Reimbursements and terms and conditions for 2027
Additional insurance package

‘Nationale-Nederlanden Extra’ additional insurance package
Product number: 6700104
Valid from 01-01-2027 to 31-12-2027 (inclusive)
The previous terms and conditions of insurance are hereby superseded.

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Alternative and psychosocial healthcare

What you are insured for under your additional insurance package

Alternative and psychosocial healthcare (clause D.7.)

Insured healthcare

- Alternative and psychosocial treatments
  Alternative treatment methods include all of the following: - acupuncture; - chiropractic treatment; - homeopathy; - osteopathy; - psychosocial treatments; We reimburse the following types of naturopathy: - an anthroposophic consultation; - auriculotherapy; - haptonomy/haptotherapy; - kinesiology; - musculoskeletal medicine; - orthomanual medicine; - reflex zone therapy/foot reflex therapy; - shiatsu; - manual therapy. We do not reimburse the costs of any other type of alternative treatment method and naturopathy.
- Alternative medicines
  Anthroposophic and homoeopathic medicines and products.

Your reimbursement

- Reimbursement of 250 euros maximum, per year, 0 for the healthcare above combined:
  - Reimbursement of 50 euros maximum, per day, 0 for alternative and psychosocial treatments.
  - Reimbursement of 100 percent 0 for alternative medicines.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for alternative and psychosocial treatments (clause D.7.1.)

Terms and conditions

- The therapist or doctor must provide the healthcare in accordance with the objectives and guidelines of the recognised professional association

Where to go for this healthcare

- Therapist or doctor who is a member of a professional association for alternative treatment methods or psychosocial care that we recognise.
  The therapist or doctor must have completed a recognised basic medical studies course (‘MBK’) that meets the training, educational and organisational requirements of PLATO (‘Platform Opleiding, Onderwijs en Organisatie’).
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed

- Healthcare reimbursed under other insurance
  We do not reimburse treatments and consultations already reimbursed under your general insurance policy, the Dutch Youth Act (‘Jeugdwet’), the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz), the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo) or another clause of your additional insurance package(s), irrespective of whether or not you are insured for this healthcare or will not be reimbursed (in part or in full) for it. Only if we know for sure that the healthcare is not covered by your general insurance policy, another insurance policy or another clause under your additional insurance package(s) will we determine whether this healthcare is eligible for reimbursement as alternative healthcare or psychosocial care.
- Experimental treatments or treatments that are still in the research phase.
- Laboratory tests that have been requested by a therapist or doctor specialising in alternative healthcare or psychosocial care

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for alternative medicines (clause D.7.2.)

Terms and conditions
- The medicines and healthcare products must come under the Dutch Medicines Act ('Geneesmiddelenwet'). They must also be registered as homeopathic or anthroposophic medicines
- The medicines must be registered in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index'
  'Z-Index' verifies, manages and distributes all medicines and healthcare products and subsequently registers them in the 'G-Standaard' (the Dutch national database of medicines). We use this 'G-Standaard' to, among other things, check the price of a medicine and whether it is in the register.

Who to get a treatment proposal from
- An alternative healthcare provider recognised by us. That healthcare provider has determined that the admission is medically necessary

Where to go for this healthcare
- Pharmacy/online pharmacy.
- Dispensing doctor or general practitioner.

What is not reimbursed
- Over-the-counter medicines
  If we do not reimburse an over-the-counter medicine under the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), we will not reimburse it under alternative medicines either. You can consult the Dutch Health Insurance Regulations ('Regeling zorgverzekering') on wetten.overheid.nl.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Abroad

What you are insured for under your additional insurance package

Urgent medical care abroad (clause D.14.a.)

Insured healthcare
- Excess rate costs
  Your insurance provides worldwide cover. This means you are insured outside the Netherlands for the same healthcare and the same scope as within the Netherlands according to the Dutch rates. If the foreign rates are higher than the Dutch rates, an 'excess rate' remains; this reimbursement concerns the 'excess rate costs'.

Your reimbursement
- Reimbursement of 100% of the claimed rate outside the Netherlands or your country of residence, this includes the reimbursement under your general insurance policy, 385 for urgent medical care abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:

    - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- The healthcare is covered under your general insurance policy, but this does not fully reimburse the costs
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- The need for the healthcare could not be foreseen at the time you left for the foreign country
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)
- You must contact the ANWB Alarmcentrale emergency assistance centre with which we have an agreement for healthcare/mediation for healthcare abroad. You can read more information on our website
  You do not need to contact the emergency service for a one-off visit to a doctor or pharmacy.
- You must cooperate fully in the provision of the healthcare and comply with the instructions of the ANWB Alarmcentrale emergency assistance centre

Where to go for this healthcare
- The healthcare provider abroad complies with the requirements, laws and regulations of that country.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Urgent oral care abroad (clause D.14.b.)

Insured healthcare
- Oral care in a foreign country

Your reimbursement
- Reimbursement of 275 euros maximum, per year, 0 for urgent oral care abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
    - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- The need for the healthcare could not be foreseen at the time you left for the foreign country
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)
- You must contact the ANWB Alarmcentrale emergency assistance centre with which we have an agreement for healthcare/mediation for healthcare abroad. You can read more information on our website
  You do not need to contact the emergency service for a one-off visit to a doctor or pharmacy.
- You must cooperate fully in the provision of the healthcare and comply with the instructions of the ANWB Alarmcentrale emergency assistance centre

Where to go for this healthcare
- A dentist abroad must comply with the requirements, laws and regulations of that country.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Repatriation in the event of illness (clause D.14.c.)

Insured healthcare
- Repatriation of the sick insured person from abroad
  Including a medical escort by a qualified doctor or nurse. This concerns patient transport from the place where you are temporarily staying or the location of your accident, sudden illness or treatment abroad to a facility for specialist medical healthcare in the Netherlands or your country of residence.

Your reimbursement
- Reimbursement of 100 percent 0 for repatriation in the event of illness.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- Repatriation must be medically necessary
  The repatriation must be medically necessary, based on us being of the opinion that one of the following situations applies to you: - the correct medical treatment is not locally available or reasonably feasible in the foreign country, while it is available in the Netherlands (or the country where you live); - having the treatment provided in that foreign country would be medically irresponsible; - treatment in that foreign country is much more expensive than treatment in the Netherlands (or the country where you live) would be.
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- The need for the healthcare could not be foreseen at the time you left for the foreign country
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)
- You must contact the ANWB Alarmcentrale emergency assistance centre with which we have an agreement for healthcare/mediation for healthcare abroad. You can read more information on our website
  You do not need to contact the emergency service for a one-off visit to a doctor or pharmacy.
- You must cooperate fully in the provision of the healthcare and comply with the instructions of the ANWB Alarmcentrale emergency assistance centre

Where to go for this healthcare
- The healthcare provider abroad complies with the requirements, laws and regulations of that country.

What is not reimbursed
- Costs of repatriation if it is not medically necessary
  For example, if you are taken back to the Netherlands on a specially chartered flight for injured skiers (‘gipsvlucht’), we will not reimburse the costs involved. However, they can be insured under a travel insurance policy.

- Transport of human remains
  Under this clause, we do not reimburse the costs that are directly related to the transport of the human remains from the country of death (foreign country) back to the Netherlands (or the country where you live). This relates to the costs of preserving and attending to the remains and preparing them for transport, the costs of transporting the remains, and administrative costs such as fees and duties.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport of human remains (clause D.14.f.)

Insured healthcare
- Transport of human remains
  The costs that are directly related to the transport of the human remains from the country of death (foreign country) back to the Netherlands (or the country where you live). This relates to the costs of preserving and attending to the remains and preparing them for transport, the costs of transporting the remains, and administrative costs such as fees and duties.

Your reimbursement
- Reimbursement of 100 percent 0 for transport of human remains.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You were temporarily abroad.
    This applies for a continuous period of a maximum of 365 days abroad. If you were abroad for more than 365 days, we do not consider this a temporary stay.

Terms and conditions
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- The need for the healthcare could not be foreseen at the time you left for the foreign country
- Your surviving relatives must contact the ANWB Alarmcentrale emergency assistance centre with which we have an agreement for healthcare/mediation for healthcare abroad. You can read more information on our website
- Your surviving relatives must cooperate fully in the provision of the healthcare and comply with the instructions of the ANWB Alarmcentrale emergency assistance centre
- Once we have paid the costs, your surviving relatives must cooperate with the transfer of the rights to another insurer (such as a travel insurer)

Where to go for this healthcare
- The healthcare provider abroad complies with the requirements, laws and regulations of that country.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Forwarding medicines and medical aids (clause D.14.g.)

Insured healthcare
- Forwarding the necessary medicines and medical aids. This concerns the costs of sending, such as the costs of a courier

Your reimbursement
- Reimbursement of 100 percent 0 for forwarding medicines and medical aids.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- The need for the healthcare could not be foreseen at the time you left for the foreign country
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)

What is not reimbursed
- Purchase costs of medicines and medical aids; these are insured under other clauses.
- Additional costs when sending medicines and medical aids, such as costs for customs levies or return freight for medicines and medical aids that have been sent

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Communications costs (clause D.14.h.)

Insured healthcare
- Costs of communications (by telephone or otherwise) with our emergency service in order to arrange the required healthcare and/or services

Your reimbursement
- Reimbursement of 350 euros maximum, per year, 0 for communications costs.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Medical advice provided by emergency service (clause D.14.i.)

Insured healthcare
- Medical advice from the Medical Team (‘Medisch Team’) of our emergency service prior to and during your temporary stay

Your reimbursement
- Reimbursement of 100 percent 0 for medical advice provided by emergency service.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - Urgent medical care if you are abroad for a maximum of 365 consecutive days but do not live abroad. This is healthcare that is medically necessary and that cannot reasonably be postponed. Furthermore, you are abroad for a continuous period of a maximum of 365 days. If you have remained abroad for an uninterrupted period of more than 365 days, we do not consider this a temporary stay. Any costs for healthcare you incur after the 365th day will not qualify for reimbursement.

Terms and conditions
- You will not be reimbursed in full under another insurance policy (including travel insurance)
- Once we have paid the costs, you must cooperate with the transfer of the rights to another insurer (such as a travel insurer)
- You must contact the ANWB Alarmcentrale emergency assistance centre with which we have an agreement for healthcare/mediation for healthcare abroad. You can read more information on our website
  You do not need to contact the emergency service for a one-off visit to a doctor or pharmacy.
- You must cooperate fully in the provision of the healthcare and comply with the instructions of the ANWB Alarmcentrale emergency assistance centre

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Dietetics

What you are insured for under your additional insurance package

Dietetics (clause D.18.1.)

Insured healthcare
- Dietetics with a medical purpose

Your reimbursement
- Reimbursement of 100 euros maximum, per year, on top of the reimbursement under the general insurance policy, we first reimburse under the general insurance policy, and then under your additional insurance package, 0 for dietetics.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- Reimbursement under the general insurance policy takes precedence over this reimbursement
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Where to go for this healthcare
- Dietician.
  Your healthcare provider is a dietician with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
- Dietetics in combination with combined lifestyle intervention. Unless this relates to a different healthcare need based on a different indication
  Also see the ‘General practitioner care with a focus on combined lifestyle intervention’ clause.
- Food products and dietary preparations
  Not even if you have a prescription from the dietician. For dietary preparations, see the ‘Dietary preparations’ clause.
- Dietary advice for weight loss or sports, for example

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Occupational therapy

What you are insured for under your additional insurance package

Occupational therapy (clause D.17.1.)

Insured healthcare
- Occupational therapy
  This concerns the provision of advice, instruction, training or treatment to help you achieve, or regain, independence and the ability to look after yourself.

Your reimbursement
- You are younger than 18: reimbursement of 2 hours maximum, per year, on top of the reimbursement under the general insurance policy, we first reimburse under the general insurance policy, and then under your additional insurance package, 0 for occupational therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You can receive treatment in your home if necessary, as long as this necessity has been recorded in your file

Where to go for this healthcare
- Occupational therapist.
  Your healthcare provider is an occupational therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Where the treatment takes place
- At the practice of the attending healthcare provider
- The occupational therapy treatment area of a facility
  Treatment in the occupational therapy treatment area of a facility as defined in the Dutch Healthcare Institutions (Accreditation) Act (‘Wet toelating zorginstellingen’, WTZi), where the therapy is provided without admission to the facility.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Training and guidance for carers in the case of occupational therapy (clause D.17.2.)

Insured healthcare
- Training and guidance for carers in the case of occupational therapy

Your reimbursement
- Reimbursement of 2 hours maximum, per year, 0 for training and guidance for carers in the case of occupational therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You receive informal care and are insured with us for occupational therapy
  The carer does not have to have insurance with us or have cover for this training. If you both have insurance that entitles you to reimbursement of a carer course, we will initially reimburse the costs of the course under the additional insurance package of the person receiving the informal care and only afterwards under the additional insurance package of the carer.

Where to go for this healthcare
- Occupational therapist.
  Your healthcare provider is an occupational therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy

What you are insured for under your additional insurance package

Screening prior to physiotherapy and exercise therapy (clause D.16.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.
- Cesar or Mensendieck exercise therapy
- Oedema physiotherapy
- Pelvic physiotherapy
  Specialist physiotherapy aimed at treating pelvic floor problems.
- Supervised walking therapy for intermittent claudication
  This physiotherapy promotes your self-management so that you can practice independently and is aimed at: - limiting the complaints caused by reduced oxygen in the legs and - reducing the risk factors of atherosclerosis.
- Supervised exercise therapy for osteoarthritis
  This physiotherapy promotes your self-management so that you can practice independently.
- Physiotherapy or exercise therapy in the form of supervised exercise therapy
  This concerns supervised exercise therapy. This is a form of physiotherapy.
- Long-term supervised exercise therapy
  This concerns personal, active exercise therapy to prevent serious deterioration.

Your reimbursement
- Reimbursement of 1 session per condition, 0 for screening prior to physiotherapy and exercise therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a (temporary) complaint or injury.
    This generally relates to a short-term, acute complaint. If you have any doubts, please ask your physiotherapist or exercise therapist or attending doctor.

Terms and conditions
- Reimbursement under the general insurance policy takes precedence over this reimbursement
- The number of sessions specified is an additional reimbursement under your additional insurance package if you are entitled to this healthcare under the general insurance policy
- Group sessions are an option as long as the group does not have more than 10 participants

Who to get a referral from
- You need a referral to receive physiotherapy or exercise therapy at home
  Before you receive physiotherapy or exercise therapy at home, you need a referral stating why you need to receive this therapy at home. These healthcare providers may make the referral: - general practitioner - doctor for the mentally disabled - geriatric specialist - youth healthcare doctor - dentist - physician assistant - clinical nurse specialist - company doctor, or - medical specialist.

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the exercise therapy
  Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  The skin therapist is registered with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- Psychosomatic physiotherapist provides psychosomatic physiotherapy
  This is a physiotherapist who is listed as a psychosomatic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- Psychosomatic exercise therapist provides psychosomatic exercise therapy
  Your healthcare provider is a psychosomatic exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
- Oedema physiotherapy following a cosmetic procedure
- Scar treatment following a cosmetic procedure
- Scar treatment after normal wound recovery
  We assess whether there is normal wound recovery.
- Sports massage

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy (clause D.16.1.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.
- Cesar or Mensendieck exercise therapy
- Oedema physiotherapy
- Pelvic physiotherapy
  Specialist physiotherapy aimed at treating pelvic floor problems.
- Supervised walking therapy for intermittent claudication
  This physiotherapy promotes your self-management so that you can practice independently and is aimed at: - limiting the complaints caused by reduced oxygen in the legs and - reducing the risk factors of atherosclerosis.
- Supervised exercise therapy for osteoarthritis
  This physiotherapy promotes your self-management so that you can practice independently.
- Physiotherapy or exercise therapy in the form of supervised exercise therapy
  This concerns supervised exercise therapy. This is a form of physiotherapy.
- Long-term supervised exercise therapy
  This concerns personal, active exercise therapy to prevent serious deterioration.

Your reimbursement

- Reimbursement of 9 sessions maximum, per year, 0 for physiotherapy and exercise therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You have a (temporary) complaint or injury.
    This generally relates to a short-term, acute complaint. If you have any doubts, please ask your physiotherapist or exercise therapist or attending doctor.

Terms and conditions

- Reimbursement under the general insurance policy takes precedence over this reimbursement
- The number of sessions specified is an additional reimbursement under your additional insurance package if you are entitled to this healthcare under the general insurance policy
- Group sessions are an option as long as the group does not have more than 10 participants

Who to get a referral from

- You need a referral to receive physiotherapy or exercise therapy at home
  Before you receive physiotherapy or exercise therapy at home, you need a referral stating why you need to receive this therapy at home. These healthcare providers may make the referral: - general practitioner - doctor for the mentally disabled - geriatric specialist - youth healthcare doctor - dentist - physician assistant - clinical nurse specialist - company doctor, or - medical specialist.

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

- A Cesar/Mensendieck exercise therapist provides the exercise therapy
  Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  The skin therapist is registered with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- Psychosomatic physiotherapist provides psychosomatic physiotherapy
  This is a physiotherapist who is listed as a psychosomatic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- Psychosomatic exercise therapist provides psychosomatic exercise therapy
  Your healthcare provider is a psychosomatic exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
- Oedema physiotherapy following a cosmetic procedure
- Scar treatment following a cosmetic procedure
- Scar treatment after normal wound recovery
  We assess whether there is normal wound recovery.
- Sports massage

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Mental healthcare

What you are insured for under your additional insurance package

Coping with traumas following a work-related incident (clause D.6.5.)

Insured healthcare
- Coping with traumas
  The immediate and long-term care provided straight after the traumatic event if you are directly involved in one of these situations: - a robbery, hostage taking or act of aggression; - an accident resulting in bodily injury, sudden death (by suicide for example); or - inappropriate behaviour.

Your reimbursement
- Reimbursement of 100 percent 0 for coping with traumas following a work-related incident.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have experienced a work-related traumatic event.

Terms and conditions
- The traumatic event must have been unexpected and have affected you to such a degree (temporarily or permanently) that you are no longer able to function normally in your daily activities

- The traumatic event relates to the performance of your work
  This involves an industrial accident, robbery, hostage taking or aggression resulting in injury, or sudden death due to suicide.
- There must be proof that the event occurred
- The traumatic event must have occurred in the Netherlands

Where to go for this healthcare
- Post-trauma care facility
  The facility specialises in post-trauma psychosocial assistance and has been recognised or contracted by us.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Skin therapies

What you are insured for under your additional insurance package

Hair removal (clause D.10.2.)

Insured healthcare
- Hair removal
  Removal of extreme hair growth in unusual places on the face or neck.

Your reimbursement
- Reimbursement of 200 euros maximum, once per insured person, 0 for hair removal.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- Treatment that includes the use of a laser is provided under the responsibility of a dermatologist or skin therapist.
  The dermatologist or skin therapist must therefore submit the claim for this healthcare.
- The invoice specifies which form of hair removal has been used
- The healthcare is provided in accordance with the ANBOS quality requirements

Where to go for this healthcare
- Cosmetologist with the electric hair removal (‘elektrisch ontharen’) and/or hair removal techniques (‘ontharingstechnieken’) specialism
  On our website, under the relevant healthcare you can find any other registers we recognise over the course of the year. The healthcare is provided in accordance with the ANBOS guidelines.
- Skin therapist.
  The skin therapist is listed on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment.
- Dermatologist.

What is not reimbursed
- Treatments that use resins, gels, creams or other hair removal products
- Cosmetic treatments
  Treatments solely aimed at improving a person’s appearance.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Acne treatment (clause D.10.3.)

Insured healthcare
- Acne treatment
  The treatment of severe acne vulgaris (acne) on the face and/or neck.

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for acne treatment.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- Treatment that includes the use of a laser is provided under the responsibility of a dermatologist or skin therapist.
  The dermatologist or skin therapist must therefore submit the claim for this healthcare.
- The healthcare is provided in accordance with the ANBOS quality requirements

Where to go for this healthcare
- Cosmetologist with the ‘acne’ specialism
  On our website, under the relevant healthcare you can find any other registers we recognise over the course of the year. The healthcare is provided in accordance with the ANBOS guidelines.
- Skin therapist.
  The skin therapist is listed on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment.
- Dermatologist.

What is not reimbursed
- Treatment of rosacea
- Cosmetic treatments
  Treatments solely aimed at improving a person’s appearance.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Camouflage therapy (clause D.10.4.)

Insured healthcare
- Camouflage therapy
  The care consists of camouflage lessons and reimbursement of the costs of the camouflage products required for the lessons.

Your reimbursement
- Reimbursement of 100 euros maximum, once per insured person, 0 for camouflage therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You learn how to camouflage birthmarks, scars and other disfiguring skin conditions visible on the face and/or neck
- The healthcare is provided in accordance with the ANBOS quality requirements

Where to go for this healthcare
- Cosmetologist with the ‘camouflage’ specialism
  On our website, under the relevant healthcare you can find any other registers we recognise over the course of the year. The healthcare is provided in accordance with the ANBOS guidelines.
- Skin therapist.
  The skin therapist is listed on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment.

What is not reimbursed
- Camouflage products outside of and after the camouflage lessons.
- Cosmetic treatments
  Treatments solely aimed at improving a person’s appearance.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Hulpmiddelen

What you are insured for under your additional insurance package

Statutory personal contribution and/or amount above the maximum reimbursement under the general insurance policy for medical aids (clause D.4.1.)

Insured healthcare
- Statutory personal contribution of hypoallergenic footwear
- Statutory personal contribution of orthopaedic shoes
- Statutory personal contribution of hairpieces/wigs
- Statutory personal contribution of hearing aids and tinnitus maskers
- Statutory personal contribution of filter lenses
  These are special coloured lenses with a medical filter that filter certain parts of light but are not sunglasses. You need a medical indication for this.
- Statutory personal contribution of contact lenses with vision correction

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for statutory personal contribution and/or amount above the maximum reimbursement under the general insurance policy for medical aids.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
- Deluxe model of the medical aid or extras outside the statutory personal contribution or the maximum reimbursement

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Head covering/headpiece other than a wig (clause D.4.4.b.)

Insured healthcare
- Headpiece other than a wig or hairpiece

Your reimbursement
- Reimbursement of 75 euros maximum, per year, 0 for head covering/headpiece other than a wig.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You acquire this medical aid; you are the owner

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- You can choose where you buy the medical aid.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Costs for purchasing a bedwetting alarm (clause D.4.6.), costs for renting a bedwetting alarm (clause D.4.6.)

Insured healthcare
- Bedwetting alarm with necessary accessories

Your reimbursement
- You can choose from one of the following reimbursements:
  1. Reimbursement of 100 percent maximum, once per insured person, 0 for costs for purchasing a bedwetting alarm.
  2. Reimbursement of 4 months maximum, once per insured person, 0 for costs for renting a bedwetting alarm.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for costs for purchasing a bedwetting alarm (clause D.4.6.)

Terms and conditions
- We only reimburse the costs of the associated underpants (max. 3) on the first occasion when you purchase or rent the equipment

Where to go for this healthcare
- Specialist medical supplies shop.
- Home care shop.
- Pharmacy.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for costs for renting a bedwetting alarm (clause D.4.6.)

Terms and conditions
- We only reimburse the costs of the associated underpants (max. 3) on the first occasion when you purchase or rent the equipment

Where to go for this healthcare
- Specialist medical supplies shop.
- Home care shop.
- Pharmacy.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Orthotic insoles and medical aids for foot care (clause D.4.8. / D.4.9.)

Insured healthcare
- Orthotic insoles from an orthopaedic shoemaker or orthopaedic instrument maker
  This relates to orthotic insoles made for you personally. This includes measuring, purchase and repairs.
- Foot care medical aids such as insoles from a podiatrist or chiropodist, tape, pressure bandages, nail prostheses and nail braces
  This relates to the purchase and repair of the medical aids.

Your reimbursement
- Reimbursement of 100 euros maximum, per year, 0 for orthotic insoles and medical aids for foot care for the healthcare above combined.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for orthotic insoles from an orthopaedic shoemaker or orthopaedic instrument maker (clause D.4.8.)

Where to go for this healthcare
- Orthopaedic shoemaker.
  Recognised by us or contracted for this healthcare.
- Orthopaedic instrument maker.
  Recognised by us or contracted for this healthcare.

What is not reimbursed
- Insoles from a podiatrist or chiropodist
  These come under the ‘Foot care, medical aids’ clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for foot care medical aids such as insoles from a podiatrist or chiropodist, tape, pressure bandages, nail prostheses and nail braces (clause D.4.9.)

Terms and conditions
- You are insured with us for treatment by a podiatrist, chiropodist or pedicurist for which the medical aids have been prescribed and supplied

Who to get a treatment proposal from
- Podiatrist, chiropodist or pedicurist

Where to go for this healthcare
- Podiatrist.
  A podiatrist with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- Registered chiropodist
  The healthcare provider who is listed as a registered chiropodist on the quality register of Kabiz (Quality Registration and Accreditation of Healthcare Professionals) or a register designated by us and who has a practice as a registered chiropodist.
- Medical pedicurist.
  A medical pedicurist listed as such on the Quality Register for Pedicurists (‘Kwaliteitsregister Pedicure’) or the Register for Allied Health Professionals for Foot Care (‘Register Paramedische Voetzorg’).

What is not reimbursed
- Medical aids for personal care
  Such as the removal of calluses for cosmetic reasons or general toenail care.
- Orthotic insoles from an orthopaedic shoemaker or orthopaedic instrument maker
  These come under the ‘Orthotic insoles’ clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Home monitor (clause D.4.10.)

Insured healthcare
- Home monitor

Your reimbursement
- Reimbursement of 12 months maximum, once per insured person, 0 for home monitor.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - There has previously been cot death in the family.

Terms and conditions
- You are given this medical aid on loan

Who to get a treatment proposal from
- A paediatrician has determined that a home monitor is medically necessary

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Personal alarm on social grounds (clause D.4.16.a.)

Insured healthcare
- Personal alarms

Your reimbursement
- Reimbursement of 150 euros maximum, per year, 0 for personal alarm on social grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You are eligible based on social grounds.
    There are no medical grounds for the personal alarm under the general insurance policy.

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Specialist medical supplies shop.
- Home care shop.
- Supplier of personal alarms

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Braces and bandages (clause D.4.18.)

Insured healthcare
- Brace and bandage

Your reimbursement
- Reimbursement of 150 euros maximum, per year, 0 for braces and bandages.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You do not have medical grounds for the brace or bandage under the general insurance policy

Where to go for this healthcare
- You can choose where you buy the medical aid.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Epileptic seizure alarms (clause D.4.20.)

Insured healthcare
- Bed mat that detects serious epileptic (tonic-clonic) seizures and raises an alert

Your reimbursement
- Reimbursement of 1.000 euros per year, 0 for epileptic seizure alarms.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have severe epilepsy.

Who to get a treatment proposal from
- Neurologist from a specialist epilepsy centre
  This healthcare provider must state that the epilepsy is so severe that the bed mat as an alarm device is indicated.

Where to go for this healthcare
- You can choose where you buy the medical aid.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Cranial orthosis (clause D.4.21.)

Insured healthcare
- Cranial orthosis

Your reimbursement
- Reimbursement of 100 percent 0 for cranial orthosis.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have plagiocephaly or brachycephaly (flat head syndrome) without craniosynostosis (fusion of the skull bones).

Who to get a treatment proposal from
- Medical specialist

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- You can choose where you buy the medical aid.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Mastectomy bra and swimwear (clause D.4.22.)

Insured healthcare
- Bra and/or swimwear designed specifically to hold a breast prosthesis

Your reimbursement
- Reimbursement of 90 euros maximum, once per insured person, 0 for mastectomy bra and swimwear.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have undergone a partial or total mastectomy, possibly with breast reconstruction surgery.

Terms and conditions
- The post-mastectomy lingerie must be purchased within 36 months of the mastectomy
  This can relate to one or several items of post-mastectomy lingerie. You can purchase them at one shop or several different shops and on one day or over several days.

Where to go for this healthcare
- You can choose where you buy the medical aid.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Informal care

What you are insured for under your additional insurance package

Carer course (clause D.24.1.)

Insured healthcare
- Carer course
  Informal care is unpaid and often long-term care for sick relatives or friends. This can be personal care or assistance with activities of daily living.

Your reimbursement
- Reimbursement of 150 euros maximum, once per insured person, 0 for carer course.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The commencement date of the course is used to calculate the reimbursement
- If both the carer and the person receiving informal care are insured for this care:
  the reimbursement will initially come from the additional insurance package of the person receiving the informal care and only afterwards through the additional insurance package of the carer.

Where to go for this healthcare
- Home care organisation.
  An organisation that is able to provide the nursing and care of an insured person in the insured person's own home.
- 'GGD' (regional health authority).
- National or regional patients' association.
- 'MantelzorgNL' association for informal care.

What is not reimbursed
- Work-related or recreational therapy
- Exercise programme to prevent illness or maintain and promote your health
  This programme is not reimbursed under this clause, but under the 'Exercise programme' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Carer relief (clause D.24.2.b.)

Insured healthcare

- Temporary carer relief
  Informal care is unpaid and often long-term care for sick relatives or friends. This can be personal care or assistance with activities of daily living.

Your reimbursement

- Reimbursement of 1.000 euros maximum, per year, 0 for carer relief.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions

- The carer or the recipient of the informal care has an additional insurance package that entitles him or her to this reimbursement
  The carer is the person who provides informal care.
- If both the carer and the person receiving informal care are insured for this care:
  the reimbursement will initially come from the additional insurance package of the person receiving the informal care and only afterwards through the additional insurance package of the carer.
- You have a long-term and/or chronic illness or condition or deteriorating health and would be unable to function independently at home without this informal care
- The carer cannot provide informal care for a short period of time
  This could concern the carer having a period of leave, going on holiday or being admitted for a scheduled operation.
- We use the commencement date of the temporary carer relief to determine the reimbursement

Where to go for this healthcare

- Nationally operating informal care organisation recognised or contracted by us.
  You can find this organisation on our website, or we can provide you with the details on request.

What is not reimbursed

- Carer relief if you are staying in a facility on the basis of a medical indication for care under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz).
- Temporary admission, respite care or support at a location other than at home

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Informal care broker (clause D.24.3.)

Insured healthcare

- Informal care broker

Your reimbursement

- Reimbursement of 7 hours maximum, once per insured person, 0 for informal care broker.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions

- Contact our Healthcare Team (‘Zorgteam’) in advance to arrange the healthcare.
  The Healthcare Team (‘Zorgteam’) will assess in a consultation session whether you will receive a reimbursement.

- If you have multiple insurance policies that reimburse this healthcare, you will receive the highest reimbursement once. If the reimbursement under both insurance policies is the same, you will receive your reimbursement from one of those polices.
  If you have taken out two or more insurance policies with us, each of which reimburses costs for oral care in the event of accidents, costs will only be reimbursed under the policy with the highest reimbursement for accident care. If both insurance policies offer the same level of reimbursement for these costs, the costs will be reimbursed through only one of these insurance policies.

Where to go for this healthcare
- Please contact the informal care brokers on our Healthcare Team (‘Zorgteam’)

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Medicines

What you are insured for under your additional insurance package

Contraceptive medicines and IUD (clause D.3.5.b. / D.3.5.c.)

Insured healthcare
- Contraceptive medicines
- IUD

Your reimbursement
- You are 21 years old or above: reimbursement of 100 percent 0, 385 for contraceptive medicines and IUD for the healthcare above combined.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for contraceptive medicines (clause D.3.5.b.)

Terms and conditions
- This relates to contraceptive medicines that we reimburse under the general insurance policy up to the age of 21
  Because you are 21 or older, you will not be reimbursed for contraceptive medicines or contraceptive medical aids under your general insurance policy.
- The medicines are listed in Appendices 1 and 2 of the Dutch Health Insurance Regulations (‘Regeling zorgverzekering’) and in the ‘G-Standaard’ (national medicines database) administered by ‘Z-Index’
- The medicines are included in the Medicines Reimbursement System (GVS)
  These may be subject to a statutory personal contribution (i.e. you must pay part of the costs yourself).
- Our preferred medicine policy may apply to your medicine
  More information on preferred medicines can be found in the clause ‘Medicines listed in the Medicines Reimbursement System (GVS)’.

Who to get a treatment proposal from
- General practitioner
- Medical specialist
- Doctor for the mentally disabled
- Physician assistant

Where to go for this healthcare
- Pharmacy/online pharmacy.

- Dispensing doctor or general practitioner.

What is not reimbursed
- A medicine for which we have no preference, while there is an equivalent and suitable medicine on the list of preferred medicines (‘Lijst voorkeursgeneesmiddelen’)
  More information on preferred medicines can be found in our Pharmacy Regulations (‘Reglement Farmacie’).
- Additional costs of submitting prescriptions and collecting medicines outside normal opening hours, except in an urgent situation
  This will be reimbursed in urgent situations.
- Additional costs, e.g. administrative, import and/or postage costs

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for IUD (clause D.3.5.c.)

Terms and conditions
- Your general practitioner fits the contraceptive device
  If the medical aid is inserted by a medical specialist, the medical aid comes under the ‘Specialist medical healthcare’ clause.

Who to get a treatment proposal from
- General practitioner
- Medical specialist
- Doctor for the mentally disabled
- Physician assistant

Where to go for this healthcare
- Pharmacy/online pharmacy.
- Dispensing doctor or general practitioner.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Statutory Medicines Reimbursement System (GVS) personal contribution for contraceptive medicines (clause D.3.2.a.)

Insured healthcare
- Statutory personal contribution of contraceptive medicines that you have to pay for yourself under the Medicines Reimbursement System (GVS)

Your reimbursement
- You are younger than 21: reimbursement of 100 percent 0 for statutory Medicines Reimbursement System (GVS) personal contribution for contraceptive medicines.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Specialist medical healthcare

What you are insured for under your additional insurance package

Vasectomy (clause D.1.1.)

Insured healthcare
- Vasectomy

Your reimbursement
- Reimbursement of 400 euros maximum, 0, 385 for vasectomy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Where to go for this healthcare
- Medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).
- General practitioner.
  A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). You can also receive the healthcare under the responsibility of a general practitioner.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Sterilisation (fallopian tubes) (clause D.1.1.)

Insured healthcare
- Sterilisation (fallopian tubes)

Your reimbursement
- Reimbursement of 1.250 euros maximum, 0, 385 for sterilisation (fallopian tubes).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Where to go for this healthcare
- Medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Oral care

What you are insured for under your additional insurance package

Statutory personal contribution for full upper and/or lower dentures (P or J codes) (clause D.8.3.b.)

Insured healthcare
- Full dentures
  This concerns one of the following types of dentures without implants: - removable full dentures (conventional dentures) for the upper and/or lower jaw; - temporary full dentures; - removable full replacement denture; - a removable full implant overdenture fitted to one or more natural teeth (i.e. your own teeth), for the upper and/or lower jaw.
- Full dentures for one jaw combined with implant-retained dentures (including snap-on system) for the other jaw
  Removable full conventional dentures together with full implant-retained dentures on the other jaw. The healthcare provider claims these costs under code J080. This includes insertion of the fixed part of the suprastructure (the snap-on system).
- Full implant-retained dentures in the upper jaw
  Removable full implant overdenture in the upper jaw. This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth.
- Full implant-retained dentures in the lower jaw
  Removable full implant overdenture in the lower jaw. This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth.
- Mesostructure for the lower or upper jaw
  This is part of the combination of dentures for one jaw combined with implant-retained dentures for the other jaw.
- Repair and filling (rebasing) of full dentures (removable full implant overdentures)

Your reimbursement
- You are 18 years old or above: reimbursement of 200 euros maximum, per year, 0 for statutory personal contribution for full upper and/or lower dentures (P or J codes).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Crown, bridge and inlay (R code) (clause D.8.2.)

Insured healthcare
- Crown, bridge or inlay
  This includes the costs of the associated dental treatments, and material and technical costs.

Your reimbursement
- You are younger than 18: reimbursement of 500 euros maximum, per year, 0 for crown, bridge and inlay (R code).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is claimed using treatment code R
  This is on the basis of the dental rates decision 'tariefbeschikking tandheelkundige zorg' compiled by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa).

Who to get a treatment proposal from
- Dentist

Where to go for this healthcare
- Dentist.
  The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Orthodontic care (clause D.8.5.)

Insured healthcare
- Orthodontic care
  This includes the costs of the associated dental treatments, and material and technical costs.

Your reimbursement
- You are younger than 18, after a waiting period of 365 days: reimbursement of 1.000 euros maximum, 75% per treatment, as long as you have this additional insurance package with us, 0 for orthodontic care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is claimed using treatment code F
  This is on the basis of the orthodontics rate decision put together by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) using treatment codes that start with the letter F, end with the letter A, and have 3 digits in between. For example, 'F121A' (the code for an initial consultation with an orthodontist). Material and technical costs associated with this orthodontic care are indicated by an asterisk (*) appended to the end of the treatment code(s).

Who to get a treatment proposal from
- Dentist

Where to go for this healthcare
- Dentist.
  The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Orthodontist.
  The orthodontist is a dental specialist listed on the specialist register for odontomaxillary surgery administered by the Royal Dutch Dental Organisation ('Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde').

What is not reimbursed
- Brace repair or replacement (code F811A*, F811B* or F811C*)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Oral care in the event of an accident (clause D.8.6.)

Insured healthcare
- Oral care following an accident
  The healthcare includes oral care (crowns, bridges, inlays, dentures, implants and other oral care) in case of accident care.

Your reimbursement
- Reimbursement of 20.000 euros maximum, per accident, 0 for oral care in the event of an accident.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have had an accident.
    See the definition of Accident.

Terms and conditions
- The healthcare is needed as a direct result of an accident
  The healthcare is required based on the standards and norms that apply to the profession of the relevant healthcare providers.
- The healthcare is not urgent
  Healthcare that takes place as a direct result of an accident and that is not urgent.
- The healthcare is necessary to restore your teeth to the status immediately prior to the accident
  If full recovery is not possible, we will reimburse healthcare that comes as close as possible to achieving recovery in line with the latest practical and theoretical standards.
- You were insured with us for this accident care at the time of the accident and the treatment
  As soon as possible after the accident, you or the healthcare provider must send us a statement informing us that an accident has occurred and on what date. This statement must also specify that the healthcare is required as a direct result of this accident. We need to have this statement before the treatment starts. If you have a police report showing the date and the circumstances of the accident, you must also send that to us.
- The treatment was completed within 2 years of the accident
  Unless it is necessary to delay the treatment or final part of the treatment because the teeth are not yet fully formed. Our consultant dentist will assess whether the teeth are fully formed or whether the treatment is of a temporary nature.
- The healthcare is claimed on the basis of the dental rates decision (‘tariefbeschikking tandheelkundige zorg’) compiled by the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa)
- If you have multiple insurance policies that reimburse oral care in the event of accidents, you will receive the highest reimbursement once. If the reimbursement under both insurance policies is the same, you will receive your reimbursement from one of those polices.

Who to get a treatment proposal from
- Dentist

Do you need approval?
- You need permission from us before starting the treatment and within 3 months following the accident

- The request for permission must be supported by a written final or provisional treatment plan with accompanying budget from your dentist or dental surgeon
  This has been drawn up in accordance with the Dutch Dental Association's emergency care guidelines ('KNMT praktijkrichtlijn opvang spoedgevallen'). These guidelines can be found on our website.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Dentist.
  The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Prosthodontist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').
- Healthcare provider who is affiliated with a centre for oral care
- Healthcare provider affiliated with a facility for youth dental care

What is not reimbursed
- Orthodontic care (treatment code F)
- Oral care that (by its nature) is covered under your general insurance policy and/or for which you need our approval
  This concerns, in any case, the following performance codes: - A20: treatment under general anaesthetic or sedation (e.g. nitrous oxide); - X611: treatment under intravenous sedation; - X631: treatment under general anaesthetic; - B10 and B11: light sedation (nitrous oxide sedation). Sedation involves reducing a patient's consciousness for the purpose of making a medical procedure or surgery more comfortable;- A30: preparatory treatment under general anaesthetic; - U05*, U06, X731* and X831*: time rates for supervision of patients who are difficult to treat. This concerns treatment within the scope of oral care for special healthcare groups; - X21: taking a panoramic dental X-ray (OPT) for insured persons under the age of 18; - H36, H37*, H38* and H39: insertion of autografts (autologous implants) for insured persons under the age of 18.
- Mandibular repositioning device (MRD)
  Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- If a treatment needs assessment was carried out before the accident and it was established that this oral care was required, or if you delayed getting the required oral care prior to the accident
- Treatments involving dental care in exceptional circumstances or dental surgery
  These are covered under the general insurance policy. See the 'Specialist medical healthcare' and 'Oral care' clauses.
- External whitening (code E97)
- Myofunctional appliance (code G74*) or a consultation on myofunctional therapy (code G76*)
  e.g. pre-orthodontic trainers.
- Treatment of white spots (codes M80* and M81*)
- Healthcare needed due to lack of maintenance of or care for your teeth
- Oral care required after consuming food or drink
- Healthcare for teeth that were already missing at the time of the accident
- Urgent oral care
- Healthcare received outside your country of residence
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001)
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002)
- External whitening per jaw (code K003)
- Incomplete cosmetic dentistry (K004)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Prevention

What you are insured for under your additional insurance package

Flu jab (clause D.2.2.i.)

Insured healthcare
- Flu jab
  Preventive influenza vaccination (the 'flu jab').

Your reimbursement
- Reimbursement of 1 time(s) maximum, per year, 0 for flu jab.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- One of the healthcare providers mentioned supplies the vaccine for the preventive vaccination. A doctor administers the vaccination or takes on responsibility for it.

Where to go for this healthcare
- Pharmacy.
- 'GGD' (regional health authority).
- Supplier contracted for this healthcare.

What is not reimbursed
- Vaccinations in accordance with the Dutch Public Health (Preventive Measures) Act ('Wet collectieve preventie volksgezondheid', Wcpv) or a national immunisation programme

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Prevention for travel abroad (clause D.2.3.e.)

Insured healthcare
- Preventive vaccinations, preventive tablets, blood tests for hepatitis B and a Mantoux test to screen for possible tuberculosis
  This concerns the following healthcare: - supply of the vaccine and/or medicines; - the injection materials; - administration by means of one or more injections; - the associated registration/administration (such as a vaccination booklet); - any additional diagnostic tests (such as a blood test) required to determine which vaccine to use; - the invoiced consultation.

Your reimbursement
- Reimbursement of 250 euros maximum, per year, 0 for prevention for travel abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You travel to foreign countries with a heightened risk of infectious diseases and parasitic conditions.

Terms and conditions
- You are prescribed the tablets for a maximum period of 6 months

- Our preferred medicine policy may apply to your medicine
  More information on preferred medicines can be found in the clause ‘Medicines listed in the Medicines Reimbursement System (GVS)’.
- The vaccines for the preventive vaccinations are supplied by a pharmacy, a ‘GGD’ regional health authority or a supplier recognised by us
  You can find a recognised supplier on our website, or we can provide a list on request.
- You have the Mantoux test carried out before the start of your trip
  We will reimburse a Mantoux test after your trip based on the ‘General practitioner care with a focus on tuberculosis and infectious diseases’ clause.

Where to go for this healthcare
- ‘GGD’ regional healthcare authority or other healthcare facility affiliated with the Dutch national coordination centre for travel advice (‘Landelijk Coördinatiecentrum Reizigersadvisering’, LCR)
- General practitioner who is registered with the body of doctors with special qualifications (‘College voor Huisartsen met Bijzondere Bekwaamheden’) or who is affiliated with the Dutch national coordination centre for travel advice (‘Landelijk Coördinatiecentrum Reizigersadvisering’, LCR).
  The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home).

What is not reimbursed
- Vaccinations in accordance with the Dutch Public Health (Preventive Measures) Act (‘Wet collectieve preventie volksgezondheid’, Wcpv) or a national immunisation programme
- Additional costs for the use of a clinic for people with a needle phobia

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Cancer/breast cancer consultation and menopause, PMS consultation or eHealth programme (clause D.2.5.a. / D.2.5.c.)

Insured healthcare
- Consultation aimed at the menopause or PMS (premenstrual syndrome, menstrual complaints)
- eHealth programme aimed at the menopause or PMS (premenstrual syndrome, menstrual complaints)

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for cancer/breast cancer consultation and menopause, PMS consultation or eHealth programme.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Where to go for this healthcare
- Menopause or PMS consultant affiliated with Care for Women or the Dutch association for specialist menopause nurses (‘Vereniging Verpleegkundig Overgangs Consulenten’, VVOC).
- Facility specialising in menopause consultations.
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare
- Healthcare provider with whom we have made agreements about this.
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed
- We do not reimburse preconception care (relating to a desire to have children) under this clause. For this, see ‘General practitioner care with a focus on advice, examination and supervision’

- We do not reimburse preconception care (relating to a desire to have children) under this clause. For this, see ‘General practitioner care with a focus on advice, examination and supervision’

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Sports medicine-related advice (clause D.2.6.)

Insured healthcare
- Sports medicine-related advice
  Sports examinations, sports medicine-related examinations or diving medical examinations.

Your reimbursement
- Reimbursement of 150 euros maximum, per year, 0 for sports medicine-related advice.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- If you have multiple insurance policies that reimburse this healthcare, you will receive the highest reimbursement once. If the reimbursement under both insurance policies is the same, you will receive your reimbursement from one of those polices.
  If you have taken out two or more insurance policies with us, each of which reimburses costs for oral care in the event of accidents, costs will only be reimbursed under the policy with the highest reimbursement for accident care. If both insurance policies offer the same level of reimbursement for these costs, the costs will be reimbursed through only one of these insurance policies.

Where to go for this healthcare
- Sports doctor.
  For a sports examination or sports medicine-related advice, you go to a doctor listed as a sports doctor on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS) in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG). The doctor works at a sports medicine-related advice centre or sports medicine-related facility certified by the Foundation for the Certification of Actors in Sports Healthcare (‘Stichting Certificering Actoren in de Sportgezondheidszorg’, SCAS).
- Doctor for a sports medicine-related diving examination.
  For a sports medicine-related diving examination, the healthcare provider is a doctor who is certified at least as a Medical Examiner of Divers (MED), level 1 with the European College of Baromedicine (ECB). Further information is available at www.duikgeneeskunde.nl (in Dutch).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Dietary advice (clause D.2.7.)

Insured healthcare
- Dietary advice consists of advice and support for weight control

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for dietary advice.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:

    ○ You are healthy and overweight (BMI between 25 and 30). Or by exception, are obese (BMI above 30).

Where to go for this healthcare
- Weight management consultant.
  Qualified and affiliated with the Dutch association of weight management consultants (‘Beroepsvereniging Gewichtsconsulenten Nederland’, BGN).
- Dietician.
  Your healthcare provider is a dietician with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Online ‘First aid for sports injuries’ course (clause D.2.8.)

Insured healthcare
- Online ‘First aid for sports injuries’ course

Your reimbursement
- Reimbursement of 1 course maximum, per year, 0 for online ‘First aid for sports injuries’ course.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Where to go for this healthcare
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Accommodation/admission

What you are insured for under your additional insurance package

Therapeutic camp (clause D.13.1.)

Insured healthcare
- Participation in and stay at a therapeutic camp

Your reimbursement
- You are younger than 18: reimbursement of 200 euros maximum, 0 for therapeutic camp.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- We use the commencement date of the camp to determine the reimbursement

Where to go for this healthcare
- The camp is organised by a facility or association we have recognised.
  Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Accommodation costs (clause D.13.2.a.)

Insured healthcare
- The accommodation costs of an overnight stay for you or your guest(s) in one room in a guest house

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for accommodation costs.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- We reimburse the overnight stay of you or a guest in a guest house if you undergo outpatient treatment several times in a short period or have been admitted to a facility for specialist medical healthcare
- We reimburse the accommodation costs through the additional insurance package of the patient who is being treated or admitted
  The guest does not have to be insured with us.
- If there are no rooms available at the guest house, you or the guest(s) may spend the night in a hotel or B&B in the area. We base the reimbursement on the costs that would have been incurred at the guest house if there had been room

Where to go for this healthcare
- Guest house.
  A non-commercial establishment affiliated with: - a hospital (facility for specialist medical healthcare) in the Netherlands or your country of residence; or - a hospital (facility for specialist medical healthcare) outside your country of residence with which we have concluded a healthcare agreement.

What is not reimbursed
- Costs that are reimbursed under the Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo) or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) as a result of a collaboration with home care, or costs that come under a Personal Care Budget (‘Persoonsgebonden Budget’, PGB)
- Accommodation costs that you incur due to admission to or treatment at the Dutch Asthma Centre in Davos (NAD)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Recuperation home (clause D.13.6.)

Insured healthcare
- Recuperation home
  Staying in a recuperation home or healthcare hotel to recover from a physical condition.

Your reimbursement
- Reimbursement of 500 euros maximum, per year, 0 for recuperation home.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- We use the date of admission to the recuperation home to determine the reimbursement
- If a new year commences while you are in hospital, we will only pay out the annual amount for that admission once

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Recuperation home or healthcare hotel recognised by us

What is not reimbursed
- We do not reimburse healthcare in a recuperation home if you are already entitled to the same or similar healthcare under the general insurance policy

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Personal contribution for a stay in a hospice (clause D.13.7.)

Insured healthcare
- Personal contribution for a stay in a hospice

Your reimbursement
- Reimbursement of 500 euros maximum, per year, €30 per day, 0 for personal contribution for a stay in a hospice.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The personal care and nursing takes place in a hospice.
  where volunteers only provide low-complex care. This is also known as a ‘bijna-thuis-huis’ in Dutch.

What is not reimbursed
- Invoices for the personal contributions for domestic help and nursing care you receive on the basis of the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) by the Dutch Central Administration Office (CAK), or invoiced to you on the basis of the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Childcare in the case of admission of a parent (clause D.13.8.c.)

Insured healthcare
- Childcare in the case of an admission

Your reimbursement
- From the 10th day of admission: reimbursement of 200 euros maximum, per year, per family, 0 for childcare in the case of admission of a parent.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- Childcare relates to your child/children in your family up to the age of 14 years
- The parent who is the primary caregiver has been admitted to a facility for specialist medical healthcare
- The parent who is the primary caregiver has an additional insurance package with us that provides reimbursement for childcare

- The childcare falls outside of the hours that were already arranged for childcare prior to the primary-caregiver parent being admitted to a facility for specialist medical healthcare

Where to go for this healthcare
- Registered childcare centre or registered childminder.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport

What you are insured for under your additional insurance package

Travel costs for parents when child has been admitted (clause D.12.2.)

Insured healthcare
- Travel costs to a facility for specialist medical healthcare if your child has been admitted

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for the healthcare above combined:
  - Reimbursement of 19 euros maximum, per kilometre, 0 for travel costs of parents for when child has been admitted (travel by car).
  - Reimbursement of 100 percent 0 for travel costs of parents for when child has been admitted (by public transport, 2nd class).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for travel costs of parents for when child has been admitted (travel by car) (clause D.12.2.b.)

Terms and conditions
- The admission is medically necessary
- The admission is in the country of residence. If your country of residence is the Netherlands, the admission can also be in Belgium or Germany
  To qualify for reimbursement of travel costs during admission in Belgium or Germany, approval is required for the admission in that country.
- The admission lasts a maximum of 365 consecutive days and is not day treatment
- We use Routenet for calculating the distance of the journey if you travel by car
  We use the most recent version of this route planner. We calculate the fastest route from the legal home address of the person who is admitted to the address of the facility. We use the usual method of rounding off.
- Your child insured with us and under the age of 18
- Insured for travel costs for a visitor and accommodation costs
  You must choose for which costs you want to be reimbursed. We regard the first invoice for travel costs or accommodation costs that you submit to be your choice.

What is not reimbursed
- Travel costs for a visit to the Dutch Asthma Centre in Davos (NAD)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for travel costs of parents for when child has been admitted (by public transport, 2nd class) (clause D.12.2.b.)

Terms and conditions
- The admission is medically necessary
- The admission is in the country of residence. If your country of residence is the Netherlands, the admission can also be in Belgium or Germany
  To qualify for reimbursement of travel costs during admission in Belgium or Germany, approval is required for the admission in that country.
- The admission lasts a maximum of 365 consecutive days and is not day treatment
- We use Routenet for calculating the distance of the journey if you travel by car
  We use the most recent version of this route planner. We calculate the fastest route from the legal home address of the person who is admitted to the address of the facility. We use the usual method of rounding off.
- Your child insured with us and under the age of 18
- Insured for travel costs for a visitor and accommodation costs
  You must choose for which costs you want to be reimbursed. We regard the first invoice for travel costs or accommodation costs that you submit to be your choice.

What is not reimbursed
- Travel costs for a visit to the Dutch Asthma Centre in Davos (NAD)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Statutory personal contribution for patient transport: transport by car, taxi, public transport (2nd class) or other transport (clause D.12.1.a.)

Insured healthcare
- Patient transport by car
  This type of healthcare includes: - patient transport by car over a distance of no more than 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases) or a guide/assistance dog.
- Patient transport by taxi
  This type of healthcare includes: - patient transport by taxi over a distance of no more than 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases), or a guide/assistance dog.
- Patient transport by public transport
  This type of healthcare includes: - patient transport by public transport (2nd class) over a distance of no more than 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases), or a guide/assistance dog.
- Patient transport by another means of transport
  Patient transport by another means of transport over a maximum distance of 200 kilometres for a one-way journey if transport by car, public transport (in the lowest class) or taxi is not possible.

Your reimbursement
- Reimbursement of 100 percent 0 for statutory personal contribution for patient transport: transport by car, taxi, public transport (2nd class) or other transport.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Additional allowance per kilometre when using a car (clause D.12.1.b.)

Insured healthcare
- Additional allowance per kilometre for transport by car

Your reimbursement
- Reimbursement of 19 euros maximum, per kilometre, on top of the reimbursement under the general insurance policy, we first reimburse under the general insurance policy, and then under your additional insurance package, 0 for additional allowance per kilometre when using a car.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- We use Routenet for calculating the distance of the journey
  We use the most recent version of this route planner. We calculate the fastest route from postcode to postcode. We use the usual method of rounding off.
- Patient transport from your home address or temporary place of residence (not a hospital) to the location where you will be treated, and back
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
- Costs of patient transport to a place further away
  If you go to a place other than the nearest place for specialist medical healthcare, even though it was not medically necessary at the time.
- Transport that can be reimbursed under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) or Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo)
- Costs of patient transport between your country of residence and another country

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport by taxi to specialist medical healthcare (clause D.12.1.c.)

Insured healthcare
- Transport by taxi from your home address to a facility for specialist medical healthcare and back

Your reimbursement
- Reimbursement of 100 percent 0 for transport by taxi to specialist medical healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- Public transport is medically irresponsible
  The attending medical specialist or nursing specialist believes that the use of public transport would not be responsible for medical reasons.
- The patient transport is necessary for specialist medical healthcare for which you are insured under your general insurance policy or an additional insurance package
- This relates to transport within the Netherlands or your country of residence
- No reimbursement of the costs of transport is given under the general insurance policy
- Patient transport from your home address or temporary place of residence (not a hospital) to the location where you will be treated, and back

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Recognised licensed taxi operator.
  This must be a recognised, licensed taxi operator (with the 'TX Keur' quality mark for taxis).

What is not reimbursed
- Costs of patient transport to a place further away
  If you go to a place other than the nearest place for specialist medical healthcare, even though it was not medically necessary at the time.
- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo)
- Costs of patient transport between your country of residence and another country

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport by car to specialist medical healthcare (clause D.12.1.d.), public transport to specialist medical healthcare (clause D.12.1.d.)

Insured healthcare
- Transport by car from your home address to a facility for specialist medical healthcare and back
- Transport by public transport (lowest class) from your home address to a facility for specialist medical healthcare and back

Your reimbursement
- You can choose from one of the following reimbursements:
  1. Reimbursement of 19 euros maximum, per kilometre, 0 for transport by car to specialist medical healthcare.
  2. Reimbursement of 100 percent 0 for public transport to specialist medical healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions for transport by car to specialist medical healthcare (clause D.12.1.d.)

Terms and conditions
- The patient transport is related to medical care for which you are insured under your general insurance policy or an additional insurance package
- No reimbursement of the costs of transport is given under the general insurance policy
- This relates to transport within the Netherlands or your country of residence
- We use Routenet for calculating the distance of the journey
  We use the most recent version of this route planner. We calculate the fastest route from postcode to postcode. We use the usual method of rounding off.

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where the treatment takes place
- From home address or place of residence to place of treatment
  You travel using patient transport from your home address or temporary place of residence (not a hospital) to the location where you will be treated, and back.

What is not reimbursed
- Costs of patient transport to a place further away
  If you go to a place other than the nearest place for specialist medical healthcare, even though it was not medically necessary at the time.
- Transport that can be reimbursed under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) or Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo)
- Costs of patient transport between your country of residence and another country

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for public transport to specialist medical healthcare (clause D.12.1.d.)

Terms and conditions
- The patient transport is related to medical care for which you are insured under your general insurance policy or an additional insurance package
- This relates to transport within the Netherlands or your country of residence
- No reimbursement of the costs of transport is given under the general insurance policy

Do you need approval?
- You need permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where the treatment takes place
- From home address or place of residence to place of treatment
  You travel using patient transport from your home address or temporary place of residence (not a hospital) to the location where you will be treated, and back.

What is not reimbursed
- Costs of patient transport to a place further away
  If you go to a place other than the nearest place for specialist medical healthcare, even though it was not medically necessary at the time.
- Transport that can be reimbursed under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) or Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo)
- Costs of patient transport between your country of residence and another country

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Foot care

What you are insured for under your additional insurance package

General foot care (chiropody and podiatry) (clause D.15.1.)

Insured healthcare
- General foot care (chiropody and podiatry)
  This concerns advice and treatment in case of general foot-related problems.

Your reimbursement
- Reimbursement of 100 euros maximum, per year, 0 for general foot care (chiropody and podiatry).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have foot problems.

Where to go for this healthcare
- Podiatrist.
  A podiatrist with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Registered chiropodist
  The healthcare provider who is listed as a registered chiropodist on the quality register of Kabiz (Quality Registration and Accreditation of Healthcare Professionals) or a register designated by us and who has a practice as a registered chiropodist.

What is not reimbursed
- Orthotic insoles
- Medical aids for foot care
- Personal foot care such as the removal of calluses or general toenail care

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Zwangerschap en baby

What you are insured for under your additional insurance package

Childbirth course (clause D.19.2.)

Insured healthcare
- Childbirth course
  The childbirth course is a health course for childbirth preparation.

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for childbirth course.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You are pregnant.

Terms and conditions
- You attend the course during your pregnancy and up to a maximum of six months after giving birth
- You provide us with proof of participation upon completion of the childbirth course
- We use the commencement date of the childbirth course to determine the reimbursement

Where to go for this healthcare
- Healthcare provider who offers a professional or commercial childbirth course
  - the healthcare provider/organisation is registered with the Chamber of Commerce as a professional or an organisation, respectively, that offers and provides childbirth courses; and the healthcare provider/organisation has articles of association and a website where it can be seen that the courses offered are aimed at childbirth preparation.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Personal contribution for outpatient childbirth (clause D.20.1.)

Insured healthcare
- Statutory personal contribution of personal contribution for outpatient childbirth or childbirth in a birth centre
  This concerns costs you have to pay yourself because these are higher than the statutory maximum reimbursement under your general insurance.

Your reimbursement
- Reimbursement of 200 euros maximum, 0 for personal contribution for outpatient childbirth.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory maximum reimbursement

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

TENS machine (clause D.20.2.)

Insured healthcare
- Loan of a TENS (Transcutaneous Electrical Nerve Stimulation) machine

Your reimbursement
- Reimbursement of 6 weeks 0 for TENS machine.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You are in pain during childbirth.

Terms and conditions
- You (the biological mother) are insured with us for this healthcare
- You must take good care of the medical aid you own or have on loan.
  You must, in any case, observe the guidelines or warranty conditions of the manufacturer or healthcare provider. As a result, replacement within the period of use will not be necessary. You must pay for damage (repair or replacement costs) caused by incorrect use or negligence on your part. If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.
- You are given this medical aid on loan

Where to go for this healthcare
- You are free to choose your own healthcare provider

What is not reimbursed
- Costs of normal use of the medical aid (such as energy consumption and/or batteries) and electrodes

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Breastfeeding-related advice (lactation consultant healthcare) (clause D.21.1.)

Insured healthcare
- Breastfeeding-related advice, help and information (lactation consultant healthcare)
  This healthcare is provided by a lactation consultant and may also be provided online or over the telephone.

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for breastfeeding-related advice (lactation consultant healthcare).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- You (the biological mother) are insured with us for this healthcare

Where to go for this healthcare
- Lactation consultant.
  Is a member of a professional group for lactation consultants and uses the Lactation Consultant Referral Protocol (‘Verwijzingsprotocol Lactatiekundige’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Statutory personal contribution for obstetric care (clause D.21.2.)

Insured healthcare
- Statutory personal contribution of obstetric care following childbirth at your home
- Statutory personal contribution of obstetric care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre
  There were no medical grounds relating to the childbirth.

Your reimbursement
- Reimbursement of 200 euros maximum, per year, 0 for statutory personal contribution for obstetric care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Terms and conditions
- The healthcare is insured under the general insurance policy and is subject to a statutory personal contribution

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Aftercare following care in an incubator (clause D.21.5.)

Insured healthcare
- Aftercare following care in an incubator (postponed obstetric care)

Your reimbursement
- Reimbursement of 15 hours maximum, 0 for aftercare following care in an incubator.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - Immediately after the birth, your child was in an incubator for 5 days or in hospital for 8 days. The admission to a facility for specialist medical healthcare was on medical grounds.

Terms and conditions
- The obstetric care is indicated on the basis of the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’)
- You are insured with us. Your child(ren) do not need to be insured with us

Where to go for this healthcare
- Birth centre
  A facility for first-line midwifery care (also known as a birth clinic or childbirth centre) in a hospital. This is a place where you can give birth and, if necessary, stay for a period of time afterwards.
- Birth clinic
  A facility where you can stay after giving birth and receive obstetric care. You cannot give birth in a birth clinic.
- Obstetric nurse
  The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - works in accordance with the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Obstetric care after hospitalisation (clause D.21.6.)

Insured healthcare
- Obstetric care after the mother and child have spent a number of days in the hospital

Your reimbursement
- Reimbursement of 15 hours maximum, 0 for obstetric care after hospitalisation.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You are allowed to return home, after spending 14 days or more in the hospital immediately following childbirth.

Terms and conditions
- The number of hours of obstetric care is indicated on the basis of the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’)

Where to go for this healthcare
- Birth centre
  A facility for first-line midwifery care (also known as a birth clinic or childbirth centre) in a hospital. This is a place where you can give birth and, if necessary, stay for a period of time afterwards.
- Birth clinic
  A facility where you can stay after giving birth and receive obstetric care. You cannot give birth in a birth clinic.

- Obstetric nurse
  The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - works in accordance with the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’).

What is not reimbursed
- Costs for obstetric care for which you are reimbursed under the general insurance policy
  Or the costs for the days you were nursed in the hospital, for which you are reimbursed under the general insurance policy.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Obstetric care or instruction after adoption (clause D.21.8.)

Insured healthcare
- Obstetric care or instruction after adoption

Your reimbursement
- Reimbursement of 3 days maximum, maximum of 3 hours a day, 0 for obstetric care or instruction after adoption.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have adopted a child. At the time of adoption, the child was no more than 6 months old.

Terms and conditions
- At least one of the adoptive parents is insured with us for this healthcare
- The number of hours of obstetric care is indicated on the basis of the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’)

Where to go for this healthcare
- Birth centre
  A facility for first-line midwifery care (also known as a birth clinic or childbirth centre) in a hospital. This is a place where you can give birth and, if necessary, stay for a period of time afterwards.
- Birth clinic
  A facility where you can stay after giving birth and receive obstetric care. You cannot give birth in a birth clinic.
- Obstetric nurse
  The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - works in accordance with the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Appendix Definitions

Additional insurance package
An agreement that you can take out in addition to your general insurance policy for the reimbursement of healthcare and healthcare costs. We determine the content and scope of your additional insurance package. We have it laid down in your terms and conditions of insurance.

Agreed rate
The (average) rate we agree in contracts with healthcare providers for certain types of healthcare. These rates are available on our website.

Pharmacy/online pharmacy
This is a pharmacist at a physical or online pharmacy with a permit to dispense medicines under the terms of the Dutch Medicines Act (‘Geneesmiddelenwet’). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence. Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit.

Dispensing doctor or general practitioner
This is a doctor or general practitioner with a permit to dispense medicines under the terms of the Dutch Medicines Act (‘Geneesmiddelenwet’). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.

AGB code
This code is a unique administrative code assigned to healthcare providers in the Netherlands, based on which Vektis identifies the healthcare provider. Vektis is a national register containing all information necessary to submit claims for the healthcare, to purchase and contract the healthcare and to help guide insured persons to the right healthcare.

Doctor for a sports medicine-related diving examination
A doctor who is certified as a level 1 Medical Examiner of Divers (MED) with the European College of Baromedicine (ECB). For more information, go to the website of the Dutch Association for Diving Medicine (‘Nederlandse Vereniging voor Duikgeneeskunde’)

Doctor for the mentally disabled
This is a doctor listed as a doctor for the mentally disabled on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in a hospital or independent treatment centre (ZBC).

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

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

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

Pelvic physiotherapist
Pelvic physiotherapy is provided by a pelvic physiotherapist. This is a physiotherapist listed as a pelvic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Abroad
Any country other than the country where you live.

CAK
The Dutch Central Administration Office (‘Centraal Administratie Kantoor’, CAK), as defined in Article 6.1.1(1) of the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz).

Central healthcare provider for the combined lifestyle intervention programme
This is a youth healthcare nurse with a degree from a university of applied sciences, who is registered in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG), and who is trained as a central healthcare provider. The training has been provided through the Netherlands School of Public & Occupational Health (NSPOH) or the Your Coach Next Door (YCND) Foundation.

Centre for dental care in exceptional circumstances
A centre providing dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

Centre for oral care
A comprehensive dental practice that not only does routine check-ups and fillings but also offers specialist treatments such as implants, dental surgery, orthodontic care, periodontology and oral hygiene. This kind of dental practice offers comprehensive dental care.

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

Day treatment
Healthcare in a department set up for day nursing in a facility for specialist medical healthcare (such as a hospital or independent treatment centre). This may also involve a medical examination or treatment in a rehabilitation facility. The healthcare is generally foreseeable and lasts for a number of hours. The patient is not admitted.

DBC healthcare product

A Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC healthcare product or DBC) is a code that describes the entire process of treatment under specialist medical healthcare. A DBC includes all the costs incurred by the healthcare provider to give you the right healthcare. The rate for a DBC is based on an average of the costs incurred for a particular course of treatment. The start date of a DBC is the date of first contact with the healthcare provider and determines the reimbursement. We settle the bill on the DBC start date. If the commencement date for a DBC is outside of the term of your insurance, none of the costs associated with that DBC are covered. A hospital can also charge for treatments that are not part of a DBC but are categorised under other healthcare products (‘overige zorgproducten’, OZP). These are, for example, single treatments that are not associated with a course of treatment, such as: - preliminary examinations, follow-up examinations or laboratory tests; - dental surgery; - certain types of expensive healthcare (e.g. healthcare in intensive care, expensive medicines and blood products).

Diagnostics

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

Dietician

Your healthcare provider is a dietician with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Sonographer

An individual listed in the register administered by the Dutch Professional Association of Sonographers (‘Beroepsvereniging Echoscopisten Nederland’, BEN). The healthcare takes place in an ultrasound centre or antenatal screening centre.

Occupational therapist

Your healthcare provider is an occupational therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

EU/EEA member state

The EU (European Union) member states are: Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek part), Czech Republic, Denmark, Estonia, Finland, France (including French Guyana, Guadeloupe, Martinique, Réunion, Saint Barthélemy and Saint Martin), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal (including the Azores and Madeira), Romania, Slovakia, Slovenia, Spain (including the Canary Islands, Ceuta and Melilla) and Sweden. Under international treaties, Switzerland is considered to be on a par with the above. The following are not part of the EU (this list is not exhaustive): Andorra, the Channel Islands, the Isle of Man, Monaco, San Marino and Vatican City. The EEA (European Economic Area) states are: the aforementioned EU states, Iceland, Liechtenstein and Norway. Explanation: On 31 January 2020, the United Kingdom, including Gibraltar, left the European Union.

Forensic doctor

A doctor on the forensic medicine register administered by the Royal Dutch Medical Association.

Fraud

Fraud is when you deliberately do or fail to do something with a view to misleading us, with the intention of causing us a loss or giving yourself or someone else an undue advantage.

Physiotherapist

Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

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

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

Geriatric physiotherapist
This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Weight management consultant
Qualified and affiliated with the Dutch association of weight management consultants (‘Beroepsvereniging Gewichtsconsulenten Nederland’, BGN).

Healthcare psychologist
Healthcare psychologist (‘GZ-psycholoog’) is a legally protected title in the Netherlands; this title may only be used by someone registered as such under the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG). This means not every psychologist working in healthcare is a ‘GZ-psycholoog’.

‘GGD’ regional healthcare authority doctor
A doctor listed as a doctor of public health (‘Arts maatschappij en gezondheid’), general infectious disease control (‘Arts infectiebestrijding’) or tuberculosis control (‘Arts tuberculosebestrijding’) in the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS) and working at a ‘GGD’ regional healthcare authority.

Gynaecologist
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

Principal contractor
A principal contractor can be a healthcare group, health centre or podiatrist. They enter into contracts with several healthcare providers, which allows them to provide different forms of healthcare, such as general practitioner care, dietetics or foot care.

Skin therapist
The skin therapist is registered with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) at the start of the treatment.

General practitioner

A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). You can also receive the healthcare under the responsibility of a general practitioner.

General practitioner for quit smoking interventions

A general practitioner will provide the healthcare or take on responsibility for it. This is a doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). Furthermore, the general practitioner must be listed on the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) and have been trained to provide intensive counselling for those trying to quit smoking.

Drop-in centre for cancer patients and survivors

Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Facility for geriatric rehabilitation permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)

In this facility, an interdisciplinary team works intensively together on your rehabilitation goals under the responsibility of the geriatric specialist.

Youth dental care facility

A specialist organisation with oral care professionals with specific expertise and skills, and facilities for consultation, diagnosis and treatment for patients under the age of 18.

Post-trauma care facility

The facility specialises in post-trauma psychosocial assistance and has been recognised or contracted by us.

Year

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

Dental surgeon

A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The dental surgeon is responsible for the healthcare provided by other authorised healthcare providers to whom he has delegated tasks.

Physiotherapist specialising in children

This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Child lifestyle coach for combined lifestyle intervention

This coach must hold a degree from higher professional education and be registered with the professional association of lifestyle coaches in the Netherlands (‘Beroepsvereniging Leefstijlcoaches Nederland’, BLCN) and have completed additional training as a child lifestyle coach provided by the Your Coach Next Door (YCND) foundation.

Cesar or Mensendieck exercise therapist specialising in children
Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Birth clinic
A facility where you can stay after giving birth and receive obstetric care. You cannot give birth in a birth clinic.

Obstetric nurse
The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - works in accordance with the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’).

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

Lactation consultant
Is a member of a professional group for lactation consultants and uses the Lactation Consultant Referral Protocol (‘Verwijzingsprotocol Lactatiekundige’).

Lifestyle coach
The healthcare is provided by a healthcare provider listed as a lifestyle coach on the Quality Register and Accreditation of Healthcare Practitioners (‘Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg’, KABIZ), the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF)/Individual Register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR) or the Dutch Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’, KP). This lifestyle coach works in consultation with and provides feedback to the referring healthcare provider.

Guest house
A non-commercial establishment affiliated with: - a hospital (facility for specialist medical healthcare) in the Netherlands or your country of residence; or - a hospital (facility for specialist medical healthcare) outside your country of residence with which we have concluded a healthcare agreement.

Speech and language therapist
Your healthcare provider is a speech and language therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Month
A calendar month.

Manual therapist
This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Informal care organisation
Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Market rate applicable in the Netherlands
This is the rate that is reasonable and appropriate in the Dutch market for a given treatment. To determine this rate, we look at what amounts healthcare providers charge on average for that treatment. This means that we will not reimburse unreasonably high costs of treatment in full. See also Article 2.2.(2)(b) of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’).

(Medical) adviser
The doctor, pharmacist, dentist, physiotherapist or other expert who advises us. This includes advice on medical, pharmacotherapy-related, dental or physiotherapy-related healthcare or any other field of healthcare expertise.

Medical pedicurist
A medical pedicurist listed as such on the Quality Register for Pedicurists (‘Kwaliteitsregister Pedicure’) or the Register for Allied Health Professionals for Foot Care (‘Register Paramedische Voetzorg’).

Medical specialist
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

Quit smoking medical specialist
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism. Furthermore, the specialist must be listed on the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) and have been trained to provide intensive counselling for those trying to quit smoking.

Medical indication/grounds
The medical condition or illness that a doctor suspects or has diagnosed so that you can access certain healthcare.

Dental hygienist
The dental hygienist manages the practice at their own expense and on their own responsibility.

Oedema therapist
The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Cesar or Mensendieck exercise therapy
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Accident

A sudden, unexpected, involuntary and external event. This event results directly in bodily injury that can be detected objectively by a medical professional. This applies even if you did not and could not reasonably foresee the event. We consider an acute, serious illness to be equivalent to an accident when: - medical care is required immediately on medical grounds and cannot be postponed, or an illness or condition is life-threatening; and - the healthcare required is covered by the general insurance policy; and - based on objective medical standards, no recovery can be expected within the next six months.

Example of an accident

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

Admission

A period of nursing and treatment with an overnight stay in a department set up for nursing in a specialist medical healthcare facility (such as a hospital). The admission must be a medical necessity in terms of medical healthcare. However, this does not include a stay in an outpatient clinic, nor day care or urgent medical care, nor a stay in a facility for rehabilitation. Your general insurance policy covers admissions of up to 1095 (3 x 365) consecutive days. The following rules apply here: - if your admission is interrupted for less than 31 days, the number of days of the interruption do not count, but we will continue to count after the interruption to determine the total; - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning to determine the total; - if your admission is interrupted for weekend/holiday leave, the number of days of interruption counts towards the total number of days.

Orthodontist

The orthodontist is a dental specialist listed on the specialist register for odontomaxillary surgery administered by the Royal Dutch Dental Organisation (‘Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde’).

Podiatrist

A podiatrist with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Policy (document)

Proof of insurance.

Psychosomatic physiotherapist

This is a physiotherapist who is listed as a psychosomatic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Psychosomatic exercise therapist

Your healthcare provider is a psychosomatic exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Registered chiropodist
The healthcare provider who is listed as a registered chiropodist on the quality register of Kabiz (Quality Registration and Accreditation of Healthcare Professionals) or a register designated by us and who has a practice as a registered chiropodist.

Rehabilitation centre
A facility for specialist medical healthcare that specialises in interdisciplinary specialist medical rehabilitation, where at least two rehabilitation doctors work and that is permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza).

Cosmetologist
is registered in the SKIN register. On our website, under the relevant healthcare you can find any other registers we recognise over the course of the year. Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Written/in Writing
A physical or electronic means of conveying information, whereby the information can be understood, stored and reproduced. An electronic means of conveying information includes the internet and emails. Written communication includes by letter, email and through the ‘Mijn’ platform.

Quit smoking coach
The healthcare provider who provides the programme and is listed in the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) who has been trained to provide intensive counselling for those trying to quit smoking.

Geriatric specialist
A doctor listed as a geriatric specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare takes place in a hospital, independent treatment centre (ZBC), or at the medical specialist’s practice.

Urgent medical care
Unexpected and unforeseeable acute medical care that you receive in situations where, without immediate intervention, there is a risk of death or irreversible damage to health.

Sports doctor
A doctor listed as a sports doctor on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS) in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG). The doctor works at a sports medicine-related advice centre or sports medicine-related facility; this facility must have been accredited by the Dutch Association for Diving Medicine (‘Nederlandse Vereniging voor Duikgeneeskunde’, NVD).

Dentist
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG).

Prosthodontist
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

Rate
The amount of money for healthcare or the resources provided, which we take as the basis for reimbursement of that healthcare or those resources. We have different types of rates.

A therapist or doctor who is a member of a professional association for alternative treatment methods or psychosocial care that we recognise
The therapist or doctor must have completed a recognised basic medical studies course (‘MBK’) that meets the training, educational and organisational requirements of PLATO (‘Platform Opleiding, Onderwijs en Organisatie’). Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Home care organisation
An organisation that is able to provide the nursing and care of an insured person in the insured person’s own home.

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

Obstetrician
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians (‘Koninklijke Nederlandse Organisatie van Verloskundigen’, KNOV).

Referral
For certain types of healthcare, you must have a referral before a consultation or before the start of the healthcare. This referral is the advice from one healthcare provider to go to another healthcare provider for a consultation or for healthcare. In the terms and conditions, we list which healthcare provider must provide this referral under ‘referral’.

Insured person
The individual entitled to insured healthcare (and reimbursement thereof) in accordance with our terms and conditions of insurance. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using ‘you’ and ‘your’. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to ‘he’, ‘him’ and ‘his’, this also means ‘she’ and ‘her’ and ‘her’ respectively.

Insurance policy
An insurance agreement may consist of a general insurance policy with one or more additional insurance packages. If the insurance consists of a combination of 2 or more insurance agreements, the combination can contain no more than one general insurance policy.

Policyholder
The person who takes out insurance with us, must pay the premium and costs and is the only person who can change and cancel the insurance. The policy is in the name of the policyholder. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using ‘you’ and ‘your’. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to ‘he’, ‘him’ and ‘his’, this also means ‘she’ and ‘her’ and ‘her’ respectively.

Transplant centre that has been recognised by law

University medical centre authorised and recognised by law to perform organ transplants, operating under the Organ Donation Act (‘Wet op de orgaandonatie’) and governed by the Dutch Transplant Foundation (‘Nederlandse Transplantatie Stichting’, NTS).

Statutory personal contribution

Healthcare that is covered under your general insurance policy and in relation to which you must pay the costs in full or in part yourself. Personal contributions are set by law. A statutory personal contribution may be a fixed amount per treatment or a set percentage of the costs. A statutory personal contribution is not the same as a deductible. Statutory personal contributions and deductibles may apply side by side for the same insured healthcare. This may mean you will be charged both a statutory personal contribution and a deductible.

Statutory maximum rate

The maximum rate set by the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg). The rate used by a healthcare provider may be lower, but never higher.

Statutory fixed rate

The fixed rate set by the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg). The rate used by a healthcare provider must be exactly the same as this rate. We sometimes refer to these rates as ‘set-point rates’.

Hospital

A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza), meaning: - a general hospital; - a specialist hospital (hospital that provides healthcare for just one or a limited number of specialist fields, such as a burns unit or psychiatric hospital); - a university hospital. We do not mean an independent treatment centre (ZBC) in this case.

Independent treatment centre (ZBC)

A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza), but not a fully fledged hospital.

Healthcare provider

The Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg) defines a healthcare provider as: - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that provides healthcare as a professional or an organisation; - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that charges for healthcare. They do this on behalf of a (different) accredited healthcare provider who provides healthcare. - the natural person who provides insured healthcare not as a professional or an organisation. This concerns district nursing that you procure yourself using a Personal Care Budget (‘Persoonsgebonden Budget’, PGB). A healthcare provider provides healthcare or provides medicines or medical aids and possible associated services.

Healthcare provider within a healthcare group

- for healthcare in the case of asthma or cardiovascular risk management for increased vascular risk, the healthcare provider is affiliated with a contracted principal contractor; - for healthcare in the case of COPD, DM type II or cardiovascular risk management for cardiovascular disease, the healthcare provider must meet the standards set out in the policy rule of the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) on general practitioner care and multidisciplinary care (‘Huisartsenzorg en multidisciplinaire zorg’). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). Or at the location where the healthcare provider (affiliated with a principal contractor or working in a regional partnership with several healthcare providers of different disciplines) works.

Healthcare provider who offers a professional or commercial childbirth course

- the healthcare provider/organisation is registered with the Chamber of Commerce as a professional or an organisation, respectively, that offers and provides childbirth courses; and the healthcare provider/organisation has articles of association and a website where it can be seen that the courses offered are aimed at childbirth preparation.

Appendix General terms and conditions

A.1A. Additional definitions

Family members
Family members living at the same address and who make up a shared household. By this we mean: - adults who are each other's sole life partner; - children up to the age of 18 (including adopted children and foster children); - children aged 18 to 30 who are students (they do not have to be living at the same address as the policyholder); - a company or facility that has entered into a group agreement with us may also designate someone as a family member. A family member has their own policy or is co-insured on the policy of another family member.

Insurer
By insurer we mean an insurance company as defined in the Solvency II Directive that is authorised as a non-life insurer as defined in the Dutch Financial Supervision Act ('Wet op het financieel toezicht'). The insurance company to which these terms and conditions of insurance apply is the insurance company stated on the policy document in that capacity and is 'Onderlinge Waarborgmaatschappij CZ groep U.A.', registered in the Trade Register of the Chamber of Commerce under number 18028752. In these terms and conditions of insurance, we refer to the insurance company as 'we' and 'us'.

A.2. Insurance fundamentals

Policy document
The details of your insurance are stated on your policy document. We will send you a new policy document every year. You will also receive a new policy document following any changes to the details on your policy.

See also:
- Polisblad (definitions)

General basis of your insurance
We base your insurance on the following: - your registration form with the details that you have entered or that someone else has entered on your behalf; - information and statements provided by you or someone else on your behalf; - the insurance policies you have selected, which are specified on your policy document; - the terms and conditions of insurance for your insurance policy or policies; - protocols, regulations and appendices; - any associated or group agreements.

Deviation from terms and conditions of insurance
If the content of a group agreement differs from the general rules and regulations in these terms and conditions of insurance, the specific rules and regulations from the group agreement will apply. This means that those specific rules and regulations will take precedence over the general rules and regulations.

'Combinatie' additional insurance package
Your additional insurance package is a 'combinatie' policy. For one part of your policy, we reimburse costs incurred for certain healthcare covered under the policy (refund), while for the other part, you are insured for healthcare (in kind). If healthcare is covered on an in-kind basis, this will be stated in the reimbursement details. All other healthcare is covered on a refund basis.

Verification of your policy document
Please verify the details on your policy document. If any details are incorrect or missing, please let us know. You must do so within 30 days of receiving your policy document. If you do not contact us about this within this time, we will assume that these details are complete and accurate.

Applicable terms and conditions of insurance
Your policy document lists the insurance policies you have selected. You can view, download and save the terms and conditions of insurance for your policies on the secure ‘Mijn’ platform. As and when new terms and conditions of insurance are adopted, the old terms and conditions of insurance will cease to apply.

Translation of the terms and conditions of insurance
The terms and conditions of insurance are in Dutch, but we do have translations. In the event of differences between the content and interpretation of the Dutch-language terms and conditions of insurance and a translation, the Dutch-language terms and conditions of insurance will apply.

If terms and conditions of insurance deviate from the law
The terms and conditions of insurance and appendices for your policy comply with current legislation. If the legislation changes or an act is repealed or new legislation is passed and this results in a discrepancy between the terms and conditions of insurance and the laws and regulations, the most recent statutory provisions, explanatory memoranda or the interpretation thereof will always apply instead of the terms and conditions of insurance.

A.3. Content and scope of your insurance

General and specific requirements
The healthcare you receive has to meet certain general requirements. Specific requirements that do not apply to all types of healthcare are specified with the healthcare in question. The following general requirements apply to all types of healthcare: - it is healthcare that healthcare providers in the relevant profession provide in accordance with their standards and norms and deem accepted. What does this mean? Healthcare providers within a profession provide the same healthcare for certain complaints and diseases. The healthcare then falls within that profession’s area of expertise. It is insured healthcare specified in the terms and conditions of insurance for your policy. - the content and scope of healthcare is determined by the latest practical and theoretical standards, or by what is deemed to constitute responsible and adequate healthcare and services in the field in question. What does this mean? There must be sufficient evidence that the healthcare you receive is effective and safe, also in the long term. The evidence must be objective scientific medical evidence. Where necessary, we will also look at the specific situation. Objective scientific medical evidence will not be required for healthcare provided under your additional insurance package. The scope of the healthcare is specified in these terms and conditions of insurance. Exactly how much you will get reimbursed is also detailed in other communications. The maximum amount, number, or period covered is specified with the healthcare in question. We never reimburse more than the amount stated on the bill. - based on your medical indication, there are reasonable medical grounds for you being provided with the healthcare in question. And the healthcare must be effective and appropriate to your individual situation. What does this mean? The healthcare in question must be a logical option given your complaints or disease, meaning that there have to be medical grounds for the healthcare you receive. New technological developments do not constitute grounds to replace a medical aid before the end of the period of use. - the healthcare must not be unnecessarily costly and not be unnecessarily extensive or involve an unnecessarily large number of treatments. If the healthcare is too expensive or too extensive, it will not be effective healthcare in your situation and is therefore not covered by your general insurance policy, not even if you pay for part of it yourself.

Worldwide cover
Your insurance has worldwide cover.

A.4. Commencement and term of your insurance

Commencement of your insurance and address
You can register with us for a general insurance policy and one or more additional insurance packages. Your insurance will take effect on the date on which we receive your request, or on a later date if you ask for this. Your request must include your address as it is recorded in the Persons Database ('Basisregistratie Personen', BRP). If your address is not recorded in the Persons Database or the address recorded there is incorrect, your insurance will only take effect if there is nothing you can do about the fact that the address recorded in the Persons Database is not the address where you actually live. You will, however, be asked to provide a good explanation and reason that we can accept.

Commencement date and changes
Your insurance will take effect on the date we receive your registration. If you are still insured with another insurer, you can choose to have your policy take effect later. The commencement date must, however, be immediately after the end date of your previous policy. The commencement date of your insurance is stated on your policy document. You can state that you wish to change your insurance policy. We will then cancel the policy you have at the time, because you cannot have two policies at the same time. Your new policy will, therefore, take the place of your old policy.

Additional insurance package commencement date with retrospective effect
You can have your additional insurance package take effect on the day after your policy with another insurer ends, provided that we have received your request within 1 month of this date.

See also:
- Aanvullende verzekering (definitions)
- Maand (definitions)

Additional insurance package insurance term
The term of your additional insurance package is one full year. If your additional insurance package takes effect part-way through the year, your additional insurance package will run until 1 January and for one full year after that.

Annual renewal
We will renew your insurance for one year on 1 January each year. We will send you a reminder of that along with the changes for the new insurance year. You then have the opportunity to change or cancel your policy.

Insurance term upon addition of a family member
If you add a family member to your policy part-way through the year, the insurance term for that family member will be the same as yours.

'Meegroeiservice'
You can make changes to your additional insurance package once only during the course of the year. Changes are accepted only if necessitated by one of the following events: - pregnancy, - adoption, - divorce, - marriage or cohabitation, - job loss, - death, - change of address, - retirement, - (one of the) children moving out. You can request such a change by telephone. When requesting a change, the new additional insurance package will take effect on the first day of the following month. You can also have it take effect later than that.

A.5. You want to terminate your insurance

Withdrawal
Soon after you take out a new insurance policy you have the right to withdraw from the policy without incurring any charges. Withdrawing means that your insurance policy will be nullified and it will be as if it never existed, and this can also be with retrospective effect. There is no need to specify a reason for withdrawing. Withdrawal is subject to the following conditions: - you are the policyholder; - the withdrawal is in writing; - the insurance policy you are withdrawing is one you took out recently; - you are withdrawing the insurance within 14 days of the commencement date or within 14 days of receiving the policy from us. If you have already paid the premium and costs, these will be refunded within 30 days. If you already received reimbursements under the insurance, you must pay these back within 30 days of receiving notice from us to this effect.

Cancelling or making changes
You may cancel your insurance every year effective from 1 January. What do you (the policyholder) have to do for that? - you must cancel in writing; - we must have received the cancellation no later than 31 December. You may change your insurance every year effective from 1 January. What do you (the policyholder) have to do for that? - you must submit the change in writing; - we must have received your request for a change no later than 31 December. If we approve the change, your old insurance will then end at the same time on 1 January.

See also:
- Verzekeringnemer (definitions)

Cancelling on account of insurance with another health insurer
If we receive notice that you have registered for health insurance with another health insurer, we will assume that you are terminating your insurance policy or policies with us. Your insurance with us will end on 1 January after we have received the notice.

Change to the terms and conditions or premium for your additional insurance package
If we decide to change the terms and conditions or the premium for your additional insurance package, and this is to your disadvantage, we will notify you of what will change and what your options are. You will then be able to cancel your insurance or change it to another additional insurance package as of that same date. What do you (the policyholder) have to do for that? - you must submit your cancellation or change within 30 days of receiving our notice; - you must submit your cancellation or change in writing. Your change is subject to our approval. If we change your insurance, we will send you new insurance documents and new terms and conditions of insurance. In case of a change necessitated by a change in the law, you will not be able to cancel or change your insurance.

Different employer group scheme
If you (the policyholder) are insured under a group insurance policy through your employer, and you switch jobs to work for another employer with a different group insurance policy, you (the policyholder) will be entitled to cancel your group insurance with your old employer part-way through the year. Please let us know in writing. Be sure to do so within 30 days of joining your new employer. Possible situations - you have group insurance with us and can join a group insurance policy with a different health insurer through your new employer. You are therefore cancelling your old group insurance with us. This group insurance with us will then be terminated as of the day that you leave your former employer; or - you have group insurance with another health insurer and can join a group insurance policy with us through your new employer. This means you are cancelling your old group insurance with the other health insurer and taking out a new group insurance policy with us. If your new jobs starts on the 1st of the month, your new group insurance will take effect on that day. If not, your new group insurance will take effect on the 1st of the next month. Your old group insurance policy will also end on that day; or - you have group insurance with us and can join a different group insurance policy with us through your new employer. In this case, you need to ask us to switch from the old to the new group insurance policy. If your new jobs starts on the 1st of the month, your new group insurance will take effect on that day. If not, your new group insurance will take effect on the 1st of the next month. Your old group insurance policy will also end on that day.

See also:
- Maand (definitions)

Insurance for someone else
If you (the policyholder) previously took out insurance for someone else and this insured person has now taken out their own insurance, you (the policyholder) are entitled to cancel this initial insurance part-way through the year. End of the cancelled insurance end - if we receive your notice of cancellation no later than the day before the commencement date of the new insurance, the cancelled insurance will end on the commencement date of the new insurance. - if we receive your notice of cancellation on the commencement date of the new insurance or later, the cancelled insurance will end on the last day of the month when we receive the notice of cancellation.

See also:
- Verzekerde (definitions)
- Verzekeringnemer (definitions)

Instances when you cannot cancel or make changes
You will not be able to cancel or change your insurance: - if you have not paid the premium or costs to us on time; and - if we have sent you a reminder about this, requesting that you pay us within 14 days; and - if we have not (yet) suspended (temporarily stopped) the insurance cover; and - if we have not agreed to the cancellation within 14 days. This means that you will not be able to cancel or change your insurance: - at the end of a contract year; - following a change to the premium or premium base; - when switching between group insurance policies; - if you had taken out insurance for someone else and this person has taken out another policy for themselves. As soon as you have paid all the premiums and costs to us in full, you can make changes to your insurance again or cancel it as of 1 January of the next calendar year.

A.6. Cancellation of your insurance by us

Legally required cancellation
In the following situations, we will terminate your insurance: - if we are no longer allowed to offer or administer insurance policies. This would be the case if our licence as a non-life insurance company were to be modified or revoked. If that happens, we will notify you 2 months in advance; - if you die. We must be informed of this within 30 days of the date of death.

In the event of a criminal offence or violation
If you were involved in a criminal offence or violation (or attempts at such) in respect of us or a contracted healthcare provider, which includes deception, fraud, coercion, or threats, we will be authorised to: - terminate your insurance policy or policies with us with immediate effect; - suspend your claim for healthcare or reimbursement of the costs of healthcare; - claim back unjustified reimbursements you and healthcare providers have received; - charge you for the costs of the investigation; - report the matter to the police; for more about fraud, see clause A.26. Fraud

If we no longer offer or administer the insurance
Given that we may stop offering and administering a certain type of insurance that you have taken out, we may terminate the relevant policy or replace it with a different policy. We will notify you of this change.

In the event of payment arrears for your additional insurance package
We can suspend your additional insurance package(s) if you are in arrears of 2 months or more.

Upon the end of family participation in your insurance
If one of the insured persons is no longer a member of your family, or an insured person is no longer staying abroad temporarily but has moved there permanently, you (the policyholder) must let us know within 30 days. We will then terminate the insurance policy or policies for this insured person.

See also:
- Verzekerde (definitions)

End of your membership of the group scheme and your additional insurance package(s)
In the following situations, we will convert your group insurance into a personal insurance policy: - if the group agreement ends; - you (the policyholder) have taken out group insurance through a legal entity who represents your interests and - this person no longer represents your interests; or - if you are no longer a family member of a person whose interests are represented. - if you (the policyholder) have taken out group insurance through your employer, and - you no longer work for that employer; or - your employer has informed you that you can no longer be a member of the group scheme; or - if you are no longer a family member of an employee with group insurance through that employer. If you have group insurance through your employer and you leave that employer, please let us know within 30 days of termination of your employment. You can then keep this group insurance until 1 January of the next year. If we receive this notice from you after more than 30 days, we will set a date on which this group insurance will be converted into a personal insurance policy. In all other situations, we will immediately convert the group insurance policy or policies into a personal insurance policy. What else happens when switching from group insurance to personal insurance: - you will get the personal insurance that most closely resembles the group insurance you had; - the terms and conditions for personal insurance will apply; - you will need to start paying the premium for personal insurance.

From group scheme to individual additional insurance package
If your group scheme membership ends, we will convert your group additional insurance package into a personal additional insurance package. You will get the insurance that most closely resembles the group insurance you had. If you do not want that, please let us know within 30 days and we will not activate the new additional insurance package.

Policy cancellation document
If your insurance has been cancelled, we will send you a ‘policy cancellation document’ (statement of cancellation). This document lists the insured persons, what was covered under the policy, what the premium was, and when the policy expired.

A.7. Amount of the premium and costs

Premium and costs for your additional insurance package
The premium will depend on which additional insurance package you choose. You can get a discount on your premium: - if you pay more than one month in advance (payment term discount). You will pay a premium surcharge for; - every insured person who only has an additional insurance package and not a general insurance policy; - insured persons aged under 18 if the parents do not have the same additional insurance package. You will also pay costs. These include: - invoices we have paid in advance to your healthcare provider for you; - personal contributions that you must pay yourself if you are not reimbursed in full; - additional costs when you, for example, do not pay by direct debit. The premium and costs are stated in euros.

Premium for additional insurance packages up to the age of 18
For the additional insurance package(s), the premium for children up to the age of 18 is also €0. These co-insured children must, however, have the same additional insurance package(s) as one of their parents or guardians. If your child does not have the same additional insurance package or not the same series of additional insurance packages, you will be charged a premium for all of this child's additional insurance packages. This will be the same premium as that charged for an insured person aged 18 or older. When the insured person turns 18, you will always start paying the premium from the 1st day of the month following their 18th birthday.

Custody or imprisonment
If you are in custody in a detention centre or in prison, we will suspend your insurance and you will not be charged the premium and costs. As soon as you are no longer in custody or imprisoned, you must let us know. Your insurance will then be reactivated and you will be liable to pay the premium and costs again.

Start, change or end of your insurance
If your insurance changes at the end of a payment period, we will recalculate the premium and deductible for the next payment period. If your insurance starts, changes or ends during a payment period, or an insured person is added or removed, we will also recalculate the premium and deductible for the next payment period, taking into account the moment when the insurance started, changed or ended. You may then get money back or have to pay extra, or we will settle the difference.

A.8. Payment of premium and costs

Paying in full and on time
As the policyholder, you have to pay all premiums and costs. These are payable for each 'payment period'. A payment period can be one month or one year. You are required to pay in full. This means: - you pay for the payment periods that have passed; - you pay for the current payment period; - and you pay for the next payment period. This means that you always pay in advance. You are also required to pay on time. This means: - the total amount due must be in our account no later than on the date stated on your premium invoice; - if you pay by direct debit, we will debit the amount due in the last week before the next payment period; -- you will first receive notification from us before we debit the amount due from your account; -- you must make sure you have sufficient funds in your bank account; -- if we cannot debit the total amount in the last week before the next payment period, you are free to agree a different direct debit payment date with us. - if you opt to use a payment method other than premium invoices or direct debit, the full amount due must be in our account before the agreed payment period. If we have received all these premiums and costs, you have fulfilled your payment obligation.

See also:
- Maand (definitions)
- Verzekeringnemer (definitions)

Off-setting
What is and is not possible: - if you have payment arrears with us, you cannot set off your arrears against any money we owe you. - we can, however, set off your arrears against money to which you are still entitled under your insurance policy or policies.

Payment method
You have agreed a payment method with us for the premium and costs due. This could be through a premium invoice, by direct debit, or by means of electronic or online payment. If you have agreed with us that we will communicate electronically, you can only pay by direct debit or electronic or online payment.

A.9. Payment arrears

What we will do if you fail to pay your premium and costs on time
If you fail to pay on time and in full, we will proceed as follows: - we will send you a reminder; - if you fail to pay within 14 days of receiving the reminder, we will send you a second reminder; - we will set off your arrears against money to which you are still entitled under your insurance policy or policies; - if there is any debt left after that, you will be required to pay it. We will engage a bailiff to collect this debt.

Repaying your debt
Every amount that we receive from you will go towards repaying your debt.

What we will do if you are in arrears on your payments
If you fail to pay your premium and costs on time, we will be authorised to: - suspend your cover under your additional insurance package(s). We will take this step if we are unable to offset your debt against money to which you are still entitled. On the day that all your debts to us have been paid, you will be entitled to cover under your additional insurance package(s) again. - terminate your additional insurance package(s). You will then not have additional insurance any more.

Payment term discount ceases to apply
If you pay over a month in advance and run up payment arrears, we will switch you to a one-month payment period. This means you lose the discount you were entitled to for paying further in advance. This payment term discount will cease to apply for all policies for which you are the policyholder. Losing the discount will not be accepted as grounds to cancel the insurance.

See also:
- Maand (definitions)
- Verzekeringnemer (definitions)

Repaying your debt on your general insurance policy
Subsequent payments will go towards repaying your debt on your general insurance policy. These will first go towards the part of the debt that has been outstanding the longest.

Repaying your debt on your additional insurance package
Subsequent payments will go towards repaying your debt on additional insurance package(s). These will first go towards the part of the debt that has been outstanding the longest.

Debt for multiple payment periods
If you have not paid for a long time and, consequently, run up a debt spanning multiple periods, your payments will first go towards repaying the period that is the furthest back in time. You must first repay the debt on all your insurance policies for a specific period before you can move on to repaying the debt for the next period. This means the debt on both the general insurance policy and on the additional insurance package(s) for that period. This means you cannot split your debt
Example
You cannot opt to first pay only the premiums due, followed by any other debts, nor can you opt to pay the premiums and costs for the general insurance policy first and then those for the additional insurance package(s).

A.10 Premium and costs upon termination

Outstanding premium and costs
If you have cancelled your insurance policy with us and still have outstanding premium and costs, we will settle this when you take out a different or a new policy with us. We will set off the outstanding debt on your old policy against reimbursements under your new insurance policy. If you still have outstanding premium and costs, we will postpone any reimbursements until you have paid everything.

Excess payment during a payment period
If you cancel or change your insurance after you have already paid the premium, we will recalculate your premium and deductible. If this shows that you have overpaid, we will refund the excess, or we will set it off against the new premium. You will receive a notification from us explaining which of these options we have selected.

A.12. Compulsory deductible

No deductible in your additional insurance package
Reimbursements under an additional insurance package are not subject to a deductible. In some cases, healthcare will first partly be covered by your general insurance policy and the remainder by your additional insurance package. The reimbursement under your general insurance policy will then be subject to your deductible, while the reimbursement under your additional insurance package will not.

Payment to the healthcare provider or to you
We pay the reimbursement to a contracted healthcare provider or a healthcare provider with a payment agreement when that party sends the invoice for your healthcare directly to us. If you still have part or all of your deductible or personal contribution outstanding, we will ask you to pay these costs to us, or otherwise settle them with you. We will reimburse you if you claim costs incurred at a non-contracted healthcare provider or a healthcare provider without a payment agreement with us. If you still have part or all of your deductible or personal contribution outstanding, we will deduct this amount from the reimbursement. It will then be your responsibility to pay the healthcare provider’s invoice in full and on time. If you send us the invoice, we will pay the reimbursement to you.

No cover for deductible under additional insurance packages
Costs incurred under your general insurance policy that have been offset against the voluntary deductible or compulsory deductible are not reimbursable under your additional insurance package.

A.14. General obligations

Your general obligations
You have a number of general obligations: - you must be able to show valid proof of identity when you need healthcare at a hospital or an independent treatment centre (ZBC). - you must provide us, our medical adviser, consultant dentist, or contracted healthcare providers with the information that is necessary, or help us or these other parties obtain the necessary information. - you must ask your doctor or medical specialist in attendance to tell our medical adviser about the reason for admission, if requested. - you must inform us within 30 days if you are taken into custody, put in prison or given a prison sentence. - you must inform us within 30 days of leaving custody or prison. - you must let us know within 30 days who will be the new policyholder if the current policyholder has lost the entitlement to dispose of his/her assets independently. - you must let us know within 30 days of the policyholder's death who will be the new policyholder.

See also:
- Medisch adviseur (definitions)
- Verzekeringnemer (definitions)

If you fail to comply with your general obligations
What we can do if you fail to comply with your general obligations and you harm our interests as a result: - you will no longer be entitled to reimbursement for healthcare. - we can possibly claim any previously paid reimbursements back from you.

If someone else is liable for the healthcare you need
Someone else may be liable for the events, circumstances or accidents that led you to need healthcare. In such cases: - you must notify us as soon as possible. - you must help us when we start proceedings to recover the costs. If you do not help us, we may hold you liable for all losses and costs incurred. - you transfer current and future receivables from third parties to us upon commencement of your insurance. - you are not allowed to make any arrangements with the persons we may hold liable for healthcare (or healthcare costs). Nor are you allowed to enter into an agreement with parties such as another insurer. Only with prior written permission from us may you make arrangements or enter into an agreement.

A.15. Provision of information

If you provide wrong information
You must provide us with correct information and help us get all the necessary information. If you fail to do that or someone else acting on your behalf fails to do that, we can: - decide to not pay reimbursements relating to this; - claim back any related reimbursements we have already paid; - terminate your insurance policy. Which of these measures we choose depends on the specifics and circumstances of the case. If you misrepresent a situation, submit false or misleading documents, or provide incorrect information, you may be committing fraud. For details of the consequences, see clause A.26. Fraud.

Significant events
Occurrences we need to know about for the proper execution of your insurance must be reported to us within 30 days. If you notify us within the specified timescale, any changes to your insurance will apply from the date of the significant event. Otherwise, the change will take effect at a moment of our choosing. Significant events include: - moving house or a change of address as registered in the Persons Database ('Basisregistratie Personen', BRP); - a change of postal address or email address; - birth or adoption; - death; - divorce; - start and end of a period of custody or prison sentence; - start and end of participation in a group agreement; - change to the family composition.

Your current address
You must submit your correct postal address and/or email address. We will assume that our correspondence reaches you when it is delivered to the most recent address you have submitted to us. Failure to provide us with your correct postal or email address may result in losses, for which we cannot be held liable.

A.16. Privacy and checks

Privacy
We process only data that we need to implement your insurance policy or policies. We do this as per the terms and conditions we have agreed on with you. We store this data in our records. Our processing of personal data on you complies with: - the Implementation Act of the General Data Protection Regulation (‘Uitvoeringswet Algemene verordening gegevensbescherming’) and the General Data Protection Regulation (EU Regulation 2016/679). Please refer to the ‘Privacy Statement’ on our website for more information about privacy and your rights and obligations with respect to the (personal) data on you that we store and process. In the event of questions or requests for further information for the attention of the Data Protection Officer, send a letter to: CZ Customer Services, Postbus 90152, 5000 LD Tilburg, Netherlands

Information that we share
We only share information when it is necessary for the adequate implementation of your insurance policy or policies. Information that we may share includes the package composition, premium, discount and personal data. We may do this to: - verify the group scheme in which you participate; - recover the costs we have paid out from third parties, such as from a travel insurance policy if you received insured healthcare outside the Netherlands.

Check-ups
We are authorised to verify details in the implementation of your insurance policy. We will always do so in accordance with: - the terms and conditions and (personal) data agreed on with you, - the Dutch Health Insurance Act (‘Zorgverzekeringswet’); - the national Protocol on Substantive Checks (‘Protocol materiële controle’). You must cooperate with us fully in this respect.

A.17. Healthcare providers

Contracted healthcare providers
We have entered into contracts with healthcare providers on the healthcare and/or resources they provide. These contracts contain agreements on the price, quality and efficacy of the healthcare. They also contain the terms and conditions under which they can provide healthcare and the way costs are claimed. On our website you can find a list of all contracted healthcare providers. The fact that we have contracted a healthcare provider does not mean we always cover all the healthcare they provide. This can mean that: - while a healthcare provider is authorised to provide certain healthcare, you are not insured for it. We have then deliberately not contracted this healthcare provider for part of their healthcare or resources. - you are dealing with a healthcare provider we have contracted up to a certain budget (revenue ceiling). Or we have volume agreements in place with this healthcare provider. This may mean that a healthcare provider will not accept you for treatment. If we have such agreements with a healthcare provider, this will be stated on our website.

Requirements for healthcare and healthcare providers
The healthcare and the healthcare provider must meet various general terms and conditions: - for each type of healthcare, we designate the type of healthcare provider that can provide the healthcare. We will not reimburse healthcare provided by another type of healthcare provider, even if this healthcare provider is authorised to provide the healthcare in question. - The aforementioned healthcare provider supplies the care themselves and has an AGB code. Another type of healthcare provider may also provide the healthcare as long as it is done under the responsibility of the healthcare provider specified, except when we have stated otherwise for a type of healthcare. - the healthcare provider specified claims the healthcare under their own name. A facility, another healthcare provider, or another party may also claim the healthcare, provided that the name of the attending, responsible healthcare provider is stated on the invoice. - the healthcare provider must be authorised to provide the healthcare. This means that they must comply with the requirements and rules governing their profession, company, and the exercise thereof. - healthcare providers based in the Netherlands must comply with the requirements laid down in the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) and the Dutch Healthcare Quality, Complaints and Disputes Act ('Wet kwaliteit, klachten en geschillen zorg', Wkkgz). -- the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg') also governs doctors, dentists, pharmacists, healthcare psychologists, psychotherapists, physiotherapists, obstetricians and nurses. They have to be registered in the national BIG registers or another register that we consider to be equivalent. -- we will only reimburse healthcare provided by other healthcare providers if they have gained a designated qualification under Section 34 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg'). They must then lawfully use the title and/or designation conferred upon them by that qualification. - as a means to assure quality, we have imposed additional terms and conditions on healthcare providers with respect to certain types of healthcare. This will be specified for the healthcare providers in question. For example: A provider of alternative healthcare, for example, must be a registered member of one of the professional associations for alternative treatment methods. The list of professional associations is available on our website. - A healthcare provider in a country outside the Netherlands complies with the requirements, laws and regulations set out for their profession in the country concerned. If such requirements, laws and regulations are lacking, the rules that apply will be those that are customarily imposed on healthcare providers in that country.

See also:
- AGB-code (definitions)
- Zorgverlener (definitions)

Going to another healthcare provider for healthcare under your additional insurance package
Our Healthcare Team ('Zorgteam') can also contact the healthcare provider on your behalf for healthcare under your additional insurance package. If this concerns healthcare insured in kind, they can help you find another healthcare provider. If this concerns healthcare insured on a refund basis, they can see whether you can be accepted for treatment all the same. Our Healthcare Team ('Zorgteam') can also help you find another healthcare provider if you prefer.

Ongoing treatment
If you are already being treated by a healthcare provider with a revenue ceiling or a volume agreement, you are free to complete the course of treatment.

See also:
- Behandeling (definitions)

Non-contracted healthcare providers under your additional insurance package
If you choose to go to a non-contracted healthcare provider under your additional insurance package, there is a chance that we will not cover all the costs. For more information, please refer to clause A.20. Rates

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

End of contract with healthcare provider during treatment
In the following cases, your treatments are insured for a maximum of one year as if they were provided by a contracted healthcare provider: - you are being treated by a contracted healthcare provider. During the treatment, the contract between your healthcare provider and us ends. - you switch to us from a different insurer part-way through your ongoing treatment. Your healthcare provider was contracted to your former insurer, but does not (yet) have a contract with us.

Location where the healthcare is provided
Your healthcare provider provides the healthcare at a location that is fit for purpose and medically appropriate, i.e. at the practice of the healthcare provider or, if this is indicated for this healthcare, at your home or at your temporary place of residence (where you are temporarily living or staying). This can also be a location concerning which we have made agreements with the healthcare provider or with you. Or a location designated by law or the Dutch Health and Youth Care Inspectorate (‘Inspectie Gezondheidszorg en Jeugd’) as a location where healthcare can be provided. In special situations or for special healthcare, we specify the location. If possible, the healthcare may also be provided online.

A.18. Approval

When permission is required
By ‘permission’ we mean a written statement of permission from our ‘Medische Beoordelingen’ (Medical assessments) department. Certain healthcare is subject to prior permission from us. If so, there will be a notice with the healthcare saying that you have to request permission for it. You must request permission before starting the treatment. We will assess whether you meet the conditions. We will also assess whether the healthcare is appropriate and effective in your case. This may mean that we need additional information from you. If we grant permission, the statement of permission will specify what we will cover and on what terms and conditions.

See also:
- Schriftelijk (definitions)

Permission for healthcare from a contracted healthcare provider
If you use a contracted healthcare provider, the healthcare provider can assess whether or not you will be granted permission for the healthcare. This is because we have made arrangements to this effect with contracted healthcare providers. The contracted healthcare provider will do the following: - assess whether you meet the terms and conditions for reimbursement of the costs of the healthcare; - assess what healthcare you need. If the healthcare provider is not sure, they will forward the request to us and we will then assess whether or not to grant you permission. You will then not have to provide us with any information yourself.

Statements and promises
Permission is valid only if we have granted it beforehand in writing. We will then send a letter to the postal or email address you have submitted. We cannot be held liable for losses arising due to not receiving our correspondence or receiving our correspondence too late. This could happen if you have given us the wrong address, for instance.

Permission for healthcare from a non-contracted healthcare provider
If you go to a non-contracted healthcare provider, you must personally request prior permission from us in writing. This will be required only if we have stipulated that the healthcare in question is subject to prior permission. You can ask the healthcare provider to help you with that. We will need the following information from you: - a formal request stating the reason why you need the healthcare; - if possible, a cost statement for the treatment and a treatment plan. If we need any further information, we will let you know what information is missing. Please send it to our ‘Medische Beoordelingen’ (Medical assessments) department. What language to use for the request for approval Requests and additional information must be in Dutch, English, German, French or Spanish. If your request is in another language, we will ask that you include a translation. You can also have us arrange a translation. We will then claim the fee charged by the translation agency back from you.

Permission for medical aids
To purchase a medical aid, get one on loan, or have one replaced, adjusted or repaired, you can go directly to a contracted healthcare provider. A contracted healthcare provider will assess whether you meet the conditions for provision of a medical aid and which medical aid would be the most appropriate in your situation. If you meet the conditions for provision, the healthcare provider will claim the costs back from us directly. If you do not meet the conditions, you can choose: - to pay for the medical aid yourself; or - to request permission from us yourself. In the latter case, please make sure you state that the healthcare provider has rejected your request for the medical aid in question. Requests for permission must be submitted in writing to our ‘Medische Beoordelingen’ (Medical Assessments) department. To do so, please send us a healthcare request. If we need additional information for the assessment of the healthcare request, we will request it from you. If you are using a contracted healthcare provider, that provider will generally submit the healthcare request to us on your behalf. If you opt to go to a non-contracted healthcare provider, you will have to submit the healthcare request to us yourself. For a number of medical aids, we have a standard application form available, which you can download from our website. You can also call our ‘Medische Beoordelingen’ (Medical Assessments) department to ask them to send you an application form. When you send us the healthcare request, you must include a written, substantiated explanation by the prescriber, stating the medical grounds, possibly supplemented by a recommendation or report if we request one. The healthcare request also specifies: - your customer number; - your name, address and place of residence; - your date of birth; - the name of the healthcare provider supplying the medical aid; - a description of the medical aid in question;- the item number from the ‘Z-Index’ (the Dutch national database of medicines) or the ‘GPH-code’ (Generic Product Code for Medical Aids): you can obtain these details from the healthcare provider; - an indication of how long you expect to need the medical aid; - and, if you are obtaining the medical aid from a non-contracted healthcare provider, a quote or cost estimate for the medical aid in question.

See also:
- Medische indicatie (definitions)

Period of validity of permission
The statement of permission is valid: - in accordance with the generally applicable legislation, regulations and terms and conditions of insurance; - for a maximum of 365 days, unless we state otherwise. If we change the specific terms and conditions for your healthcare within this period, you can complete the treatment as per the statement of permission. Our statement of permission will cease to be valid if: - the relevant laws and/or regulations change; or - your insurance policy has changed or stops, unless the commencement date of a treatment with a Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC) healthcare product code lies within the term of your insurance policy.

See also:
- DBC Zorgproduct Diagnose Behandel Combinatie (definitions)

A.19. Invoices

Reimbursement in general
Your reimbursement will never exceed the actual costs of the healthcare specified on the invoice.

Invoices in general
If you are entitled to reimbursement, it will be paid into the bank account (IBAN) we have on record for you. Claims and reimbursements for invoices can be processed in various ways: - a contracted healthcare provider will generally claim the costs directly from us. We will then pay these directly to that healthcare provider. - a non-contracted healthcare provider issues or sends you an invoice. You can then submit this invoice to us to claim a reimbursement. We will subsequently pay you a reimbursement, provided you are entitled to it. - the following actions or arrangements are excluded: -- you may not transfer your claim or another right in respect of us to a non-contracted healthcare provider or any other third party; -- you may not provide a security interest, such as a pledge, to a non-contracted healthcare provider or any other parties with whom we do not have a contract; -- you may not give permission, an order, instruction or similar to claim on your behalf to a non-contracted healthcare provider or any other third party. Such parties are not allowed either to receive a payment for you, or to accept a payment that fulfils an obligation of yours to that third party, not even if you have given permission or an order to that effect.

Requirements for invoices
Requirements that an invoice must meet - the healthcare must actually have been provided; - we must have received the invoice within 36 months of you receiving the healthcare. You will cease to be entitled to reimbursement if after 36 months we do not have the invoice. - the invoice must be in one of the following languages: Dutch, English, German, French or Spanish. The same applies to your treatment reports. If the invoice is not in one of these languages, we will ask that you include a translation. Alternatively, you can have us arrange to have the invoice translated. If you choose this option, you will be required to repay the fee charged to us by the translation agency; - you must have submitted the invoice or a contracted healthcare provider must have done so on your behalf; - we must be able to process the invoice without further enquiries, processing, or investigation. We go by the same requirements for invoices as the Dutch tax authorities and, if applicable, by the Generic Claiming Standard (‘Generieke Declaratiestandaard’, GDS). The invoice must always at least state the following: -- name and address of the healthcare provider; -- your name and date of birth; -- specifics of the healthcare provided; -- the date on which, or the period over which, the healthcare was provided; -- the costs of the healthcare provided; -- the right Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC) healthcare product code, if it concerned specialist medical healthcare; -- the healthcare provider’s BIG register number, if the healthcare provider is required to be registered in the BIG register; -- the AGB code (administrative code assigned to healthcare professionals in the Netherlands), if applicable. -- the requirements set by the Dutch tax authorities regarding VAT on invoices. For reimbursement of healthcare, we need the date of treatment or supply. The invoice date or the order date for a medical aid or other resource is not relevant. This is what we will not do: - we will not reimburse costs on the basis of quotes, advance invoices, reminders or final demands; - we will not return invoices or documents enclosed with the invoice, not even if only part or nothing at all of the invoice has been reimbursed. You can, however, request a certified copy from us, i.e. a copy of the invoice with an original certification stamp.

See also:
- AGB-code (definitions)
- DBC Zorgproduct Diagnose Behandel Combinatie (definitions)

Claiming healthcare costs
How to claim your healthcare costs - use our app on your smartphone to submit invoices electronically; - use the ‘Mijn’ platform to submit invoices electronically; - send us the original hard copies of invoices in the post; in some cases we will accept copies, provided that you have arranged this with us first. This is an exception. Your contracted healthcare provider will send the invoices directly to us.

If we pay the healthcare provider directly
If we have made arrangements with a healthcare provider for them to send invoices directly to us, we will also pay them directly. You must cooperate with us in this respect. This means that our obligation to reimburse you for these costs ceases to exist. We may also set off an invoice from a healthcare provider against an advance that the healthcare provider has already received.

Retention of original invoices
When submitting invoices online, in the app, or on the 'Mijn' platform, you have to retain the original hard copies for at least 2 years, as we may ask to see them during a check.

Reimbursement for invoices during the insured period
We only pay reimbursements for invoices for healthcare during your insured period. If you have submitted a claim for treatment with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC healthcare product) code, the start date of the DBC must fall within your insured period. If the start date is before the commencement date of your insurance with us, the entire DBC will be considered not to fall within your insured period. This includes if the treatment continues partly during your insurance term with us. You will then have to submit the invoice for the DBC to your former insurer.

See also:
- DBC Zorgproduct Diagnose Behandel Combinatie (definitions)

Priority of reimbursement
When it comes to processing invoices, we adhere to a certain sequence. This is how we determine whether you will receive a reimbursement, and if so, how much. We first look at whether an invoice has to be covered under another kind of insurance, such as a national insurance scheme or social security, such as the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), the Dutch Youth Act ('Jeugdwet'), or the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).

Sequence for the reimbursement of healthcare under the additional insurance package
Finally, we will process the invoice in accordance with your additional insurance package(s). We do this in the following order: - first a group additional insurance package that you have taken out with us through your employer, for example; - then a personal additional insurance package, which provides reimbursement for various types of healthcare; - and then a specific additional insurance package, i.e. one that provides reimbursement for only one or a few different types of healthcare, for example, oral care only.

Insurance for only part of the year
Certain reimbursements are subject to a maximum amount or a maximum number of treatments per year. If your insurance policy stops part-way through the year, your reimbursement will not be lower. We will not reduce the maximum amount or maximum number of treatments for that year.

Change to an additional insurance package
For healthcare covered by your additional insurance package, you may receive a maximum or partial reimbursement per insured person over a certain period. This period may be a number of years, but also a one-off reimbursement for the whole period that you are insured with us. If you change your additional insurance package, take out an additional insurance package again at a later stage, or take out a different additional insurance package with us, - the amount you have already been reimbursed under your previous additional insurance package counts towards the maximum amount of your new additional insurance package; - the number of treatments that you used under your previous additional insurance with us counts towards the maximum number of treatments under your new additional insurance package; - and the period in which you are entitled to limited reimbursement continues, uninterrupted, in your new additional insurance package. This period starts at the moment you first incur costs; - if we provide reimbursement for healthcare once per insured person, reimbursements you received in previous years will also count towards the maximum under a subsequent additional insurance package, even if you were insured elsewhere in the meantime. Including when we change reimbursements or the number of treatments in your additional insurance package, any reimbursements you received previously will also count towards the maximum. Orthodontic care under your additional insurance package is an exception. For this type of healthcare, previous reimbursements do not count towards the maximum under a new or later additional insurance package.

See also:
- Aanvullende verzekering (definitions)
- Jaar (definitions)

Healthcare in current insurance policies also in your additional insurance package
Your additional insurance package may provide cover for healthcare that has already been partly reimbursed under other insurance, such as the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz), the Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo), or your general insurance policy. How to claim these costs Submit your invoice along with the original hard copy of a written statement by the other insurer or implementing body confirming that the invoice has already been claimed and settled. We will then assess whether or not we will still reimburse you (for all or part of it) under your additional insurance package.

A.20. Rates

Here you can read about:
on our rates

Amount of the rates: You need healthcare covered on a refund basis
For healthcare insured on a refund basis, we will reimburse 100% of the insured healthcare provided, but not more than: - the statutory rate, or if there is no statutory rate; - the statutory maximum rate, or if there is no statutory maximum rate; - the market rate applicable in the Netherlands. We never reimburse more than the claimed rate or the maximum stated for the insured healthcare. Tip: If you go to a contracted healthcare provider, we will reimburse 100% of the agreed rate. With contracted healthcare providers, we have generally agreed rates that are lower than the rate charged by a non-contracted healthcare provider. So in most cases, you will pay less deductible when you go to a contracted healthcare provider.

See also:
- Gedeclareerde tarief (definitions)
- Marktconform tarief (definitions)
- Tarief (definitions)
- Wettelijk maximum tarief (definitions)
- Wettelijk vast tarief (definitions)

Amount of the rates: You need healthcare covered under an ‘in-kind’ policy
Choice of healthcare provider for healthcare covered under an ‘in-kind’ policy: a. You use a contracted healthcare provider; or b. You want to go to a contracted healthcare provider, but are not able to: -- because you need the healthcare urgently; or -- because a contracted healthcare provider is not available; or -- because the contracted healthcare provider will not be able to provide timely healthcare. Timely healthcare is subject to a medically appropriate waiting period. This waiting period is also generally accepted by society. We will reimburse 100% of the insured healthcare provided by this healthcare provider, but not more than: -- the statutory rate, or if there is no statutory rate: -- in situation a.: the agreed rate or -- in situation b.: in case of urgent medical care or after healthcare mediation (see clause A.3.) by us: the bill, but never more than the statutory maximum rate (Rate under the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’ (Wmg) or the market rate applicable in the Netherlands). We will never reimburse more than the claimed rate or the maximum stated for the insured healthcare. c. You can go to a contracted healthcare provider, but you opt to go to a non-contracted healthcare provider. We will reimburse the lower percentage* (as shown below) of: - the statutory rate, or if there is no statutory rate; - the average agreed rate (but never more than the statutory maximum rate or the market rate applicable in the Netherlands); or - the claimed rate if that is lower. We never reimburse more than the maximum stated for the insured healthcare.

See also:
- Afgesproken tarief (definitions)
- Gedeclareerde tarief (definitions)
- Marktconform tarief (definitions)
- Wettelijk maximum tarief (definitions)
- Wettelijk vast tarief (definitions)

VAT
A healthcare provider may be under an obligation to levy VAT on the amount they charge for the healthcare, or to levy a similar tax outside the Netherlands. If the healthcare provider charges you VAT, we will reimburse you for that as well.

A.21. General exclusions

Here you can read about:
on our general exceptions

General exclusions
There are some costs of healthcare that we do not reimburse: - if you fail to comply with an agreement with a healthcare provider; - the costs of urgent treatment outside the Netherlands that a travel insurance provider or insurer claims from us: -- this travel insurance provider or insurer has not signed the covenant on overlap of insurance policies (‘Convenant Samenloop’); -- if you were not insured with us, these costs would be covered by your travel or other insurance policy. Your travel insurance provider or insurer has, therefore, excluded the costs if you have an insurance policy with us; - this may also concern costs other than those paid or advanced by that travel insurance provider or insurer. Explanation: This travel insurance provider or insurer has not signed the covenant on overlap of insurance policies (‘Convenant Samenloop’). This covenant regulates the division of costs reimbursed to the insured persons. This is irrespective of whether the travel or other insurance took effect before or after your insurance with us. Our insurance serves as a ‘top-up’, i.e. we only reimburse costs that exceed the cover provided by this separate travel or other insurance policy; - healthcare that would also be covered under another insurance policy or scheme and you have not informed us of the name of that insurer; - costs of money transfers, administration, billing or shipping costs. - more than one treatment of the same type of healthcare in one day. We will only reimburse this if specifically included in the cover provided by your insurance policy. - a treatment that is not deemed to constitute responsible and adequate healthcare or services. We assess this based on the latest medical practical and theoretical standards. Or if the healthcare is not recognised as per the medical standards that apply in the Netherlands; - a treatment that, in our view, is still at a scientific or experimental stage; - a treatment that, in our view, does not address the illness or condition, or that does not prevent an illness or condition; - healthcare with a treatment date outside your insured period, i.e. before your insurance started or after your insurance ended. In case of a Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC), only the start date has to fall within your insured period; - healthcare provided over the telephone, online, or remotely that, in our view, is not logical and not appropriate. This means that we do not expect the healthcare to produce the desired result. For example: a dentist cannot fix a cavity over the telephone. Mental healthcare, on the other hand, can be provided over the telephone; - self-administered healthcare; - healthcare costs exceeding the maximum amount or maximum number. This is regardless of whether or not you used everything that is included in that healthcare; - healthcare that you receive from a healthcare provider who is your partner or a first or second-degree family member and/or relative; - treatments that are necessary as a result of nuclear reactions. However, we will reimburse healthcare required because of nuclear material outside a nuclear plant, but only on the following conditions: - there is a permit from the Dutch government for the installation of the nuclides; - the location of this material does not contravene the Dutch Nuclear Incidents (Third Party Liability) Act (‘Wet aansprakelijkheid kernongevallen’); - a third party is not liable for the losses, under Dutch law or that of a foreign country. - healthcare you receive while in custody or prison, regardless of whether that is in the Netherlands or another country. In that case, you will receive healthcare arranged by the facility. In the Netherlands, this is the responsibility of the Dutch Ministry of Justice (‘Ministerie van Justitie’). - a new medical aid because your old medical aid no longer works properly: - because you deliberately did not follow the instructions or explanation of use; - as a result of your improper use of the medical aid. - (statutory) personal contributions payable in accordance with the Dutch Youth Act (‘Jeugdwet’), the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) and the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo) or the Dutch Health Insurance Act (‘Zorgverzekeringswet’, Zvw); A personal contribution may be reimbursed under an additional insurance package; - costs exceeding the maximum rate for which you are insured.

See also:
- Behandeling (definitions)
- Buitenland (definitions)
- DBC Zorgproduct Diagnose Behandel Combinatie (definitions)
- Jaar (definitions)
- Spoedeisende zorg (definitions)
- Tarief (definitions)

No reimbursement under your additional insurance package
We will not reimburse healthcare or the costs thereof under your additional insurance package if it could be covered by one of these other schemes or insurance arrangements: - a Dutch or foreign national insurance scheme, social security act or other statutory scheme. Examples include the Dutch Health Insurance Act (‘Zorgverzekeringswet’), the Dutch Youth Act (‘Jeugdwet’), the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) and the Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo); - a Dutch or foreign government scheme or a subsidy scheme, such as a national immunisation programme; - an EU regulation, EU treaty, EEA treaty or a bilateral social security treaty that the Netherlands has signed; - another agreement. This is irrespective of whether this agreement took effect before or after your additional insurance package with us. We never reimburse the costs of more than 1 of the same type of treatment on 1 day. A ‘type of treatment’ refers to the healthcare described in a clause, i.e. one clause or part of a clause deals with one type of healthcare.

No reimbursement in case of acts of war and/or terrorism
We will not reimburse the following costs: - damage or losses in connection with acts of war. These are costs resulting from armed conflict, civil war, insurrection, domestic civil commotion, riots and mutiny taking place in the Netherlands. This is specified in Article 3:38 of the Dutch Financial Supervision Act (‘Wet op het financieel toezicht’). We go by the definitions drawn up by the Dutch Association of Insurers (‘Verbond van Verzekeraars’). - terrorism risk. These are costs resulting from terrorism, malicious contamination, preventive measures or preparatory actions and behaviour, both in the Netherlands and abroad. We will reimburse these costs only insofar as we are able to pay them from the amount we receive under reinsurance from the Dutch Terrorism Claims Reinsurance Company (‘Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V.’, NHT) in Amsterdam. Reinsurance provided by the NHT covers the costs of terrorism risk up to a maximum of 1 billion euros per year. This amount is subject to change on an annual basis. The amount is for all NHT-affiliated insurers combined. After a terrorist act as specified in Article 33 of the Dutch Health Insurance Act (‘Zorgverzekeringswet’), an additional contribution may be made available. You will then be insured for additional reimbursement. The level of this reimbursement is set based on the aforementioned Article 33. If you do not live in the Netherlands, you are not covered by this reinsurance scheme and will, therefore, not receive a reimbursement. For more about terrorism, please visit the NHT website. A national terrorism clause sheet (‘Clausuleblad Terrorisme’ published by the NHT) has been published. For more information, see the NHT clause sheet under NHT documents on the NHT website.

No reimbursement in case of intentional acts and negligence
Guilt, recklessness or intent If you fall ill, develop a condition, or become injured due to negligence, recklessness, or intentional acts on your part, we will not reimburse the healthcare needed to treat that illness, condition, or injury. Examples include the following: - driving a vehicle, piloting a vessel, or flying an aircraft without meeting statutory requirements. For these purposes, ‘aircraft’ also extends to an aeroplane, helicopter, parachute, hot air balloon, and hang-glider; - taking part in races or speed trials in a vehicle, vessel, or aircraft; - engaging in professional sports; - taking part in a brawl, assault or other violent act; - taking part in armed activities as part of foreign armed forces, navy, or air force, except if you exclusively provide humanitarian aid or care or exclusively perform medical activities as an aid worker working on behalf of a recognised humanitarian aid organisation. In the latter cases, we will cover the healthcare you need. - failing to cooperate in your healing process or undermining the healing process; - travelling to or staying in a country for which the Dutch government had issued negative travel advice before your departure. Negative travel advice is: -- the advice to only travel if absolutely necessary (code orange); - the advice not to travel at all (code red). The negative travel advice was issued on account of: -- current or imminent war, riots or other circumstances where a threatening situation may arise; -- a risk of infectious pathogens, such as viruses, bacteria, fungi or other forms or combinations of these. The treatment or healthcare you receive must have a causal relationship with the negative travel advice. except if you exclusively provide humanitarian aid or care or exclusively perform medical activities as an aid worker working on behalf of a recognised humanitarian aid organisation. In the latter cases, we will cover the healthcare you need. What we do reimburse We do reimburse healthcare needed as a result of: - lawful self-defence; - saving yourself, others or animals; - saving your or others’ property. The rescue, act, or behaviour listed as an exclusion must then be justified in all reasonableness or be part of a statutory duty of care. Criminal offences, violations and fraud If you fall ill, develop a condition, or become injured as a result of a criminal offence, violation, or fraud that you committed, we will not reimburse the healthcare needed to treat that illness, condition, or injury. This also applies if you are only an accessory to an attempted criminal offence, violation, or fraud. If someone else with an interest in the reimbursement or the insurance contract, such as a healthcare provider, commits a criminal offence, violation, or fraud, we will not reimburse the costs of the resulting healthcare either. For details of the consequences of fraud, see clause A.26. Fraud.

A.23. Complaints

Complaint
If you have a complaint about your insurance, you can file it in writing or by telephone. We will let you know our decision on the complaint. Our contact details are available on our website. If you do not agree with our decision and/or your complaint has not been resolved satisfactorily, you have various options as to what to do next: - you can go to the competent court or - you can refer your complaint to the Health Insurance Disputes Committee (‘Geschillencommissie Zorgverzekeringen’) of the Health insurance Complaints and Disputes Committee (‘Stichting Klachten en Geschillen Zorgverzekeringen’, SKGZ). You must do so in writing to Postbus 291, 3700 AG Zeist. The Dutch Health Insurance Ombudsman (‘Ombudsman Zorgverzekeringen’) works for SKGZ. The ombudsman will try to resolve the complaint through a process of mediation. If this proves unsuccessful, the SKGZ can issue a final and binding recommendation. Once you have chosen one of the above possibilities, you cannot go back later and choose another one.

Complaints about standard forms
If you think our forms are overly complicated or unnecessary, or your healthcare provider or another health insurer thinks that, you or the person with the complaint can take the complaint to Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa): Postbus 3017, 3502 GA Utrecht, Netherlands. The NZa will issue a binding decision on the complaint.

A.24. Dutch law

Dutch law
Your insurance is subject to Dutch law.

A.25. Situations not covered

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

A.26. Fraude

Fraud and fraud screening
Fraud is when you deliberately do or fail to do something with a view to misleading us, with the intention of causing us a loss or giving yourself or someone else an undue advantage. Fraud may include (attempted) deception, falsification, misleading, concealment, a criminal offence, coercion, threats or infringement against us or a healthcare provider. We are authorised to screen for fraud in the implementation of your insurance policy. We will always do so in accordance with: - the terms and conditions and (personal) data agreed on with you, - the Dutch Health Insurance Act (‘Zorgverzekeringswet’); - the national Protocol on Incident Warning Systems for Financial Institutions (‘Protocol Incidentenwaarschuwingssystemen Financiële Instellingen’). You are under an obligation to cooperate in a fraud screening. This means, among other things, that you must provide us with correct and complete information when we ask for it. You must also help us obtain all the information we need. If you notice any (potential) irregularities at or fraud committed by a healthcare provider, for example in claims, you must report this to us

See also:
- Fraude (definitions)

Consequences of fraud
Fraud committed by you
If we suspect fraud, we will not pay any invoices relating to the suspected fraud while we investigate. If we find that you have indeed committed fraud, we may take one or several of the following measures: - terminate your insurance policy or policies. You will not receive a refund of the premiums you have paid or any costs, such as debt collection costs and interest; - terminate your entitlement to healthcare or reimbursement for healthcare costs. Any invoices that we had put on hold during the investigation will not be paid after the investigation; - claim back all reimbursements you have received from us that relate to the fraud. This applies to payments we made to you and to healthcare providers; - charge you for the costs of the fraud investigation; - record your details in our internal registration systems and incident register; - record your details in the recognised warning system used by insurers (the External Reference Index (EVR) of the Dutch Central Information System Foundation (‘Stichting CIS’); - report the fraud to the police; - refuse to insure you under any new policy for five years. Fraud committed by a healthcare provider
If a healthcare provider commits fraud, we will record the healthcare provider’s details in our internal registration systems and incident register. We may also register the healthcare provider in the recognised warning system used by insurers. If we decide that we will no longer reimburse healthcare provided by this healthcare provider in the future, we will inform the healthcare provider of our decision. The healthcare provider must inform you of this before providing any healthcare

See also:
- Fraude (definitions)