast prostheses in circumstances other than following a mastectomy or in the case of agenesis/aplasia of the breast(s).
- one of the situations described in clause B.4.5. must exist.

Please note!
- replacement of a breast prosthesis (or two breast prostheses) implanted following a mastectomy or as a result of the complete failure of one or both breasts to develop in women (agenesis/aplasia) can be reimbursed under the health insurance. For more information, please refer to clause B.4.1.

Healthcare provider
The healthcare is provided by a facility for specialist medical healthcare or a medical specialist.
Approval
Approval (see clause A.18.) is required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2. Prevention

D.2.1. Deleted

D.2.2. Prevention: examinations, training and vaccinations

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the following examinations, health courses or healthcare:

a. preventive examination to identify risk factors related to cardiovascular disease;
b. online health check or a basic preventive examination to identify risk factors related to conditions that could restrict or limit the ability to work. This examination or check is carried out in the manner agreed with the healthcare provider or healthcare facility we have contracted to provide this healthcare.
c. the Basic Health Check and finger prick ('Gezondheidscheck Basis en vingerprik') carried out following a health check designated by us. The health check consists of a personal account where you are given access to selected modules. After completing the health check, you receive a personalised health report and health plan with practical advice and suggestions on where to get the help required;
d. examination to identify complaints restricting the ability to work;
e. deleted;
f. deleted;
g. e-Health: this is a personalised online training course with both educational and action modules aimed at motivating the participant to make changes in his or her behaviour to prevent symptoms and/or reduce their impact;
h. health check: this is a health check using an online health questionnaire and could also possibly include a blood test to determine several baseline values. After the check, you receive online feedback with practical advice;
i. preventive influenza vaccination (the 'flu jab');
j. preventive meningococcal vaccination.
k. online course on infant nutrition;
l. online 'healthy cooking' course
m. webinars;
n. 'Kanjertraining' course;
o. vitality/lifestyle check;
p. vitality/lifestyle coaching;

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse:
  - self-tests;
  - examinations (preventive or otherwise) relating to prevention programmes;
  - examinations (preventive or otherwise) for which a permit is required under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO);
  - imaging diagnostics (a Total Body Scan, for example);
  - tests that are obligatory by law or are based on a collective labour agreement;
- vaccinations that have been or should have been given in accordance with the Dutch Public Health (Preventive Measures) Act ('Wet collectieve preventie volksgezondheid', WCPV) or a national immunisation programme;
- examinations, tests and treatments (all preventive or otherwise) of a sports medicine nature are reimbursed under clause D.2.6. 'Sports medicine-related advice', not under the present clause;
- laboratory tests are reimbursed under clause B.3. 'General practitioner care' if they are carried out by the general practitioner, or under clause B.4. 'Specialist medical healthcare' if they are carried out by a laboratory. They are not reimbursed under the present clause.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the preventive examination is aimed at conditions, or risk factors for conditions, for which an effective, targeted treatment is possible;
- the health check referred to in clause D.2.2.c. and any follow-up checks are conducted on a website designated by us;
- follow-up examinations take place in direct response to and on the recommendation of the health check.

Healthcare provider

- the preventive examination referred to in clause D.2.2.a. is carried out by your general practitioner or an authorised healthcare provider or employee within the practice of the general practitioner who works under the final responsibility of the general practitioner.
- the preventive examination referred to in clause D.2.2.b. is only performed by a healthcare provider who or healthcare facility that has a contract with us for this healthcare.
- the health check and any follow-up examinations as specified in clause D.2.2.c. are

conducted by the healthcare provider who is affiliated with the website that has been contracted by us for this healthcare.
- for the examination to identify complaints restricting the ability to work referred to in clause D.2.2.d, the healthcare provider or healthcare facility does not need to have a contract with us.
- The e-Health referred to in clause D.2.2g. is provided by a healthcare provider with whom we have made agreements concerning this service. You will find the details for this/these healthcare provider(s) on your Reimbursements Overview or on our website. The name of the programme is listed on your Reimbursements Overview.
- the preventive vaccinations referred to in clauses D.2.2.i. and D.2.2.j. are performed by or under the responsibility of a doctor; the vaccine is supplied by the 'GGD' (regional health authority) or a supplier who has a contract with us for this healthcare.
- The health check, the courses, examinations and such referred to in clause D.2.2.h. and D.2.2.k. to p. are provided by a healthcare provider with whom we have made agreements concerning these services. The details for this/these healthcare provider(s) are available on our website.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.3. Prevention for travel abroad

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse preventive measures for trips to a country with a heightened risk of infectious diseases and parasitic conditions.
If a vaccination booklet is classed as an official certificate for this healthcare, we reimburse this too. We also reimburse the costs of consultation (we do not reimburse additional costs for the use of a clinic for people with a needle phobia).
The healthcare and the amount we reimburse is shown on your Reimbursements Overview.

We reimburse the following for the prevention of infectious diseases and parasitic conditions:
a. pills (with a prescription for enough pills to last a maximum of six months) to prevent:
   - malaria;
   - typhoid;

b. a vaccination for:
   - diphtheria;
   - tetanus;
   - polio;
   - measles, mumps and rubella (MMR);
   - hepatitis A;
   - hepatitis A/B (TwinRix combination vaccine);
   - hepatitis B;
   - yellow fever;
   - typhoid;
   - and/or a blood test in connection with hepatitis B;

c. a vaccination for and/or examination concerning:
   - tuberculosis;
   - meningitis;
   - Japanese encephalitis;
   - tick-borne encephalitis;
   - rabies;

   and/or a Mantoux test to screen for possible tuberculosis. The Mantoux test is carried out as a preventive measure before travelling to a country with a heightened risk of infectious diseases and parasitic conditions;
d. (deleted);
e. preventive vaccinations and preventive medicines (with a prescription for enough pills to last a maximum of six months), blood test in connection with hepatitis B and a Mantoux test to screen for possible tuberculosis in preparation for a trip (for holiday or other reason) to a country with a heightened risk.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse vaccinations that have been or should have been given in accordance with the Dutch Public Health (Preventive Measures) Act ('Wet collectieve preventie volksgezondheid', WCPV) or a national immunisation programme.
- we do not reimburse the Mantoux test under this clause if it is given after returning from a trip, but the test may possibly come under the healthcare provided by clause B.3.2.
- the healthcare is not subject to a deductible.

Terms and conditions

General
You will be going on a trip to a country with a heightened risk of illnesses for which preventive vaccinations, medicines or tests are prescribed.
Healthcare provider
- the preventive medicines or vaccinations are administered and/or tests are performed by a doctor, company doctor or healthcare facility

registered and affiliated with the Dutch national coordination centre for travel advice ('Landelijk Coördinatiecentrum Reizigersadvisering', LCR) (such as a 'GGD', regional health authority), or by a doctor registered with the body of doctors with special qualifications ('College voor Huisartsen met Bijzondere Bekwaamheden') or who is affiliated with the LCR.
- the vaccines for the preventive vaccinations are supplied by a pharmacy, a 'GGD' (regional health authority) or a supplier recognised by us. You can find out which these are on our website.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.4. Deleted

D.2.5. Consultation on menopause, PMS or breast cancer

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of consultations relating to:
a. menopause and PMS (premenstrual syndrome)
b. cancer/breast cancer.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- for preconception care (relating to a desire to have children) see clauses B.3.1. and B.5.1.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
- The menopause and PMS consultations (a.) are given by:
  - a menopause or PMS consultant affiliated with Care for Women or the Dutch association for specialist menopause nurses ('Vereniging Verpleegkundig Overgangs Consulenten', VVOC);
  - a facility specialising in menopause consultations.
- the other consultations (b.) are given by a consultant affiliated with Care for Women.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.6. Sports medicine-related advice

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse:
- sports examinations;
- sports medicine-related examinations.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The healthcare provider is a doctor listed as a sports doctor on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS) in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg') and working in a sports medicine-related advice centre or sports medicine-related facility certified by the Foundation for the Certification of Actors in Sports Healthcare ('Stichting Certificering Actoren in de Sportgezondheidszorg', SCAS).
By way of exception, the healthcare provider for a diving medical examination is a sports doctor who is:
- registered as an SCAS-certified diving medical examiner (SCAS is the Foundation for the Certification of Actors in Sports Healthcare ('Stichting Certificering Actoren in de Sportgezondheidszorg')); or
- a Medical Examiner of Divers (MED) level 1 with the European College of Baromedicine (ECB).

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.7. Dietary advice

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of dietary advice, i.e. advice and support for weight control.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- you can receive treatment and support if you are healthy and if you are overweight (BMI between 25 and 30) or, by way of exception, obese (BMI above 30);
- the healthcare is aimed at weight control.

Healthcare provider

The healthcare is provided by:

- a qualified weight management consultant affiliated with the Dutch association of weight management consultants ('Beroepsvereniging Gewichtsconsulenten Nederland', BGN);
- a dietician.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.2.8. Health course

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse health courses aimed at preventing illnesses and/or improving your health or in which you learn how to deal with your illness. The health course will allow you to maintain and/or improve your physical or mental health.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse:
  - work-related and/or recreational therapy;
  - exercise programmes — these come under clause D.22. Check your Reimbursements Overview to see if you are covered for these;
  - company emergency responder courses, including Baby and Child First Aid courses for registration as a childminder ('Gastouder') as defined in the Dutch Childcare Act ('Wet kinderopvang').
- the healthcare is not subject to a deductible.

Terms and conditions

General

- we use the commencement date of the health course to determine the reimbursement.
- in this context, a health course is also defined as:
  - a First Aid course if you complete that course with an examination and are awarded a valid and registered certificate/diploma;
  - a First Aid refresher course if this extends the validity of a certificate/diploma you have already been awarded;
  - separate First Aid modules;
  - a membership fee, if this entitles you to First Aid refresher courses;
  - a First Aid for toddlers course.
- on completion of the First Aid course/First Aid module, you must enclose a copy of your certificate/diploma when you submit the invoice.

Healthcare provider

The health course is provided by:

- a home care organisation;
- a 'GGD' (regional health authority);
- a national or regional patients' association;
- a hospital (facility for specialist medical healthcare) or outpatient clinic of such a facility;
- in the case of First Aid courses, an organisation or association that is the qualitative equivalent of the 'Oranje Kruis' or Red Cross. This healthcare provider gives courses for insured persons who are not taking the course in connection with practising a profession or for occupational use. A list of professional organisations is available on our website;
- a healthcare group with which we have entered into agreements on the specified health course;
- an organisation, other than those mentioned above, that has a contract with us for this healthcare.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.2.9. Patients' association

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the contribution and/or the

registration fees for:
a. one or more patients' associations;
b. a district nursing association ('kruisvereniging') or home care organisation.

Please see your Reimbursements Overview to find out which healthcare is reimbursed, as well as the number of associations/organisations and the amount of the contribution/registration fee.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The contribution and/or the registration fee is for membership of:
- a national or regional patients' association;
- a district nursing association ('kruisvereniging') or home care organisation that can be organised/can operate either regionally or nationally.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.10. Fall prevention

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse programmes aimed at decreasing your chance of falling.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse programmes other than those specifically named below.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- you have participated in a programme designated as 'bewezen effectief' (proven effective) by the Dutch Centre for Healthy Living ('Centrum Gezond Leven'). These are the 'In Balans' (in balance), 'Zicht op Evenwicht' (a view to balance), 'Vallen Verleden Tijd' (falling, a thing of the past) and 'Otago' programmes.
- we use the commencement date of the fall prevention programme to determine the reimbursement.
- on completion of the programme, you must send us proof of participation together with a claim form.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.11. Self-management course

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse courses aimed at increasing your independence so that you can carry out, on your own – completely or in part – the required healthcare activities. The purpose of these self-management courses is to teach you how to deal with your own chronic condition better and, as a result, make fewer demands on formal healthcare.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse:
  - work-related and/or recreational therapy;
  - health courses — these come under clause D.2.8. Check your Reimbursements Overview to see if you are covered for these;
  - exercise programmes — these come under clause D.22. Check your Reimbursements Overview to see if you are covered for these.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- we use the commencement date of the self-management course to determine the reimbursement.
- you have a chronic condition. This is the case, for example, if you are entitled to receive multidisciplinary care in relation to:
  - diabetes mellitus type II (DM Type II) in insured persons who are aged 18 or above;
  - vascular risk management (VRM) to manage cardiovascular disease;
  - chronic obstructive pulmonary disease (COPD);
  - asthma.
- on completion of the self-management course,

you must enclose a copy of your certificate/diploma when you submit the invoice.

Healthcare provider
The self-management course is given by:
- a home care organisation;
- a 'GGD' (regional health authority);
- a national or regional patients' association;
- an organisation, other than those mentioned above, that has a contract with us for this healthcare.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.2.12. Health test

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of an integrated medical health test. This test is aimed at the prevention and early detection of diseases and disorders, and is followed by recommendations. The medical health test comprises:
- a general questionnaire about your health;
- measuring your blood pressure and your waist, and calculating your BMI (Body Mass Index);
- a blood test to check your cholesterol and glucose level;
- urinalysis for protein, blood and glucose;
- a pulmonary function test;
- an eye test;
- a written report at the end with the results of the various tests and recommendations.

This medical health test can be supplemented with:
- audiological screening;
- exercise stress test ('bike test');
- personal lifestyle discussion.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of:
  - preventive medical examinations for cancer or other serious diseases or abnormalities for which no prevention or treatment is possible;
  - a preventive medical examination as part of the preventive medical examination for workers ('Preventief Medisch Onderzoek van werkenden; 'PMO') carried out in accordance with the Dutch Working Conditions Act ('Arbeidsomstandighedenwet');
  - MRIs, CT scans and total body scans.
- the bill must specify all the components (tests, etc.) of the health test.
- the healthcare is not subject to a deductible.

Healthcare provider
The health test is carried out by a general practitioner, company doctor or medical specialist.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.3. Medicines

D.3.1. Medicines, general

Clause B.15.1. contains the general terms and conditions that apply to your medicines under the health insurance. The terms and conditions in clause B.15.1. also apply to the medicines specified under clause D.3.1. to D.3.5. inclusive.
Waar wij het begrip "geneesmiddel(en)" gebruiken, bedoelen wij medicijn(en) en andersom.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the following costs, not even from one of the other components of your additional insurance package:
  - medicines that we have not designated (non-preferred medicines);
  - tonics/invigorating agents, slimming preparations, dietary supplements (apart from a few registered dietary supplements), dietary preparations and vitamin preparations;
  - personal care products such as soaps, shampoos, bath oils, balsams, lotions and/or hair growth preparations;
  - medicines to treat nicotine dependency. For more information, please refer to clause B.21.2. Quit smoking course.
- we do not reimburse the costs mentioned below, except where, according to your Reimbursements Overview, you are expressly insured for the relevant section of clause D.3.
  - alternative (homoeopathic and anthroposophic) medicines (see clause D.7.2. for more information);
  - statutory personal contributions for medicines covered by the health insurance;
  - medicines not covered by the health insurance because they are not included in the Medicines Reimbursement System (GVS);
  - medicines that do not satisfy the terms and

conditions in Appendix 2 (medicines) of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), the text of which is available (in Dutch) on the government website at wetten.overheid.nl (in Dutch);
  - medicines that are precautionary, or aimed at preventing illness in relation to trips abroad;
  - certain registered dietary supplements.
- the healthcare is not subject to a deductible.

D.3.2. Medicines, statutory personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the statutory personal contributions that you must pay for the following under the Medicines Reimbursement System (GVS):

a. contraceptive medicines;
b. medicines other than contraceptives;
c. all medicines.

The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- see clause D.3.1. to find out which medicines we do not reimburse.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.3.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

Under the health insurance, you receive partial reimbursement for the medicines for which a statutory Medicines Reimbursement System (GVS) personal contribution applies.

Healthcare provider

The medicines are supplied by or under the supervision of a pharmacist, dispensing general practitioner or online pharmacy.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.3.3. Medicines for erectile dysfunction

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of medicines for erectile dysfunction (e.g. Viagra®, Cialis®, Levitra®, Androskat®, Spedra® and Muse®).

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.3.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- the medicines are registered in accordance with the Dutch Medicines Act ('Geneesmiddelenwet').
- the medicines are registered in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index'.

Healthcare provider

The medicines are supplied by or under the supervision of a pharmacist, dispensing general practitioner or online pharmacy.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.3.4. Medicines, other

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse registered medicines that are not reimbursed under the health insurance.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- see clause D.3.1. to find out which medicines we do not reimburse.

- we do not reimburse medicines under this clause that are covered by one of the other clauses in D.3.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.3.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The products concerned are certain medicines or dietary supplements that have a European registration in an EU or EEA member state, recognisable by an EU number, and which also have an 'RVG' number.

Medicines and dietary supplements that are proven to be effective and safe and are registered in the Netherlands are given an 'RVG' number.

To see whether a medicine or supplement is registered, please visit www.geneesmiddeleninformatiebank.nl/en/.

Examples:

- registered glucosamine in the case of joint complaints;
- registered melatonin for children with ADHD.

Healthcare provider

The medicines are supplied by or under the supervision of a pharmacist, dispensing general practitioner or online pharmacy.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.3.5. Contraceptives

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the following contraceptive medicines and contraceptive medical aids that are reimbursed up to a specific age under the health insurance:

a. contraceptive pill ('the pill');
b. all contraceptive medicines and/or contraceptive medical aids.

The amount we reimburse and up to what age is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.3.1. for the terms and conditions for contraceptive medicines and clause D.4.0. for the terms and conditions for contraceptive medical aids. The terms and conditions that apply to fitting a diaphragm or inserting an intrauterine device (based on clause D.4.0.) are listed in our regulations on medical aids ('Reglement Hulpmiddelen'). The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- the contraceptive medicine or medical aid is reimbursed up to the age of 21 under the health insurance.
- you are not reimbursed for the contraceptive medicines and/or medical aids under the health insurance because your age does not meet the conditions stipulated for this.

Healthcare provider

- the contraceptive medicine is supplied by or under the supervision of a pharmacist, dispensing general practitioner or online pharmacy.
- the contraceptive medical aid is supplied by a healthcare provider designated by us.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.4. Medical aids

D.4.0. Medical aids, general

General

- under the health insurance, you are insured for the provision of functioning medical aids. 'Functioning' is taken to mean that the medical aids are ready for use on delivery. These medical aids are described in our regulations on medical aids ('Reglement Hulpmiddelen') and the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), the text of which is available (in Dutch) on the government website at wetten.overheid.nl (in Dutch).
- medical aids may already be covered, in part or in whole, under the health insurance. Clause B.17. will tell you whether you are insured for this

healthcare.
- furthermore, you may be entitled, under D.4., to reimbursement for certain medical aids for which no reimbursement is provided under the health insurance.

Healthcare provider
- the medical aid is supplied by a healthcare provider designated or contracted by us, which may differ per medical aid.
- if we have not contracted or designated a healthcare provider, you may decide for yourself where to purchase the medical aid.

Prescription
If you require a treatment proposal, we state this for the medical aid concerned.

Approval
- approval (see clause A.18.) is required if this is stated for that particular aid in the clause.
- if we have issued approval for a medical aid under your health insurance, this applies to an additional insurance package too.

D.4.1. Medical aids

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

Under the health insurance, you are insured for the provision of functioning medical aids. 'Functioning' is taken to mean that the medical aids are ready for use on delivery. These medical aids are described in our regulations on medical aids ('Reglement Hulpmiddelen') and the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), the text of which is available on the government website at wetten.overheid.nl (in Dutch).
A statutory personal contribution and/or statutory maximum reimbursement applies to a number of medical aids.
In addition to cover provided by the health insurance, we reimburse the following for these medical aids:
- the statutory personal contributions; and/or
- costs above the statutory maximum reimbursement.

The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the exclusions stated under clause B.17.1. apply here as well.
- additional costs and the costs for a deluxe model of a medical aid are not reimbursed.
- the healthcare is not subject to a deductible.

D.4.2. Orthopaedic shoes, statutory personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse all or part of the statutory personal contribution that you have to pay under the health insurance for orthopaedic shoes produced individually and specifically for you (or a modification to such shoes).

Please note!
see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General
You are reimbursed in part or in whole through the health insurance for bespoke orthopaedic shoes or the modification of such shoes.

Approval
Approval is not required.

D.4.3. Deleted

D.4.4. Wig or other headpiece

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse (or reimburse part of):
a. the amount you have to pay yourself for a wig because the costs exceed the statutory maximum reimbursement under the health insurance; or
b. another form of headpiece.

The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

For another form of headpiece as referred to in clause D.4.4.b., the terms and conditions of clause D.4.0. apply as if the headpiece were a wig. The terms and conditions for functioning medical aids in the regulations on medical aids ('Reglement Hulpmiddelen') are therefore applicable.

Approval

Approval (see clause A.18.) is required.

D.4.5. Hearing aids, statutory personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse all or part of the statutory personal contribution that you have to pay yourself under the health insurance for one or more hearing aids.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

See clauses A.21. and C.10. for general exclusions.

- the healthcare is not subject to a deductible.

Explanation:
If you receive a partial reimbursement under the health insurance for a tinnitus masker, you can also use the reimbursement from the additional insurance package for the tinnitus masker.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You are reimbursed in part or in whole for the costs of the hearing aid through the health insurance.

Approval

Approval is not required.

D.4.6. Bedwetting alarm

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse a bedwetting alarm with the necessary accessories when purchased or hired.
The amount we reimburse is shown on your Reimbursements Overview. The reimbursement is provided one time for as long as you are insured with us.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of hire if we have already reimbursed purchase costs and vice versa.
- we only reimburse the costs of the associated underpants (max. 3) on the first occasion when you purchase or rent the equipment.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

Healthcare provider

You buy or hire the bedwetting alarm from a medical supplies shop, home care shop or pharmacy.

Approval

Approval is not required.

D.4.7. Glasses and lenses

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the following vision aids:

a. contact lenses (daytime and/or overnight contact lenses);
b. lenses for glasses;
c. frame for glasses that you purchase at the same time as the lenses for glasses.

We also reimburse all or part of the statutory personal contribution that you have to pay yourself under the health insurance for the glasses or contact lenses.

The amount we reimburse is shown on your Reimbursements Overview. This shows the maximum amount up to which we reimburse in a specific period.

The period stated on your Reimbursements Overview starts on 1 January of the year in which you receive your glasses or contact lenses.

Example:
Let's say that for 4 years you've had an additional insurance package under which we reimburse a maximum of €100 for lenses for glasses and

contact lenses over a period of two calendar years. You order a pair of glasses for which the lenses cost €230 and you pick them up on 7 June 2022. You submit the invoice to us. This is the first invoice we have received from you in the 4 years that you have had this additional insurance with us. The period in which the reimbursement falls starts on 1 January 2022 (the year in which you buy the glasses) and runs to 31 December 2023 (two years later). We reimburse €100 of the costs invoiced for the glasses.
On 15 November 2022, you purchase new lenses. Since this falls within the original two-year period (1 January 2022 to 31 December 2023) and you have already received the maximum reimbursement for this period, we will not reimburse you for the cost of these new lenses.

In some additional insurance packages, eyesight correction (clause D.1.4.) can come under the same maximum reimbursement as vision aids. To find out whether this applies to you, please see the Reimbursements Overview for your additional insurance package.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- if you do not submit an invoice in a particular period, the amount for that period is not carried over to the next.
- we do not reimburse:
  - frames for glasses that are not purchased at the same time as the lenses for glasses;
  - non-optical accessories (such as a glasses case or cleaning solution);
  - service agreements or insurance;
  - non-prescription optical products;
  - grinding and/or refitting lenses for a different frame;
  - additional costs.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
General
- prescription vision aids are involved.
- glasses and contact lenses are prescription and are used for vision correction; overnight contact lenses are used for vision correction as well.
- you have not yet reached the maximum level of reimbursement within the specified period.
- the invoice must be sufficiently detailed (details of all items).

Approval
Approval is not required.

D.4.8. Orthotic insoles

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse measurement, purchase and repair of orthotic insoles.
The amount we reimburse is shown on your Reimbursements Overview. The maximum reimbursement stated here applies to orthotic insoles and medical aids for foot care (see clause D.4.9.) together.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
General
This concerns orthotic insoles made for you personally.
Healthcare provider
The orthopaedic shoemaker or the orthopaedic instrument maker who makes the orthotic insoles has been recognised by us or has a contract with us for this healthcare.
Approval
Approval is not required.

D.4.9. Foot care, medical aids

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the purchase and repair of medical aids for foot care.

Example:
insoles, tape, pressure bandage, nail prostheses and nail braces.

The amount we reimburse is shown on your Reimbursements Overview. The maximum reimbursement stated here applies to medical aids for foot care and orthotic insoles (see clause D.4.8.) together.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of medical aids for personal foot care such as the removal of calluses for cosmetic reasons or general toenail care.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You are insured with us for treatment by a podiatrist, chiropodist and pedicurist for which the medical aids for foot care have been prescribed and supplied.

Healthcare provider

The medical aids for foot care are supplied by a podiatrist, chiropodist or pedicurist.

Prescription

A podiatrist, chiropodist or pedicurist must have determined that the medical aids are medically necessary.

Approval

Approval is not required.

D.4.10. Home monitor

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We provide you with a home monitor on loan.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

There must have been a previous cot death (sudden infant death syndrome) in the family.

Prescription

A paediatrician must have determined that a home monitor and any renewal of the loan period is medically necessary.

Approval

Approval (see clause A.18.) is required.

D.4.11. Medical aids for ADLs

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse medical aids for Activities of Daily Living (ADLs), i.e. medical aids that help you to carry out Activities of Daily Living.
The amount we reimburse is shown on your Reimbursements Overview.

Example:
Simple, supporting medical aids that help you to wash, dry and dress yourself, go to the toilet and cook and eat meals. The list of these medical aids is available on our website.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You have a serious joint condition or long-term neurological disorder.

Healthcare provider

The medical aid is supplied by one of our recognised suppliers, a medical supplies shop, home care shop or another supplier if they have been recommended by the occupational therapist; this can even be a retail shop selling housewares.

Prescription

An occupational therapist must have determined which medical aid for ADLs is the most suitable for you. You must send this treatment proposal along with the bill.

Approval

Approval is not required.

D.4.12. Home care items

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the cost of home care items like latex gloves, ketone strips or a Haberman teat.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The home care items are used for the care and/or protection of a sick person and of the formal or informal carer in the home situation.

Approval

Approval (see clause A.18.) is required for ketone strips.

D.4.13. Deleted

D.4.14. Support pessary

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of a support pessary and its insertion.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

The support pessary is necessary to treat a prolapse.

Healthcare provider

The support pessary is fitted by a general practitioner.

Approval

Approval is not required.

D.4.15. Test strips

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse diabetes testing supplies, specifically test strips and the related lancets, lancing devices and/or blood glucose meter.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- you are a diabetic who does not use insulin; and/or
- you are not entitled to reimbursement of this healthcare under the health insurance.

Healthcare provider

A pharmacy, dispensing general practitioner or medical supplies shop supplies the test strips and the related lancets, lancing devices and/or blood glucose meter.

Approval

Approval is not required.

D.4.16. Personal alarms

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse:

a. connection charges and subscription costs for an emergency centre for personal alarms, based on social grounds;

b. connection charges and subscription costs for an emergency centre for personal alarms:
   - for which you are insured under the health insurance based on medical grounds; or
   - for which you are insured, under the Dutch Social Support Act (Wmo) based on social grounds, through the municipality.

The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

Healthcare provider

The loan, purchase or hire takes place through a medical supplies shop, home care shop or personal alarm service.

Approval

Approval (see clause A.18.) is required.

D.4.17. Deleted

D.4.18. Braces and bandages

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse braces and bandages, if they are not reimbursed under the health insurance.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

Approval

Approval is not required.

D.4.19. Hypoallergenic footwear, statutory personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse all or part of the statutory personal contribution that you have to pay under the health insurance for hypoallergenic footwear produced individually and specifically for you.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You are reimbursed in part or in whole for the costs of the footwear through the health insurance.

Approval

Approval is not required.

D.4.20. Epileptic seizure alarms

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse a bed mat that detects serious epileptic (tonic-clonic) seizures and raises an alert.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

Prescription

A neurologist from a specialist epilepsy centre must have determined that the epilepsy is so severe that the bed mat as an alarm device is indicated.

Approval

Approval is not required.

D.4.21. Cranial orthosis

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse a cranial orthosis.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General
You child has plagiocephaly or brachycephaly (flat head syndrome) without craniosynostosis (fusion of the skull bones).
Prescription
A medical specialist must have determined that a cranial orthosis is required for your child's treatment.
Approval
Approval (see clause A.18.) is required.

D.4.22. Post-mastectomy lingerie

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse (or reimburse part of) the costs of post-mastectomy lingerie (bras and/or swimwear) designed specifically to hold a breast prosthesis.
The amount we reimburse is shown on your Reimbursements Overview.

Explanation:
You can buy a single item of post-mastectomy lingerie or several and you can purchase them at one shop or several different shops and on one day or over several days.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.4.0. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
General
- you must have undergone a mastectomy (complete or partial), regardless of whether breast reconstruction surgery was carried out afterwards.
- the post-mastectomy lingerie must be purchased within 36 months of the mastectomy.

Approval
Approval is not required.

D.4.23. Hand and finger splints

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of a hand and/or finger splint. The hand and/or finger splint is used temporarily as part of treatment to stabilise, support and/or correct a joint.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of a splint used to prevent injury, for example while playing sports.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The healthcare is provided by a healthcare provider recognised by us. A list of these healthcare providers is available on our website.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.4.24. Walking aid following an accident

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of simple walking aids, i.e. crutches, walking frame, walking stick, quad cane and/or walker, if you need this/these for your recovery after an accident.

Terms and conditions

General
Refer to clause C.12. for a description of 'accident care'.
Healthcare provider
The medical aid is supplied by a healthcare provider who has a contract with us. A list of these healthcare providers is available on our website.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.5. Stammer therapy

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse:
a. stammer therapy using one of the following methods:
   - Del Ferro; or
   - BOMA; or
   - Hausdörfer Institute for Natural Speech ('Hausdörfer Instituut voor Natuurlijk

Spreken'); and
b. accommodation costs.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- stammer therapy also comes under healthcare, as provided by a speech and language therapist, which is insured under the health insurance. Clause B.10. will tell you whether you are insured for this healthcare. If you are, cover under the health insurance takes precedence over reimbursement through this additional insurance package.
- we do not reimburse any travel/transport costs that you incur in connection with the stammer therapy.

Terms and conditions

General

Costs of accommodation are only eligible for reimbursement:
- if you are also insured under the terms of clause D.5.b.; and
- if the stammer therapy is also reimbursed; and
- if these accommodation costs are essential costs directly related to your stay; and
- if and only for as long as the stammer therapy is given on an in-patient basis.

Approval

Approval (see clause A.18.) is required for stammer therapy (with or without a stay). We may stipulate other conditions as well for the approval.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6. Mental healthcare

D.6.1. Deleted

D.6.2. Deleted

D.6.3. Drop-in centre

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse social-mental healthcare for cancer patients/survivors and, where applicable, their partners and family members, provided in a drop-in centre.

If the partner and family members are insured with us for social-mental healthcare themselves, the costs will be eligible for reimbursement under their own additional insurance package.

If the partner and family members are not insured for social-mental healthcare themselves, or are not insured with us at all, the costs will be eligible for reimbursement under the insured patient's additional insurance package.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider

The care is provided in a drop-in centre for cancer patients/survivors that we have recognised, as long as the centre, in our view, provides a satisfactory level of care. A list of the conditions a drop-in centre must meet is available on our website.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6.4. Light therapy, seasonal affective disorder

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse hire or purchase costs for equipment that is necessary for light therapy at your home to treat seasonal affective disorder (SAD), or you will receive the equipment on loan.

What we will provide you with and the amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for the general exclusions.
- the cost of light therapy glasses is not reimbursed because they cannot provide a light intensity of 10,000 lux.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the device is equipped for full-spectrum light therapy at an intensity of 10,000 lux.
- the healthcare is provided in your own home.

Treatment proposal

A psychiatrist or psychotherapist must have determined that the light therapy is medically necessary to treat your seasonal affective disorder.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6.5. Coping with traumas

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

The healthcare comprises immediate and long-term care provided straight after a work-related traumatic event if you are the victim of or are directly involved in:

- a robbery, hostage taking, act of aggression;
- an accident resulting in bodily injury, sudden death (by suicide for example); or
- inappropriate behaviour.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the traumatic event must have been unexpected and have affected you to such a degree (temporarily or permanently) that you are no longer able to function normally in your daily activities.
- the traumatic work-related event must relate to the performance of your work, and must involve an industrial accident, robbery, hostage taking or aggression resulting in injury, or the suicide of a co-worker.
- there must be proof that the event occurred.
- the traumatic event must have occurred in the Netherlands.

Healthcare provider

The healthcare is provided by a facility specialising in the provision of post-trauma psychosocial assistance contracted or recognised by us.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6.6. Online psychological programme

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of an online psychological programme.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider

The psychological programme is offered online by a healthcare provider who has a contract with us for this healthcare. The name of the programme or the healthcare provider is listed on the Reimbursements Overview.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6.7. Mindfulness

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of telephone support (coaching over the telephone) when you are following an e-Health (blended care) mindfulness programme for stress-related complaints or burnout (or impending burnout). This is an occupational psychological intervention comprising an initial assessment by telephone and follow-up telephone calls with a mindfulness trainer for a total of 90 minutes.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider

The telephone support is provided by a

mindfulness trainer from a nationally operating organisation recognised or contracted by us. You can find this organisation on our website or we can provide you with the details on request.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.6.8. Mindfulness training

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

Online mindfulness training.

Healthcare provider

The mindfulness training is provided by a healthcare provider with whom we have made agreements concerning this training. The details for this/these healthcare provider(s) is available on our website.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.7. Alternative treatment methods

D.7.1. Alternative and/or psychosocial treatments

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of the following types of treatment:

- acupuncture;
- chiropractic treatment;
- homoeopathy;
- osteopathy;
- naturopathy. This includes:
  - anthroposophic medicine consultation;
  - auriculotherapy;
  - haptonomy/haptotherapy;
  - kinesiology;
  - musculoskeletal medicine;
  - orthomanual medicine;
  - reflex zone therapy/foot reflex therapy;
  - shiatsu;
  - manual therapy.

  We do not reimburse the costs of any other type of natural medicine.
- psychosocial healthcare.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of:
  - healthcare (consultations and treatments) covered under your health insurance, the Dutch Youth Act ('Jeugdwet'), the Dutch Long-Term Care Act (Wlz), the Dutch Social Support Act (Wmo) or another clause of your additional insurance package(s), regardless of whether you are insured for treatment under that other clause or do not qualify for full or partial reimbursement under the other clause. You cannot choose under which clause the healthcare will be reimbursed, nor can you be reimbursed twice for the same healthcare.

    Only after it has been determined that the healthcare is not covered by your health insurance, the Dutch Youth Act ('Jeugdwet'), the Dutch Long-Term Care Act (Wlz), the Dutch Social Support Act (Wmo) or another clause in your additional insurance package(s) will we determine whether this healthcare is eligible for reimbursement as alternative healthcare or psychosocial care;
  - experimental treatments or treatments that are still in the research phase;
  - laboratory tests that have been requested by a therapist or doctor specialising in alternative healthcare or psychosocial care;
- the healthcare is not subject to a deductible.

Terms and conditions

General

The healthcare takes place in accordance with the objectives, treatment protocols and guidelines of the professional association to which the attending healthcare provider is affiliated or the professional register on which the attending healthcare provider is listed.

Healthcare provider

The treatments are provided exclusively by a therapist or doctor who is a member of a professional association for alternative treatment methods or psychosocial healthcare recognised by us and who has completed a recognised basic medical or psychosocial studies course ('MBK' or 'PsBK') that meets the training, educational and organisational requirements of PLATO ('Platform Opleiding, Onderwijs en Organisatie').

A list of the professional associations we have recognised is available on our website.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.7.2. Alternative medicines

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse anthroposophic and homoeopathic medicines and products.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- if an over-the-counter medicine is not eligible for reimbursement under the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), we do not reimburse it as an alternative medicine either. The text of the Dutch Health Insurance Regulations is available on the government website at wetten.overheid.nl (in Dutch).
- the healthcare is not subject to a deductible.

Terms and conditions

Clause B.15.1. contains the general terms and conditions that apply to your medicines under the health insurance. They also apply to clause D.7.2. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
General
- the medicines and products are registered as homoeopathic and/or anthroposophic medicines in accordance with the Dutch Medicines Act ('Geneesmiddelenwet').
- the medicines and products are registered in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index'. This database is available at https://www.z-index.nl/english.

Healthcare provider
The medicines are supplied by or under the supervision of a pharmacist, dispensing general practitioner or online pharmacy.
Treatment proposal
An alternative healthcare provider recognised by us must have determined that the medicine is medically necessary.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.8. Oral care

D.8.1. Oral care, general

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse oral care, as specified in clauses D.8.1. to D.8.6 inclusive.
The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the following:
  - costs of a mandibular repositioning device (MRD) including diagnostics and aftercare (codes G71*, G72 and G73*). A mandibular repositioning device is a medical aid used to treat snoring;
  - costs for oral care which, due to their nature, form part of the health insurance and for which approval must be granted prior to the start of the treatment. We specifically mention the following treatment codes:
    - A20: treatment under general anaesthetic or light sedation;
    - X611: treatment under intravenous (injection) sedation;
    - X631: treatment under general anaesthetic;
    - B10, B11 and B12: light sedation (nitrous oxide sedation). Sedation involves reducing a patient's consciousness for the purpose of making a medical procedure or surgery more comfortable;
    - A30: preparatory treatment under general anaesthetic;
    - U05*, X731 and X831*: time rates for supervision of patients who are difficult to treat. This concerns treatment within the scope of oral care for special healthcare groups;
    - X21: taking a panoramic dental X-ray (OPT) for insured persons under the age of 18;
    - J39: insertion of autografts (autologous implants) for insured persons under the age of 18;
  - E97: the costs of external teeth

bleaching/whitening;
  - placement of a myofunctional appliance (pre-orthodontic trainers, for example), under the code G74*;
  - treatment of white spots (codes M80* and M81*);
  - F811A*: repair or replacement of braces damaged through intentional acts or negligence.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
- a dentist;
- a dental hygienist;
- a prosthodontist;
- a healthcare provider affiliated with a centre for oral care;
- a healthcare provider affiliated with a facility for youth dental care.

Treatment proposal
A dentist must have determined that the healthcare is medically necessary.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.8.2. Crowns, bridges and inlays

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of crowns, bridges and inlays, including the costs of the associated dental treatments, and material and technical costs.
The amount we reimburse is shown on your Reimbursements Overview.

One of the forms of reimbursement specified below will apply:
- maximum amount:

If the Reimbursements Overview for your additional insurance package shows that we reimburse this oral care up to a maximum amount, this maximum reimbursement applies per year, unless the Reimbursements Overview states otherwise;
- maximum amount and specified age:

If the Reimbursements Overview for your additional insurance package shows that we reimburse this oral care up to a maximum amount and up to a certain age, this maximum reimbursement applies per year, unless the Reimbursements Overview states otherwise;
- reimbursement increase and maximum amount:

If the Reimbursements Overview for your additional insurance package states that we reimburse this oral care up to a maximum amount that increases annually, your reimbursement will increase each year by an amount that is stated in your Reimbursements Overview; the maximum amount that can be reached is also stated on your Reimbursements Overview.

Example of a 'maximum amount and reimbursement increase':
You have additional insurance with a reimbursement increase for crowns, bridges and inlays. This additional insurance package commenced on 1 January 2020, at which time the maximum reimbursement for oral care was €300. You submit an invoice for €200. Since this amount is lower than the maximum reimbursement for 2020, we fully reimburse the amount of this invoice and you still have €100 of the maximum reimbursement remaining for 2020.

On 1 January 2021, the maximum reimbursement increases for the first time by €300. You have carried over €100 from 2020, meaning that your maximum reimbursement for 2021 will be €400. This year, you do not submit any invoices for this oral care.

On 1 January 2022, the maximum reimbursement increases by €300 for the second time. You have carried over €400 from 2021, meaning that your maximum reimbursement for 2022 will be €700. Again this year, you do not submit any invoices for this oral care.

On 1 January 2023, the maximum reimbursement increases for the third time, but this time only by €200 since you have reached the maximum reimbursement amount of €900. Again this year, you do not submit any invoices for this oral care.

However, on 1 January 2024 the reimbursement does not increase any further since you have reached the maximum reimbursement amount of €900. In 2023 you submit an invoice for €1100. We reimburse €900 of this, meaning your maximum reimbursement is used in full and you will need to pay the remaining €200 yourself.

On 1 January 2025, the maximum reimbursement starts/grows again by €300, meaning your maximum reimbursement for 2025 is €300. The €200 that you had to pay yourself in 2024 is, of course, not reimbursed now since the treatment took place

in another year.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- costs not reimbursed under clause D.8.1. are not reimbursed under this clause either.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.8.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The healthcare is claimed on the basis of the dental rates decision ('tariefbeschikking tandheelkundige zorg') compiled by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). Treatment codes starting with the letter 'R' are used.

Healthcare provider

The healthcare is provided by a dentist.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.8.3. Dentures and implants

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of the following types of oral care:

a. removable partial dentures;
b. the statutory personal contributions you have to pay under your health insurance for:
   - removable full dentures, not fitted to implants;
   - removable full dentures, fitted to implants and the fixed part of the suprastructure (the 'snap-on' system);
c. implants not reimbursed under clause B.12.2. of the health insurance and the suprastructure if this is not reimbursed under clause B.14. of the health insurance.

For all of these reimbursements, this includes the costs of the dental treatments and the associated material and technical costs.

The amount we reimburse is shown on your Reimbursements Overview.

One of the forms of reimbursement specified in clause D.8.2. under 'Healthcare: what you are insured for' will apply.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- costs not reimbursed under clause D.8.1. are not reimbursed under this clause either.
- the health insurance may already provide cover for some of this healthcare or for similar healthcare in part and/or under certain circumstances. Clauses B.12.2., B.13. and B.14. will tell you whether you are entitled for reimbursement of this healthcare.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.8.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The healthcare is claimed on the basis of the dental rates decision ('tariefbeschikking tandheelkundige zorg') compiled by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). Treatment codes starting with the letter 'P' or 'J' are used.

The dental surgeon uses reimbursement codes for healthcare he or she is authorised to provide.

Healthcare provider
- the healthcare is provided by a dentist, prosthodontist or qualified healthcare provider affiliated with a centre for oral care or a centre for dental care in exceptional circumstances.
- a dental surgeon affiliated with a hospital (facility for specialist medical healthcare) provides the healthcare concerning inserting implants.

Referral

A dentist must provide a referral if the prosthetic care is to be provided by a prosthodontist. This concerns healthcare with a code starting with the letter 'P' or 'J' for insured persons who still have their own teeth and/or dental implants.

A dentist must also provide a referral if the implant care is to be provided by a dental surgeon.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.8.4. Other oral care

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse other forms of oral care insofar as this oral care is not specified under clauses D.8.2., D.8.3., D.8.5. or D.8.6.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- costs not reimbursed under clause D.8.1. are not reimbursed under this clause either.
- the health insurance may already provide cover for some of this healthcare or for similar healthcare in part and/or under certain circumstances. Clause B.13. and B.14. will tell you whether you are insured for this healthcare.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.8.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General
The healthcare is claimed on the basis of the dental rates decision ('tariefbeschikking tandheelkundige zorg') compiled by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa). Treatment codes other than those stated in clauses D.8.2., D.8.3., D.8.5. and D.8.6. are used. The dental surgeon uses reimbursement codes for healthcare he or she is authorised to provide.

Healthcare provider
The healthcare is provided by a dentist, dental hygienist, prosthodontist or other authorised healthcare provider affiliated with a centre for oral care or a facility for youth dental care.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.8.5. Orthodontic care

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of orthodontic care, including the associated costs of the associated dental treatments, and material and technical costs.
The amount we reimburse is shown on your Reimbursements Overview.

One of the forms of reimbursement specified below will apply:
- maximum amount:

If the Reimbursements Overview for your additional insurance package shows that we reimburse orthodontic care up to a maximum amount, this maximum reimbursement applies for the entire period that you have that additional insurance package with us, unless your Reimbursements Overview states otherwise.
- maximum amount and specified age:

If the Reimbursements Overview for your additional insurance package shows that we reimburse orthodontic care up to a maximum amount and up to or from a specific age, this maximum reimbursement applies for the entire period that you have that additional insurance package with us and up to or from the specified age;

Please note!
- see clauses A.21. and C.10. for general exclusions.
- costs not reimbursed under clause D.8.1. are not reimbursed under this clause either.
- clause C.9.3 does not apply to the reimbursement of orthodontic care specified in this clause.
- the healthcare is not subject to a deductible.

Waiting period
If the Reimbursements Overview for your additional insurance package shows that a waiting period applies,
you will only be able to start making use of the reimbursement for orthodontic care after you have had the additional insurance package for at least one year (a full 365 days). This waiting period applies to each insured person individually.

Example:
You take out a new additional insurance package that entitles your child to orthodontic care after a waiting period of one year. This additional insurance package comes into effect on 15 March 2022, meaning you can start receiving reimbursements for orthodontic care from 15 March 2023.

The waiting period does not apply to children up to the age of 17 who are or will be co-insured under your additional insurance package with cover for orthodontic care.
This additional insurance package must then have been in effect for at least 1 year.

Example:
You have an additional insurance package with cover for orthodontic care that came into effect on 1 March 2021. As of 1 January 2022, your 40-year-old partner and your 12-year-old child will be co-insured on your policy with the same additional insurance package. You are the policyholder and your partner and child are therefore co-insured persons.

Your child can make use of the reimbursement for orthodontic care from 1 March 2022, because you will then have had this additional insurance for 1 year. A 1-year waiting period does apply to your partner however: he or she can start receiving reimbursements for orthodontic care from 1 January 2023.

Terms and conditions

See clause D.8.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

The healthcare is claimed on the basis of the orthodontics rate decision ('tariefbeschikking orthodontie') put together by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa), using treatment codes that:

- start with the letter 'F';
- end in the letter 'A'; and
- have 3 numbers in between.

Example:
'F121A' (the code for an initial consultation with an orthodontist).

Material and technical costs associated with this orthodontic care are indicated by an asterisk (*) appended to the end of the treatment code(s).

Healthcare provider

A dentist or an orthodontist provides the healthcare.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.8.6. Oral care in the event of an accident

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse oral care insofar as this oral care is specified under clauses D.8.2., D.8.3. or D.8.4., in cases of accident care as defined in clause C.12. The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- costs not reimbursed under clause D.8.1. are not reimbursed under this clause either.
- dental care in exceptional circumstances and/or dental surgery are covered under the general insurance (see clauses B.4., B.12., B.13. and B.14.).
- we do not reimburse the costs of:
  - oral care required due to the consumption of food or drink; or
  - orthodontic care.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause D.8.1. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- the healthcare is claimed on the basis of the dental rates decision ('tariefbeschikking tandheelkundige zorg') put together by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa), using the treatment codes referred to in clauses D.8.2., D.8.3. and D.8.4.
- the treatment has been completed within 2 years of the accident occurring, unless it is necessary to delay the treatment or final part of the treatment because the teeth are not yet fully formed. Our consultant dentist will assess whether the teeth are fully formed or whether the treatment is of a temporary nature.
- if a treatment needs assessment was carried out before the accident and it was established that this oral care was required, or if you delayed getting the required oral care prior to the accident, you will not be entitled to reimbursement of the costs of the treatment for which approval is being requested.

Approval

See clause C.12. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

- approval is required prior to the treatment and within three months of the accident.
- the request must contain a written treatment plan and an estimate made by the dentist or dental surgeon and must be drawn up in accordance with the dental trauma guidelines ('Praktijkrichtlijn Tandletsel') of the Dutch Dental Association (NMT). These guidelines form part of these terms and conditions and can be found on our website.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.8.7. Dental reimbursement rollover

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

With your additional insurance package, 100% of your unused cover for dental costs, up to a maximum of €250, is rolled over to the next policy year.

Please note!

- any reimbursements rolled over to the next year that are not used that year will expire.
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- to be able to make use of the reimbursement that has been rolled over, for both the current and subsequent policy year you must have an additional insurance package that includes a reimbursement for dental costs.
- the reimbursement from your current additional insurance package will be used first, after which the unused reimbursement rolled over from the previous year is used.
- if you switch to a different additional insurance package, as long as this includes a reimbursement for dental costs you can still make use of the unused reimbursement rolled over during the first year of the new additional insurance package.
- if you switch to a different additional insurance package and this does not include a reimbursement for dental costs, no unused reimbursement will be rolled over to a following policy year.
- if we change the amount of reimbursement for dental costs under your additional insurance package, this will not affect the amount of reimbursement that was rolled over.

Example 1:
You keep the same additional insurance package and you have incurred dental costs:

- in 2021 you were covered for up to €500 in dental costs per year. In 2021 you were reimbursed for €150 in dental costs, meaning you did not use €350 of the covered costs. In this case the maximum of €250 in dental costs reimbursement is rolled over to 2022, meaning you are insured for €750 in dental costs in 2022.
- in 2022 you claim €600 in dental costs. The first €500 of this is reimbursed under your current additional insurance package and the remaining €100 is taken from the reimbursement rolled over from 2021.
- the remaining €150 from the 2021 reimbursement expires on 1 January 2023, meaning that, assuming you keep the same additional insurance package, you will be insured for €500 in dental costs from this date.

Example 2:
You keep the same additional insurance package and you have not incurred any dental costs:

- in 2021 you were covered for up to €500 in dental costs per year, but did not incur any dental costs that year. In this case the maximum of €250 in dental costs reimbursement is rolled over to 2022, meaning you are insured for €750 in dental costs in 2022.
- again in 2022, you do not incur any dental costs. However, the reimbursement rolled over from 2021 expired on 1 January 2022. Accordingly, only the maximum of €250 in reimbursements from 2022 is rolled over to 2023, meaning that, assuming you keep the same additional insurance package, you will be insured for €750 in dental costs this year.

Example 3:
You switch to a different additional insurance package that provides reimbursement for dental costs:

- starting in 2021 you are covered for up to €500 in dental costs per year. In 2021 you were reimbursed for €300 of these costs, which means that, under this additional insurance package, €200 is rolled over to 2022.
- however, with effect from 1 January 2022, you switch from this additional insurance package to another that also provides reimbursement of dental costs.
- your new additional insurance package insures you for a maximum of €1150 in dental costs per year. Because you still have €200 remaining from 2021, in 2022 you are insured for a maximum of €1350 in dental costs.

Example 4:
You switch to a different additional insurance package that does not provide reimbursement for dental costs:

- starting in 2021 you are covered for up to €500 in dental costs per year. In 2021 you were reimbursed for €300 of these costs, which means that, under this additional insurance package, €200 is rolled over to 2022.
- however, with effect from 1 January 2022, you switch from this additional insurance package to another that does not provide reimbursement for dental costs.
- the unused €200 from 2021 will not be rolled over to 2022, because you have switched to an additional insurance package that does not

reimburse dental costs and so you no longer meet the conditions for having the unused portion of the cover for dental costs rolled over to the next year.

Example 5:
We change your additional insurance package:
- starting in 2021 you are covered for up to €500 in dental costs per year. In 2021 you were reimbursed for €300 of these costs, which means that, under this additional insurance package, €200 is rolled over to 2022.
- we remove the cover for dental costs from your additional insurance package with effect from 1 January 2022. This does not affect the reimbursement rolled over from 2021: in 2022 you can still make use of the €200 rolled over from 2021.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.9. Health resort treatment

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of a health trip arranged through an organisation or on your own, including:
- your transport to a health resort;
- treatment in a health resort;
- your stay at a health resort, including costs of accommodation, breakfast, lunch and dinner.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- costs for staying in a health resort only include the costs of the components offered under an arrangement/programme claimed using a single arrangement rate. Costs for extra food or drinks, newspapers, magazines, cosmetics and other items and services falling outside of the arrangement/programme are not reimbursed.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- the treatment concerned has been personalised for you, recorded in writing and lasts at least one week.
- you are suffering from a severe form of:
  - rheumatoid arthritis; or
  - psoriatic arthritis; or
  - Bechterew's disease (ankylosing spondylitis).

Healthcare provider
- the healthcare takes place at a health resort in the Netherlands that specialises in the treatment of conditions of the musculoskeletal system, rheumatic conditions in particular, and is a health resort that we have recognised. Please see our website to find out which health resorts we recognise. We do not reimburse any other health resorts.
- a doctor should be involved in the treatment.

Treatment proposal
A rheumatologist must have determined that the treatment is necessary.
Approval
Approval (see clause A.18.) is required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.10. Skin therapies

D.10.1. Deleted

D.10.2. Hair removal

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the removal of extreme hair growth in unusual places on the face and/or neck using, for example, an epilator or a hair removal laser. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse: treatments that use resins, gels, creams or other hair removal products nor the costs of such products.
- we do not reimburse treatment by a cosmetologist who uses a laser to remove hair independently and on his or her own responsibility.
- the healthcare is not subject to a deductible.

Terms and conditions

General

The bill specifies which form of hair removal has been used.

Healthcare provider

The healthcare is provided by:

- a dermatologist;
- a skin therapist;
- a cosmetologist registered with the Dutch association of cosmetologists ANBOS with the electric hair removal ('elektrisch ontharen') and/or hair removal techniques ('ontharingstechnieken') specialism.
  Healthcare from the cosmetologist will only qualify for reimbursement if it is carried out in accordance with the ANBOS guidelines.
  If the cosmetologist uses a laser for hair removal, this must be done under the responsibility of a dermatologist or skin therapist. Only a dermatologist or skin therapist may claim this healthcare.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.10.3. Acne treatment

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the treatment of severe acne (acne vulgaris) on the face and/or neck.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse treatment by a cosmetologist who uses a laser to treat acne independently and on his or her own responsibility.
- we do not reimburse the costs of treating rosacea.
- the healthcare is not subject to a deductible.

Terms and conditions

General

This concerns a severe form of acne (acne vulgaris) on the face and/or neck.

Healthcare provider

The healthcare is provided by:

- a skin therapist;
- a cosmetologist registered with the Dutch association of cosmetologists ANBOS with the 'acne' specialism, in which case the healthcare will only qualify for reimbursement if it is carried out by the cosmetologist in accordance with the ANBOS guidelines.
  If the cosmetologist uses a method of acne treatment that includes the use of a laser, this must be done under the responsibility of a dermatologist or skin therapist. Only a dermatologist or skin therapist may claim this healthcare.
- a dermatologist.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.10.4. Camouflage therapy

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse:

- camouflage lessons;
- the purchase costs of camouflage products required during the lessons.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the purchase costs of camouflage products outside of and after the camouflage lessons.
- the healthcare is not subject to a deductible.

Terms and conditions

General

The aim of the camouflage lessons is to learn how to camouflage birthmarks, scars and other disfiguring skin conditions visible on the face and/or neck.

Healthcare provider

The healthcare is provided by:

- a skin therapist;
- a cosmetologist registered with the Dutch association of cosmetologists ANBOS with the 'camouflage' specialism, in which case the healthcare will only qualify for reimbursement if it is carried out by the cosmetologist in accordance with the ANBOS guidelines.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.11. Obesity treatment

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of participation in a part-time day-treatment programme for obese patients. The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the part-time day-treatment programme is aimed at behavioural change using a non-surgical, multidisciplinary treatment;
- you must be morbidly obese, i.e. have a body mass index (BMI) of 40 or higher;
- you must have completed the entire programme;
- the reimbursement is provided once only for the entire period that you have an additional insurance package with us that entitles you to this reimbursement.

Healthcare provider

The healthcare is provided by a healthcare provider in a treatment centre that has been recognised by us or that has a contract with us for this healthcare. A list of such treatment centres is available on our website.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.12. Transport

D.12.1. Transport (patient transport by car, public transport or taxi)

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

For patient transport, we provide:

a. reimbursement of the statutory personal contribution that you have to pay each year under the health insurance for the use of a car, public transport or a taxi;
b. an additional allowance per kilometre above the allowance per kilometre provided under the health insurance when using a car;
c. a reimbursement when using a taxi within the Netherlands or your country of residence from your home address to a facility for medical specialist care or the practice of a medical specialist and back;
d. a reimbursement when using a car or public transport (lowest class) within the Netherlands or your country of residence from your home address to a facility for medical specialist care or the practice of a medical specialist and back.

Your Reimbursements Overview shows whether the statutory personal contribution is reimbursed and the amount of the allowance or additional allowance per kilometre.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- this healthcare is already covered in part under the health insurance. Clause B.18.2. will tell you whether you are entitled to this healthcare.
- we do not reimburse:
  - the costs of patient transport if you travel to a different location (i.e. further away) than the closest location where treatment and nursing is available without this being medically necessary at the time;
  - the costs of patient transport in connection with care under the Dutch Long-Term Care Act (Wlz);
  - costs of transport (patient transport or otherwise), travel or escort between your country of residence and another country where you will be undergoing medical treatment.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the reimbursements apply per kilometre travelled.
- for clauses D.12.1.c and D.12.1.d, the patient transport is related to healthcare for which you are insured under your health insurance or additional insurance package.
- no reimbursement of the costs of transport is given under the health insurance in the case of D.12.1.c.and D.12.1.d.
- the distance of the journey is determined using the latest version of the Routenet route planner (which can be consulted for free online), by entering the postcode for the starting point and for the destination to determine the quickest route. The reimbursement is based on full kilometres, with rounding off being done in the usual way.

- you travel using patient transport from your home address or temporary place of residence (not a hospital) to the location where you will be treated, and back.

Additional condition for D.12.1.c.
The attending medical specialist or nursing specialist believes that the use of public transport would not be responsible for medical reasons.
Healthcare provider
For patient transport as referred to in clause D.12.1.c., the taxi operator must be a recognised operator (with the 'TX Keur' quality mark for taxis) and must be properly licensed.
Approval
Approval (see clause A.18.) is required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.12.2. Travel costs

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the travel costs of:

a. your partner if you have been admitted;
b. the parents if your child has been admitted. Your child must be insured with us and must be under the age of 18;
c. your visitor if you or your child have been admitted.

The admission (not for day treatment) is medically necessary and is at a facility for specialist medical healthcare in the Netherlands (if you live in the Netherlands this can also be in Belgium or Germany) or in your country of residence and does not last more than 365 consecutive days.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse travel costs for a visit to the Dutch Asthma Centre in Davos (NAD).
- the healthcare is not subject to a deductible.

Terms and conditions

General
For a., b. and c. under D.12.2.:
we determine the distance of the journey using the Routenet route planner (which can be consulted for free online), based on the fastest route, by entering the postcode for the official home address of the person who has been admitted to the facility and the postcode for the facility. We reimburse the costs based on full kilometres, with rounding off being done in the usual way.
For D.12.2.c.:

- the admission may also be in a rehabilitation facility or a facility for specialist medical healthcare;
- for each, visit we reimburse the costs of one visitor at most. The visitor does not need to be insured with us;
- the costs are, in principle, reimbursed from the additional insurance package of the person who has been admitted to the facility. If that person is not insured for travel costs, however, we will reimburse the costs from the visitor's insurance, but only if the visitor is insured for such;
- if you are covered for both travel costs and costs of accommodation (see clause D.13.2.), you will need to choose which costs you would like to have reimbursed: if you decide to have the costs of accommodation reimbursed, you will not be reimbursed for travel costs (and vice versa). We regard the first invoice for travel costs or accommodation costs that you submit to be your choice.

Approval
To qualify for eligibility for reimbursement of travel costs during admission to a facility in Belgium or Germany, you must have been given our approval (see clause A.18.) beforehand for the admission in that country.

D.12.3. Deleted

D.13. Accommodation/admission

D.13.1. Therapeutic camp

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of participation in and staying at a therapeutic camp for children under the age of 18 years, organised by an establishment we have recognised.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The camp is organised by an association, foundation or other establishment we have recognised. You can see which these are on our website or we can provide a list on request.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.13.2. Accommodation costs

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

For you (i.e. the person who is admitted or being treated) we reimburse:
a. overnight accommodation for you or your guest(s) in one room of a guest house;
b. a stay for your child under the age of 18 in a Mappa Mondo house.

Example:
By guest house we mean accommodation like a Ronald McDonald house or a 'sleepover house' at a general hospital or a specialist facility like the Dr. Daniel den Hoed Clinic or the Antoni van Leeuwenhoek Hospital.

Explanation:
You may require a number of outpatient treatments over a short period of time without admission or nursing being required, in which case you can also use the guest house.

It sometimes happens that there are no rooms available at a guest house or Mappa Mondo house, in which case you or the guest(s) can stay at a hotel or B&B nearby and claim the costs of accommodation. In such a case, we base the reimbursement on the costs that you and/or your guest(s) would have incurred if you had stayed at a guest house or Mappa Mondo house had there been room. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse:
  - costs that are reimbursed under the Dutch Social Support Act (Wmo) or the Dutch Long-Term Care Act (Wlz) as a result of a collaboration with home care, or costs that come under a Personal Care Budget ('Persoonsgebonden Budget', PGB);
  - accommodation costs incurred due to admission to or treatment at the Dutch Asthma Centre in Davos (NAD).
- you (the person being admitted or treated) must be insured with us for accommodation costs; the reimbursement applies to you, not to the guest.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- the costs of overnight accommodation for you and/or your guests in a guest house are reimbursed if you are being treated in a hospital (facility for specialist medical healthcare).
- the person who has been admitted or is being treated sends the bill from the guest house together with our accommodation costs declaration form ('Declaratieformulier Logeerkosten'). This form is available (in Dutch) on our website. If you and/or the guest(s) stay at a hotel, you will need to provide us with proof that the guest house was full at the time.
- if your additional insurance package reimburses both accommodation costs and visiting costs (see clause D.12.2.c.), you must choose which of these you want to have reimbursed; If you opt for reimbursement of accommodation costs, you will not be reimbursed for visiting costs and vice versa. We regard the first invoice for visiting costs or accommodation costs that you submit to be your choice.

Healthcare provider
The accommodation is provided by a Mappa Mondo house or guest house. The guest house is a non-commercial establishment and is affiliated with:
- a hospital (facility for specialist medical healthcare) in the Netherlands or your country of residence; or
- a hospital (facility for specialist medical healthcare) outside your country of residence with a contract with us for this healthcare.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.13.3. Nursing care category surcharges

Your Reimbursements Overview will show whether or not you

are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the additional costs for nursing in a higher nursing care category at a hospital (facility for specialist medical healthcare). By 'additional costs' we mean those in excess of the costs for the lowest category of nursing care.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of:
  - nursing in the lowest category: this is reimbursed under the health insurance;
  - nursing in a second category for which the facility charges the same rate as that for nursing in the lowest category in the Netherlands;
  - nursing in a higher category if you have been admitted to and receive nursing care at a specialist mental healthcare hospital.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- you are 18 years old or above.
- your insured category is higher than the lowest category.
- the rate for the higher category is higher than the rate for the lowest category.

Healthcare provider

The hospital (facility for specialist medical healthcare) invoices the costs using the DBC healthcare product code or the care category supplement.

Approval

approval (see clause A.18.) is required for the costs reimbursed under the health insurance for which approval is required under the terms and conditions of the health insurance.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.13.4. Hospitalisation and allowances

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

a. In-patient accommodation payment:
   We pay you a fixed amount per day if you have been admitted to and are receiving nursing care at a hospital (facility for specialist medical healthcare).

b. Luxury/comfort package:
   We reimburse the costs of a luxury/comfort package if you have been admitted to and are receiving nursing care at a hospital (facility for specialist medical healthcare).

   Example:
   The luxury or comfort package may include anything that can make your stay at the hospital more pleasant, like the use of a TV, radio, telephone and/or internet in your room, for example. The package might also include a more luxurious room, a more extensive menu, a newspaper or magazine, unrestricted visiting hours and tea and/or coffee for visitors.

c. Compensation allowance:
   We pay you a fixed amount per day over the period that you are admitted and are receiving nursing care at a hospital (facility for specialist medical healthcare) and do not use or are unable to make use of the luxury/comfort package as referred to under clause D.13.4.b. This could be because the hospital does not provide both standard and higher-category nursing, for example, or does not offer a luxury/comfort package.

The reimbursement and the amount we reimburse is shown on your Reimbursements Overview.

Tip:
You must personally submit a request to us in advance for the in-patient accommodation payment or compensation allowance. You must submit an invoice to us for the luxury package.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the normal costs (not relating to a luxury/comfort package) for a stay in the hospital (facility for specialist medical healthcare) under this clause.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- we assume that you have opted for the compensation payment (clause D.13.4.c.) if you have not submitted invoices for a luxury package that you have enjoyed (clause D.13.4.b.) before we have received the claim(s) for your admission to the hospital (facility for specialist medical healthcare).

- if the admission continues from one year into the next, the maximum in-patient accommodation payment or compensation payment is only made once.
- admission to a facility for specialist medical healthcare (hospital) for a maximum of 365 consecutive days, and not on an outpatient (day treatment) basis.

Approval
Approval is not required.

D.13.5. Deleted

D.13.6. Recuperation home

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of staying in a recuperation home to recover from a physical condition.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of staying in a recuperation home:
  - if you are entitled to the same or comparable healthcare under the law;
  - if the stay continues from one year into the next and your additional insurance package has already reimbursed the maximum amount over the first year.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The healthcare is provided by a recuperation home recognised by us.
Approval
Approval (see clause A.18.) is required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.13.7. Hospice care

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the personal contribution for hospice care. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the personal contributions for domestic help and nursing care invoiced to you on the basis of the Dutch Long-Term Care Act (Wlz) by the Dutch Central Administration Office (CAK), or invoiced to you on the basis of the Dutch Social Support Act (Wmo).
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The personal care and nursing takes place in a hospice where only low-complex care is provided by volunteers. This is also known as a 'bijna-thuishuis' in Dutch.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.13.8. Childcare when a parent is admitted to hospital

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse:
a. 24-hour care in the case of a chronic illness;
b. home support after an admission, such as a nanny service, dog-walking service or help with essential domestic activities;
c. childcare in the case of an admission.

The healthcare and the maximum amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- for clause D.13.8.a. and b., you must have irresolvable problems at home which require support by means of professional help.
- the following applies to clause D.13.8.c.:
  - the childcare relates to your child/children in your family up to the age of 14 years;
  - the parent who is the primary caregiver is

hospitalised in a facility for specialist medical healthcare;
- the parent who is the primary caregiver has an additional insurance package with us that provides reimbursement for childcare;
- the reimbursement starts on the day after admission of the parent who is the primary caregiver;
- the childcare falls outside of the hours that were already arranged for childcare prior to the primary-caregiver parent being admitted to a facility for specialist medical healthcare.

Healthcare provider
For 24-hour care (a.) and care support (b.), the care is provided by a professional organisation.
The childcare (c.) takes place at a registered childcare centre or with a registered childminder.

Approval
Approval (see clause A.18.) is only required for 24-hour care (a.) and for care support (b.).

Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.13.9. Deleted

D.14. Urgent care abroad

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

The healthcare includes the types of urgent medical care during a stay abroad as described below. Urgent medical care is care that is medically necessary and that cannot reasonably be postponed.
We reimburse:

a. the 'excess rate' costs.
   In foreign countries you are insured for the same healthcare (in terms of content and scope) as for which you are insured in the Netherlands (or your country of residence). Your health insurance and your additional insurance package reimburse costs according to the Dutch rates.
   Contacting the emergency service is compulsory, i.e. you must contact the emergency service with which we have entered into an agreement for healthcare/mediation for healthcare abroad.
   However, the rates for foreign healthcare may differ from the Dutch rates. If the foreign rates:
   - are lower than the Dutch rates, we reimburse the lower foreign rates;
   - are higher than the reimbursement in accordance with the Dutch rates under your health insurance or additional insurance package, there is an excess amount. We call this the 'excess rate'.
     Under this clause, we reimburse this 'excess rate' (including the reimbursement in accordance with the Dutch rates) up to the maximum rate stated on your Reimbursements Overview;

b. urgent oral care provided by a dentist;
c. repatriation of the sick insured person (bringing him or her back home) including a medical escort by an authorised doctor or nurse. This concerns patient transport from the place where you are temporarily staying or the location of your accident, sudden illness or treatment abroad to a facility for specialist medical healthcare in the Netherlands, or if you do not live in the Netherlands, to a facility for specialist medical healthcare in your country of residence.
   Contacting the emergency service is compulsory, i.e. you must contact the emergency service with which we have entered into an agreement for healthcare/mediation for healthcare abroad.
   The repatriation must be medically necessary, because we are of the opinion that:
   - the correct medical treatment is not locally available or reasonably feasible in the foreign country, while it is available in the country of residence or the Netherlands (as applicable);
   - having the treatment provided in that foreign country would be medically irresponsible;
   - treatment in that foreign country is much more expensive than treatment in the country of residence or the Netherlands (as applicable) would be;

d. escort of the sick insured person who is being repatriated under c. by a number of the family members;
e. (deleted);
f. transport of human remains:
   1. back to the Netherlands if the insured person who has died outside the Netherlands was a resident of the Netherlands until his or her death; or
   2. back to the country of residence for the insured person who has died outside his or her country of residence.

   The reimbursement is for costs directly related to transporting the human remains from the country of death back to the Netherlands or to the country of residence, including the costs of

preserving and attending to the remains and preparing them for transport, the costs of transporting the remains, and administrative costs such as fees and duties.
Contacting the emergency service is compulsory, i.e. you must contact the emergency service with which we have entered into an agreement for healthcare/mediation for healthcare abroad.;

g. costs for forwarding the necessary medicines and/or medical aids, such as the costs of using a courier. This does not mean the purchase costs of the medicines and/or medical aids;
h. costs of communications (by telephone or otherwise) with our emergency service in order to arrange the required healthcare and/or services;
i. medical advice from the Medical Team ('Medisch Team') of our emergency service prior to and during your temporary stay abroad.

Your Reimbursements Overviews shows whether your additional insurance package provides cover for this healthcare and, if so, it will also show the maximum reimbursement for this provided by the additional insurance and the health insurance combined.

Please note!

- this healthcare is already covered, in full or in part, under the health insurance. Clause B.2.2. will tell you whether you are insured for this healthcare. Healthcare under the health insurance takes precedence over the reimbursement under this additional insurance package.
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse additional costs, costs for customs levies or return freight for medicines and/or medical aids that have been sent.
- if you have to be brought back to the Netherlands on a specially chartered flight for injured skiers ('gipsvlucht'), for example, the associated costs do not come under either the health insurance or the additional insurance package. However, they can be insured under a travel insurance policy.
- repatriation of human remains does not come under the health insurance, nor does it come under every type of additional insurance package – only a few very comprehensive additional insurance packages reimburse these costs. However, they can be insured under a travel insurance policy.
- we only reimburse healthcare in a foreign country if you are staying there temporarily. If you have remained in that country for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- you will not be reimbursed or you will only receive partial reimbursement under the health insurance or another insurance policy, like a travel insurance policy, taken out separately.
- your stay is temporary, i.e. you have been in the foreign country for an uninterrupted period of no more than 365 days.
- the amount that you claim for healthcare abroad must not be higher than is customary in the country where you are staying temporarily.
- the need for the healthcare could not be foreseen at the time you left for the foreign country.
- once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer).
- you must cooperate fully in the provision of healthcare and comply with the instructions of the emergency services that have become involved.

Healthcare provider

The healthcare is provided by a healthcare provider established in the foreign country where you are staying temporarily. This healthcare provider complies with the requirements, laws and regulations set out for their profession in the country concerned.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.14.2. Deleted

D.15. Foot care

D.15.1. General foot care

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse foot care (chiropody and podiatry). The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the following is not reimbursed under this clause (D.15.1.):
  - orthotic insoles;
  - medical aids for foot care;
  - treatment of patients with rheumatoid arthritis or severe circulation problems in the legs;
  - personal foot care such as the removal of calluses for cosmetic reasons or general toenail care.
- the health insurance may already provide cover for this healthcare in part and/or under certain circumstances. Clause B.23. will tell you whether you are insured for this healthcare. Healthcare under the health insurance takes precedence over the reimbursement under this additional insurance package.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider

The foot care is provided by a podiatrist or a chiropodist.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.15.2. Foot care for severe circulation problems and/or for rheumatoid arthritis

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse foot care to treat foot problems relating to:

- rheumatoid arthritis; or
- severe circulation problems in the legs.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the following is not reimbursed under this clause (D.15.2.):
  - orthotic insoles;
  - medical aids for foot care;
  - personal foot care such as the removal of calluses for cosmetic reasons or general toenail care.
- the healthcare is not subject to a deductible.

Terms and conditions

General

You suffer from rheumatoid arthritis or severe circulation problems in the legs.

Healthcare provider

The healthcare is provided by a podiatrist.

Foot care in the case of rheumatoid arthritis can also be provided by:

- a pedicurist listed as a pedicurist with the RV (rheumatoid arthritis) specialism on the Quality Register for Pedicurists ('Kwaliteitsregister Pedicure') or on the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg'); or
- a medical pedicurist listed as such on the Quality Register for Pedicurists ('Kwaliteitsregister Pedicure') or the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg'); or
- a pedicurist listed as a medical foot care provider on the Quality Register for Medical Foot Care Providers ('Kwaliteitsregister Medisch Voetzorgverlener');
- a pedicurist listed as an allied chiropodist in the Register for Allied Health Professionals for Foot Care ('Register Paramedische Voetzorg').

Approval

Approval (see clause A.18.) is required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.15.3. Deleted

D.16. Physiotherapy and/or Cesar/Mensendieck exercise therapy

D.16.0. Physiotherapy and/or Cesar/Mensendieck exercise therapy after an accident

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for physiotherapy and/or exercise therapy necessary for your recovery after an accident.

This must form part of 'accident care' as defined in

clause C.12. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- if you are insured for clause D.16.0. and D.16.1., we will first reimburse under to clause D.16.0. and then under clause D.16.1.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- refer to clause C.12. for a description of 'accident care'.
- this healthcare may be provided at your home if this is medically necessary.

Healthcare provider
The healthcare is provided by a physiotherapist or an exercise therapist with whom we have an agreement for the provision of accident care. These physiotherapists and exercise therapists are listed on our website.

Approval
Approval (see clause A.18.) is required. To be eligible, you must report the accident to us within three months of it occurring.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.16.1. Physiotherapy and/or Cesar/Mensendieck exercise therapy

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are covered for physiotherapy and/or exercise therapy, or the reimbursement of the costs of such as applicable.
We deem screening to be one session of physiotherapy and exercise therapy. If a screening is mentioned separately on your Reimbursements Overview, however, this screening will be reimbursed separately and will not be deducted from the number of sessions or the total reimbursement amount for sessions stated in addition to the screening.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- under certain conditions, the health insurance covers physiotherapy and/or exercise therapy from the 21st session onwards for insured persons who are 18 or older. Clause B.8.1. will tell you whether you are insured for this healthcare. The first 20 sessions or the sessions for medical conditions that are not covered by the health insurance may be reimbursed under this clause (D.16.1.) if you are insured for this.
- the health insurance also covers, in part and/or under certain conditions, pelvic physiotherapy, physiotherapy to treat osteoarthritis in the hip or knee joint, walking therapy to treat intermittent claudication, exercise therapy for COPD patients and physiotherapy and/or exercise therapy for insured persons under the age of 18. You can check your Reimbursements Overview to see whether you are insured for this healthcare and clauses B.8.2., B.8.3., B.8.4., B.8.5 and B.8.6. to see whether you meet the terms and conditions for receiving this healthcare. Healthcare under the health insurance takes precedence over the reimbursement under this clause (D.16.1.).
- when it comes to treatment as a result of an accident and you are insured for clause D.16.0. and D.16.1., we will first reimburse under clause D.16.0. and then under clause D.16.1.
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse:
  - oedema physiotherapy/scar treatment as a result of cosmetic procedures;
  - scar treatment after what we consider to be normal wound recovery.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- for the terms and conditions under which this healthcare is provided, see the section under clause B.8.3. entitled 'Terms and conditions (B.8.1., B.8.2. and B.8.3.)'. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
- the number of sessions specified is a maximum. You, your physiotherapist and/or exercise therapist and, where applicable, the person who referred you, will agree the number of sessions required for your condition.

Healthcare provider
If you are insured for clause D.16.0. and D.16.1., the healthcare is provided by a physiotherapist or an exercise therapist with whom we have an agreement for the provision of accident care. These physiotherapists and exercise therapists are listed on our website.

In other cases, the healthcare is provided by:
- a physiotherapist or an exercise therapist as specified in clauses B.8.1., B.8.2. and B.8.3.
- a psychosomatic physiotherapist. This means a physiotherapist listed as a psychosomatic physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or any register(s) designated by us;
- a psychosomatic exercise therapist, i.e. an exercise therapist with 'kwaliteitsgeregistreerd' (quality registered) status as a psychosomatic exercise therapist on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.16.2. Deleted

D.16.3. Work-related physiotherapy

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for the initial assessment for the form of physiotherapy that relates to the work situation and that is part of the Participative Work Adjustment Protocol ('Protocol Participatieve Werkaanpassing', PPAW):
- the initial assessment consists of a review of the patient's medical history, task analysis and possibly a physical examination;
- PPAW is a preventive programme designed in collaboration with the Dutch Association for Company and Work-Related Physiotherapists ('Nederlandse Vereniging voor Bedrijfs- en arbeidsfysiotherapeuten', NVBF) for tackling work-related complaints;
- as part of the reimbursement for the initial assessment for occupational physiotherapy, one physiotherapy session is also deducted from the number of sessions for which you are insured under your additional insurance package.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse healthcare that cannot be deemed to be physiotherapy. We do not cover, for example:
  - occupational curative care. This concerns healthcare focusing on healing and treating both acute and chronic work-related physical disorders (like a workplace assessment, for example);
  - reintegration programmes. Reintegration is the collection of measures aimed at guiding occupationally disabled employees back into the work process;
  - treatments and programmes aimed at improving fitness, such as medical training therapy, physio fitness, exercise for the elderly, exercise for overweight people, and cardio training.
- the healthcare is not subject to a deductible.

Terms and conditions

General
The healthcare is provided at the practice of the attending work-related physiotherapist or at your place of work.
Healthcare provider
The healthcare is provided by a work-related physiotherapist recognised by us. A list of the therapists we have recognised is available on our website. Alternatively, you can request a list from us.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.16.4. Physiotherapy rollover service

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

With your additional insurance package, you can have a maximum of 9 sessions of physiotherapy and/or exercise therapy you did not use in one year rolled over to the next year.

Please note!
- sessions that roll over to the next year may only be used within that year, after which they expire.
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- to be able to make use of the treatments rolled over, you must be insured for this rollover service for at least 1 full, uninterrupted year.
- the sessions rolled over from the previous year are used first, after which the sessions from the

current year are used.
- if, immediately after ending an additional insurance package that offers the 'physiotherapy rollover service', you switch to another additional insurance policy that does not offer this service but which does reimburse the costs of physiotherapy and/or exercise therapy, you will retain the sessions that were rolled over from the previous year for one more year.
- if you switch to a different additional insurance package and this includes neither the 'physiotherapy rollover service' nor reimbursement of the costs of physiotherapy and/or exercise therapy, no sessions will be rolled over to the following policy year.
- if we change the number of physiotherapy and/or exercise therapy sessions covered under your additional insurance package, this will not affect the number of sessions rolled over.

Example 1
You keep the same additional insurance package and you have had physiotherapy:
- from 1 January 2021, you are insured for 9 sessions of physiotherapy and/or exercise therapy and have the 1-year 'physiotherapy rollover service'. In 2021, you are reimbursed for 5 of these sessions, which means that, under this additional insurance package, 4 sessions roll over to 2022. You are therefore covered for 13 sessions of physiotherapy and/or exercise therapy in 2022.
- of these 13 sessions you make use of 10 in 2022. The costs of the 4 sessions rolled over from 2021 are reimbursed first and then the costs of the 6 sessions from the 2022 additional insurance package.
- this leaves 3 sessions (9 minus 6) to roll over to 2023. This means that, assuming you keep the same additional insurance package, in 2023 you will be insured for 12 sessions of physiotherapy and/or exercise therapy.

Example 2
You keep the same additional insurance package and you have not had any physiotherapy:
- from 1 January 2021, you are insured for 14 sessions of physiotherapy and/or exercise therapy and have the 1-year 'physiotherapy rollover service'. You do not have any physiotherapy in 2021, which means that the maximum number of 9 sessions roll over to 2022. You are therefore covered for 23 sessions of physiotherapy and/or exercise therapy in 2022.
- again in 2022, you do not need any physiotherapy. However, the sessions from 2021 have expired, so only the maximum number of 9 sessions from 2022 roll over to 2023. This means that, assuming you keep the same additional insurance package, in 2023 you will be insured for 23 sessions of physiotherapy and/or exercise therapy.

Example 3
You switch to a different additional insurance package that provides reimbursement the costs of physiotherapy and/or exercise therapy:
- from 1 January 2022, you are insured for 9 sessions of physiotherapy and/or exercise therapy and have the 1-year 'physiotherapy rollover service'. In 2022, you are reimbursed for 5 of these sessions, which means that, under this additional insurance package, 4 sessions roll over to 2023.
- however, with effect from 1 January 2023, you switch from this additional insurance package to one that does not include the 'physiotherapy rollover service'.
- your new additional insurance package covers 18 sessions of physiotherapy and/or exercise therapy. Because you still have 4 sessions left from 2022, you are entitled to 22 sessions of physiotherapy and/or exercise therapy in 2023.

Example 4
You switch to a different additional insurance package that does not provide reimbursement for the costs of physiotherapy and/or exercise therapy:
- from 1 January 2022, you are insured for 9 sessions of physiotherapy and/or exercise therapy and have the 1-year 'physiotherapy rollover service'. In 2022, you are reimbursed for 5 of these sessions, which means that, under this additional insurance package, 4 sessions roll over to 2023.
- however, with effect from 1 January 2023, you switch from this additional insurance package to one that, with effect from 2023, does not provide reimbursement for the costs of physiotherapy and/or exercise therapy.
- the unused 4 sessions from 2022 will not be rolled over because you have switched to an additional insurance package that does not provide reimbursement for the costs of physiotherapy and/or exercise therapy: you no longer meet the conditions for having the unused reimbursement of costs of physiotherapy and/or exercise therapy rolled over.

Example 5
We change your additional insurance package:
- from 1 January 2022, you are insured for 9 sessions of physiotherapy and/or exercise therapy and have the 1-year 'physiotherapy rollover

service'. In 2022, you are reimbursed for 5 of these sessions, which means that 4 sessions roll over to 2023.
- from 1 January 2023, under your additional insurance package we no longer reimburse the costs of physiotherapy and/or exercise therapy. This does not affect the sessions that are rolled over from 2022: in 2023 you can still make use of the 4 sessions that were rolled over from 2022.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.16.5. Physiotherapy roll-over

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

With your additional insurance package, you can have a maximum of 5 sessions of physiotherapy and/or exercise therapy you did not use in one year rolled over to the next year.

Please note!
- sessions that roll over to the next year may only be used within that year, after which they expire.
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- to be able to make use of the sessions that have been rolled over, for both the current and subsequent policy year you must have an additional insurance package that includes physiotherapy and/or exercise therapy.
- sessions from your current additional insurance package will be used first, after which the sessions rolled over from the previous year are used.
- if you switch to a different additional insurance package and this does not provide reimbursement for the costs of physiotherapy and/or exercise therapy, you can still use the sessions rolled over from the year before the switch during the first year of the new additional insurance package.
- if you switch to a different additional insurance package and this does not provide reimbursement for the costs of physiotherapy and/or exercise therapy, no sessions will be rolled over to the following policy year.
- if we change the number of physiotherapy and/or exercise therapy sessions covered under your additional insurance package, this will not affect the number of sessions rolled over.

Example 1
You keep the same additional insurance package and you have had physiotherapy:
- as of 1 January 2021, you are covered for 9 sessions of physiotherapy and/or exercise therapy. In 2021, you are reimbursed for 5 of these sessions, which means that, under this additional insurance package, 4 sessions roll over to 2022. You are therefore covered for 13 sessions of physiotherapy and/or exercise therapy in 2022.
- of these 13 sessions you make use of 11 in 2022. First, the 9 sessions covered under your additional insurance package from 2022 are used and then 2 of the 4 sessions rolled over from 2021.
- the remaining 2 sessions rolled over from 2021 expire the next year and no sessions are rolled over to 2023. This means that, assuming you keep the same additional insurance package, in 2023 you will be insured for 9 sessions of physiotherapy and/or exercise therapy.

Example 2
You keep the same additional insurance package and you have not had any physiotherapy:
- as of 1 January 2021, you are covered for 14 sessions of physiotherapy and/or exercise therapy. You do not have any physiotherapy in 2021, which means that the maximum number of 5 sessions roll over to 2022. You are therefore covered for 19 sessions of physiotherapy and/or exercise therapy in 2022.
- again in 2022 you do not need any physiotherapy. However, the sessions from 2021 have expired, so only the maximum number of 5 sessions from 2022 roll over to 2023. This means that, assuming you keep the same additional insurance package, in 2023 you will be insured for 19 sessions of physiotherapy and/or exercise therapy.

Example 3
You switch to a different additional insurance package that provides reimbursement the costs of physiotherapy and/or exercise therapy:
- as of 1 January 2021, you are covered for 9 sessions of physiotherapy and/or exercise therapy. In 2021, you are reimbursed for 5 of these

sessions, which means that, under this additional insurance package, 4 sessions roll over to 2022.
- however, with effect from 1 January 2022, you switch from this additional insurance package to another, one that also provides reimbursement for the costs of physiotherapy and/or exercise therapy.
- your new additional insurance package covers 21 sessions of physiotherapy and/or exercise therapy. Because you still have 4 sessions left from 2021, you are entitled to 25 sessions of physiotherapy and/or exercise therapy in 2022.

Example 4
You switch to a different additional insurance package that does not provide reimbursement for the costs of physiotherapy and/or exercise therapy:
- as of 1 January 2021, you are covered for 9 sessions of physiotherapy and/or exercise therapy. In 2021, you are reimbursed for 5 of these sessions, which means that, under this additional insurance package, 4 sessions roll over to 2022.
- however, with effect from 1 January 2022, you switch from this additional insurance package to one that, with effect from 2022, does not provide reimbursement for the costs of physiotherapy and/or exercise therapy.
- the unused 4 sessions from 2022 will not be rolled over because you have switched to an additional insurance package that does not cover physiotherapy and/or exercise therapy: you no longer meet the conditions for having the unused reimbursement of costs of physiotherapy and/or exercise therapy rolled over.

Example 5
We change your additional insurance package:
- as of 1 January 2021, you are covered for 9 sessions of physiotherapy and/or exercise therapy. In 2021, you are reimbursed for 5 of these sessions, which means that 4 sessions roll over to 2022.
- from 1 January 2022, under your additional insurance package we no longer reimburse the costs of physiotherapy and/or exercise therapy. This does not affect the sessions that are rolled over from 2021: in 2022 you can still make use of the 4 sessions that were rolled over from 2022.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.16.6. Hydrotherapy for babies

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for hydrotherapy for babies up to the age of 1 year.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

Healthcare provider
The hydrotherapy is provided by a healthcare provider with whom we have made agreements concerning this form of therapy. The details for this/these healthcare provider(s) are available on our website.
Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.17. Occupational therapy

D.17.1. Occupational therapy up to the age of 18

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

In addition to the reimbursement under the health insurance, you are insured for occupational therapy if you are younger than 18 years.
If you are entitled to this healthcare under the health insurance (see clause B.9.), this takes precedence over the reimbursement under this additional insurance package.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.9.

D.17.2. Supervision for your carer if you receive occupational therapy

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse training and supervision for carers of insured persons who receive occupational therapy. The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.9. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

- the person receiving the occupational therapy has a health insurance policy or additional insurance package with us that covers this occupational therapy;
- the person who incurs the costs (i.e. the carer) on behalf of the person insured by us does not need to be insured by us;
- if both the carer and the person receiving occupational therapy have an additional insurance package with cover for this carer reimbursement, the costs of such will initially be reimbursed through the additional insurance package of the person receiving the occupational therapy and only afterwards through the additional insurance package of the carer.

D.18. Dietetics

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for dietetics in addition to the reimbursement under the health insurance. See clause B.11. Healthcare under the health insurance takes precedence over the reimbursement under this additional insurance package.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare does not include the following, even if prescribed by the dietician:
  - foods;
  - dietary preparations (see clause B.16. for more information);
  - dietetics without a strictly medical objective, such as dietary/nutritional advice relating to slimming or sports.
- you are not entitled to dietetics or dietary advice (see clause D.2.7.) (or to reimbursement of the costs of dietetics or dietary advice) in combination with the combined lifestyle intervention programme (see clause B.3.4.) for the same indication without there being an additional healthcare need.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.11.

D.19. Healthcare before childbirth

D.19.1. Antenatal screening

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse non-medically necessary antenatal screening (a combined test), consisting of the nuchal translucency (NT) scan and serum test (blood test).
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the health insurance already provides cover for this healthcare under certain circumstances. Clause B.5.3. will tell you whether you are insured for this healthcare.
- the healthcare is not subject to a deductible.

Terms and conditions

General

The combined test is not medically necessary — it is carried out at your request.

Healthcare provider

The combined test is carried out by a medical specialist, general practitioner, obstetrician or sonographer who has a permit under the Dutch Population Screening Act (‘Wet op het bevolkingsonderzoek’, WBO) or by one of these healthcare

providers who has a partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that has a permit under the WBO.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.19.2. Childbirth course

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

For insured pregnant women, we reimburse health courses for childbirth preparation.

The course starts during the pregnancy and ends no later than six months after the birth.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- you are not entitled to reimbursement for exercise programmes under this clause. These programmes are reimbursed under clause D.22.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- on completion of the childbirth course, you provide us with proof of participation.
- we use the commencement date of the childbirth course to determine the reimbursement.

Healthcare provider

- the childbirth course is given by a healthcare provider registered with the Chamber of Commerce as a professional or an organisation, respectively, that offers and provides childbirth courses.
- the healthcare provider has articles of association, and a website where it can be seen that the courses offered are aimed at childbirth preparation.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.20. Healthcare during childbirth

D.20.1. Childbirth, personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs above the statutory maximum reimbursement for outpatient childbirth without medical grounds in:

- a facility for specialist medical healthcare; or
- a birth centre with which we have an agreement.

The maximum amount and the amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- midwifery care is already covered, in full or in part, under the health insurance. Clause B.6. will tell you which healthcare is covered.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.6. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You (the birth mother) are partially reimbursed under the health insurance.

Healthcare provider

An obstetrician or general practitioner supervises the outpatient childbirth without medical grounds or the birth in the birth centre with which we have an agreement.

Approval

Approval is not required.

D.20.2. TENS machine

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We provide a Transcutaneous Electrical Nerve Stimulation (TENS) machine on loan for the relief of pain during childbirth.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.

- you are not entitled to reimbursement of the costs of the normal use of the medical aid (such as energy consumption and/or batteries) or for electrodes.
- the healthcare is not subject to a deductible.

Terms and conditions

See clauses B.17.4. and B.17.5. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You (the birth mother) are insured with us.

Healthcare provider

You are free to select the supplier.

Approval

Approval (see clause A.18.) is required.

D.21. Healthcare after childbirth

D.21.1. Lactation consultant healthcare

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse healthcare provided by a lactation consultant, i.e. advice, information and practical support while breastfeeding the newborn. The consultations can also be by telephone or online.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- you are not entitled to reimbursement of travel costs and medical aids.
- the healthcare is not subject to a deductible.

Terms and conditions

General

You (the birth mother) are insured with us.

Healthcare provider

The lactation consultant:

- is a member of a professional group for lactation consultants; and
- uses the Lactation Consultant Referral Protocol ('Verwijzingsprotocol Lactatiekundige').

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.21.2. Obstetric care, statutory personal contribution

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the statutory personal contribution for obstetric care. See clause B.7. for obstetric care.

The maximum amount and the amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the statutory personal contribution for:
  - obstetric care for a greater number of days of admission or a greater number of days and/or hours of obstetric care than you are entitled to under the health insurance;
  - obstetric care for days for which you receive an obstetric care payment under your additional insurance package.
- healthcare provided after childbirth is already covered, in full or in part, under the health insurance. Clause B.7. will tell you which healthcare is covered.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.7. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.

General

You receive partial reimbursement for obstetric care through the health insurance.

D.21.3. Obstetric care payment

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for an obstetric care payment instead of the reimbursement for obstetric care (or the statutory personal contribution for this). See clause B.7. for obstetric care.

When calculating the amount of the obstetric care payment:

- we consider the day that you give birth in a facility for specialist medical healthcare (not as an outpatient) as a nursing day. You are not entitled to an obstetric care payment for that day.
  If you give birth as an outpatient and so are only

invoiced one nursing day for that, we do not consider this to be a nursing day and you are entitled to an obstetric care payment for that day.
- the number of children you give birth to has no bearing on the amount of the obstetric care payment.
- if you are discharged before 6pm on the last day that the hospital (facility for specialist medical healthcare) invoices for you, we do not consider this a nursing day. You are therefore entitled to an obstetric care payment for that day.

The amount of the obstetric care payment is stated on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not give an obstetric care payment:
  - for the days on which you receive obstetric care or for which you receive a reimbursement for obstetric care and/or statutory personal contributions for obstetric care;
  - for the days that a facility for specialist medical healthcare invoices us for your admission;
  - for more days of admission or for more days of obstetric care than you are entitled to under your health insurance or additional insurance package.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.7.

D.21.4. Obstetric care, additional

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse additional obstetric care on top of the number of hours of obstetric care that you are entitled to under your health insurance. See clause B.7. for obstetric care.
The amount of additional obstetric care we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- healthcare provided after childbirth is already covered, in full or in part, under the health insurance. Clause B.7. will tell you which healthcare is covered.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- you (the birth mother) are insured with us.
- you (the birth mother) or your newborn baby or babies present with serious medical problems connected to the birth.
- the additional obstetric care follows immediately after the obstetric care covered by the health insurance.

Healthcare provider
The obstetric care is indicated based on the national indication protocol ('landelijk indicatie protocol', LIP) and is provided by:
- a facility that provides obstetric care; or
- an obstetric nurse working independently.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.21.5. Aftercare following care in an incubator

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse aftercare following care in an incubator.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- on days that we provide reimbursement under the health insurance for obstetric care or, as a substitute, for nursing days, we do not reimburse the costs for aftercare following care in an incubator.
- healthcare provided after childbirth is already covered, in full or in part, under the health insurance. Clause B.7. will tell you which healthcare is covered.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- you (the birth mother) are insured with us for aftercare following care in an incubator; and
- your newborn baby or babies has/have been in an incubator for at least 5 days immediately following the birth; and/or

- your newborn baby or babies has/have remained in a facility for specialist medical healthcare on medical grounds for at least eight days immediately following the birth.

Healthcare provider
The obstetric care is indicated based on the national indication protocol ('landelijk indicatie protocol', LIP) and is provided by:
- a facility that provides obstetric care; or
- an obstetric nurse working independently.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.21.6. Obstetric care after hospitalisation

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse obstetric care after you (the birth mother) and your newborn baby/babies have been discharged from the hospital (facility for specialist medical healthcare). See clause B.7. for obstetric care.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of obstetric care or a substitute on the days on which we provide reimbursement for nursing days under the health insurance.
- healthcare provided after childbirth is already covered, in full or in part, under the health insurance. Clause B.7. will tell you which healthcare is covered.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- you (the birth mother) and your newborn baby or babies being admitted to a facility for specialist medical healthcare is based on medical grounds relating to you (the birth mother).
- you (the birth mother) have been hospitalised for at least fourteen days immediately following the birth in the hospital (facility for specialist medical healthcare).

Healthcare provider
The obstetric care is indicated based on the national indication protocol ('landelijk indicatie protocol', LIP) and is provided by:
- a facility that provides obstetric care; or
- an obstetric nurse working independently.

Approval
Approval is not required.
Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.21.7. Deleted

D.21.8. Obstetric care in the case of adoption

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for reimbursement of the costs of obstetric care including instruction. See clause B.7. for obstetric care.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

See clause B.7. The following terms and conditions are in addition to or deviation from the terms and conditions of that clause.
General
- this involves adoption of a child by one or more individuals who have taken out an additional insurance package with us.
- you register the child that is to be adopted with us as an insured person.
- the adopted child is no more than six months old at the time of the adoption.
- you notify us of the adoption at least 4 months prior to the expected date of adoption by calling our customer services team.

Healthcare provider
The obstetric care is indicated based on the national indication protocol ('landelijk indicatie protocol', LIP) and is provided by:
- a facility that provides obstetric care; or;
- an obstetric nurse working independently.

Approval
Approval (see clause A.18.) is required and must

be obtained at least 4 months prior to the expected date of adoption. You can contact us by telephone or visit our website to arrange this.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.22. Exercise programme

D.22.1. Exercise programmes, general

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of exercise programmes generally aimed at preventing illnesses and/or maintaining and improving your health.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of:
  - sports massage;
  - work-related and/or recreational therapy.
- the healthcare is not subject to a deductible.

Terms and conditions

General

On completion of the exercise programme, you provide us with proof of participation.

Healthcare provider

The exercise programme is provided by:

- a home care organisation;
- a 'GGD' (regional health authority);
- a national or regional patients' association. For diabetes patients, this patients' association must represent the health interests of diabetes patients;
- a hospital (facility for specialist medical healthcare) or outpatient clinic of such a facility;
- a physiotherapist or exercise therapist with whom we have entered into agreements on the specified exercise programme;
- a healthcare group with which we have entered into agreements on the specified exercise programme. This must be an organisation responsible for care/multidisciplinary care for a group of chronically ill persons, such as those diagnosed with COPD or diabetes mellitus.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.22.2. Exercise programme for certain medical conditions

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse exercise programmes that are certified by the Royal Dutch Association for Physiotherapy ('Koninklijk Nederlands Genootschap Fysiotherapie', KNGF) or that carry the Physiotherapy Quality Label ('Keurmerk Fysiotherapie') in the case of one of the following conditions:

- osteoarthritis in the hip and/or knee;
- COPD;
- diabetes mellitus type 2:
- coronary heart disease;
- osteoporosis;
- oncology;
- being overweight and obesity in children.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- the exercise programme is aimed at motivation and coaching so you can continue to exercise independently, in a responsible manner, afterwards; and
- the reimbursement is made after completion of the exercise programme; and
- we use the commencement date of the exercise programme to determine the reimbursement.

Healthcare provider

The exercise programme is run by a physiotherapist who has been trained to run this programme and with whom we have made agreements concerning the exercise programme.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.23. Wmo - Dutch Social Support Act ('Wet maatschappelijke ondersteuning')/Wlz - Dutch Long-Term Care Act ('Wet langdurige zorg')/domestic assistance

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

You are insured for reimbursement of the statutory personal contribution collected through the Dutch Central Administration Office (CAK) for:

a. entitlement to home nursing, support and/or personal care under the Dutch Long-Term Care Act (Wlz);
b. entitlement to domestic assistance under the Dutch Social Support Act (Wmo);
c. the Dutch Social Support Act (Wmo).

The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the personal contribution (statutory or otherwise) for residential care.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- you have been given a care needs assessment by:
  - the Dutch care assessment centre (CIZ) for a care intensity package ('Zorgzwaartepakket', ZZP) that has been translated into extramural functions and categories of care in accordance with the Dutch Long-Term Care Act (Wlz);
  - the municipality for the 'domestic assistance' function under the Dutch Social Support Act (Wmo).
- the Dutch Central Administration Office (CAK) has imposed a statutory personal contribution on you.

Approval

Approval is not required.

D.24. Informal care

D.24.1. Carer course

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse a course for a carer.
The amount we reimburse is shown on your Reimbursements Overview.

Please note!

- see clauses A.21. and C.10. for general exclusions.
- we do not reimburse the costs of:
  - work-related and/or recreational therapy;
  - exercise programmes — these come under clause D.22. Check your Reimbursements Overview to see if you are covered for these.
- the healthcare is not subject to a deductible.

Terms and conditions

General

- we use the commencement date of the carer course to determine the reimbursement.
- the carer or the recipient of the informal care has an additional insurance package that entitles him or her to reimbursement.
- if both the carer and the person receiving informal care have an additional insurance package with entitlement to reimbursement of carer courses, the costs of this course will initially be reimbursed through the additional insurance package of the person receiving the informal care and only afterwards through the additional insurance package of the carer.

Healthcare provider

The carer course is provided by:

- a home care organisation;
- a 'GGD' (regional health authority);
- a national or regional patients' association;
- the 'MantelzorgNL' association for informal care.

Approval

Approval is not required.

Rates

We use a variety of rates. For more information, please refer to clause A.20.

D.24.2. Carer relief

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse temporary carer relief for:
a. you as the carer;
b. you as the carer and/or the person receiving the informal care.

The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- we use the commencement date of the temporary carer relief to determine the reimbursement.
- if you receive the informal care, you require this care because you have a long-term and/or chronic illness or condition and/or deteriorating health and would be unable to function independently at home without this informal care.
- the carer is unable to provide this care for a week or a few weeks due to certain circumstances, such as the carer having a period of leave, holiday or being admitted for a scheduled operation.
- the carer relief is provided for at least one morning or afternoon (at least 4 consecutive hours).
- for D.24.2.a., you (the carer) must be insured with us for the carer relief; the reimbursement applies to you, not to the recipient of the informal care.
- for D.24.2.b., you (the carer) or the recipient of the informal care must be insured with us for the carer relief; if you are both insured for carer relief, the costs of carer relief are first reimbursed under the additional insurance package of the recipient of the informal care and only then under the additional insurance package of the carer.

Healthcare provider
The carer relief is organised and/or provided by a nationally operating organisation recognised or contracted by us. You can find this organisation on our website or call us to find out more.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

D.24.3. Informal care broker

Your Reimbursements Overview will show whether or not you are entitled to reimbursement.

Healthcare: what you are insured for

We reimburse the costs of using one of our own or an external informal care broker for you as a carer. The amount we reimburse is shown on your Reimbursements Overview.

Please note!
- see clauses A.21. and C.10. for general exclusions.
- the healthcare is not subject to a deductible.

Terms and conditions

General
- to arrange the informal care broker, please contact our Healthcare Team ('Zorgteam'). They will assess in a consultation session whether you are eligible for reimbursement.
- you (the carer) must be insured with us for the informal care broker; the reimbursement applies to you, not to the recipient of the informal care.
- for an individual informal care recipient (informal care situation) only one carer is entitled to an informal care broker.

Healthcare provider
Our Healthcare Team ('Zorgteam') will arrange either one of our own or an external informal care broker for you.

Approval
Approval is not required.

Rates
We use a variety of rates. For more information, please refer to clause A.20.

Nationale-Nederlanden Zorg

Postal addresses

General address
Nationale-Nederlanden
Postbus 4016, 5004 JA Tilburg, Netherlands

Address for submitting bills:
Nationale-Nederlanden
Postbus 370, 5000 AJ Tilburg, Netherlands

Address for submitting complaints:
Nationale-Nederlanden klachten zorgverzekering
Postbus 4016, 5004 JA Tilburg, Netherlands

'Stichting Klachten en Geschillen Zorgverzekeringen'
(the Dutch Health Insurance Ombudsman is also part of this organisation)
Postbus 291, 3700 AG Zeist, Netherlands

'Nederlandse Zorgautoriteit' (NZa)
Postbus 3017, 3502 GA Utrecht, Netherlands

'Zorginstituut Nederland'
Postbus 320, 1110 AH Diemen, Netherlands

Data Protection Officer
Please send a letter to:
CZ Customer Services
Postbus 90152
5000 LD Tilburg
Netherlands

Telephone numbers

Maternity Care Service: +31 (0)13 593 82 25
Nationale-Nederlanden Emergency Service (for problems abroad):
+31-20-594 80 70
Medical Aid Helpline: +31 (0)13 593 82 25
Waiting list mediation: +31 (0)13 593 82 25
'Stichting Klachten en Geschillen Zorgverzekeringen': +31 (0)88 900 69 00

Internet and email addresses

For more information, check your personal online policy folder at www.nn.nl (in Dutch)
For a list of contracted healthcare providers, go to www.nn.nl/zorgvergelijker (in Dutch)
'Stichting Klachten en Geschillen Zorgverzekeringen': www.skgz.nl (in Dutch)

Legal entity and Zorgverzekeringen CoC registration:
Centrale Zorgverzekeringen NZV N.V. CoC no. 27118912
Onderlinge Waarborgmaatschappij CZ groep U.A. CoC no. 18028752

575.778.004.001.2150