Policy Conditions 2024
Basisverzekering
Natura Select

P.O. Box 2705 • 6401 DE Heerlen • T 088 - 35 35 763
www.aevitae.com • info@aevitae.com

Welcome to Aevitae

These are the policy conditions that apply to your public healthcare insurance. This basic insurance is an insurance policy from EUCARE Insurance PCC Limited (NLCare cell). Aevitae takes care of the execution of this insurance on behalf of EUCARE. These conditions include your and our rights and obligations. There are separate policy conditions for supplementary insurance policies. You can consult the conditions of the supplementary insurance policies via our website www.aevitae.com or you can request them from us.

In these policy conditions we occasionally refer to our website for more information about a specific subject. If you do not have internet access, you can call us. If required, we can send you the requested information.

In the text blocks below you will find an explanation about a number of practical issues. Do you want to know more? Then go to www.aevitae.com. You will find all information about your basic insurance and additional insurance.

Sincerely,
Aevitae

These conditions are divided as follows:

Index

AEV-24004 (A)

Important information and service

If you have questions, or something you think we should know, we will be happy to offer our assistance!

Our website
Comprehensive information about your health insurance is available at aevitae.com. This is where you can find answers to frequently-asked questions, calculate your premium, submit invoices online, find healthcare providers and review and compare all reimbursements from A to Z.

Contact
You can contact us by phone, e-mail, regular mail or social media. Our Service Desk is open on weekdays from 08:30 to 17:30. We can be reached on 088 353 57 25. For current opening hours, please refer to aevitae.com/service-contact. During the weeks in December when many people change providers, we offer expanded hours of operation in order to provide you with even better service.

If you have questions about your health insurance, you can also send us a private message through Facebook or Twitter. Follow @aevigram on Instagram for a peek behind the scenes at Aevitae!

Submitting care invoices
If you have received an invoice for care, you can digitally submit it for reimbursement through Mijn Aevitae. First, log in securely and easily using iDIN. In order to use iDIN, you must first complete the one-time activation process. More information on logging in using iDIN can be found here. In the Mijn Aevitae digital environment, you can also easily and conveniently edit your personal details, view your healthcare costs or make changes to your coverage package(s).

You can submit an invoice to us by regular mail as well. To do so, simply print out and fill in a declaration form and mail it, along with the original invoice, to the postal address below. The declaration form is available here.

Mailing address
Aevitae
P.O. Box 2705
6401 DE Heerlen

Visiting address
Aevitae
Nieuw Eyckholt 284
6419 DJ Heerlen

Need permission for care?
To find out which healthcare requires our permission in advance, please refer to the policy terms & conditions. You will need to send a request for permission for the treatment in question to the mailing address above, for the attention of Team Medical.

More information on requesting permission can be found on our website. The request forms are also available for download here.

Complaints
We do everything we can to provide Aevitae clients like yourself with the best possible service. If you are unsatisfied with a decision we have taken regarding our service, or the service of one of your healthcare providers, please do not hesitate to let us know. For more information on complaints and disputes, please visit aevitae.com/klachten.

Find a healthcare provider
Healthcare providers have agreements in place with health insurance companies. Such providers are referred to as 'contracted care providers'. They have signed contracts with the insurers that include agreements on things like quality of care. The healthcare providers with whom we have such agreements are listed in the CareFinder. Our CareFinder is available here.

Aevitaal
Health and vitality are incredibly important to us. This is why we are eager to help you stay healthy and fit as well. On the Aevitaal platform, you'll find information on health, vitality, employability and resilience. Are you experiencing symptoms or having trouble sleeping, or would you like to adopt a healthier lifestyle or enhance your employability? Go to Aevitaal and sign up today!

I General Section

As a courtesy we provide you with an English translation of our policy conditions. You can and may not derive any rights, entitlements or obligations from this English translation. Our health insurance policies are regulated by Dutch law and as such, our Dutch conditions and entitlements documents are the only legal documents from which you can derive your rights, entitlements and obligations.

Article 1 Covered healthcare

1.1. Contents and scope of covered healthcare

The Basisverzekering Natura Select is a reimbursement policy of the healthcare insurer, further referred to as 'the healthcare policy'. Pursuant to this healthcare policy, you are entitled to reimbursement of the cost of healthcare as set out in these policy conditions. You are also entitled to healthcare advice and healthcare mediation at request.

> Healthcare advice and mediation
> Our Team Medical advises you about the healthcare provider you can consider for your healthcare issue. Please also contact our Team Medical if you are confronted with a nonacceptable long waiting list for visiting a policlinic or for hospitalisation, for example. You can reach our Team Medical through our website.

Medical necessity

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

1.2. Authorised healthcare providers

Your healthcare provider must comply with certain conditions. The relevant healthcare provision sets out which healthcare providers may provide the healthcare services and the supplementary conditions the healthcare provider must meet. If the healthcare provider does not meet with the imposed conditions, then you are not entitled to reimbursement of the cost.

1.3. Healthcare provided by a contracted healthcare provider

The care in kind is provided by a care provider with whom the health insurer has a agreement: a contracted healthcare provider. The healthcare provider receives reimbursement of the costs of healthcare directly from us. This is done based on the rate agreed to with the relevant healthcare provider.

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

1.4. Healthcare provided by a non-contracted healthcare provider

Are you going to a care provider whom we have not contracted for the care in question? Then you may have to pay part of the bill yourself. The cost of the (covered) healthcare will be reimbursed up to 70% of the average rates, and in case of medical specialist care up to 75% of the average rates, as agreed with the relevant healthcare providers for the relevant forms of healthcare ('average contracted rates'). If no rates were agreed with healthcare providers for the relevant healthcare and Wmg (Healthcare Market Organisation Act) rates apply, the costs are reimbursed up to 70%, and in case of medical specialist care up to 75%, of the Wmg rates. Part of the bill total may then be charged to you.

Do you wish to go to a non-contracted healthcare provider, but does the amount of the reimbursement (70%) prevent you from getting healthcare? Then you can let us know why this lower reimbursement prevents you from going to your chosen healthcare provider and ask for a higher reimbursement. Please contact our Complaints Management department.
We will process your request and inform you within 4 weeks whether we can give you a higher reimbursement. Your the request may be granted mostly depending on the amount of the costs and the type of care. Any personal contributions, mandatory and voluntary excess owed will be deducted from the reimbursed amount.

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

General practitioner care
Do you use general practitioner care as set out in Article 12, General practitioner care or Article 14, Multidisciplinary care (chain healthcare) at a general practitioner or healthcare group that we have contracted for such healthcare? Then you are entitled to reimbursement up to a maximum of the applicable Wmg rates (Market Regulation Healthcare Act (Wmg Act)). We reimburse the cost of tests requested by your general practitioner to be carried out by another non-contracted healthcare provider (for example X-rays or blood tests) up to a maximum of 70% of the average contracted rate.

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

Assignment ban
Your claim for Nursing and care (Article 16), Mental Healthcare (Article 27 and 39), Pharmaceutical care (Article 36 Medicines) and Medical aid care (Article 38) cannot be transferred to healthcare providers or others with whom we have not entered into a contract for this care. This is a clause as referred to in Article 3:83 paragraph 2 of the Dutch Civil Code.

We have contracted a limited number of care providers for specialist medical care. This is called selective contracting.

1.4.1 Selective contracting of specialist medical care

For medical specialist care (Article 18 Medical specialist care, Article 19 Rehabilitation, Article 21 In vitro fertilisation (IVF) and other fertility-promoting treatments, Article 23 Plastic and/or reconstructive surgery and Article 39 Residence) you can go to a limited number of contracted hospitals in the Netherlands. We call this selective contracting. An overview of the hospitals contracted by us can be found on our website or requested from us. Are you going to a hospital that is not contracted for the Basisverzekering Natura Select? Then you will receive a lower compensation. This reimbursement is a maximum of 75% of the average rate for which we have purchased this care (from contracted care providers).

For a number of treatments, the application of the lower reimbursement for non-contracted hospitals in Article 1.4 and this Article does not apply. These are:
a. emergency care;
b. obstetrics;
c. treatments that fall under 'other care products', such as oral surgery, laboratory tests or X-rays;
d. treatments for which you have been referred by your treating specialist to another healthcare institution (tertiary referral);
e. care in accordance with the Special Medical Operations Act ('Wet bijzondere medische verrichtingen');
f. treatments that are part of mental healthcare (GGZ);
g. follow-up treatments to the treatments from a to f, if they are part of the same demand for care.

For this care you can go to all hospitals in the Netherlands.

The reimbursement of this care is limited by the (maximum) rate that was determined at that time on the basis of the Healthcare Market Regulation Act (Wmg). Is there no (maximum) rate based on the Wmg? Then we will reimburse the costs up to a maximum of the market-based amount applicable in the Netherlands..

This article, with the exception of emergency care, does not apply to treatments abroad. See article 9 of the General section.

Is there a maximum reimbursement for non-contracted care providers based on 75% of the average contracted rate or the Wmg rate? Then you will find a list of the amount of these maximum fees on our website. You can also request it from us.

Is there a maximum compensation based on the amount applicable in the Netherlands? Then you can request an indication of this amount from us. Please note! Do you start a new treatment after these treatments that can be planned? First check with which hospital we have made appointments. You can easily do this via the Care Finder on our website or contact us. This prevents you from having to pay the bill yourself or part of the bill first.

1.5. How do you claim a reimbursement?

Most healthcare providers send us the invoices directly. If you receive an invoice at home, please complete an expense form and submit it together with the original invoice. Please do not send us a copy or a reminder. We can only process originals. You may submit invoices latest up to 3 years after the start of your treatment.

The invoice must contain at least the following information:

a. The date on which the invoice was created by the healthcare provider and the invoice number (successive and each invoice number may only appear once);
b. Your name, address and date of birth;
c. The type of treatment, the amount per treatment and the date of the treatment;
d. The name and address of the healthcare provider;
e. The AGB code (for Dutch healthcare providers).

These invoices have to be specified, ensuring that the reimbursements we must pay out can be derived from the specifications directly and without any ambiguity. We deduct any excess and statutory personal contribution from the reimbursement. For conversion of foreign invoices in currencies other than euros, we use the historical rates available from www.xe.com. This is based on the exchange rate on the date of treatment. Invoices must be in Dutch, English, French, German or Spanish. If a translation is necessary to our discretion, we may request you to provide a certified translation of the invoice. We will not refund the translation expenses.

> Online claim forms
> Online submission of claims is quick and easy. Go to Mijn Aevitae. You must retain the original invoice for at least one year after submitting the relevant claim form. We may request the invoices for inspection. If you are unable to submit the invoices, we may recover the amounts paid out from you, or settle the relevant amounts with amounts due to you.

1.6. Temporary healthcare provision

If a contracted healthcare provider is unable to deliver the relevant service or treatment at all or in time, you are entitled to healthcare mediation. In that case, you can contact our Team Medical. We may grant permission to see a non-contracted healthcare provider for the relevant healthcare. In such cases we reimburse the costs up to the statutory Wmg rates. If no Wmg rates have been determined, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands.

To determine if healthcare was provided in due time, we take into consideration:

- specific medical factors;
- general, socially acceptable waiting lists based on psychological, social and ethical factors.

1.7. Direct payment

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

1.8. Settlement of costs

If we pay costs directly to the healthcare provider and we reimburse an amount higher than our contractual obligation pursuant to your healthcare insurance policy, or the costs of the relevant healthcare services are otherwise charged to you, the relevant excess amount is charged to you as the policyholder. We will charge these amounts to you at a later stage. You have a legal obligation to pay such amounts. We reserve the right to settle such amounts with amounts due to you.

1.9. Referral, prescription or permission

For some types of healthcare, you require a referral, prescription and/or prior permission in writing demonstrating that you are dependent on this healthcare. Details are set out in the relevant healthcare article. The healthcare articles are mentioned in chapter II. Does the healthcare article set out that you require a referral or a prescription? Then you can request one from the relevant healthcare provider referred to in the Article. This is generally the general practitioner.

A referral, prescription or request for permission must be given prior to the treatment by the referrer. The referral, the prescription, or the request for permission must include the following data:

- the insured's name, address, and date of birth;
- the referrer's name, position, AGB code, and signature;
- date of issue;
- reason for referral, diagnosis, and any other relevant information.

A refererral or prescription is valid for up to 1 year after issue.

A prior referral, prescription and/or permission is not required for emergency healthcare, i.e. healthcare that cannot reasonably be postponed.

Single diagnosis for chronic conditions
If you have a (permanent) chronic condition, a one-off statement proving this diagnosis is sufficient. In that case, a current version is not required.

Permission

In some cases you also require our permission prior to receiving the healthcare. This permission is referred to as prior permission. This permission will also include a validity period. If you have not obtained prior permission, or if the care is provided outside the validity period, then you are not entitled to reimbursement of the healthcare in question.

If you selected a healthcare provider whom we have contracted for the care in question, you do not require prior permission. Your healthcare provider will in such cases assess if you fulfil the conditions and/or requests permission from us on your behalf. Alternatively, you may submit a request for permission to us. Please find our address on the cover sheet of the conditions.

If you selected a healthcare provider whom we have not contracted for the care in question, then you are responsible for requesting permission from us.

If you have permission for insured healthcare, this also applies if you transfer to a different healthcare insurer or if you received permission from your previous insurer.

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

You are entitled to reimbursement of the cost of healthcare if the healthcare was delivered during the term of your healthcare insurance policy.

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

We do not process invoices if you declare them later than 3 years after the treatment date and / or the date of delivery of the care.

1.11. Exclusions

You are not entitled to:

- Reimbursement of forms of healthcare or healthcare services that are funded pursuant to other legal regulations, including the Wlz (Long-Term Healthcare Act), the Youth Act or the Wmo (Social Support Act) 2015;
- Reimbursement of personal contributions or excess payable under the terms of the healthcare insurance, except if and where these policy conditions determine otherwise;
- Reimbursement of fees for not appearing at your appointment with a healthcare provider (the 'no-show fee');
- Reimbursement of costs related to not collecting medical aids, medicines and/or dietary preparations;
- Reimbursement of fees for written statements, mediation fees charged by third parties without our prior permission in writing, administrative fees or charges incurred by past-due payment of invoices from healthcare providers;
- Reimbursement of healthcare costs caused by or resulting from armed conflict, civil war, uprising, civil disorder, riots or mutiny occurring in the Netherlands, as defined in Section 3.38 of the Financial Supervision Act (Wet op het financieel toezicht);
- Reimbursement of losses that are an indirect result of our actions or omissions;
- Reimbursement of the costs of healthcare if the costs of care are charged by yourself, your partner, child, parent, or resident (other) family member, unless we have given prior permission;
- Reimbursement of the costs of healthcare if you are referred by yourself, your partner, child, parent, or resident (other) family member, unless we have given prior permission.

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

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

The exact definitions and provisions for the above-mentioned entitlement are included in NHT's Clauses Sheet Terrorism Cover.

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

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

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

In reality, this may mean you are not paid out the full amount claimed. However, you are at least assured that you will receive payment of at least part of your claim.

Article 2 General provisions

2.1. Basis and contents of the healthcare insurance

The insurance contract was concluded based on the details you submitted in the application form or in writing.
After taking out the healthcare insurance policy, you will receive a healthcare policy from us as soon as possible. Furthermore, you will receive a new healthcare policy prior to each new calendar year.

These policy conditions form an integral part of the healthcare policy. The policy cover will state the persons insured and the healthcare insurance taken out for them.

2.2. Scope of application

The healthcare policy is available to all persons subject to mandatory insurance, residing in the Netherlands or abroad.

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

2.3. Corresponding documents

These policy conditions refer to documents. These documents are part of the conditions. It concerns the following documents:

- 'Besluit Zorgverzekering' (Healthcare Insurance Decree);
- Appendix 1 to the Healthcare Insurance Decree;
- 'Regeling zorgverzekering' (Health Insurance Regulation);
- Clauses Sheet Terrorism Cover;
- Premium appendix;
- 'Lijst maximale vergoedingen niet-gecontracteerde zorgaanbieders' (List of maximum reimbursements for non-contracted healthcare providers);
- Landelijk Indicatie Protocol Kraamzorg (LIP - National Indication Protocol Maternity Care);

- ‘Kraamzorg Landelijke Indicatie Methodiek’ (KLIM - Maternity Care National Indication Methodology), at the time of writing these policy conditions, the definitive version of this methodology is not yet available;
- Overview of contracted healthcare providers;
- Standard of care for Diabetes mellitus, VRM, COPD, Obesity and Asthma;
- NHG guideline on overweight and obesity in adults and children;
- Limitative list of DBCs (Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland (Healthcare Insurers Netherlands) to be requested in advance;
- Pharmaceutical Care Regulation;
- Medical Aids Regulation;
- Nursing and care personal budget regulations;
- Reference guide assessment plastic surgery treatments;
- List GGZ Therapies (Mental Healthcare);
- Information documet IVF abroad.

You can find these documents on our website. You may also request these documents from our customer service desk.

2.4. Fraud

Fraud (full or partial) will result in claims not being paid out, and/or recovery of claims already paid out. If you commit fraud, your entitlement to healthcare or reimbursement of healthcare costs lapses. This applies to healthcare provided by contracted as well as non-contracted healthcare providers.

We will claim any amounts paid out from you in a recovery process. You will also be charged the cost ensuing from the fraud audit/inspections.

In case of fraud, we register your personal data and the personal data of the accomplice(s) or co-perpetrator(s) in our Incident register. Your personal data and the personal data of the accomplice(s) and co-perpetrator(s) may also be registered:

- with the Centre for Countering Insurance Fraud (CBV - Centrum Bestrijding Verzekeringsfraude) of Dutch Association of Insurers (VvV - Verbond van Verzekeraars);
- in the external referral register of the foundation Central Information System (CIS).

We can also report the fraud to the police and investigative authorities.

If you commit fraud, we will terminate your healthcare insurance policy. In that event, you will not be accepted for a new healthcare insurance policy for 5 years. We will also terminate your supplementary insurance. In that event, any applications for supplementary insurance will be rejected for a period of 8 years by EUCARE.

2.5. Private data protection

We take your privacy seriously. The collection and processing of your personal data is necessary for entering and carrying out your (additional) (health) insurance(s). We will include your personal data in our insurance administration.

Processing personal data

We process your personal data for the following purposes:

- for entering into and carrying out your insurance contract(s) or financial service;
- for checks and/or research among insured parties, care providers and/or suppliers to see whether the care has actually been provided;
- for research into the quality of the care received by insured parties;
- for statistical analysis;
- to comply with legal obligations;
- in the context of security and integrity of the financial sector (preventing and combating fraud);
- if you participate in a group contract: for data exchange with the contractor of the group contract for the assessment of your right to premium discount;
- recruitment for this insurance and recruitment for own and similar services and products and associated marketing activities (up to 1 year after termination of the insurance contract).

The privacy legislation applies to the processing of your personal data, including the General Data Protection Regulation (AVG), the ZN Code of Conduct for the Processing of Personal Data for Healthcare Insurers, the General Provisions BSN Act, the Use of BSN in Healthcare Act and our Privacy Statement.
You will find the code of conduct and the privacy statement on our website.

We are legally obliged to use your citizen service number (BSN) in our administration and in communications (data exchange) with healthcare providers. The BSN is also used for claims traffic. For the security and integrity of the financial sector, we can consult your data at the CIS, www.stichtingcis.nl.
Do you want more information, view, correct or object to your personal data? You can read all about it in our www.aevitae.com/privacy-statement.

> Use of personal data by healthcare providers
> If we receive your bills directly from healthcare providers and pay them, your healthcare insurance will be carried out faster and easier. This may require the care provider to know how you are insured. For that reason, the healthcare providers can view your address, policy details and citizen service number (BSN) in a secure manner. They are only allowed to do this if they actually treat you. If there is an urgent reason to not allow healthcare providers access to your personal details, please let us know. You can submit this request in writing and send it to the attention of the Data Protection Officer of Aevitae. We will then ensure that this data is protected.

2.6. Notifications
Any notifications sent to the most recent address in our system are deemed to have reached you. If you choose to contact us electronically, we will also send you notices electronically.

> E-mail
> Where the insurance terms and conditions refer to “in writing” it is also understood to mean “by e-mail” if you do have chosen this method of communication. In that case, “address” means “e-mail address”.

2.7. Cooling-off period
Upon taking out your healthcare insurance policy, you have a 14-day cooling-off period as the policyholder. You are entitled to cancel the insurance policy in writing within 14 days of signing the contract. In that event the insurance contract is deemed to have never been concluded.

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

2.9. Dutch law
This healthcare insurance is governed by Dutch law.

Article 3 Premium

3.1. Premium base and premium discounts
The premium base is the premium without premium discount for any voluntary excess. The premium base and the premium discount for voluntary excess are set out in the premium appendix as amended annually. Please find this premium appendix on our website.

The premium base and premium discounts applicable to you are set out in your policy cover.

3.2. Group contract
3.2.1. The conditions as set out in the group contract will lapse on the date you can no longer participate in the group contract. From this date onwards, the healthcare insurance is continued on an individual basis.
3.2.2. You may not participate in more than one group contract at the same time.

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

Example
Someone who turns 18 on 1 July pays premium commencing on 1 August.

3.4. Payment of premium, statutory contributions, excess and costs

3.4.1. The premium due date depends on the period over which the premium applies. For the first premium period during a calendar year, the premium due date is the same as the commencement date of the policy (usually January 1 of the relevant policy year). In the case of follow-up payments for monthly, quarterly or semi-annual payers, this is the first of the month, quarter or six months for which the premium is calculated. If you pay an annual premium, you will receive a payment discount on the premium due. The amount of the discount is stated on the policy cover.

3.4.2. You pay the premium, excess, personal contributions and any reimbursement amounts paid out to you unjustified in the payment method as agreed with us.

Payment options

a. You authorize us for direct debit of amounts due (also see article 3.4.3).
b. You use the option to receive a digital invoice for free via your My environment. In that case, you must ensure timely payment yourself. If desired, this can be done directly via iDeal.
c. Your employer deducts the premium from your salary and transfers it to us. This payment option only applies to the premium.

Do you use the option to receive a paper invoice? In that case, you must ensure timely payment yourself. You will also receive a paper invoice if a direct debit cannot be collected.

If you (the policyholder) choose to receive a paper invoice, you (the policyholder) may have to pay administration costs. More information and the amount of the costs for paper mail can be found on our website.

3.4.3. Your authorisation for direct debit is valid for payment of the premium, the excess, personal contributions and any reimbursement amounts paid out to you unjustified. Such an authorisation applies during and if necessary after expiration of the insurance contract. Please refer to your policy schedule to check the date of direct debit collection of the premium for the entire calendar year. For the other costs, we will notify you at least 2 days before the date on which the amount is collected, stating the amount to be taken out of your account and the direct debit transaction date. If you disagree with a processed payment, you can have the payment reversed later. Please contact your bank within 8 weeks of processing the payment.

3.5. Settlement

You may not settle any amounts due with any amounts payable to you.

3.6. Overdue payments

3.6.1. If you do not pay the premium, statutory contributions, personal contributions, the excess and any reimbursement amounts paid out unjustified in due time, we will send you a reminder. If you do not pay within the period of at least 14 days as specified in the reminder, we may decide to suspend cover of this healthcare insurance policy. In that case you are not entitled to healthcare and reimbursement of healthcare costs from the last premium due date before the reminder. Your obligation to pay the premium will continue during any period of suspension. Entitlement to (reimbursement of the cost of) healthcare is restored on the date following the date on which the amount due plus any fees were received.

We reserve the right to terminate the healthcare insurance policy if payments are in arrears. The insurance will not be terminated with retroactive effect in that case.

3.6.2. We may charge the following fees in the event of overdue payment:
- statutory interest from the day following the due date of the original invoice;
- debt collection fees from the day following the due date of the original invoice.

3.6.3. If you have received a reminder for overdue payment of premiums, statutory contributions, excess, personal contributions or reimbursements paid out to you that prove unjustified, then we do not have a legal obligation to send you a separate written reminder if payment for the subsequent invoice is overdue.

3.6.4. We reserve the right to settle any arrears in premiums, costs and statutory interest due with any healthcare expense forms or other amounts payable to you.

3.6.5. If we terminate the healthcare insurance policy due to overdue payment of the premium, we reserve the right to reject any applications from you for insurance contracts for 5 years.

3.6.6. Consequences of non-payment of 2 or more monthly premiums

If you have payment arrears amounting to two monthly premiums, we offer you as policyholder a payment schedule. We do this no later than 10 working days after we have established this payment arrears. This payment arrangement consists of at least:

a - your authorization for direct debit of new premium owed, or;
- your assignment to your employer, pension fund, benefits agency or another third party from whom you receive periodic payments, to pay the new premiums owed directly to us on your behalf as the policyholder;

b agreements on how you will pay us your debts, including interest and collection costs, and within what terms;

c our commitment that we will not terminate, suspend or suspend your health insurance policy as long as you do not withdraw your authorization or order for payment as stated under a and comply with the agreements as included in the payment arrangement.

We will give you 4 weeks to decide to accept our offer for a payment schedule. We will also inform you of the consequences of not accepting our offer and your arrears run up to 6 or more monthly premiums; also see article 3.6.8.
It may also be that you have insured someone else for health insurance with us, where premiums are in arrears. In that case, we will also include a statement of willingness to cancel the insurance in our offer for a payment arrangement per the day on which the payment arrangement takes effect, on condition that:
- the insured has taken out another health insurance policy with effect from the same day;
- or the insured has issued the authorization or order for payment as described under a in case the new health insurance has also been taken out with us.

We will send this insured a copy of all the documents referred to in this article at the same time that the documents are sent to you as a policyholder.

If you have payment arrears of 2 monthly premiums, we will also inform your municipality about that. Municipalities are required to pick up these signals and to offer help.

3.6.7. Consequences of not paying 4 monthly premiums

a If you, as the policy holder, have a payment arrears of 4 monthly premiums, we will notify you that we will register you with the CAK for the defaulters scheme once the payment arrears reaches 6 monthly premiums, as explained in article 3.6.8.

b You or the insured must inform us within no more than 4 weeks in case you dispute the existence or the amount of the debt. If we have received your dispute on time, we will start an investigation. When we inform you that we are maintain our position, you can submit a dispute to the Complaints and Disputes Foundation (SKGZ) within 4 weeks or to the civil court.

c If the payment arrangement described in article 3.6.6 commences after the payment arrears has reached 4 monthly, we will not send you a notification as stated under a as long as you pay the new premiums.

3.6.8. Consequences of not paying 6 monthly premiums

If you, as the policy holder, have a payment arrears of 6 or more monthly premiums, we will report you to the CAK. After the registration confirmation from the CAK you are obliged to pay an administrative premium between 110% and 130% of the average premium to the CAK. For the period that you owe the premium to the CAK, you do not owe us any premium. The CAK collects this premium until you have paid all due amounts including interest and collection costs.

We do not register you with the CAK if:

a you have disputed the premium arrears on time and we have not yet communicated our position to you;

b you have submitted the dispute to the SKGZ or the civil court within 4 weeks after we have informed you that we will maintain our position and report the premium debt to the CAK, and as long as the dispute has not been irrevocably decided;

c you have signed up with a professional debt counselor and show that you have a written agreement to stabilize your debts;

d you have agreed a payment arrangement with us for both the premium arrears and any arrears in the payment of the excess and/or personal contribution.

Our statement that we have complied with Article 18b and the second paragraph of Article 18c Health Insurance Act is part of the notification to the CAK.

3.6.9. We will immediately inform you and the CAK of the date on which:

a the debts arising from the health insurance have been paid in full or have been canceled;

b the court declares that the debt rescheduling scheme for natural persons, as referred to in the Bankruptcy Act, applies to you;

c you are going to participate in a debt (reorganization) arrangement established through the intervention of a professional debt counselor, or when we have agreed a payment arrangement with you to pay off the debt in full, or;
d you meet conditions to be determined by ministerial regulation.

The obligation to pay the administrative premium to the CAK ends on the first day of the month following the dates mentioned above. From this moment on you are obliged to pay us the premium.

3.6.10. You do not owe us any premium for the period referred to in Article 18d, first paragraph, or Article 18e of the healthcare law.

3.6.11. Do you apply for insurance from us after non-payment? And do we register you? Then you (policyholder) must have 2 months prepay premium.

Article 4 Other obligations

You are required to:

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

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

Article 5 Change in the premium or premium base and conditions

5.1. Change in conditions

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

5.2. Cancellation right

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

Article 6 Start date, term and termination of healthcare cover

6.1. Start date and term

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

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

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

6.1.4. If the previous insurance policy has been terminated effective 1 January of a calendar year or due to a change in the conditions, the new insurance policy will commence at the new insurer as per the termination date of the old insurance policy. In that case you must register with the new healthcare insurer within one month of termination of the previous insurance policy.

6.1.5. If the insurance contract becomes effective within 4 months of the start date of mandatory insurance, the healthcare policy will become effective on that start date.

> Example
> It is mandatory for you to insure your child within 4 months of childbirth, ensuring that your child is insured from the date it was born.

6.1.6. The Health Insurance Act contains an insurance obligation. We are not obliged to take out a health insurance with or for a person who is already insured under the Health Insurance Act.

6.2. Termination by operation of law

The healthcare insurance terminates by operation of law from the day following the day on which:

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

You, as the policyholder, have the obligation to inform us of the death of an insured or of the end of mandatory insurance of an insured as soon as possible. If you do not notify us of the end of mandatory insurance of an insured on time and we pay the cost of healthcare to a healthcare provider, we will claim these costs from you. If we conclude that the healthcare insurance cover has terminated, we will send you a confirmation accordingly as soon as possible.

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

6.3.1 Change

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

6.3.2. Annual cancellation

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

6.3.3. Intermediate termination

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

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

> Cancellation upon 18th birthday
> You may cancel your child's insurance upon his/her 18th birthday. Your child may then conclude his/her own healthcare insurance policy.

6.3.4. Cancellation service

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

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

6.4. When are we entitled to cancel, dissolve or suspend the insurance contract?
We are entitled to cancel, dissolve or suspend the insurance policy in writing:
- in the event of past-due payments as set out in Article 3.6;
- in the event of fraud (see Article 2.4);
- if you intentionally have not provided any, incomplete or incorrect information or documents that have or could have worked to our disadvantage;
- if you acted with the intent of misleading us, or if we had not accepted your application for a healthcare insurance policy/ policies if we had known the actual circumstances.

In such cases we reserve the right to cancel the healthcare policy within 2 months of detection and with immediate effect. In such cases we are not liable for paying out any amounts, or we may reduce the amount to be paid out. We reserve the right to set off such recovery claims against other payments.

6.5. Certificate of cancellation
Upon termination of the healthcare policy, you will receive a termination confirmation with the following details:
- name, address, place of residence and citizen service number (BSN) of the insured;
- name, address and place of residence of the policyholder;
- the day on which the healthcare policy terminates;
- whether on that day an excess applied and if yes, the amount of this excess.

Upon termination of mandatory insurance, the end date is also stated in the confirmation.

6.6. Insuring non-insured persons
If the CAK concluded this healthcare policy on your behalf pursuant to Section 9d, subsection 1 of the Health Insurance Act, the following applies:
a. you may deem this healthcare policy null and void if you can demonstrate within 2 weeks to both us and the CAK that you already have healthcare insurance. This 2-week period starts on the date on which the CAK informed you that it concluded this healthcare policy on your behalf;
b. we may lawfully reverse this healthcare policy due to error if you demonstrate that you are not subject to mandatory insurance;
c. you are not permitted to cancel this healthcare policy during the first 12 months. After these 12 months, the customary termination options as stated in Article 6.3 become effective.

Article 7 Statutory excess

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

7.2. The types of care to which the statutory excess does not apply
The statutory excess is applicable to all types of care as included in these policy conditions, with the exception of:
- general practitioner care as described in Article 12. Please take into account that medicines prescribed by your GP do not fall under GP care. The same applies to laboratory tests related to GP care performed and charged by another care provider at the request of the GP. For this care, the statutory excess applies. See Article 12, General practitioner care;
- care programs as described in article 14, Multidisciplinary care (chain healthcare). The deductible does apply to medicines and laboratory tests;
- a combined lifestyle intervention as set out in Article 15; The deductible does apply to medicines and laboratory research;
- nursing and care as set out in Article 16;
- obstetric care by an obstetrician, general practitioner or gynaecologist. The excess does not apply to prenatal screening and the NIPT. However, the excess does apply to costs related to obstetric care. This means that medicines, blood tests and patient transport, charged separately, are counted towards the excess. See Article 17.1 Obstetric care, and Article 18 Specialist medical care;

- maternity care. Please refer to Article 17.2, Maternity care;
- leased medical aids. Please refer to Article 38, Medical aids and bandaging;
- post-op check-ups after a kidney or liver donation, after the period set out in Article 24, item d, Tissue and organ transplants has expired;
- transport of a donor as set out in Article 24, Tissue and organ transplants;
- care by a care provider specifically designated by us. You can find this care provider(s) on our website;
- any personal contributions and/or personal payments.

7.3. Calculation method of amount of statutory excess

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

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

This amount will be rounded off to the nearest whole euro.

> Example
> The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2024 has 366 days. The excess is: € 385 x 30 divided by 366 is € 31.56 and is rounded off to € 32.

7.4. Calculation of statutory excess

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

Article 8 Voluntary excess

8.1. Variations voluntary excess

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

8.2. The relevant types of care to which the voluntary excess is applicable

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

8.3. Calculation method of amount of voluntary excess

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

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

This amount will be rounded off to the nearest whole euro.

> Example
> You selected a voluntary excess of € 500. The healthcare policy term is 1 January through 30 January. This is a total of 30 days. The calendar year 2023 has 366 days. The voluntary excess is: € 500 x 30 divided by 366 is € 40,98 and is rounded off to € 41. The statutory excess is € 385 x 30 divided by 366 is € 31.56 and is rounded off to € 32. The total excess amounts to € 73 (€ 32 statutory excess and € 41 voluntary excess).

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

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

8.4. Amendments to voluntary excess

You may change the voluntary excess annually as per 1 January. You are required to forward us such changes in writing or via Mijn Aevitae no later than 31 January.

8.5. Calculation of statutory and voluntary excess

If a voluntary excess applies, the healthcare costs will first be deducted from the statutory excess and subsequently from the voluntary excess. The provisions set out in Article 7.4 apply for the calculation of the voluntary excess amount relating to treatment spread over 2 calendar years.

Article 9 Abroad

9.1 General

We make the following distinctions for the reimbursement of treatments abroad:

- insured persons living in the Netherlands (see Article 9.4);
- insured persons who live or stay in another EU/EEA country or treaty country and stay in the Netherlands or another treaty country, whether temporarily or not (see Article 9.5);
- insured persons who live or stay abroad, but not in an EU/EEA country or treaty country (see Article 9.6)

9.2 Permission requirement for care abroad

Do you wish to receive treatment abroad? If you are admitted to a hospital or other institution for 1 or more nights for this treatment, or if it concerns care for which permission would be required if it was provided in the Netherlands, you will require our prior permission. You can request this via the 'Application form for medical treatment abroad' on our website. You do not need permission if you are unexpectedly admitted and the treatment cannot reasonably be postponed until you have returned to your country of residence. If you are admitted for 1 or more nights, you must call our emergency center. You will find the telephone number on your health insurance card and on our website.

9.3 Referral and/or permission requirement

Is a specific referral, prescription and/or permission required aside from the permission for requesting care (Article 9.2)? Then you can find this in the relevant healthcare article (see also Article 1.9 of this General section).

9.4 You live in the Netherlands and receive care abroad

If you live in the Netherlands, you are entitled to reimbursement of insured care provided by a care provider outside the Netherlands contracted by us. A list of contracted healthcare providers is available from our website.

Are you going to a care provider who has no contract with us for the care in question? Then we will reimburse the costs up to the amount you would have received if the treatment had taken place in the Netherlands. Therefore, keep in mind that you may have to pay a (large) part of the costs yourself for treatments abroad.

9.5. If you are living in or residing in an EU/EEA or treaty country outside the Netherlands

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

- healthcare in accordance with the statutory insurance package in an EU/EEA country or treaty country, if applicable to you. This right to healthcare is set out in the EU social security regulations or a social security treaty;
- healthcare provided by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to a maximum of the market price perceived as reasonable in the Netherlands.

> Please note!
> In the event of emergency care provided by a non-contracted healthcare provider, you are entitled to reimbursement of the costs up to the Wmg rates applicable in the Netherlands or the reasonable market-level rates as applicable in the Netherlands. In the event of foreseeable healthcare where a contracted healthcare provider knows or expects that it cannot be delivered or not in time, we may reimburse the healthcare costs for a non-contracted healthcare provider up to a maximum of the Wmg rates applicable in the Netherlands or the reasonable marketlevel rates as applicable in the Netherlands. You will require our prior permission for this.

European health card (EHIC)
On the reverse of your healthcare card, you can find the EHIC. If you travel to an EU/EEA country or Switzerland, this card entitles you to necessary medical care abroad. You can use the EHIC in Australia for emergency medical care. You may only use this EHIC if you are insured with us. If you use this EHIC abroad, while you know or could reasonably know that it is no longer valid, the cost of healthcare will be charged to you. Please note that the EHIC is only valid for one calendar year.

9.6. If you are living in or residing in a non-EU/EEA country or non-treaty country

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

- reimbursement of healthcare costs by a contracted healthcare provider or healthcare institution;
- reimbursement of healthcare costs by a non-contracted healthcare provider. We will reimburse the costs up to a maximum of the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to a maximum of the market price perceived as reasonable in the Netherlands.

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

Article 10 Complaints and disputes

10.1. Do you have a complaint? Please submit your complaint to the Complaints Management department

You may rest assured that we organise everything carefully relating to your healthcare insurance policy. However, one hundred percent satisfaction is not always achievable. We are open to hearing your complaints and suggestions. You can easily submit your complaint via the online complaint form on the Aevitae website. Are you unable to submit your complaint digitally? Then you can submit your complaint in writing to Aevitae, afdeling Klachtenmanagement' (the Complaints Management department), PO Box 2705, 6401 DE Heerlen, the Netherlands. The Complaints Management department acts on behalf of the management board.

Tips for submitting a complaint

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

You will receive a response from us within 10 days. If you are not satisfied with the decision or if you have not received any response within 20 days, please feel free to submit your complaint or dispute to SKGZ (Foundation Complaints and Disputes Healthcare Insurance), PO Box 291, 3700 AG Zeist, the Netherlands, www.skgz.nl. Instead of going to the SKGZ, you can file your complaint also to the arbiter for financial services in Malta (Office of the Arbiter for Financial Services, 1st Floor, St Calcedonius Square, Floriana FRN 1530, Malta, telephone +356 8007 2366 or +356 21 249 245 or complaint.info@financialarbiter.org.mt). We would like to point out that the arbitrer in Malta will only investigate your complaint if you have received a final decision received from us on your complaint. Alternatively, you may submit the dispute to the competent court of law.

10.2. Complaints about our forms

Do you find a form superfluous or complicated? You can submit your complaint via our website. It is also possible to add your to submit a complaint about this in writing to the 'afdeling Klachtenmanagement', PO Box 2705, 6401 DE Heerlen, the Netherlands.

You will receive a response from us about your complaint about forms within 10 days. If you are not satisfied with the answer or if you have not received a response within 20 days, you can submit your complaint to the Dutch Healthcare Authority for the attention of the Information Line/the Notification Centre, PO Box 3017, 3502 GA Utrecht, the Netherlands, email: info@nza.nl. The website of the Dutch Healthcare Authority, www.nza.nl, sets out how to submit a complaint about forms.

Article 11 Long-term Care Act (Wlz)

In addition to your health insurance, you are insured under the Long-term Care Act (Wlz) for certain long-term forms of care. During the term of the health insurance, we will register you with the Wlz provider that works in your region for the implementation of the Wlz. If you live abroad, we will register you for the Wlz with Zilveren Kruis Zorgkantoor NV. EUCARE will register for the Wlz on your behalf, for which EUCARE will make your BSN and date of birth available to the relevant Wlz provider.

The actual implementation of the Long-Term Care Act does not take place by the Wlz implementer, but by the 'care office' of the region where you live. You can find out which care office is active in your place of residence at www.zn.nl and then choose 'care offices.'

II Healthcare Provisions

MEDICAL CARE

Article 12 General practitioner care

This is your cover
You are entitled to:

1. Medical care as offered by general practitioners including the associated laboratory tests and diagnostics
   Healthcare provided by general practitioners also includes health advice, counselling for quitting smoking, pre-conception healthcare (pregnancy wish visit) and foot care.

   Quit smoking
   Counselling on how to quit smoking is defined as:
   - short treatments, such as one-off short counselling sessions on how to quit smoking;
   - intensive forms of treatment aimed at behavioural change (in a group or as an individual).

   If you attend a Quit Smoking programme with your general practitioner in accordance with the 'Zorgstandaard Tabaksverslaving 2022' (Healthcare Standard for Tobacco Addiction), please refer to Article 26. Your general practitioner can provide more details.

   Pre-conception healthcare
   Pre-conception healthcare (pregnancy wish visit) is defined as:
   - advice on healthy nutrition;
   - advice on intake of folate acid;
   - advice on intake of vitamin D;
   - advice on how to quit smoking, alcohol and drugs, if necessary with active counselling to realise this;
   - advice on using medication;
   - advice on treatment of existing conditions and previous pregnancy complications;
   - advice on infectious diseases and vaccinations;
   - tracking risks based on your health history and offering genetic counselling if you are not (yet) pregnant.

   Foot care at an increased risk of foot ulcers, due to loss of protective sensibility of the feet, decreased blood flow of the feet, a sensitive skin or increased pressure on the skin due to diabetes mellitus, or another disease or due to a medical treatment
   By the aforementioned foot care we mean:
   1. Annual foot examination to assessrate if someone with risky feet can possibly get wounds (Sims 1)
      You are entitled to this if there is a loss of protective sensibility (PS) or directions for peripheral arterial disease (PAV) without signs of locally increased pressure. The performance includes anamnese, foot examination and risk-inventorisation at high risk of wound/amputation.
   2. Preventive foot care to protect high risky feet without locally increased pressure of getting wounds (Sims 2)
      You are entitled to this if there is a loss of the protective sensibility in combination with directions for peripheral arterial disease (PAV) without signs of locally increased pressure.

3. Preventive foot care to protect high risky feet with locally increased pressure of getting wounds (Sims 2)
   You are entitled to this if there are:
   - directions for peripheral arterial disease (PAV) in combination with signs of locally increased pressure.
   Or;
   - a loss of protective sensibility (PS) in combination with signs of locally increased pressure. Or;
   - a loss of PS in combination with directions for PAV and signs of locally increased pressure.
4. Preventive foot care to protect very high risky feet of getting wounds (again) (Sims 3)
   You are entitled to this if there are:
   - foot ulcers or amputation in the past. Or;
   - inactive Charcot-foot. Or;
   - the final stage of kidney failure. (eGER <15ml/min) or kidney dialysis.

These foot treatments do not include foot care such as removing calluses for purely cosmetic or personal care reasons and general nail care such as clipping nails.

The services to be billed include the total package of activities, insofar as these have been designated by the care institute of the Netherlands (Zorginstituut Nederland) as medical care that can be charged to the basic health insurance.

Foot care as part of multidisciplinary care
Do you have diabetes mellitus type 2 and do you receive foot care through a care program as described in article 13? In that case you are not entitled to the foot care described in this article.

2. Specialist medical care closely linked to the medical domain of the general practitioner
Examples of such healthcare include:
- regular or minor surgery interventions;
- ECG diagnostics (heart images);
- lung function test (spirometrics);
- diagnostics based on the Doppler test (testing the blood flow in the vascular system);
- MRSA screening (screening for Meticillin Resistant Staphylococcus Aureus);
- audiometrics (hearing system testing);
- IUD (pessary) application or removal, implantation or removal etonogestrel implantation rod. If you are age 21 and up, you are not entitled to reimbursement of a contraceptive, excepting for treatment of endometriosis or menorrhagia (if suffering from anaemia). See Article 37;
- medically necessary circumcision;
- therapeutic injections (Cyriax).

Excess
No excess applies to this care. Please note that medicines prescribed by the general practitioner are not classified as GP care. The same applies to laboratory tests related to GP care and requested by the general practitioner but carried out and charged by another care provider. The excess applies to these forms of care. For more information, see Articles 7 and 8 of these insurance conditions.

This is where to go
General practitioner, care providers within the practice and care providers outside the practice, insofar as competent and competent. Under the medical responsibility of a general practitioner, this care may also be provided by a doctor's assistant, nurse, social worker, nurse practitioner (NP), physician assistant (PA) or practice assistant (Somatic or GGZ).

You can also go to a certified midwife to place or remove a coil. Your midwife can inform you about this.

For the foot care referred to in this article you may visit:
- a podiatrist registered in the Paramedics Quality Register;
- medical pedicure or pedicure registered in the Quality Register for the pedicure (KRP) of ProCert, Quality Register for Medical Foot Care Providers (KMV) of the Dutch Foot Care Providers Society (NMMV) or Register for Paramedic Foot Care (RPV) of the Foundation pedicure in healthcare (Stipezo), in case of cooperation with the podiatrist.

A list of contracted healthcare providers is available from our website. The partnerships between podotherapists and pedicures are also available from our website.

Are you going to a general practitioner with whom we do not have a contract for general practitioner care? Then you are entitled to reimbursement up to the then current (maximum) rate based on the Healthcare Market Regulation Act (Wmg).

Are you going to a care provider other than a general practitioner whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Article 13 Medical care for specific patient groups

This is your cover

1. You are entitled to medical care and care in a group offered by specialists in geriatric medicine (SO), doctors for the mentally handicapped (AVG) and behavioural scientists. This concerns generalist medical care aimed at vulnerable elderly people, people with chronic progressive degenerative diseases, non-congenital brain injury or an intellectual disability.
2. This care also includes:
    a. Day treatment in a group of vulnerable patients aimed at learning to deal with and compensate for limitations in order to allow the patient to live at home for as long as possible. For example, elderly people with multiple problems, people with Parkinson's, Korsakov, Multiple Sclerosis (MS) or an intellectual disability;
    b. Day treatment in a group of people with a physical disability or non-congenital brain injury;
    c. Day treatment in a group of people with Huntington's disease;
    d. Care for people with severely disturbed behavior and a slight intellectual disability.

The directing practitioner draws up your treatment plan and manages the multidisciplinary team. In the treatment plan, the care and the number of half-days of care in a group are recorded.

Specific patient groups
Do you have, for example, dementia, MS, Parkinson's, a non-congenital brain injury or an intellectual disability? Then you need specific care in your own environment. The specialist in geriatric medicine and the doctor for the mentally handicapped play an important role in this. These care providers are specifically trained to provide expert guidance and care. As a result, the care you need is better aligned.

Group care
This care makes it possible to offer specific, vulnerable patient groups an integral program in a group. Within this form of care, the professional therapeutic climate is paramount. Care in a group can be used by your directing practitioner as part of the individual treatment plan.

Excess
The excess applies to this care. For more information, see Articles 7 and 8 of these policy conditions.

This is where to go

1. For care mentioned under 1: a specialist in geriatric medicine (SO), doctor for the mentally handicapped (AVG), or a behavioral scientist.
2. For care mentioned under 2: a multidisciplinary team led by a directing practitioner.
   The coordinating practitioner is responsible for drawing up the treatment plan, which also includes collaboration with the various care providers are described. The coordinating practitioner also ensures that you have a say about your treatment options.

The coordinating practitioner is a specialist in geriatric medicine (SO), doctor for the mentally handicapped (AVG), health care psychologist, remedial educationalist generalist, clinical psychologist, clinical neuropsychologist or psychiatrist.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner, specialist in geriatric medicine (SO) or medical specialist.

Particularities

- For paramedical care that is not provided as an integral part of care in a group, see Articles 28 to 31;
- Please see our website for information about the nationally established minimum starting points for individual performance or care in a group GZSP a healthcare provider must comply with.

Article 14 Multidisciplinary care (chain healthcare)

This is your cover
You are entitled to one of the following care programs (chain care):
1 Diabetes mellitus type 2 (DM type 2);
2 Vascular risk management (VRM; this is the management of (risks of) cardiovascular disease);
3 Chronic obstructive pulmonary disease (COPD; this is a collective term for the chronic bronchitis and emphysema)
4 Asthma (if you are 16 or older).

All care components of the care program must comply with the Diabetes mellitus, VRM, COPD or Asthma standard of care. The care programs are funded in accordance with the Dutch Healthcare Authority's policies for general practitioner care and multidisciplinary care. You can find the care standards on our website.

Excess
No excess applies to this healthcare. The excess does apply to medicines and laboratory tests. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A contracted healthcare group. A list of contracted healthcare providers is available from our website. You could also ask your general practitioner about the options for multidisciplinary care.

Do you receive multidisciplinary care from a care provider with whom we do not have a contract for multidisciplinary care? Then you are entitled to reimbursement up to the then current (maximum) rate based on the Healthcare Market Regulation Act (Wmg).

If you do not receive multidisciplinary care or if multidisciplinary care is not available in your region, you are entitled to healthcare provided by individual healthcare providers pursuant to the relevant healthcare provisions, including general practitioner healthcare services (Article 12) and dietetics (Article 31).

Particularities
Specialist medical care is not covered by the multidisciplinary care program (chain care). Please see Article 18, Specialist medical care.

Multidisciplinary care (chain healthcare)
Multidisciplinary care programs have been specially developed to improve the quality and efficiency of care for the chronically ill organizing within a region. The care providers work closely together in a care group to ensure better coordination of the care you need. An integral rate applies to all care within the program. That is why you can only go to care providers affiliated with the care group we have contracted.

Healthcare group
The healthcare group is a partnership of healthcare providers with various disciplines under supervision of a general practitioner. Together, they provide chain healthcare. Aside from the general practitioner, healthcare may also be delivered by a nurse, physician's assistant, dietician, podotherapist or pedicure.

Article 15 Combined lifestyle intervention

This is your cover
You are entitled to a combined lifestyle intervention (GLI). A GLI is an accredited programme concerning healthy diet, eating habits and increased exercise to develop and maintain a healthy lifestyle.

You are eligible for an accredited programme if you are at a medium increased weight-related health risk (GGR). The GGR is determined on the basis of the indication criteria from the NHG guideline on overweight and obesity in adults and children and the Obesity care standard.

A combined lifestyle intervention is only reimbursed if it is recognized by the health insurer and the RIVM (National Institute for Public Health and the Environment). A program lasts 24 consecutive months.

You are not entitled to:
- reimbursement of (guidance with) exercise;
- reimbursement of a fitness subscription, registration at a sports club, sportswear;
- reimbursement of psychological treatment in addition to a GLI, unless there is a separate, specific indication for this. See Article 27 for the reimbursement of mental healthcare;
- reimbursement of dietetics in addition to a GLI, unless there is a separate, specific indication for this. See Article 31 for the reimbursement of dietetics.

Excess
No excess applies to this healthcare.

This is where to go
A combined lifestyle intervention may be provided by:
1 a lifestyle coach that is included in the register of the 'Beroepsvereniging Leefstijlcoaches' (BLCN - Professional Association of Lifestyle Coaches);
2 a physiotherapist, remedial therapist or dietician registered as a lifestyle coach.

We have contracted care groups for GLI, which work together with health care providers who offer the effective GLI. Does your health care provider work on behalf of the care group? Then you will be reimbursed in full. The care group bills the costs to us quarterly; the health care provider bills the costs to the care group.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

You require prior permission from us if you go to a healthcare provider with whom we have not concluded an agreement for the relevant care. You must include an explanation from your referrer with your application. The procedure to obtain permission can be found in article 1.9 of these conditions.

Referral letter required from
General practitioner, medical specialist or youth nurse (for children up to 18 years old).

Article 16 Nursing and care (district nurses)

This is your cover
You are entitled to nursing and/or care as nurses tend to provide without having this care be accompanied by a stay in an institution. This care includes nursing, care, coordination, signaling, prevention, instruction, strengthening of the client's personal control and self-reliance, and the client system and case management. The care is related to the need for medical care as described in Article 2.4 of the Health insurance decree (Besluit zorgverzekering) or a high risk thereof. You also have the right to care as a nurse usually provides if you have used an emergency call via a personal alarm (for example, if you have fallen at home).

This care also includes intensive child care in a nursing day care center or childcare home. Intensive child care (IKZ) is care for children up to 18 years old, who are dependent on nursing and care because of a complex general medical condition or physical disability. They are in need of medical care such as nurses generally provide or have a high risk of needing such care. They also require permanent supervision or 24-hour care in the vicinity.

Personal Budget (pgb)
You may be entitled to reimbursement of nursing and care in the form of a Personal Budget (PGB). This requires our prior permission. You can request this permission with the Personal Budget Application Form. You can find this form on our website. In the Personal Budget Regulations for nursing and care you will find the conditions under which you are eligible for a PGB. The Personal Budget Regulations for nursing and care can be found on our website.

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

This is where to go
Nurse specialist, nurse, level 3 carer, or carer in individual health care (VIG-er).
The care provider provides the care in accordance with the 'Standards for indication and organization of nursing and care in the personal environment' of the professional association of Nurses and Carers in the Netherlands (V&VN).

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Permission
You require our prior permission for care provided by a care provider whom we have not contracted for the care in question.

You can request this permission using the Application Form non-contracted Nursing and/or Care. This form can be found on our website. The reimbursement of care by a non-contracted care provider will be paid out to you. No reimbursement will be made until we have given permission.

Referral letter required from
A pediatrician: for nursing or care for insured persons under the age of 18.

Particularities
1. You are only entitled to this care if you have an indication for nursing and care and a care plan has been drawn up. The indication is made by an HBO nurse. The nurse will draw up a care plan in consultation with you meets the guidelines of the Dutch nursing & care professional group. The care plan describes the care that you needs in nature, scope and duration, with the associated goals.
2. The indication for nursing and care for insured persons younger than 18 years is determined by a BIG registered HBO pediatric nurse and/or a nurse-specialist who works for a care provider affiliated with BINKZ. This states draw up a care plan together with the parents and pediatrician. This care plan describes the required care in nature, scope and duration, with the corresponding goals.
3. In the case of specialized nursing, an execution request must be drawn up by the attending physician if it concerns a reserved act. In the case of risky actions, it must be demonstrated that these are carried out on behalf of a doctor. The specialized nursing must be provided by a BIG-registered nurse who is qualified and competent for the care needed for the condition. The nature, scope and content of care is elaborated in the care plan.
4. Palliative terminal care only includes care as indicated by a professional nurse. Only when it's medically necessary and your attending physician has determined that the palliative terminal phase has arrived, supervision (monitoring) can be included in the indication statement. The scope and duration of the supervision (monitoring) must be clearly traceable from the indication statement and the care plan. Insured care does not include the sole presence of a health care provider, without the care as provided by nurses. Also in the palliative terminal phase, insured care does not include the presence that arises from the lack of an informal care network.

Article 17 Obstetric care and maternity care

17.1. Obstetric care

This is your cover
You are entitled to obstetric care, including prenatal and postnatal care, as offered by obstetricians. Obstetric care includes the use of a delivery room if the delivery takes place in a hospital or birth clinic due to medical necessity.

This care also comprises:
- pre-conception healthcare (pregnancy wish consultation): if you wish to get pregnant, you can make use of pre-conception healthcare. Article 12, item 1 indicates the elements included in this type of care;
- counselling: if you are pregnant and you are considering pre-natal screening for birth defects, you will generally require an extensive consultation with your general practitioner, obstetrician or medical specialist first. This consultation is referred to as counselling. During this consultation you will receive information on the content and scope of pre-natal screening. You are then well equipped to make a decision on this screening. This refers primarily to the screening for Down, Edwards or Patau syndrome and the thirteen and twenty week ultrasound scan (SEO; Structural Echoscopic Testing);
- the non-invasive prenatal test (NIPT) if you have a medical indication;
- invasive diagnostics (chorionic villus testing or amniocentesis) if a NIPT shows that you have a significant risk of having a child with a chromosome anomaly.

The NIPT and invasive diagnostics (chorionic villus testing or amniocentesis)
Do you have a medical indication?
If your medical healthcare provider indicates you have an elevated risk of a child with Down syndrome, Edwards syndrome or Patau's syndrome (trisomy 21, 18 or 13), you are entitled to the reimbursement of prenatal diagnostics.

Do you have no medical indication?
If you do not have a medical indication, then the NIPT is reimbursed from a government scheme.
- Does the NIPT show that you have a significant risk of having a baby with a chromosomal anomaly? Then you are entitled to invasive diagnostics.

Excess
No excess applies to obstetric care, prenatal screening, and the NIPT. However, the excess does apply to costs related to obstetric care. This means that medicines, blood tests and patient transport, charged separately, are counted towards the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A midwife or general practitioner who has further training and has specifically focused on physiological obstetrics. For a NIPT you can go to a blood collection location for NIPT. The blood test is carried out by a university centre. For invasive diagnostics you can go to a center for prenatal diagnostics. Integrated maternity care may only be provided by an Integrated Maternity Care Organization (IGO) contracted by us.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Particularities
For obstetric care provided by a gynecologist, see Article 18, Specialist medical care.

17.2. Maternity care

This is your cover
You are entitled to nursing as generally offered by maternity assistants to the mother and child in connection with childbirth, during a period of no more than 42 days counting from the day of the childbirth.

Personal contributions
You owe a statutory personal contribution of:
- € 5.10 per hour for maternity care at home or in a birth center;
- € 20 per day for both mother and child when giving birth in a birth center or in a hospital, without this being medically necessary. In addition to the personal contribution, you must pay the difference in costs between the rate charged by the birth center or hospital and the maximum reimbursement of € 143 per day for both mother and child.

Excess
No excess applies to this healthcare.

This is where to go
Certified maternity nurse or nurse.

A list of contracted healthcare providers is available from our website.

Please note!
Arrange your application in time. Contact the health care provider of your choice at least 5 months prior to the expected date of delivery.

You can make an appointment directly with a maternity care agency, birth or maternity center. You do not have to inform us of your choice.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Particularities

1 The maternity nurse or obstetrician determines the number of maternity care hours based on the National Referral Protocol Maternity Care (LIP - Landelijk Indicatie Protocol Kraamzorg), or – once it is introduced – the Maternity Care National Indication Methodology (KLIM - Kraamzorg Landelijke Indicatie Methodiek). You are entitled to at least 24 hours up to 80 hours, divided over a maximum of 42 days. Please find this protocol on our website.
2 Did you select a non-contracted maternity assistant or obstetrician? Along with your invoice for maternity care, please also send us:
   - the assessment in accordance with the National Referral Protocol Maternity Care (LIP - Landelijk Indicatie Protocol Kraamzorg), or – once it is introduced – the Maternity Care National Indication Methodology (KLIM - Kraamzorg Landelijke Indicatie Methodiek); and
   - if the care is provided by a maternity care assistant: the certificate Maternity Care Assistant (diploma Kraamverzorgende).
3 For every day of hospitalisation during which maternity care was provided in hospital for some part, we will deduct the average number of hours of maternity care (this is the number of indicated hours of maternity care divided over 10 days) per day from the number of maternity care hours as indicated.
4 If more than one healthcare institution (for example hospital and maternity care organisation) has charged maternity care for the same day, you are also entitled to maternity care on this 'double day'.

Note

Request maternity care with a maternity care agency at least 5 months before the expected delivery date. Then you can be sure that your application will be processed on time.

Which obstetric care and maternity care are included in your healthcare policy?

Delivery and maternity care at home	
Delivery at home	Yes.
Maternity care at home	Maximum of 42 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to € 5.10 per hour.
Delivery and maternity care in birth clinic or hospital with medical necessity	
Delivery in birth clinic or hospital with medical necessity	Yes.
Maternity care in a birth clinic	Maximum of 42 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to € 5.10 per hour.
Maternity care in hospital after childbirth with medical necessity	Yes. This is not subject to a personal contribution.
Delivery without medical necessity and maternity care in birth clinic or hospital	
Delivery in birth clinic delivery room without medical necessity	Yes. The total reimbursement for mother and child is €246 per day. This reimbursement is calculated as follows: • Maximum reimbursement 2 x € 143: € 286 per day • Minus: contribution 2 x € 40: € 40 per day € 246 per day The difference between the rates charged by the birth clinic or the hospital and the maximum reimbursement of € 246 per day is charged to you personally.
Delivery and maternity care without medical necessity for stay in a hospital	
Maternity care in a birth clinic	Maximum of 42 days, counting from the date of childbirth. Subject to a personal contribution for maternity care amounting to € 5.10 per hour.

Medical necessity

If necessary, your midwife or general practitioner can refer you to a medical specialist. The medical specialist determines whether the delivery in hospital is medically necessary.

The healthcare costs that are for your own account may be reimbursed if you have additional insurance.
For more information, see the conditions of your additional insurance.

Integrated maternity care
Obstetricians, maternity nurses and gynecologists who work together in a birth care organization are allowed to agree on an integral rate for maternity care with us. Integrated maternity care aims to make cooperation between the various care providers easier and to improve the quality of care for mother and child.
The birth care organization may only charge this maternity care if it has an agreement with us. An overview of these organizations can be found on our website.

You may also change healthcare providers during pregnancy, birth and aftercare.

Article 18 Specialist medical care

This is your cover
You are entitled medical care as provided by medical specialists, including related care (laboratory tests, medicines, bandages and medical aids). Specialist medical care also includes:

- care provided by a thrombosis unit;
- second opinion from a medical specialist. You will need a referral from the healthcare provider treating you. This may be your general practitioner, obstetrician or medical specialist, for example. The second opinion must relate to the medical care that you have already discussed with your first healthcare provider. You are required to return to your original healthcare provider with the second opinion, your original healthcare provider will supervise your treatment;
- dialysis in a dialysis centre, hospital or at home;
- chronic intermittent respiration and the required equipment;
- medically necessary circumcision;
- costs directly related to deployment of an AED (Automatic External Defibrillator).

Conditional admission
The Minister for Medical Care and Sport can temporarily admit care that has not yet been proven effective to the basic package. The minister sets the condition that during the period of temporary admission the researchers collect data about the effectiveness and cost-effectiveness of healthcare. This concerns promising new care for which the treatment results are being scientifically investigated. For the most current overview, please see Article 2.2 of the Healthcare Insurance Regulation. You can find the Healthcare Insurance Regulation on our website or at www.wetten.overheid.nl. Article 2.2 of the Healthcare Insurance Regulation.

Research is defined as:

- main research into the effectiveness of the healthcare funded by the Dutch organisation for healthcare research and healthcare innovation (ZonMW), and/or;
- supplementary national observational research into the healthcare set up and performed in collaboration with the main research if you:
  1 meet all the criteria relating to the content of the healthcare, but you do not meet other criteria for participation in the research, or;
  2 have not participated in the main research and the inclusion for the main research has been completed, or;
  3 have participated in the main research without having received the healthcare and participation to the main research is completed for you.

You are not entitled to:
a treatments with uvuloplastic surgery for snoring;
b treatments aimed at sterilisations (for both male and female);
c treatments aimed at reversing sterilisations (for both male and female);
d treatment of plagiocephaly and brachycephaly without craniosynostosis with a cranial band;
e fertility-related care if you are a woman age 43 or older, unless it concerns an in-vitro fertilisation attempt that was started before reaching age 43.

Excess
The excess applies to specialist medical care.
No excess applies to obstetric care or prenatal screening. However, the excess does apply to costs related to obstetric care. This means that medicines, blood tests and patient transport, charged separately, are counted towards the excess. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
Medical specialist affiliated with a hospital or independent treatment center (ZBC). If the care belongs to the area of expertise of the care provider, the care may also be provided by a clinical physicist, audiologist, specialist in geriatric medicine, emergency room physician KNMG (emergency care physician), nurse specialist or physician assistant (PA).

Please note!
Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner, nurse specialist, physician assistant (PA), emergency room doctor KNMG (emergency room doctor), triage hearing care professional (to the ENT doctor), company doctor, youth doctor, specialist in geriatric medicine, doctor for the mentally handicapped, dentist, orthodontist, prosthodontist, midwife, optometrist (to the ophthalmologist), orthoptist (to the ophthalmologist), medical specialist (including sports doctor), oral surgeon, GGD doctor (in case of applications for laboratory diagnostics (IZB, TB and STD)) or clinical physicist audiologist (ENT doctor).

Permission
Some treatments are subject to prior permission if specific conditions apply. Such treatments are included in the Limitative list of DBCs (Diagnosis Treatment Combinations) issued by Zorgverzekeraars Nederland to be requested in advance. Please refer to our website to see this list. Please find more information about requesting permission in Article 1.9 of these conditions.

For which care do you need prior permission?
Some treatments in the context of Ophthalmology, Otorhinolaryngology, Surgery and Dermatology are subject to our prior permission because specific conditions apply.

Ophthalmology:	refractory surgery (eye laser treatments or lens implants aimed at reducing dependency on spectacles or contact lenses), eyelid corrections.
Otorhinolaryngology (ENT):	ear treatments and treatment of nasal shape deviations.
Surgery:	gynecomastia (breast formation in men), mammary hypertrophy (abnormal breast size), abdominal wall corrections.
Dermatology:	benign (non-malignant) tumors, pigment disorders, vascular dermatosis (wine spots).

If in doubt, we recommend contacting us to check if prior permission is required for any treatment. Your medical specialist must notify you that you need to pay the cost of healthcare personally unless prior permission was issued.

Please note!
Any treatments with a plastic surgery nature are always subject to prior permission. For details, please refer to Article 23, Plastic and/or reconstructive surgery.

Particularities
1 The equipment and accessories with which you can measure the clotting time of your blood fall under medical aids, see Article 38, Medical aids and bandaging.
2 Please find more information on home dialysis on our website.
3 The Healthcare Insurance Regulation may exclude certain forms of medical care as generally offered by specialists. The Healthcare Insurance Regulation (Regeling zorgverzekering) is available from our website.
4 For specialist medical care provided by a general practitioner, see Article 12, General practitioner care.
5 For care provided by psychiatrists and clinical psychologists, see Article 27, Mental healthcare.
6 For oral care by a dental surgeon, see Article 33, Special dentistry and Article 34, Oral surgery for insured persons aged 18 and older.

Article 19 Rehabilitation

19.1 Rehabilitation

This is your cover

Your right to medical care as referred to in Article 12 (General practitioner care) and Article 18 (Specialist medical care) during rehabilitation includes: examination, advice and treatment of a combined medical-specialist, paramedical, scientific-behavioural and technical rehabilitation nature, exclusively if and insofar as:

- this care is considered to be the most effective for you to prevent, reduce or overcome a disability that is the result of impairments or limitations in the ability to move or a disability that is the result of a central nervous system disorder that leads to limitations in communication, cognition or behavior, and;
- this care enables you to achieve or maintain a degree of independence which, given your restrictions, is within reason.

The rehabilitation as set out above also includes:

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

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A multidisciplinary team of experts attached to a rehabilitation institution or hospital under the guidance of a medical specialist. The quick scan as set out above must be performed with a rehabilitation doctor in charge.

A list of contracted healthcare providers is available from our website.

Please note!

Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from

General practitioner, company doctor, youth doctor, nursing specialist, physician assistant, specialist geriatrics doctor, doctor for mentally handicapped or medical specialist.

Permission

You need our prior permission if:

- the care is provided by a care provider whom we have not contracted for the care in question;
- the care concerns a second treatment trajectory of medical specialist rehabilitation in an independent treatment center (ZBC).

Your healthcare provider can request permission for this with the 'Aanvraagformulier medisch specialistische revalidatiezorg'. This form can be found on our website.

19.2. Geriatric rehabilitation

This is your cover

Your right to geriatric rehabilitation includes integral and multidisciplinary rehabilitation healthcare such as geriatric medicine specialists generally offer in the context of vulnerability, complex multi-morbidity (simultaneous presence of 2 or more conditions) and reduced learning and training ability, aimed at reducing the function limitations to such extent that it enables returning to the home situation. You are entitled to geriatric rehabilitation for a maximum of 6 months. In special cases, we may allow for a longer rehabilitation period.

You are entitled to this healthcare only if:

1 the healthcare is consecutive within a week to hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree (see Article 39, Stay), where the hospitalisation was not preceded by a stay as set out in Section 3.1.1 of the Long-Term Healthcare Act;

2 you have an acute condition that caused acute mobility disorders or reduced independence, and you received prior specialist medical care for the same condition. The assessment of this (geriatric assessment) takes place by a specialist in geriatric medicine from the home situation or a primary care stay (ELV) or by a (clinical) geriatrician, internist in geriatric medicine or specialist in geriatric medicine in the emergency room or via an emergency consultation at the geriatric outpatient clinic. The geriatric rehabilitation must be in line with the geriatric assessment within a week. You must have been referred by a general practitioner, specialist in geriatric medicine or doctor for the mentally handicapped;
3 the healthcare is initially paired with hospitalisation as set out in Section 2.12 of the Healthcare Insurance Decree.

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

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

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

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner, specialist geriatric medicine (SO), internist geriatric medicine, doctor for the mentally handicapped (AVG) or medical specialist.

Article 20 Genetic testing

This is your cover
Your right to medical care as set out in Article 18 (Specialist medical care) in the context of genetic testing includes: research into and testing of genetic disorders by means of family tree research, chromosome testing, biochemical diagnostics, ultrasound testing and DNA testing, genetic counselling and the psychosocial counselling associated with this form of care. If required for the advice to you, the research will also include research with regard to persons other than the insured. In that case those persons may also receive advice.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A centre for genetic counselling. This is an institution admitted as such and holds a licence for the application of clinical genetic research and genetic counselling.

A list of contracted healthcare providers is available from our website.
Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner or medical specialist.

Article 21 In-vitro fertilisation (IVF) and other fertility-enhancing treatments

21.1. In-vitro fertilisation (IVF)

This is your cover

Your right to medical care as set out in Article 18 (Specialist medical care) in the context of in-vitro fertilisation (IVF) includes the first, second and third IVF attempts for each intended pregnancy as a maximum, subject to the condition that you are age 42 or younger. If you started with a first, second or third IVF attempt, you may complete this attempt after your 43rd birthday with cover of your healthcare policy. If you are under age 38, you are only entitled to the first and second IVF attempts if 1 embryo is placed each time.

A realised pregnancy is defined as an ongoing pregnancy of at least 10 weeks from the date of the follicular puncture. Fertilisation of the egg cell takes place immediately consecutive to the puncture. For cryos (cryo-preserved embryos), a term of at least 9 weeks and 3 days after the implantation date applies to define an ongoing pregnancy.

An IVF or ICSI attempt, being healthcare in accordance with the in-vitro fertilisation method, comprises:
a. the maturation of egg cells in the woman's body by means of hormonal treatment;
b. acquiring mature egg cells (follicular puncture);
c. the fertilisation of egg cells and cultivation of embryos in the laboratory;
d. the implantation (once or several times) in the womb of one or two embryos in order to cause pregnancy.

An IVF or ICSI attempt does not count until successful follicular puncture has been performed in phase b (acquiring mature egg cells). Only attempts completed or broken off beyond this point will count as attempts. Placing the embryos obtained from a previous treatment phase (whether or not cryopreserved) is part of the IVF or ICSI attempt with which the embryos were acquired. If any embryos remain after an ongoing pregnancy was achieved, you are entitled to having the embryos placed pursuant to Article 21.2, Other fertility-enhancing treatments.

> When are you entitled to another 3 IVF or ICSI attempts?
> After an ongoing (realised) pregnancy or (successful) childbirth, either with or without IVF or ICSI, another right to 3 attempts for a new pregnancy wish arises in the event of undesired infertility. Also after having a change of partner, another right to an IVF treatment process of 3 attempts arises in the event of double infertility.

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A gynaecologist in an institution licensed to this end.

A list of contracted healthcare providers is available from our website.

Please note!

Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from

General practitioner, gynecologist or urologist.

Particularities

If an IVF treatment, including an intracytoplasmic sperm injection (ICSI treatment), is based on egg cell donation, the above conditions for IVF and ICSI also apply. You are not entitled to (reimbursement of the cost of) the egg cell donation or sperm donation. The costs for donor seed are also not eligible for reimbursement.

> IVF or ICSI treatment abroad
> Your eligibility for IVF or ICSI treatment depends on your personal situation, for example your age and how long you have attempted to become pregnant. If you want to have IVF or ICSI treatment abroad, please contact us prior to your decision. Please find our telephone number on our website.

21.2. Other fertility-enhancing treatments

This is your cover

With regard to other fertility-enhancing treatments, your right to medical care as referred to in Article 18 (Specialist medical care) includes: gynaecological or urological treatments and fertility-enhancing surgery. This healthcare also includes artificial insemination and intra-uterine insemination. If you are a woman age 43 and up, you are not entitled to fertility-enhancing treatments.

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A gynaecologist or urologist.

A list of contracted healthcare providers is available from our website.

Please note!

Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from

General practitioner or medical specialist.

Article 22 Audiological care

This is your cover

With regard to audiological care, your right to medical care as referred to in Article 18 (Specialist medical care) includes care in connection with:

- hearing tests;
- advice about the hearing aid to be purchased;
- information about the use of the equipment;
- psychosocial care if required in connection with problems with impaired hearing;
- assistance in making a diagnosis in cases of speech impediments and language development disorders in children.

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A multidisciplinary team of experts attached to an audiology centre under the responsibility of a medical specialist. The audiological centre must be admitted as such in accordance with the Act on the Accession of Healthcare Providers (Wtza).

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from

General practitioner, hearing care professional, oral surgeon, youth doctor, company doctor, nurse specialist, physician assistant, emergency room doctor KNMG (emergency doctor), specialist in geriatric medicine, doctor for the mentally handicapped or medical specialist.

Particularities

1 For hearing aids, see Article 38, Medical aids and bandaging.
2 For diagnosis of language development disorders in young people up to the age of 23, see Article 25, Sensory disability care.

Article 23 Plastic and/or reconstructive surgery

This is your cover

Your right to medical care as referred to in Article 18 (Specialist medical care) includes treatment of a plastic surgery nature only if this serves to:

1. correct abnormalities in appearance accompanied by demonstrable physical functional disorders;
2. correct disfigurement caused by a disease, an accident or a medical procedure;
3. correct paralysed or weakened upper eyelids if resulting in serious limitation of the visual field, or if it is a result of a congenital deformity or a chronic disorder present at birth. Serious limitation of visual field due to paralysed or weakened upper eyelids is defined as:
   - the weakening/paralysis of the upper eyelid causes the vertical eyelid split to decrease to 7 mm or less. This means a situation where the lower edge of the upper eyelid or the overhanging skin fold hangs above the centre of the pupil by 1 mm or more. In other words, if the distance between the (lower edge of the) overhang and the centre of the pupil is 1 mm or less. The measurement is made near the centre of the pupil while you look straight ahead without straining (relaxed and measured in primary position). It must be plausible that correction of the upper eyelid will resolve the decreased visual field;
   - this must concern a visual impairment that forms an impediment in daily routines. Subjective complaints only, such as tired eyes, pressure on eyeballs, headaches, looking tired etc, are not sufficient reason or indication for limited visual field;
4. correction of congenital deformities in connection with lip, jaw and palate clefts, deformities of the facial bones, benign proliferations of blood vessels, lymphatic vessels or connective tissue, birthmarks and deformities of the urinary tract and sexual organs;
5. correction of primary sexual characteristics where transsexuality has been established;
6. reconstructive treatments, as described in the “Guideline Medical care for women and girls with female genital mutilation”;
7. surgical insertion and replacement of a breast prosthesis other than after a full or partial mastectomy;
8. surgical insertion and surgical replacement of a breast prosthesis in the event of agenesis/aplasia of the breast (lack of breast formation) in women and in male-female transgenders, subject to the following criteria:
   - absence of an inframammary fold (fold under the breast) and;
   - gland tissue of less than 1 cm, shown by an ultrasound, to be measured at the part with the largest diameter.

What is the definition of plastic surgery treatments?

Plastic surgery treatments are defined as: intervention in the way you look by changing a shape or aspect. Such interventions are not limited to plastic surgery specialists.

When are you entitled to reimbursement of the cost of plastic surgery treatments?

Please find more details on eligibility for this type of healthcare and the criteria in the ‘Reference guide assessment plastic surgery treatments’. This reference guide was prepared by the Vereniging van artsen, tandartsen en apothekers werkzaam bij (zorg)verzekeraars (VAGZ - Association of doctors, dentists and pharmacists working with healthcare insurers), Zorgverzekeraars Nederland (ZN, Healthcare Insurers Netherlands) and the Healthcare Institute Netherlands. This reference guide is available on our website.

You are not entitled to:

a treatment of paralysed or weakened upper eyelids other than listed in item 3;
b abdominal liposuction;
c surgical insertion and/or removal of a breast prosthesis without medical necessity or for cosmetic reasons.

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

A medical specialist.

A list of contracted healthcare providers is available from our website.

Please note!

Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

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

Permission
You require our prior permission. The application must be accompanied by an explanation from your treating medical specialist. Please find more information about requesting permission in Article 1.9 of these conditions. Our permission is not required for primary and secondary breast reconstruction and for correction of primary sexual characteristics in gender dystrophy.

Article 24 Tissue and organ transplants

This is your cover
Your right to medical care as referred to in Article 18 (Specialist medical care) includes tissue and organ transplants, exclusively if the transplant procedure is performed in an EU or EEA member state. If the transplant procedure is performed in a different country, you are only entitled to such healthcare if the donor is your spouse, registered partner or relative in the first, second or third degree and the relevant person resides in that country.

The care mentioned in this Article also includes reimbursement of the costs of:
a. specialist medical care in connection with the selection of the donor;
b. specialist medical care in connection with the surgical removal of the transplant material from the selected donor;
c. the examination, preservation, removal and transport of the post-mortem transplant material in connection with the intended transplant;
d. the care of the donor arranged in these policy conditions for a maximum period of thirteen weeks, or in the case of a liver transplant for a maximum period of six months, after the date of discharge from the institution in which the donor was hospitalised for selection or removal of the transplant material insofar as this care is associated with this hospitalisation;
e. the transport of the donor in the lowest class of a means of public transportation within the Netherlands or, if due to medical necessity, transport by car within the Netherlands, in connection with the selection, hospitalisation and discharge from the hospital together with the care as referred to under d;
f. the transport to and from the Netherlands of a donor residing abroad, in connection with a transplant of a kidney, a liver or bone marrow with regard to an insured person in the Netherlands plus other costs involved in the transplant which are related to the fact that the donor resides abroad. The costs of staying in the Netherlands and any loss of income are not covered.

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

Excess
The excess applies to this care. The excess does not apply for:
- care to the donor after the period under point d has passed, insofar as the care is related to the donation;
- transport of a donor such as set out under e and f.

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

This is where to go
A medical specialist associated with a hospital.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Article 25 Sensory disability care

This is your cover
You are entitled to sensory disability care. This healthcare is aimed at learning how to manage, reverse or compensate for the disability, with the purpose of optimising independence in daily life. This type of healthcare is defined as multidisciplinary healthcare relating to:
- a visual impairment, and/or
- an auditive impairment, and/or

- a communicative impairment (you have severe difficulties with speech and/or language) as a result of a language development disorder and you are younger than 23 years old. This is the case if the disorder can be traced back to neurobiological and/or neuropsychological factors.

The language development disorder must be the primary disorder. That is to say, the other problems (psychiatric, physiological, neurological) are secondary to the developmental language disorder.

You are not entitled to:
- support in social functioning (such as sign language interpreter care);
- complex, long-term and life-wide support for deaf-blind and prelingually deaf adults.

Visual impairment
You are visually impaired if you have:
- a visual acuity of <0.3 in the best eye; or
- a field of vision of <30 degrees; or
- visual acuity between 0.3 and 0.5 in the best eye with associated severe visual impairment in daily functioning.

This determination is in accordance with the guidelines of the Nederlands Oogheelkundig Gezelschap (NOG) for diagnostics for the determination of a visual impairment.

Auditory impairment
You have an auditory impairment if:
- your audiogram threshold loss is at least 35 dB, obtained by averaging the hearing loss at frequencies of 1,000, 2,000 and 4,000 Hz; or
- your threshold loss is greater than 25 dB when measured according to the Fletcher index, the average loss at frequencies of 500, 1,000 and 2,000 Hz.

This provision is in accordance with the guidelines of the Federation of Dutch Audiological Centers (FENAC).

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

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

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

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

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
- Auditory or communicative impairment: general practitioner, medical specialist or a clinical physicist-audiologist of an audiological centre. The referral is based on the guidelines of the Federation of Dutch Audiological Centers (FENAC).
- Visual impairment: general practitioner, medical specialist on the basis of the guideline Vision disorders, rehabilitation and referral of the Netherlands Ophthalmic Society (NOG).

Article 26 Quit Smoking programme

This is your cover
You are entitled to healthcare in accordance with the Quit Smoking programme. This programme comprises healthcare focusing on behavioural change. You are also entitled to medications prescribed as part of the programme, to support behavioural change. You may attend the programme in a group or as an individual. The objective of the programme is for you to quit smoking. You may attend a Quit Smoking programme once per calendar year.

Excess
No excess applies to the Quit Smoking programme and the medications prescribed as part of the programme. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
Healthcare providers who work according to the 'Zorgstandaard Tabaksverslaving 2022' (Healthcare Standard for Tobacco Addiction).

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Or are you getting medicines from a pharmacist or dispensing general practitioner whom we have not contracted for the medicines in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

MENTAL HEALTHCARE (GGZ)

Article 27 Mental healthcare (GGZ) for insured from age 18

27.1 Mental healthcare from age 18

This is your cover
If you are 18 years of age or older, you are entitled to reimbursement of the costs of medical mental healthcare (GGZ) aimed at recovering or preventing the worsening of a mental disorder (or psychiatric disorder), including the associated medicines, aids and bandages.

Do you need to be admitted for the treatment of your mental disorder? Then, in addition to medical mental healthcare, you are also entitled to:
- Your stay with nursing and caring;
- Paramedical care, medicines, medical aids and bandages which belong to the treatment during the stay.

The content and scope of the care to be provided will be limited by what psychiatrists and clinical psychologists as caring can offer.

You are entitled to medically necessary admission during a continuously period, with a maximum of 1095 days. An interruption, with a maximum of 30 days is not considered an interruption, but these days don't count for the calculation of the 1095 days. Interruptions due to weekend- and vacation leave do count for the calculation of the 1095 days.

Conditions for the reimbursement of medical mental healthcare (GGZ) with or without stay:
1. You must be 18 years of age or older;
2. The referral must comply with the 'Verwijsafspraken Geestelijke gezondheidszorg' as established by the Ministry of Health, Welfare and Sport;
3. A referral is valid for a maximum of 9 months. This means that your treatment should start within 9 months of issuing the referral. Is there more than 9 months in between? Ask for a new referral;
4. Your healthcare provider has a quality status that is registered with ggzkwaliteitsstatuut.nl; Look for this on the website of your healthcare provider or ask for the quality statute;
5. For your treatment in mental health care, it is necessary that you have a coordinating practitioner. Which mental health care providers may be coordinating practitioners is described in the applicable field agreement. You can find this on our website.

You are not entitled to:
- treatment of adjustment disorders;
- help with work and relationship problems;
- psychosocial support;
- care for learning disabilities;
- self-help;
- meddling care from the OGGZ. The municipality is responsible for this;
- prevention, except in case of indicated or care-related prevention;
- services;
- psychological help that is part of the treatment of a physical or somatic disorder;
- intelligentieonderzoek;
- guidance of a non-medical nature, such as training, coaching and courses;
- interventions that do not meet the state of the art of science and practice, as mentioned in the 'Lijst therapieën GGZ'. You can find this overview on our website.
- Mental healthcare for insured persons up to the age of 18. This falls under the Youth Act. You can contact your municipality for this.

Excess
The excess applies to this care. For more information, see articles 7 and 8 of these insurance conditions.

This is where to go
A healthcare provider must have a quality statute that is registered with ggzkwaliteitsstatuut.nl. Look for this on the website of your healthcare provider or ask for the quality statute.

If, because of the built-up treatment relationship, the care with the existing (directing) practitioner wishes to continue but this is prevented by the obligation arising from the 'Landelijk Kwaliteitsstatuut GGZ', you can make use of a transitional arrangement. The following conditions apply:
- You are already in care with the directing practitioner for your 18th birthday; and
- the directing practitioner has a postmaster registration in the SKJ or BIG register; and
- the continuation of treatment is aimed at closure or transfer; and
- the treatment has a maximum period of 365 days after the day you turn 18.

The same preconditions apply to the continuation of this treatment as under the Youth Act and policy rules for curative mental healthcare. This transitional arrangement applies to both Section II and Section III

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner, company doctor, medical specialist, psychiatrist, specialist in geriatric medicine, doctor for the mentally handicapped, directing practitioner GGZ or street doctor. The street doctor is a doctor and registered with an association of street doctors (for example the 'Nederlandse Straatdokters Groep') and in the municipality(s) where he/she works. The street doctor may only refer if you do not have a general practitioner.

Did you receive mental healthcare on the basis of the Youth Act and do you not have a referral letter from a referrer mentioned above? Then you will need a new referral letter.

Permission
In a number of cases, you need our prior consent:
1. Are you going to a healthcare provider with whom we have concluded an agreement for the care in question? Then this healthcare provider is aware of the situations in which permission must be requested. Your healthcare provider will fill in the application form for this and send it to us. We then assess the application for effectiveness and legality. We will let your healthcare provider know if we give permission or if we reject the application.
2. With a healthcare provider with whom we have not concluded an agreement for the care in question, you need our prior consent in the following situations:
   - If there is mental healthcare with residence (see Article 39, Stay);
   - If there is mental healthcare in case of one of the DSM-5 main groups;
   - Substance-related and addiction disorders;
   - Disruptive impulse control and other behavioral disorders;

- Neurobiological developmental disorders;
- Somatic symptom disorder and related disorders;
- Residual group;
- Other problems that may be a cause for concern.

You can request permission for this with the 'Aanvraagformulier GGZ'. This form can be found on our website.

Will the period for which consent has been given expire soon? Then you have to apply for permission again. You can fill in the GGZ application form together with your healthcare provider.

Request the consent at least 2 months before the expiry of the period. Then you can be sure that your application will be processed on time. In the front of these conditions you will find where you can send the request. The consent procedure can be found in Article 1.9 of these terms and conditions.

PARAMEDICAL CARE

Article 28 Physiotherapy and Cesar/Mensendieck remedial therapy

This is your cover
You are entitled to healthcare as generally offered by physiotherapists and remedial therapists.

Up to age 18:
- From the first treatment onwards, you are entitled to treatment of conditions requiring long-term or chronic treatment. This is set out in the List of Conditions for Physiotherapy and Remedial Therapy (Appendix 1 of the Healthcare Insurance Decree). Please take into consideration that the duration of treatment of certain conditions is limited to a certain term.
- If you have a condition that is not specified in the List of conditions for physiotherapy and remedial therapy, you are entitled to a maximum of 9 sessions per condition per calendar year. If you still have problems with the relevant condition after these 9 sessions, you are entitled to another series of maximum 9 sessions for such a condition. In total, you are entitled to a maximum of 18 sessions per condition per calendar year.

Over age 18:
Pelvic physiotherapy for urinary incontinence
You are entitled to reimbursement of the costs of the first 9 treatments of pelvic physiotherapy in connection with urinary incontinence.

Exercise therapy for intermittent claudication
You are entitled to reimbursement of the costs of up to 37 treatments of exercise therapy under the supervision of a physiotherapist or exercise therapist (gait training) for peripheral arterial disease in stage 2 Fontaine in a period of up to 12 months.

Exercise therapy for osteoarthritis hip or knee joint
You are entitled to reimbursement of the costs of a maximum of **12** treatments of exercise therapy under the supervision of a physiotherapist or exercise therapist in osteoarthritis of hip or knee joint in a period of up to **12** months.

Exercise therapy for COPD
You are entitled to reimbursement of the costs of exercise therapy under the supervision of a physiotherapist or exercise therapist in COPD (Chronic Obstructive Pulmonary Disease) GOLD class II and above. The number of treatments depends on the severity of the complaints and the risk of lung attacks according to the GOLD group A, B, C or D. Group B is then divided into:
- B1: moderate burden of disease or sufficient physical capacity
- B2: high burden of disease and limited physical capacity

Group	A	B1	B2 and C	D
First 12 months The number of treatments in the period of 12 months after the start of treatment is a maximum of	5	27	70	70
After 12 months The number of treatments for each period of 12 months after the first year is a maximum of	0	3	52	52

Treatment of chronic conditions

From the 21st treatment onwards, you are entitled to reimbursement of the costs of treating conditions that require long-term or chronic treatment. You can find these in the 'Lijst met aandoeningen voor fysiotherapie en oefentherapie' (Appendix 1 of the Health Insurance Decree). Please note that the duration of treatment of certain conditions is limited to a certain period of time.

> **Chronic list**
> The list of conditions for physiotherapy and exercise therapy is also called the 'Chronic list'. This name does not actually cover it all, because not all chronic conditions are on this list. Conditions that are on the list include certain disorders of the nervous system or musculoskeletal system, certain lung and vascular disorders, lymphedema, soft tissue tumors and scar tissue of the skin. In some cases, it also involves the treatment of a condition after admission to hospital to speed up recovery. Are you unsure whether your condition is on this list? Please contact us in advance. You will find our telephone number on our website. You will find the List of conditions for physiotherapy and exercise therapy (Appendix 1 of the Health Insurance Decree) on our website. You can also request this list from us by telephone. You will find our telephone number on our website.

The following performance descriptions are distinguished:

1. *Intake fall preventive exercise intervention*
   An intake takes place prior to a fall-preventive exercise intervention. During the intake, the care needs and goals of the patient with a high fall risk are identified. Based on this and with taking into account the degree of vulnerability and mobility of the patient, fall prevention is assessed exercise intervention can connect to this.
2. *Fall preventive exercise intervention*
   A fall-preventive exercise intervention is a structured and time-delimited training program for patients at high risk of falls. These may differ in content, as can the duration. The fall-preventive exercise intervention can be charged monthly and, if possible, is completed with an evaluation.

   This is a condition for reimbursement for these services:

- the referrer has identified the high fall risk based on the fall risk assessment. Depending on the high fall risk, the referrer may refer to a fall-preventing exercise intervention if there are underlying or additional conditions.
- There is a minimum of 12 months between the start of one fall preventive exercise intervention and any subsequent one.

Physiotherapy and exercise therapy after severe COVID-19

Until 1 January 2025, you can claim reimbursement of the following costs after severe COVID-19:

a. A maximum of 50 physiotherapy and/or exercise therapy treatments in a maximum period of 6 months after the first treatment. You will need a referral letter from a general practitioner or a medical specialist. The referral letter must be issued no later than four months after the acute disease stage of severe COVID-19. You must start physiotherapy and/or exercise therapy within one month after your general practitioner or medical specialist has issued the referral letter.
b. A maximum of 50 physiotherapy and/or exercise therapy treatments in a maximum period of another six months in connection with the period referred to in point a. You will need a referral letter from the general practitioner or a medical specialist. The referral for the 2nd treatment period must show that the additional treatment is necessary and promising. You must start physiotherapy and/or exercise therapy within one month after the medical specialist has issued the referral letter.

You must participate in research and, where applicable, an additional analysis of the provision of care. Or, if the research and analysis have not yet started, you should be willing to participate. You also give consent to the collection of additional data on the basis of questionnaires and additional studies. You are also required to give consent to the anonymous sharing of your treatment data. Only if you meet all these conditions, you are entitled to the reimbursement of this care. Research is understood to mean main research into the effectiveness of care funded by the Dutch organisation for health research and care innovation (ZonMW) and additional national observational research into care that is set up and carried out in collaboration with the main study.

You are not entitled to:

- Occupational curative care. This concerns healthcare aimed at healing and treating acute and chronic physical occupational conditions
- Reintegration processes. Reintegration is the set of measures aimed at allowing the incapacitated employee to return to work;
- Treatments and treatment programs with the aim of improving fitness, such as medical training therapy, physio fitness, exercise for the elderly, exercise for overweight people and cardio training.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
1 Physiotherapy: physiotherapist, remedial gymnast masseur or specialized physiotherapist.
A specialized physiotherapist is a pediatric physiotherapist, pelvic physiotherapist, geriatric physiotherapist or manual therapist. The specialized physiotherapist must be registered as such at the Central Quality Register (CKR - Centraal Kwaliteitsregister) of the Royal Netherlands Society for Physiotherapy or in the register of the Physiotherapy Quality Mark (Keurmerk Fysiotherapie), or in the individual Register Physiotherapy within the Quality House Physiotherapy of the KNGF and SKF (individueel Register Fysiotherapie binnen het Kwaliteitshuis Fysiotherapie).
2 Edema therapy: edema (physical) therapist or skin therapist.
The edema (physiotherapist) therapist must be registered as such in the Central Quality Register (CKR- Centraal Kwaliteitsregister) of the Royal Netherlands Society for Physiotherapy or in the register of the Physiotherapy Quality Mark (Keurmerk Fysiotherapie), or in the individual Register Physiotherapy within the Quality House Physiotherapy of the KNGF and SKF (individueel Register Fysiotherapie binnen het Kwaliteitshuis Fysiotherapie).
The skin therapist must be registered as such in the Paramedics Quality Register (KP - Kwaliteitsregister Paramedici).
3 Cesar/Mensendieck exercise therapy: Cesar/Mensendieck exercise therapist or pediatric exercise therapist.
The (child) remedial therapist must be registered as such in the Paramedics Quality Register (KP - Kwaliteitsregister Paramedici).
Would you like to know with which healthcare providers we have concluded a contract for which care? You will find this information on our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

ParkinsonNet
Do you have Parkinson's disease and do you need physiotherapy or exercise therapy? Then you can go to physiotherapists or exercise therapists affiliated with ParkinsonNet. For more information, please visit our website.

Chronisch ZorgNet
Do you need exercise therapy (gait training) because of intermittent claudication? Then you can go to physiotherapists or exercise therapists affiliated with Chronisch ZorgNet. For more information, please visit our website.

Where may the care be provided?
This care may be provided in the practice room of your care provider, in a hospital, or in a nursing home.
If your treating care provider considers it medically necessary, this care can also be provided at home.

Permission
You require our prior permission if you are treated for a condition specified in the List of conditions for physiotherapy and remedial therapy. You will find this list on our website. Please find more information about requesting permission in Article 1.8 of these conditions.

Referral letter required from
You will require a statement from your general practitioner, company doctor or medical specialist demonstrating that you need treatment for a condition specified in this list.

Article 29 Speech therapy

This is your cover
You are entitled to healthcare as generally offered by speech therapists if this care serves a medical purpose and recovery or improvement of the speech function or the power of speech can be expected from the treatment. This care includes the Hanen Parent Course.

You are not entitled to speech therapy treatment due to:
- dyslexia;
- impaired language development in connection with a dialect or a different mother tongue;
- music therapy;
- speaking in public;
- the art of declamation.

Speech therapy after severe COVID-19
Until 1 January 2025, you can claim reimbursement of the following costs after severe COVID-19:
a. Speech therapy in a period of up to 6 months after the first treatment. You will need a referral letter from a general practitioner or medical specialist. The referral letter must be issued no later than four months after the acute disease stage of severe COVID-19. You must start speech therapy within one month after your general practitioner or medical specialist has issued the referral letter.
b. Speech therapy for a maximum of another 6 months in connection with the period referred to under a. You will need a referral letter from the general practitioner or a medical specialist. The referral for the second treatment period must contain a clear description of why the additional treatment is needed and promising. You must start speech therapy within one month after the medical specialist has issued the referral letter.

You must participate in research and, where applicable, an additional analysis of the provision of care. Or, if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data on the basis of questionnaires and additional studies. You must also consent to the anonymous sharing of your treatment data. Only if you meet all these conditions, you are entitled to this care. Research is understood to mean main research into the effectiveness of care funded by the Dutch organisation for health research and care innovation (ZonMW) and additional national observational research into care that is set up and carried out in collaboration with the main study.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A speech therapist.

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

Stutter therapy may also be given by a stutter therapist registered with the Dutch Association for Stutter Therapy (NVST - Nederlandse Vereniging voor Stottertherapie).

Please note!
For the treatment of Parkinson's disease we have only contracted specialized care providers who are affiliated with ParkinsonNet.
Do you want to know with which care providers we have a contract for which care? You will find this information on our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Where may the care be provided?
This care may be provided in the practice room of the speech therapist or stutter therapist, a hospital or nursing home. If your treating care provider considers it medically necessary, this care can also be provided at home.

Article 30 Occupational therapy

This is your cover
You are entitled to healthcare as generally offered by an occupational therapist on the condition that this care aims to encourage or restore your self-care and self-reliance, up to a maximum of 10 treatment hours in each calendar year.

Occupational therapy after severe COVID-19
Until 1 January 2025, you can claim reimbursement of the following costs after severe COVID-19:
a. Up to 10 hours of occupational therapy in a period of up to 6 months after the first treatment. You will need a referral letter from a general practitioner or medical specialist. The referral letter must be issued no later than four months after the acute disease stage of severe COVID-19. You must start occupational therapy within one month after your general practitioner or medical specialist has issued the referral letter.

b. A maximum of 10 hours of occupational therapy for a maximum of another 6 months in connection with the period referred to under a. You need a referral letter from the general practitioner or a medical specialist for this. The referral for the second treatment period must contain a clear description of why the additional treatment is needed and promising. You must start occupational therapy within one month after the medical specialist has issued the referral letter.

You must participate in research and, where applicable, an additional analysis of the provision of care. Or, if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data on the basis of questionnaires and additional studies. You must also consent to the anonymous sharing of your treatment data. Only if you meet all these conditions, you are entitled to this care. Research is understood to mean main research into the effectiveness of care funded by the Dutch organisation for health research and care innovation (ZonMW) and additional national observational research into care that is set up and carried out in collaboration with the main study.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
An occupational therapist.

Please note!
For the treatment of Parkinson's disease we have only contracted specialized occupational therapists who are affiliated with ParkinsonNet.

Do you want to know with which care providers we have a contract for which care? You will find this information on our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Where may the care be provided?
This care may be provided in the practice room of your care provider, in a hospital, or in a nursing home.
If your treating care provider considers it medically necessary, this care can also be provided at home.

Article 31 Dietetics

This is your cover
Your right to dietetics includes healthcare as generally offered by dieticians, if this healthcare has a medical purpose, and up to a maximum of 3 treatment hours per calendar year.

Dietetics is defined as education with a medical purpose and treating patients with diet-related therapy, focusing on eliminating, reducing or compensating for diseases or complaints that are related to or can be influenced with nutrition.

Dietetics after severe COVID-19
Until 1 January 2025, you can claim reimbursement of the following costs after severe COVID-19:
a. Up to 7 hours of dietetics in a period of up to 6 months after the first treatment. You will need a referral letter from a general practitioner or medical specialist. The referral letter must be issued no later than four months after the acute disease stage of severe COVID-19. You must start dietetics within one month after your general practitioner or medical specialist has issued the referral letter.
b. A maximum of 7 hours of dietetics for a maximum of another 6 months in connection with the period referred to under a. You need a referral letter from the general practitioner or a medical specialist for this. The referral for the second treatment period must contain a clear description of why the additional treatment is needed and promising. You must start dietetics within one month after the medical specialist has issued the referral letter.

You must participate in research and, where applicable, an additional analysis of the provision of care. Or, if the research and analysis have not yet started, you should be willing to participate. You must also consent to the collection of additional data on the basis of questionnaires and additional studies. You must also consent to the anonymous sharing of your treatment data. Only if you meet all these conditions, you are entitled to this care. Research is understood to mean main research into the effectiveness of care funded by the Dutch organisation for health research and care innovation (ZonMW) and additional national observational research into care that is set up and carried out in collaboration with the main study.

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

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dietician.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Where may the care be provided?
This care may be provided in the practice room of your care provider, in a hospital, or in a nursing home.
If your treating care provider considers it medically necessary, this care can also be provided at home.

ORAL CARE

Article 32 Dental care for insured persons under the age of 18

This is your cover
If you are under age 18, you are entitled to healthcare as generally offered by a dentist.
The care includes the following provisions/treatments:

1. check-ups (periodical preventive dental examination): once annually. If necessary, you are entitled to such check-ups more than once per year;
2. incidental visit;
3. removing plaque;
4. fluoride treatment from the date the first element of the adult teeth has broken through: twice annually. If necessary, you are entitled to such check-ups more than twice per year;
5. sealing (sealing pits and grooves in teeth and molars);
6. gum treatment (periodontal treatment);
7. anaesthetics;
8. root canal treatment (endodontic treatment);
9. fillings (restoration of teeth and molars with plastic materials);
10. treatment after maxillary complaints (gnathological treatment);
11. full dental prosthesis for upper and/or lower jaw, plate prosthesis or frame prosthesis (removable prosthetic devices);
12. specialist dental surgery with the exception of the insertion of dental implants;
13. X-ray tests. You are not entitled to X-ray tests for orthodontics.

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

Excess
Are you 18 or older? Then the excess applies to this healthcare. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental surgeon, dental prosthodontist or dental hygienist. The dentist or dental hygienist may work in an institution for paediatric dental care.

Permission

You only need our prior permission if it concerns:

- crowns, bridges and implants as described for persons younger than 23 years old;
- an orthopantomogram (X21), skull photo X24, 3D photos (X25 and X26) for insured persons younger than 18 years of age. For a orthopantomogram and other photos for the purpose of orthodontics, no authorization requirement applies. This concerns the performance codes F152A, F155A, F156A, F157A, F158A, F159A, F160A, F161A and F162A.

More information about applying for permission can be found in Article 1.9 of these policy conditions.

Article 33 Special dental care

Special dental care is dental care for people with a specific condition. Such dental care requires more time and expertise. You are only entitled to special dental care if this enables you to retain or obtain a dental function equivalent to the dental function you would have had without the specific condition.

33.1 Dental and orthodontic care in special cases

This is your cover

You are entitled to healthcare as generally offered by dentists and orthodontists which is necessary:

1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system;
2. if you have a non-dental physical or mental condition;
3. if you must undergo a medical treatment and this treatment would have inadequate results without such special dental care. This generally concerns eliminating inflammation in the mouth. Examples of eliminating inflammation in the mouth are treatment of the gums, extracting teeth or molars, or administering antibiotics.

You are only entitled to orthodontic care if you have a very severe developmental or growth impairment in your mouth or teeth, where diagnostics or treatment by disciplines other than dental in team context is required.

Personal contribution

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

Excess

The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go

1. Dental healthcare in special cases: dentists, certified oral hygienist working in a centre for special dental care, dental surgeon or orthodontist in collaboration with a dental surgeon.
2. Orthodontic care in special cases: an authorized oral care provider working in a center for special dental care, dental surgeon or an orthodontist in collaboration with a dental surgeon.

Where may the care be provided?

The healthcare may be provided in a:

1. dental care practice;
2. hospital;
3. centre for special dental care.

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

A centre for special dental care is:

1. an institution for special dental care accredited by the Dutch Healthcare Authorities (NZa);
2. a centre that complies with the following requirements:
   - a positive audit report by NVA (Dutch Association for Anaesthetics) was issued;
   - the centre works with an anaesthesiologist who is an NVA member;
   - there is a written agreement with an ambulance service or hospital for transport to a hospital if required;
   - there is a written agreement with a hospital near the centre for taking in patients if required;

- the centre applying the helium or other sedation is certified by ACTA (Academic Dental Care Centre Amsterdam);
- when treating children, the dentist must be an accredited dentist-paedo-dontologist.

Referral letter required from
Dentist, orthodontist or dental surgeon.

Permission
You require our prior permission. Please find more information about requesting permission in Article 1.9 of these conditions.

33.2 Dental implants

This is your cover
You are entitled to reimbursement of the cost of having a dental implant placed in the context of special dental care:
1. if you have a severe impairment in development or growth, or have acquired a deviation in the dental/maxillary/mouth system;
2. if you have a deformation in the dental/maxillary/oral system with later onset in the form of a very severely lapsed toothless jaw and the implants serve to affix a removable prosthesis.

> Implants in a very severely lapsed toothless jaw
> If you have had a full dental prosthesis (dentures) for a long time, your jaw may lapse so severely that your dental prosthesis hardly has any grip. In such a case, implants can be a solution. This generally concerns 2 implants in the lower jaw with 2 buttons or a rod screwed in that serve to click on the dentures. The dentures remain removable. For prosthetic devices for insured persons of 18 and over, please refer to Article 36.

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

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

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

A list of contracted healthcare providers is available from our website.

Where may the care be provided?
The healthcare may be provided in a:
1. dental care practice;
2. hospital;
3. centre for special dental care.

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

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

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

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
Dentist, orthodontist or dental surgeon.

Permission
You require our prior permission. Please find more information about requesting permission in Article 1.9 of these conditions.

Article 34 Dental surgery for insured persons age 18 and older

This is your cover
If you are 18 or older, you are entitled to dental surgery and associated X-ray examinations, as provided by dentists. This may be combined with a stay in a hospital. You are not entitled to the surgical treatment of gums (periodontal surgery), the application of an implant (see Article 34.2) and uncomplicated (tooth or molar) extractions by a dental surgeon. Extractions are considered uncomplicated if they can also be performed by your dentist.
You are entitled to nursing and/or stay if this is necessary for dental surgery. See article 39 “Stay”.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dental surgeon.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

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

Permission
You need prior permission for a number of treatments. You can find these treatments in the ‘Limitatieve Lijst Machtigingen Kaakchirurgie’ on our website. More information about applying for permission can be found in Article 1.8 of these terms and conditions.

Article 35 Prosthetic devices for insured persons of age 18 and over

This is your cover
If you are 18 or older, you are entitled to reimbursement of the cost of a removable full dental prosthesis for the upper and/or lower jaw, whether or not placed on implants. A removable full dental prosthesis to be placed on dental implants also includes applying the fixed part of the supra structure (the meso structure). You are also entitled to filling up (rebasing) and repairing such dental prosthesis.

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

Your personal contribution is 17% of the cost of simultaneously creating a standard dental prosthesis on one jaw and an implant-supported prosthesis on the other jaw (code J80).

Personal contribution dental prosthesis
You are entitled to a dental prosthesis for the upper and/or lower jaw. This is subject to a personal contribution. The personal contribution also applies to the cost of placing the fixed part of the supra structure (meso structure). A meso structure is the non-removable construction between implants and the dentures (the click system). The costs of extracting teeth and molars are not eligible for reimbursement, but may be reimbursed if you have a supplementary dental or other cover.
Please refer to Article 33.2 for an implant for full dental prosthesis if you have a severely lapsed toothless jaw.

Please note!
In addition to a personal contribution, an excess may apply.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A dentist, dental implantologist or dental prosthodontist.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
A dentist, for a dental prosthesis on implants.

Permission
1. You require our prior permission for a conventional (regular) dental prosthesis:
   a. if the total cost (including the technology expenses) of the dental prosthesis exceeds:
      - € 675 for an upper or lower jaw;
      - € 1,350 for an upper and lower jaw jointly;
   b. if you want to replace your dental prostheses within 5 years of acquiring them;
   c. if you want to replace your immediate prosthesis within six months;
   d. if the technical and material costs exceed our maximum amount.
2. You require our prior permission for:
   a. dental prosthesis on implants;
   b. rebasing (filling) or repairing dental prosthesis on implants;
   c. a bar or buttons (meso structure).

Please find more information about requesting permission in Article 1.9 of these conditions.

PHARMACEUTICAL CARE

Article 36 Medications

This is your cover
Your right to pharmaceutical care comprises delivery of medications and advice and counselling as pharmacists generally offer for medication assessment and responsible use of medications.
This care also comprises:
- issuing a drug subject to prescription;
- issuing a drug subject to prescription with an instruction talk if the drug is new to you;
- instructions for a medical aid to be used for a drug subject to prescription;
- medication assessment of chronic use of medications subject to prescription.

Registered medications
You are entitled to reimbursement of the costs of delivery of the registered person designated by the Minister of Public Health, Wellbeing and Sports. You will find the medicines designated by the Minister in Appendix 1 of the Healthcare Insurance Regulation (Regeling zorgverzekering).

Additional conditions apply to a number of medicines. You are only entitled to these medicines if you meet these conditions. You will find these medicines and the conditions in Appendix 2 of the Healthcare Insurance Regulation.

For the most up-to-date text of Appendix 2, please refer to wetten.overheid.nl (search for 'Regeling zorgverzekering' and scroll under the chapters on the left to Appendix 2) and the publication of the changes in the Government Gazette (Staatscourant).

Over-the-counter products and antacids

You are entitled to reimbursement of the costs of over-the-counter medicines and antacids if you need to take these medicines for more than 6 months. Over-the-counter medicines are registered medicines that you can obtain at a pharmacy or drugstore without a prescription. Usually, this drug group is excluded from reimbursement. Only with chronic use of these products, a reimbursement scheme applies to certain antacids, laxatives, calcium tablets, and other products for allergies, medicines for diarrhea, medicines for emptying the stomach and medicines for dry eyes. These medicines are included in Appendix 1 of the Healthcare Insurance Regulation and are eligible for reimbursement if the conditions and requirements as stated in Appendix 2 of the Healthcare Insurance Regulation are met. For the first 15 days the costs of the medicine will be at your expense.

Vitamin D containing medications

The medications alfacalcidol, calcitriol and dihydrotachysterol are only imbursed when there is a medical indication for which the medicinal product is registered under the Medicines Act (Geneesmiddelenwet). You are not entitled to reimbursement of all colecalciferol-containing medications and calcifediol.

Non-registered medications

You are entitled to non-registered medications in the event of rational pharmaco therapy. Rational pharmaco therapy is treatment, prevention or diagnostics of a condition with a drug in a form suitable for you of which the effectiveness and action are determined based on scientific research and testing, and which is also the most economical for the healthcare policy.
You are entitled to the following non-registered medications:

- medicines prepared on a small scale by or on behalf of a pharmacy in its pharmacy;
- medicines prepared in the Netherlands at the request of a doctor in accordance with Article 40, third paragraph, under c, of the Medicines Act by a manufacturer as referred to in Article 1, first paragraph, under mm, of the Medicines Act;
- medicines that, according to Article 40, third paragraph, under c, of the Medicines Act, are on the market in another Member State or in a third country and are brought within the territory of The Netherlands at the request of a doctor. These medicines must be intended for a patient of that physician who has an illness with an incidence of less than 1 in 150,000 in the Netherlands;
- medicines that, according to Article 40, third paragraph, under c, of the Medicines Act, are on the market in another Member State or in a third country and are brought within the territory of The Netherlands to replace a registered medicine that is temporarily unavailable or cannot be supplied in sufficient numbers by the holder(s) of the marketing authorization or parallel trade authorization according to Article 1, paragraph 1, under fff, of the Medicines Act, or;
- medicines that, according to Article 52, paragraph 1, under c, of the Medicines Act, are meant to replace a registered medicine that is temporarily unavailable or cannot be supplied in sufficient numbers by the holder(s) of the marketing authorization or parallel trade authorization according to Article 1, paragraph 1, under fff, of the Medicines Act.

You are not entitled to:

- pharmaceutical care and services relating to a medication not covered by insurance;
- education on pharmaceutical self-management for a patient group;
- advice pharmaceutical self-care;
- advice use of medications subject to prescription during travel;
- advice risk of disease when travelling;
- pharmaceutical care in the cases indicated in the Healthcare Insurance Regulation;
- preventive travel kit of medications and vaccinations;
- medications for research as referred to in Section 40, third subsection, under b, of the Medicines Act (Geneesmiddelenwet);
- medications that are equivalent or virtually equivalent to a registered medication not on the preferred list of the Minister of Public Health, Wellbeing and Sport;
- medications as referred to in Section 40, third subsection, under e, of the Medicines Act;
- medications for treatment of one or more indications that have been excluded by the Healthcare Insurance Regulation. Please find the full Healthcare Insurance Regulation on our website;
- vitamins, minerals and paracetamol for which an equivalent or nearly equivalent alternative in the free market exists.

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

Personal contribution
Some medications are subject to a statutory personal contribution.

Your statutory personal contribution amounts to a maximum of €250 per calendar year. If your healthcare policy does not start or end on 1 January, we calculate the personal contribution as follows:

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

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

Excess
The excess applies to this care. Please note that the services of the pharmacy, for example the handover costs, the counseling interview with a new medicine or an inhalation instruction are subject to the excess.

This is where to go
Pharmacist or dispensing general practitioner.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Prescription
General practitioner, midwife, dentist, orthodontist, medical specialist, dental surgeon specialist nurse or physician assistant.

Permission
1. You require our prior permission for a number of registered medications included in Appendix 2 of the Healthcare Insurance Regulation. To apply for permission, your doctor can download and complete a doctor's statement from www.znformulieren.nl or a permission form from our website.
2. You require our prior permission for the following non-registered medications:
   - a number of pharmacy preparations (custom medication) supplied. These are preparations your pharmacy makes and delivers to your pharmacy;
   - medications that your doctor specifically orders for you from a manufacturer with a manufacturer licence as referred to in the Medicines Act;
   - medications that are not available in the Netherlands, but are imported at the request of the doctor who is treating you.

Please find more information about requesting permission in Article 1.9 of these conditions.

Are you going to a pharmacist or dispensing general practitioner whom we have not contracted for the care in question? You can request permission in advance by submitting the doctor's statement directly to us. Look for the address in these policy conditions or on our website.

Contraceptives
Are you younger than 21 years old? Then you are entitled to the reimbursement of contraceptives, including the contraceptive pill. Some items are subject to a personal contribution.

Are you 21 or older? You are only entitled to contraceptives if these items are used to treat endometriosis or menorrhagia (if suffering from anaemia). If you are not entitled to such reimbursement, you may be reimbursed for the cost of the contraceptive if you have supplementary insurance. For more details, please refer to the conditions of your supplementary insurance policy.

Article 37 Dietary preparations

This is your cover
You are entitled to polymeric, oligomeric, monomeric and modular dietary preparations.
You are only entitled to such dietary preparations if adjusted regular nutrition and other special nutrition products are not working for you, and you are:
a. suffering from a digestive disorder;
b. suffering from a food allergy;
c. suffering from a resorption disorder;
d. suffering from disease-related malnutrition or risk of malnutrition as indicated based on a validated screening instrument; or
e. you are reliant on this product in accordance with the guidelines accepted by the relevant professional groups in the Netherlands.

Excess
The excess applies to this care. For more information about excess, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A pharmacist, dispensing general practitioner or a contracted care provider.

A list of contracted healthcare providers is available from our website.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

Permission
You require our prior permission. To request permission, you can use the statement of dietary preparations (ZN Statement polymere, oligomere or modular dietary preparations) completed by your general practitioner, your medical specialist, oral surgeon, physician assistant, nurse or dietician. You can find more information in article 1.9 of these conditions.

Diet products (no reimbursement) A diet product is a food with a different composition. Examples are gluten-free or low-salt products. We do not reimburse these products.

MEDICAL AIDS

Article 38 Medical aids and bandaging

This is your cover
You are entitled to functional medical aids and bandaging as set out in the Healthcare Insurance Decree (Besluit zorgverzekering) and the Healthcare Insurance Regulation (Regeling zorgverzekering). In the Medical Aids Regulation (Reglement hulpmiddelen) we set out further conditions for obtaining such medical aids. The Healthcare Insurance Decree, the Healthcare Insurance Regulation and the Medical Aids Regulation are available from our website. Certain groups of medical aids are included in the Healthcare Insurance Regulation with a functional description. This means that the healthcare insurer can determine which medical aids are covered in the Medical Aids Regulation. If you want a medical aid that is part of the group of functional descriptions of medical aids, but the specific medical aid is not included in the Medical Aids Regulation, you may submit an application form to us.

Most medical aids and bandaging are given to you under direct ownership. If you receive a medical aid as such, you simply own the medical aid permanently. Other medical aids are generally leased out to you. Lease means that you may use the medical aid as long as you need and as long as you remain insured with us. You can conclude a lease contract with us or with the healthcare provider. This contract sets out your rights and obligations. Leased medical aids can only be obtained from a contracted healthcare provider.

In the Medical Aids Regulation you will find the following information:
- whether you will lease or own the medical aid;
- the quality standards the healthcare provider must meet;
- whether or not you require a referral, and, if yes, who issues it;
- if you require our prior permission (for first procurement, repeat or repair);
- term of use of the relevant medical aid. This term of use is indicative. If required, you may ask us to deviate from it;
- maximum number of pieces to be delivered. Such numbers are indicative. If required, you may ask us to deviate from it;
- specific details such as maximum reimbursements or statutory personal contributions.

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

Personal contribution/maximum reimbursement
The Medical Aids Regulation sets out the statutory personal contribution or maximum reimbursements for the relevant medical aids.

Excess
The excess applies to this care. The excess does not apply to medical aids on a lease basis. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
A healthcare provider for medical aids.

A list of contracted healthcare providers is available from our website.

Please note!
Are you ordering visual aids, diabetes aids, mobility aids, nursing aids and care in bed or incontinence or stoma materials not online or not from a supplier that we have contracted especially for the Basisverzekering Natura Select? Then we reimburse a maximum of 70% of the average rate which we have agreed upon with contracted suppliers.

Information about contracted healthcare providers
We make agreements with healthcare providers about quality, price and service. If you go to a care provider whom we have contracted for the care in question, you can expect a good product and excellent service. You also do not have to apply for permission or advance costs yourself. We pay the costs directly to the healthcare provider.

Are you going to a care provider whom we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. Did you receive an aid on lease that would have been reimbursed if it were provided a contracted care provider? Then the reimbursement amounts to a maximum of 70% of the average costs per user per year. The amount of the average costs is equal to the costs we would have paid for a leased medical aid. For more information, see articles 1.4 and 1.6 of these policy conditions.

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

Permission
The Medical Aids Regulation sets out which medical aids require prior permission. Please find more information about requesting permission in Article 1.9 of these conditions.

Particularities
1. Take good care of the medical aid. Within the normal average term of use, you will only receive permission for replacement of a medical aid if the current medical aid is no longer adequate. You, or your care provider, may submit an application for replacement to us with a motivation within the term of use, modification or repair.
2. You may obtain permission for a second piece of the medical aid if you are reasonably relying on it.
3. Leased medical aids may be subject to inspection. If, in our opinion, you are not or no longer reasonably relying on the medical aid, we may claim the medical aid from you.

STAY IN AN INSTITUTION

Article 39 Stay

This is your cover
You are entitled to hospitalisation for 24 hours or longer if due to medical necessity in connection with general practitioner care (Article 12), obstetric care (Article 17.1), specialist medical care (Articles 18 through 25), mental healthcare (Article 27) and specialist dental surgery (oral hygiene, Articles 34 and 35), as set out in these policy conditions, during an uninterrupted period of no more than 3 years (1095 days) as set out in Article 2.12 of the Healthcare Insurance Decree. A stay also includes the necessary nursing, care and paramedical care. Stay is also possible for insured under age 18 who require intensive childcare as set out in Article 16, Nursing and care.
Interruptions of no more than thirty days are not regarded as interruptions, but these days do not count towards the calculation of the 3-year (1095-day) period. Interruptions for weekend and holiday leave do count towards the calculation of the 3-year period.

You are also entitled to reimbursement of the costs of staying outside an expert hospital if this is necessary in connection with medical care such as medical specialists who usually provide it and which is not accompanied by nursing, care or paramedical care. A condition for claiming this compensation is that you:

- must be a resident at a distance of more than 50 kilometres (one way) from the expert hospital and;
- due to the risk of serious medical complications, need to stay closer to the hospital.

The reimbursement for the costs of staying outside an expert hospital is a maximum of € 89 per night.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

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

Please note!
Selective contracting applies to this article. You can read more about this in article 1.4.2. of the General Section.

Are you going to an institution that we have not contracted for the care in question? Please take into account that you may have to pay some of the costs yourself. For more information, see articles 1.4 and 1.6 of these policy conditions.

The stay outside the hospital must take place in the vicinity of the hospital in a hotel, holiday home or similar accommodation.

Subject to prescription by
General practitioner, obstetrician, medical specialist, psychiatrist or dental surgeon. The stay related to intensive child care, a paediatrician or paediatric nurse, level 5, may provide a prescription. They determine whether stay is medically necessary in connection with the medical care or is medically necessary in connection with surgical help of a specialist nature as set out in Article 34, Dental surgery for insured persons age 18 and older.

Permission
You will need prior permission for stays in connection with specialist medical care (Article 18), rehabilitation (Article 19.1), plastic and/or reconstructive surgery (Article 23), mental healthcare (Article 27) and oral hygiene (Articles 34 and 35) if this is indicated in the relevant healthcare provision. For more information, please refer to the relevant healthcare article. You have also need our permission when staying outside the hospital. If we give you permission, we may be able to set out terms and conditions set the duration of the stay.

TRANSPORT OF THE PATIENT

Article 40 Transport by ambulance and transport of the patient

This is your cover
You are entitled to:
1. transport by ambulance due to medical necessity as referred to in Section 1, first subsection, of the 'Tijdelijke Wet ambulancezorg' (Temporary Ambulance Healthcare Act), over a distance of no more than 200 km, single journey:
   a. to a healthcare provider or institution for healthcare of which the cost is fully or partially covered under the healthcare insurance policy;
   b. to an institution where you will stay with the costs fully or partially covered pursuant to the Wlz;
   c. if you are under age 18, to a healthcare provider or institution where you will receive mental healthcare, of which the cost is fully or partially covered under the competent Municipal Executive pursuant to the Youth Act;
   d. from a Wlz institution as set out in this article under item 1b, to:
      - a healthcare provider or institution for examination or treatment that is fully or partially covered by the Wlz;
      - a healthcare provider or institution for measuring and fitting a prosthesis that is fully or partially covered by the Wlz;
   e. to your home or a different residence if your home does not reasonably allow for the required healthcare if you come back from one of the healthcare providers or institutions as referred to in this article under items 1a through 1d;
2. transport of the patient over a distance of no more than 200 km, single journey. Transport of the patient includes transport of the patient by car, other than by ambulance, or transport in the lowest class of a means of public transport to and from a care provider, institution or home, as referred to under point 1.

You are exclusively entitled to such transport in the following situations:
a. you need to undergo kidney dialysis;
b. you must undergo oncological treatment with chemotherapy, immunotherapy or radiotherapy;
c. you can only move in a wheelchair;
d. your eyesight is so limited that you cannot move around unaccompanied.

> When are you eligible for transport of the patient based on a visual impairment?
> Your visual impairment must be such that you are not capable of travelling by public transport. This is determined by your visus (how sharp you can see) and your visual field (angle of your vision). You are entitled to transport if the visus in both your eyes is below 0.3 or if your visual field is impaired to less than 20 degrees. Some people have a combination of low visus and a very serious visual field impairment. In such cases individual assessments are required to assess your right to transport.

e. you are dependent on geriatric rehabilitation care, as referred to in Article 19.2;
f. you are younger than 18 years old and you rely on nursing and care because of complex somatic problems or because of a physical disability, where there is a need for permanent monitoring or the availability of 24-hour care in the vicinity;
g. you are dependent on day treatment that is part of a care program for chronically progressive degenerative disorders, non-congenital brain damage or intellectual disability.
h. you are dependent on transport and for the treatment of a long-term illness or condition failure to provide or reimburse that transport will lead to serious unfairness for you (hardship clause).

> When may you apply for a hardship clause?
> If the outcome of the sum 'number of consecutive months that transport is necessary X number of times per week X number of km, single journey' exceeds or is equal to 250. For instance: you had to go to hospital twice per week for 5 months. The single journey was 25 km. In this case you may apply for the hardship clause, as 5 months x 2 times per week x 25 km makes 250.

The transport of the patient as included in this article also includes the transport of someone assisting the patient if assistance is necessary or if the patient is under the age of 16. In special cases we may allow for transportation of 2 assistants.

The patient transport as included in this article in paragraph 2, parts a, b and f also includes transport to consultations, research and controls that are necessary as part of the treatment.

If you are dependent on transport as included in this article in paragraph 2 and this transport on at least three consecutive occasions days, we can provide a reimbursement for accommodation costs instead of a reimbursement at your request for transportation costs. Your request must show that staying at home is less stressful for the patient than traveling back and forth. The maximum reimbursement for accommodation costs is € 89 per night.

Personal contribution
You are charged a statutory personal contribution amounting to a maximum of € 118 per calendar year for transport of the patient. There is no personal contribution for transport by ambulance.

Excess
The excess applies to this care. For more information, please refer to Articles 7 and 8 of these policy conditions.

This is where to go
1. For ambulance transport: a licensed ambulance transporter.
2. Relating to patient transport:
   - taxi driver/firm;
   - public transport company. Reimbursement is based on public transport pass, 2nd class;
   - private transportation using a private car, of yourself or family care providers (family members, people from the immediate environment): reimbursement of € 0.38 per km. The distance is calculated based on the quickest route as provided by the ANWB route planner. The two single journeys (there and return) are calculated separately.

Do you use an ambulance or taxi transporter that we have not contracted? Then take into account that you will probably have to pay part of the costs yourself. For more information, see Articles 1.4 and 1.6 of these policy conditions.

Referral letter required from
General practitioner or medical specialist. You need a referral for patient transport as stated under description, item 2f from the pediatrician. You do not need a referral for emergency ambulance transport.

Permission
You need our prior permission for patient transport. You can request this permission with the 'Application form for patient transport'. You can find this form on our website. On our website you will also find the 'Application form for accommodation assistance' that allows you to request permission for the reimbursement of accommodation costs instead of reimbursement of transport costs.

Permission for patient transport for kidney dialysis and oncological treatments with chemotherapy, immunotherapy or radiotherapy can also be requested by telephone via telephone number 088 35 35 763.

Do you already have our permission? Then you can contact Transvision to arrange the taxi transport. You can reach them on 0900 – 33 33 330 (choose option 1).

Particularities
1. If we grant you permission to go to a certain healthcare provider or institution, the 200-km limitation does not apply.
2. if we give permission, we can impose conditions on the mode of transport.
3. In cases where transport of the patient by ambulance, car or a public means of transport is not possible, we may allow the transport of the patient to take place by another means of transport to be designated by us.

HEALTHCARE MEDIATION

Article 41 Healthcare advice and mediation

This is your cover
You are entitled to mediation for care in the event of an unacceptably long waiting time for treatment by a healthcare provider who may provide this care according to this healthcare insurance policy. You may use the services of our Team Medical for such mediation services. Please find the application form on our website.

You may also approach our Team Medical for general questions on care, such as relating to looking for a healthcare provider with a certain area of expertise or help in navigating through the care sector. We will be happy to review the options with you.

If no solution can be offered or if the healthcare cannot be provided in time due to this solution, you are allowed to make use of a healthcare provider not contracted to us. You are entitled to reimbursement of this non-contracted healthcare provider up to the Wmg rates applicable in the Netherlands. If no Wmg rates apply, we will reimburse the costs up to the market price perceived as reasonable in the Netherlands.

III Definitions

Acute healthcare: Acute care or crucial care can be regarded is determined in the Availability Contribution Decree (Besluit beschikbaarheidbijdrage Wmg). This concerns ambulance care, emergency care, acute obstetrics, mental healthcare crisis relief (GGZ). If care is received abroad, acute care also concerns care that cannot reasonably be postponed until you return to your country of residence.

Aevitae B.V.: The authorized agent to whom the health insurer has granted power of attorney as referred to in the Financial Supervision Act (Wft - Wet op het financieel toezicht) with regard to the execution of the health insurance policies.

Basisverzekering Natura Select: A healthcare insurance policy taken out by the policyholder with Aevitae on behalf of the healthcare insurer for a person subject to statutory insurance. These policy conditions refer to the Basisverzekering Natura Select as 'the healthcare insurance'.

Birth clinic: First-line birth clinic for facilitating natal care (healthcare during delivery) and postnatal care (healthcare during the first 10 days after delivery), of which the management and operations are performed by healthcare providers of first-line natal healthcare. The management and operations of the first-line birth clinic may also be performed by healthcare providers other than first-line obstetricians, such as maternity care institutions.

CAK: Central Administration Office (CAK - Central Administrative Bureau).

Diagnosis Treatment Combination (DBC): A DBC uses a DBC code issued by the Dutch Healthcare Authority (NZa - Nederlandse Zorgautoriteit) to describe the completed and validated process of specialist medical care and specialist GGZ (mental healthcare) (second-line curative GGZ). This includes part of the care process or the full care process of the diagnosis as made by the healthcare provider up to the ensuing treatment (if any).

The DBC regimen begins at the moment that the insured person registers with the care need, and ends at the end of the treatment or after 120 days for medical specialist care and after 365 days for specialist mental healthcare.

European Union and EEA Member State: includes the following countries other than the Netherlands in the European Union: Austria, Belgium, Bulgaria, Croatia Cyprus (the Greek area), the Czech Republic, Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Martinique, St. Barthélemy, St. Martin and La Réunion), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal (including Madeira and the Azores), Romania, Slovakia, Slovenia, Spain (including Ceuta, Mellilla and the Canaries), and Sweden. Under convention provisions Switzerland is considered as equivalent to these countries. EEA countries (Member States who are a party to the Agreement on the European Economic Area) are also included: Iceland, Liechtenstein and Norway.

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

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

GGZ: Mental Healthcare.

GGZ Institution: An institution providing medical care pertaining to a psychiatric condition, and that is licensed as such under the Healthcare Providers Accession Act (Wtza - Wet toetreding zorgaanbieders).

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

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

Healthcare: Care, healthcare or other services.

Healthcare insurance policy: A non-life insurance or healthcare non-life insurance contract concluded between a healthcare insurer and a policyholder for a person subject to mandatory insurance as set out in Section 1 subsection d of the Healthcare Insurance Act (Zorgverzekeringswet), of which these conditions form an integral, inseparable part.

Healthcare insurer/ EUCARE: The insurance company that is admitted as such and offers insurances within the meaning of the Health Insurance Act (Zorgverzekeringswet). For the purposes of this insurance contract, this is EUCARE Insurance PCC Limited (NLCare cell), which has its registered office in Malta. The insurer is authorized by the Malta Financial Services Authotority (MFSA). Legal address: 16 Europa Centre, Triq John Lopez, Floriana, FRN 1400 Malta.

The healthcare insurer is referred to as 'we' and 'our' in these policy conditions.

Healthcare Policy: The instrument in which the healthcare insurance taken out by the policyholder with the healthcare insurer is laid down. The healthcare policy consists of a policy cover and these policy conditions.

Healthcare provider: The natural person or legal entity providing healthcare professionally as set out in Section 1, preamble and subsection c, part 1 of the Wmg. Healthcare provider also includes all treatment professionals who are involved in delivering healthcare at the healthcare provider's risk and expense.

Healthcare provision: Provision relating to certain healthcare. See Section II, Healthcare Provisions.

Hospital: An institution for specialist medical care that is accepted in accordance with the Healthcare Providers Accession Act (Wtza - Wet toetreding zorgaanbieders). Hospital stays of 24 hours or longer are also covered.

Independent treatment center (ZBC): An institution for specialist medical care, which is approved as such according to the Healthcare Providers Accession Act (Wtza - Wet toetreding zorgaanbieders).

Institution:
1. An institution as referred to in the Care Institutions Accreditation Act (Wet toelating zorginstellingen);
2. A legal entity with its primary place of business abroad providing care in the country concerned according to the social security system existing in that country or which is aimed at providing care to specific groups of public officials.

Insured: A person whose risk of needing medical care as referred to in the Healthcare Insurance Act is covered by a healthcare insurance policy and who is stated as such on the policy cover as issued by the healthcare insurer.

In writing: where the policy conditions refer to 'in writing', this also includes 'by email'.

KNMG: the Royal Dutch Company to Promote Medicine (KNMG - Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst) is a federation of professional associations of medical doctors and the association The Medical Student, and represents the interests of doctors in the Netherlands.

NZa: Dutch Healthcare Authorities (Nederlandse zorgautoriteit).

Premium Due Date: The date on which the premium for the relevant payment period must be paid.

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

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

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

Policy Conditions Basisverzekering Natura Select/policy conditions: The healthcare insurer's model contract as referred to in Section 1j of the Healthcare Insurance Act.

Policyholder: The person who concluded an insurance contract with the healthcare insurer. These policy conditions refer to the policyholder and the insured as 'you'. Provisions referring only to the policyholder specifically state this in the relevant article.

Stay: A stay of 24 hours or longer.

Treaty country: A country not being a Member State of the European Union or the EEA, with which the Netherlands has entered into a social security convention including provisions for rendering medical care. This includes the following countries: Australia (for holidays/temporary stay), Bosnia-Herzegovina, Cape Verde Islands, Macedonia, Morocco, Serbia-Montenegro, Tunisia and Turkey.

In 2020, the United Kingdom (including Gibraltar) entered a treaty with the European Union (EU) for the reimbursement of healthcare costs. At the moment of writing these policy conditions for 2023, the United Kingdom does not yet recognize the EHIC and S2 statement. Should law and regulation change, we will implement that change from the starting date.

Wlz: Long-Term Healthcare Act (Wet langdurige zorg).

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

You: Policyholder and/or insured.

More information?
If you have questions, or something you think we should know, we will be happy to offer our assistance! Our Service Desk is open on weekdays from 08:30 to 17:30.
We can be reached on 088-35 35 763.

You can find answers to frequently asked questions at
www.aevitae.com.

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