Basic and supplementary insurance policy conditions 2024

Date of commencement 1 January 2024

Basis Budget
Basis Zeker
Basis Exclusief
and supplementary insurance Vitaal and Aanvullend +

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Conditions of the basic insurance and supplementary insurances policies offered by Zilveren Kruis.

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

The government determines the contents of the basic insurance

This is laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the corresponding legislation. Every health insurer must comply strictly with these conditions. This ensures that the care covered by basic insurance is the same for everyone in the Netherlands. Basic insurance policies are 'health insurance policies' in the sense of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

What is the difference between arranged care insurance and combined insurance?

Do you have an arranged care policy? In that case, you are entitled to care (arranged by us). Do you have a combined insurance? In that case, you are entitled to reimbursement of the costs of care with the exception of B.26 Nursing and care in your own surroundings (extramural) and B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare), for which you are entitled to care (arranged by us).

How is this difference reflected in the policy conditions?

These policy conditions apply to all forms of basic insurance. No matter what kind of basic insurance you have, in these policy conditions we always refer to 'entitlement to care, medicines or medical devices'. Do you have an arranged care insurance? In that case, you should read this as 'entitlement to care, medicines or medical devices (arranged by us)'. Do you have a combined insurance? In that case, you should read this as 'entitlement to reimbursement of the costs of care, medicines or medical devices with the exception of B.26 Nursing and care in your own surroundings (extramural) and B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare) for which you have care arranged by us'

Lower reimbursement if treatment is provided by non-contracted care providers

An arranged care policy or a reimbursement policy also affects the level of reimbursement if you use a non-contracted care provider, healthcare institution or supplier. You can find out more about the lower reimbursement and contracted and non-contracted care providers, healthcare institutions and suppliers in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note!

Do you have a Basis Budget policy? Then we have contracted a limited number of hospitals for specialist medical care. What happens if you receive planable care from a non-contracted hospital? What if you use a hospital that is not contracted for Basis Budget insurance? For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Advantages of contracted care

We have contracts with a large number of care providers, healthcare institutions and suppliers. What are the advantages of using a contracted care provider?

- The contracted care provider sends the invoice directly to us. This means that you do not receive a bill from the care provider.
- No matter what kind of policy you have, the invoice is reimbursed in full if, according to the policy conditions, you are entitled to full reimbursement. The mandatory excess, any voluntarily chosen excess and (statutory) personal contributions will be deducted from the reimbursement.
- Our contracted care providers meet our quality criteria.

What applies to contracted and non-contracted care if you have supplementary insurances?

If you have supplementary insurances you are entitled to reimbursement of the costs of care. However, even if you have supplementary insurance a lower reimbursement tariff may apply if you use a non-contracted care provider. If this is the case, it will say so in the article in chapter D. Reimbursements covered by Basis Vitaal, Vitaal 1, 2, 3, Premium and Aanvullend +. The lower reimbursement tariff will also be specified. In some situations, we only reimburse the costs of care if the care is provided by our contracted care providers, even if you have supplementary insurance. Should this be the case, you will not receive any reimbursement of the costs of treatment provided by a non-contracted care provider. These conditions will also say if this applies.

How do you find a contracted care provider?

It is important for you to know whether or not we have a contract with a particular care provider. Do you want to know with which care providers and healthcare institutions we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

What information can be found in these conditions?

These conditions tell you what care is and is not reimbursed by our basic insurance and supplementary insurance policies.

The conditions are organised as follows:

- the 'Terms and conditions of the basic insurance policies' (general information about our basic insurance, such as the premium, excess and rules with which you must comply);
- the 'Care covered by the basic insurance policies' (the care to which you are entitled and the applicable terms and conditions);
- the 'Terms and conditions of the supplementary insurances policies';

- the ‘Reimbursements covered by the supplementary insurances policies’.

How do you find the care you are looking for?

Your care may be reimbursed by your basic insurance and/or your supplementary insurance. The care covered by our basic insurance can be found in chapter B. Care covered by basic insurance. The reimbursements under the supplementary insurances can be found in chapter D. Reimbursements covered by Basis Vitaal, Vitaal 1, 2, 3, Premium and Aanvullend +.

Please note!

Your care may be reimbursed by both your basic insurance and your supplementary insurance. In that case you will have to read several items in these conditions in order to discover the total reimbursement. The reimbursement under the supplementary insurance applies in addition to the reimbursement under the basic insurance.

Do you need permission?

You will see that for certain reimbursements we must give permission in advance. You can request this permission online or by telephone. Please contact us or visit our website for more information regarding permission.

The mandatory excess

For everyone aged 18 or older, basic insurance involves a mandatory excess. The government has set the mandatory excess for 2024 at €385. You are not required to pay an excess for:

- care reimbursed by any supplementary insurance you have taken out;
- care provided by a general practitioner;
- care provided for children up to the age of 18;
- items on loan, excluding maintenance costs and costs of use;
- maternity care and obstetric or midwifery care (excluding medicines, blood pressure tests and patient transport);
- integrated care;
- after-care for a donor;
- the donor’s transport costs if they are reimbursed by the donor’s basic insurance;
- the costs of nursing and care in your own surroundings.

Article A.6 What is your mandatory excess? explains more about the mandatory excess.

Voluntarily chosen excess

In addition to the mandatory excess, you can also opt for a voluntarily chosen excess. This means that you can increase your excess by € 100, € 200, € 300, € 400 or € 500. The premium for your basic insurance will then be lower. Article A.7 What is a voluntarily chosen excess? explains more about the voluntarily chosen excess.

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A. Terms and conditions of the basic insurance policies

A.1 What is the regulatory basis for basic health insurance?

1.1 This insurance contract is based on:

a. the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the accompanying explanatory notes;
b. the Health Insurance Decree (Besluit zorgverzekering) and the accompanying explanatory notes;
c. the Health Insurance Regulations (Regeling zorgverzekering) and the accompanying explanatory notes;
d. interpretations (so-called 'standpunten') adopted by the Dutch National Health Care Institute (Zorginstituut Nederland (ZINL);
e. the care advice programmes of Zorgverzekeraars Nederland;
f. our own scientific research in accordance with the guidelines of the Netherlands Healthcare Institute 2015, ratified by the Supreme Court on 30 March 2018. You can find an overview of our scientific research on our website zilverenkruis.nl/zorgaanbieders/zorgsoort/msz;
g. the application form that you (the policyholder) completed.

If these insurance conditions are inconsistent with one or more legislative provisions, explanatory notes or the interpretation thereof, the legislative provisions, explanatory notes and interpretation take precedence.

Uninsured care is never eligible for reimbursement.

1.2 This insurance contract is also based on established medical science and medical practice

The contents of the basic insurance are determined by the government and laid down in the legislation and regulations referred to in article 1.1. Among other things, these laws and regulations state that, in terms of the nature and extent of care, your entitlement to care is determined by established medical science and medical practice. What if no such criteria exist? In that case, the standard is whatever the professional field involved regards as responsible and adequate care and services.

Temporary entitlement to care that does not comply with established medical science and medical practice

The effectiveness of certain forms of care has not yet been sufficiently proven. Therefore these forms of care do not comply with established medical science and medical practice. However, in some cases, you are entitled to receive this care on a temporary basis. Until 1 January 2019, the Dutch Minister of Health, Welfare and Sport was authorised to allocate care on the basis of "conditional admission" for a certain period. For the most recent overview of this type of care, please see article 2.2 of the Health Insurance Regulations (Regeling zorgverzekering), which can be found at https://wetten.overheid.nl/jci1.3:c:BWBR0018715&hoofdstuk=2&paragraaf=1&sub-paragraaf=1.1&artikel=2.2&z=2020-05-09&g=2020-05-09. The temporary entitlement to paramedical recovery care for patients who have suffered severe COVID-19 is also included in this Regulation under articles 2.2.2 and 2.2.3.

1.3 Cooperation with municipal authorities

We have made agreements with municipal authorities in order to ensure that the care services provided in your area are organised as efficiently as possible. Some of these care services (such as nursing and care in your own surroundings for example) are reimbursed by us. Other care services, such as assistance, are reimbursed by the municipality under the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)). Under article 14a of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), we are obliged to make agreements regarding the provision of these services with the municipal authorities. These agreements are incorporated in the policy conditions insofar as they are relevant. If you receive care services provided both by the municipality and by us, please contact us.

A.2 What does the basic insurance cover and for whom is it intended?

2.1 Care entitlement

This basic insurance entitles you to healthcare. The government decides which care is insured. The insurance can be taken out with or for:

a. people living in the Netherlands who are obliged to take out insurance;
b. people living in a country other than the Netherlands who are obliged to take out insurance.

The section on 'B. Care covered by basic insurance' provides details of the care covered by your basic insurance.

2.2 Procedure for taking out insurance

You (the policyholder) apply for the basic insurance by filling in the online application form on our website or by printing the application form (PDF), filling it in, signing and posting it to us.

2.3 Application and registration

When you apply, we check whether you meet the conditions for registration under the Health Insurance Act. If you meet the conditions, we will issue a policy document. The insurance agreement is set out on the policy shedule. Every year, we will inform you (policyholder) about changes in the insurance and the new premium (for you and your co-insureds). You will receive a (family) policy shedule for this purpose. In addition, we make policy shedules available annually via Mijn Zilveren Kruis. Customers with a preference for postal communication will receive a new policy shedule when policy changes are communicated. You will also receive a health insurance card from us. You must show the policy sheet or health insurance card to the health care provider when invoking care. Thereafter, you are entitled to care according to the Dutch Healthcare Insurance Act.

2.4 The nature and extent of the care to which you are entitled is determined by the Dutch Health Insurance Act

Your entitlement to care is set out in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), the Health Insurance Decree (Besluit zorgverzekering) and the Health Insurance Regulations (Regeling zorgverzekering), which stipulate the nature and extent of the care to which you are entitled. You are only entitled to care if you are reasonably reliant on care of that nature and to that extent. We may check contracted and non-contracted care for legitimacy and efficacy.

A.3 What is not insured (exclusions)?

3.1 You are not entitled to reimbursement for care required as a consequence of an extraordinary situation in the Netherlands

You are not entitled to reimbursement for care required as a consequence of one of the following situations in the Netherlands:

a. armed conflict;
b. civil war;
c. uprising;
d. civil disturbances;
e. riot and mutiny.

This is stipulated in article 3.38 of the Dutch Financial Supervision Act (Wet op het financieel toezicht (Wft)).

3.2 Check-ups, flu vaccinations, doctors' statements and certain treatments

You are not entitled to:

a. check-ups;
b. flu vaccinations;
c. treatments for snoring (uvulopalatoplasty);
d. treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis;
e. treatments designed to result in sterilisation;
f. treatments designed to undo sterilisation;
g. treatments for circumcision without medical necessity;
h. issuance of doctors' statements.

Please note!

In some cases, you are entitled to these forms of care. For this to apply, the policy conditions must state that these forms of care are reimbursed.

3.3 Failure to uphold agreements or collect prescribed resources

You are not entitled to care if you:

- fail to uphold care agreements;
- fail to collect medical devices, medicines and dietary preparations.

In this respect it is irrelevant whether the devices, medicines or dietary preparations are supplied by the care provider or healthcare institution at your request or at the request of the prescriber.

3.4 No reimbursement for laboratory tests requested by a doctor who practices alternative medicine

You are entitled to laboratory tests and/or X-rays requested by a general practitioner, a geriatric specialist, a doctor specialised in treating people with an intellectual disability, a doctor specialised in juvenile health care, an obstetrician or midwife, an optometrist, a GGD (municipal health service) doctor (for TBC or STIs), or a medical specialist.

You are not entitled to laboratory tests and/or X-rays requested by a care provider in their capacity as a practitioner of alternative or complementary medicine.

3.5 Costs of self-administered care or care provided by a family member

You may not claim the costs of self-administered or self-referred care from your insurance. You are not entitled to these forms of care. Do you want your partner, a family member and/or a first-degree or second-degree family member to administer your care? And do you want to claim the costs of this treatment? In that case we must give you permission in advance. We only grant permission in exceptional cases. Exceptional circumstances exist if you can prove that it is necessary for care to be provided by a family member rather than another care provider.

Please note!

This condition does not apply to care paid for with a personal care allowance (persoonsgebonden budget (Zvw-pgb)).

3.6 Care required as a result of terrorism

3.6.1 Entitlement to reimbursement for part of the care

If you require care as a consequence of one or more terrorist acts, you may only be entitled to reimbursement for part of this care. This will apply if a very large number of insured persons submit a health insurance claim as a consequence of one or more terrorist acts. In that case, each insured party will only receive a percentage of their claim. In other words, if the total amount claimed from insurers or in-kind funeral insurers governed by the Financial Supervision Act (Wft) in a calendar year for damage resulting from terrorist acts is expected to exceed the maximum sum that the insurance company re-insures per calendar year, you are only entitled to care up to a percentage of the costs or value of the care or other services. This percentage is the same for all forms of insurance and is determined by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT)).

3.6.2 Definitions and provisions

The precise definitions and provisions that apply to the above-mentioned entitlement are set out in the NHT clause sheet on terrorism cover. This clause sheet and the corresponding Claims Settlement Protocol are an integral part of these policy conditions. You can find the protocol at nht.vereende.nl. The policy sheet can be found on our website or obtained from us.

3.6.3 Additional payment

We may receive an additional payment following a terrorist act. This possibility exists under article 33 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). In that case, you are entitled to an additional reimbursement as defined in article 33 of the Dutch Health Insurance Act.

3.7 No entitlement to care reimbursed under another law

You are not entitled to forms of care or other services that qualify for reimbursement under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)), the Dutch Youth Act (Jeugdwet), the Dutch 2015 Social Support Act (Wet maatschappelijke ondersteuning (Wmo) 2015) or any other statutory regulations. The nature of your care need determines the legislation under which you will be reimbursed for the care. If there is any ambiguity on the matter, we reserve the right to discuss it with all parties involved (e.g., CIZ (Dutch Care Assessment Centre), the municipal authorities, informal carers, you and Achmea) to determine the act or provisions under which entitlement to care exists. The entitlement under the Zvw ends when the care can be paid for under the Wlz.

A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

4.1 Conditions for entitlement to care from contracted and non-contracted care providers

This basic insurance entitles you to healthcare. We reimburse the part of this care that is not covered by personal contributions (including your mandatory excess). The extent of the reimbursement will depend on, among other things, which care provider, healthcare institution or supplier you choose. You can choose from:

- care providers, healthcare institutions and suppliers that have a contract with us (contracted care providers, healthcare institutions and suppliers, hereafter referred to as 'contracted care providers');
- care providers, healthcare institutions and suppliers that do not have a contract with us (non-contracted care providers, healthcare institutions and suppliers, hereafter referred to as 'non-contracted care providers').

4.2 Contracted care providers

Do you need care that is covered by the basic insurance? In that case you can choose any care provider in the Netherlands that has a contract with us. The care provider will claim the costs directly from us.

The fact that we have contracted a particular hospital or independent treatment centre does not mean that the hospital or independent treatment centre is contracted to provide all care and/or treatments provided by that facility. The hospital or independent treatment centre may only be contracted to provide certain treatment.

Do you want to know with which care providers we have a contract? Or what care and/or treatments hospitals or independent treatment centres are contracted to provide? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Remuneration ceiling

1. We agree on a remuneration ceiling with our contracted care providers. This means that, in any one calendar year, these care providers will only be paid up to a predetermined maximum amount for the care they provide. We do this to control the costs of care. This is necessary in order to prevent a significant increase in the premiums paid for care.
2. We do everything we can to minimise the impact of the remuneration ceiling as far as you are concerned. Nevertheless, you may be affected by the remuneration ceiling. For example, a care provider may not be able to schedule an appointment for you until the following year. Or, if you want to receive care without having to wait until the following year, we may ask you to see another contracted care provider. You are not obliged to comply with our request. You can choose to wait until the following year.
3. You can use the Zorgzoeker on zk.nl/zorgzoeker to find care providers with whom we have agreed a remuneration ceiling.
4. We reserve the right to temporarily or permanently remove certain care providers from the list of contracted care providers in the Zorgzoeker on our website during the course of the calendar year if the remuneration ceiling has been reached. This means that some of the care providers on the list of contracted care providers on 1 January 2024 may be removed from the list during the course of the year. As such, you may find that there is less choice on 1 December 2024 than on 1 January 2024. Please keep this in mind.

Please note:

If you have a combined policy, revenue ceilings do not affect your eligibility for reimbursement, with the exception of B.26 Nursing and care in your own surroundings (extramural) and B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare). However, you may have to submit invoices yourself in future.

4.3 Non-contracted care providers

Using a non-contracted care provider may affect your reimbursement. The level of reimbursement, if applicable, depends on your basic insurance. For each form of basic insurance the following list shows the tariffs that apply for services provided by non-contracted care providers.

Please note!

This article does not apply to any supplementary insurance policy you have taken out. Article C.2.1 What we reimburse explains the conditions that apply to the reimbursement of non-contracted care under supplementary insurance.

4.3.1 Arranged care policy (Basis Zeker)

Do you have an arranged care policy and do you use a non-contracted care provider? In that case, you are entitled to reimbursement of up to 75% of the average rate we pay for this care (provided by contracted care providers). The average contracted rate is calculated using the average of all contracts or the basic or standard rate for regular services under the Healthcare Insurance Act. Because there is no insight into the quality of the care provided by non-contracted care providers, no value is attached to the surcharges for quality.

The average contracted rate for independent treatment centres is calculated on the basis of the ZBC rate list. The lists with the amount of compensation for non-contracted hospitals and independent treatment centres can be found on our website or can be requested from us.

For examinations (first-line diagnostics) that the general practitioner or midwife requests for you and that are performed by another non-contracted care provider, e.g. an X-ray or blood test, we reimburse the costs up to a maximum of 75% of the average contracted rate.

If we purchased insufficient care and/or a contracted care provider is unable to supply the care on time, we will reimburse the costs of care up to the current maximum tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands.

If there is a maximum reimbursement for non-contracted care providers based on 75% of the average contracted tariff or the Dutch Healthcare Market Regulation Act tariff, you can ask us about the insured amount. The list of rates can also be found on our website.

If there is a maximum reimbursement based on market value in the Netherlands, you can ask us for an indication of this amount.

4.3.2 Arranged care policy with selective contracting (Basis Budget)

In addition to the limitation referred to in article 4.2 for care and/or treatment which we have not contracted in every hospital or ZBC, a Basis Budget for specialist medical care (article B.23 Plastic surgery, B.24.1 Specialist medical rehabilitation, B.25 Second Opinion, B.28 Specialist medical care and stay, B.31.1 IVF or ICSI and B.31.2 Other fertility-enhancing treatments) allows you to visit a limited number of contracted hospitals in the Netherlands. We call this selective contracting. A list of the hospitals contracted for Basis Budget insurance can be found on our website or obtained from us What if you use a hospital that is not contracted for Basis Budget insurance? What if you use a hospital that is not contracted for Basis Budget insurance? As in the case of a standard arranged care policy, you are entitled to reimbursement of up to 75% of the average tariff we pay for arranged care (provided by contracted care providers).

An exception to this is the operation for prostate cancer. Selective contracting does not apply here. You can go to all hospitals that we have contracted for prostate cancer operations.

4.3.3 The following care can also be received at non-contracted hospitals

The lower reimbursement tariff for non-contracted hospitals (referred to in articles 4.3.1 and 4.3.2) does not always apply. These include:

a. urgent medical care;
b. obstetric or midwifery care;
c. treatment provided as part of other care, such as dental surgery, laboratory tests or X-rays;
d. treatments for which you are referred to another healthcare institution by a specialist treating you (tertiary referral);
e. care that falls under the Dutch Special Medical Procedures Act (Wet op bijzondere medische verrichtingen (Wbmv));
f. treatment that falls within the scope of mental healthcare (GGZ);
g. follow-on treatments to the treatments referred to in (a) to (f) that form part of the same care need.

You can receive this care at any hospital in the Netherlands. The reimbursement of this care is limited to the current (maximum) tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, In that case, we reimburse the costs of care up to the prevailing market rate in the Netherlands.

With the exception of urgent medical care, this article does not apply to treatments abroad. For more information, see article A.15.

If there is a maximum reimbursement for non-contracted care providers based on 75% of the average contracted tariff or the Dutch Healthcare Market Regulation Act tariff, you can ask us about the insured amount. You can also find a list of rates based on 75% of the average contracted rate on our website.

If there is a maximum reimbursement based on market value in the Netherlands, you can request an indication of this amount from us.

Please note!

Are you starting a new plannable treatment after receiving one of these treatments? First check which hospitals have been contracted by Zilveren Kruis. Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. That way you can avoid having to pay part of the bill yourself or having to pay the bill and then submitting a claim.

4.3.4 Combined policy (Basis Exclusief)

If you have a combined policy and visit a non-contracted care provider other than B.26 Nursing and care in your own surroundings (extramural) and B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare), we will reimburse the costs of care up to the current maximum rate established based on the Dutch Healthcare Market Regulation Act (Wmg). If no maximum rate has been established based on the Wmg, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. Please contact us for more information about this rate.

If there is a maximum reimbursement for non-contracted care providers based on the Dutch Healthcare Market Regulation Act tariff, you can ask us about the insured amount.

Mental healthcare (GGZ) and community nursing

If you have a combined policy and visit a non-contracted health care provider for B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare) or B.26 Nursing and care in your own surroundings (extramural), you are entitled to reimbursement of up to 85% of the average rate we pay for this care provided by contracted care providers. The average contracted rate is calculated using the average of all contracts or the basic or standard rate for regular services under the Healthcare Insurance Act. Because there is no insight into the quality of care provided by non-contracted care providers, we do not reimburse quality surcharges.

4.4 You may occasionally have to repay an amount

We sometimes pay a care provider or healthcare institution more than the amount to which you are entitled under the insurance contract. This might happen if, for example, you are required to pay part of the amount yourself as a personal contribution or mandatory excess. In that case, you (the policyholder) are required to repay anything over and above the amount to which you are entitled. We will collect the amount in question by direct debit. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

4.5 Healthcare mediation services

You are entitled to healthcare mediation services. These services mean that you receive information about treatments, waiting times and differences in quality between care providers or healthcare institutions, for example. Based on this information:

- you can make your own choice, or
- if there is a waiting list, we will mediate with the care provider or healthcare institution on your behalf We call this waiting list mediation.

You are also entitled to healthcare mediation if you are looking for a new care provider or healthcare institution, possibly because you have moved home. In that case, we help you find the care provider or healthcare institution. Do you want healthcare and/or waiting list mediation services? In that case, please contact us.

A.5 What are your obligations?

5.1 You are not entitled to care if you do not fulfil your obligations

Your obligations are listed below. If you have harmed our interests by failing to fulfil these obligations, In that case you are not entitled to care.

5.2 General obligations

You are entitled to care if you fulfil the following obligations:

a. Are you obtaining care from a hospital or outpatient clinic? In that case you must hand over one of the following valid documents as proof of identity:
   - driver's license;
   - passport;
   - Dutch identity card;
   - aliens' document.

b. Does our medical advisor want to know why you were admitted? In that case you must ask your doctor or medical specialist to inform our medical adviser.

c. You must provide all the information we need and cooperate in our efforts to obtain this information. This information is used by our medical advisers and teams responsible for monitoring or conducting investigations. Naturally, we always comply with the requirements of privacy legislation.

d. You must cooperate if we want to recover costs from an accountable third party.

e. You are obliged to inform us of (possible) irregularities or fraud by care providers (in claims for example).

f. You are obliged to inform us of (possible) irregularities or fraud by care providers (in claims for example). The referral or statement is only valid if it was issued less than a year prior to the date on which you first contact the specialist to whom you have been referred. As long as you are still being treated by the same care provider for the same care need you do not have to present another referral or statement.

g. You are obliged to request our permission in advance in cases in which this is required. If you receive a positive medical assessment we will issue permission in the form of an authorisation document. What happens if you switch to another health insurer while your authorisation document is still valid? In that case your new insurer will take over the authorisation and reimburse the treatment in accordance with the insurance conditions that then apply.

5.3 Obligations if you are detained in custody

a. Are you being detained in custody? Inform us, within 30 days after being detained, when the detention started (date of commencement) and how long it will last.

b. If you have been released, you must inform us, within 2 months of being released, of the date on which you were released.

5.4 Obligations if you submit invoices yourself

Do you receive invoices from a care provider, healthcare institution or supplier? In that case send us the original and clearly specified invoices (keep a copy for your own files). You can also scan the original invoices and send them to us digitally through the Declaratie-app or Mijn Zilveren Kruis. We do not accept copies of invoices, reminders, pro-forma invoices, budgets statements, estimates, not fully used multi-use tickets (prepayment of multiple treatments at once) or any other such documents. We only issue reimbursement if we receive an original and clearly specified invoice that notes the treatment code. The treatment codes are established by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)). If you paid a healthcare provider yourself, we may request proof of payment. This applies even if you paid the invoice in question in cash. If you are unable to provide proof of payment or the original invoice when requested, we will reject your claim and you will be notified accordingly. A healthcare invoice does not qualify as proof of payment; examples of proof of payment include a written confirmation from the healthcare provider, PIN receipt or bank statement.

Do you (the policyholder) submit invoices online? In that case, you are obliged to keep the original invoices for two years after we receive them. We may ask you to submit the original invoices.

The invoice must include a valid personal AGB code if:

- under laws and regulations, the health care provider is required to have an AGB code to provide the care you received; or
- under these policy terms and conditions, the health care provider is required to have an AGB code for reimbursement of the care you received.

The care provider who treats you must issue invoices in their own name. Is the care provider a legal person (such as a foundation, a practice or a limited company)? In that case the name of the doctor or specialist who treated you must be stated on the invoice. In that case the name of the doctor or specialist who treated you must be stated on the invoice. Reimbursements to which you are entitled are always paid to you (the policyholder), via the international bank account number (IBAN) known to us. You cannot authorise a third person to receive the payment on your behalf.

5.5 Obligation to submit claims within a specified period

Be sure to submit your invoices to us as soon as possible. In any event, you must do this within 12 months of the end of the calendar year in which you were treated.

Please note!

The date of treatment and/or the supply date noted on an invoice is decisive in determining whether you are entitled to care. In other words, the date on which the invoice was drawn up is not the determining factor.

What if treatment is invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? In that case the date on which treatment starts is decisive in determining entitlement to care. You must be insured with us on the date on which treatment starts. Do you want to know what applies in your case? In that case, please contact us.

Are you submitting invoices more than 12 months after the end of the calendar year in which you were treated? In that case you may receive a lower reimbursement than the reimbursement to which you would otherwise be entitled in accordance with the conditions. We do not process invoices submitted more than 3 years after the date of treatment and/or the date on which care was provided. This is pursuant to article 942, Book 7 of the Dutch Civil Code.

5.6 Obligation to inform us about changes in your situation within 1 month

Has there been a change in your personal situation? Or in the situation of one of the other persons covered by your policy? Then you (the policyholder) must notify us of the change within 1 month. This applies to any occurrence which may be relevant to the proper implementation of the basic insurance Obvious examples include termination of the insurance obligation, emigration, a change in your international bank account number (IBAN), divorce, death or a prolonged stay abroad. If we write to you (the policyholder) at your last-known address, we are entitled to assume that the letter reached you.

Please note!

If you are moving within the Netherlands, inform your municipality on time. The Municipal Personal Records Database (Basisregistratie personen (BRP)) is leading for our administration.

A.6 What is your mandatory excess?

6.1 If you are 18 or older, you pay the first € 385 of your healthcare costs yourself

If you are 18 or older and liable to pay a premium, you have a mandatory excess for the basic insurance. The government determines what the amount is. In 2024 the mandatory excess is € 385 per insured person per calendar year.

We apply the mandatory excess to your entitlement to care. This applies to costs covered by your basic insurance incurred during the course of the calendar year. Example: you are treated in a hospital, but you receive no invoice. In that case, we reimburse the hospital directly. You (the policyholder) receive an invoice from us for € 385.

Please note!

Physiotherapy treatments for disorders on the list approved by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' (B.1 Physiotherapy and Cesar or Mensendieck remedial therapy) are always deducted from your mandatory excess. Treatments that continue into the following year are deducted from the mandatory excess for the following year.

6.2 There is no mandatory excess for some healthcare costs

We do not deduct mandatory excess from:

a. the costs of care or other services incurred in 2024 for which the invoices are not received until after 31 December 2025, unless you are responsible for submitting the invoice after that date;
b. the costs of care normally provided by general practitioners. The following care is an exception to this:
   - the costs of care associated with the care that GPs tend to provide, if this examination is performed elsewhere and is charged separately. The person or institution that carries out the examination must be authorised to charge the rate fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit);
   - care that general practitioners tend to provide but which, pursuant to article B.42 Medical care for specific patient groups is provided by a geriatrician or a doctor specialised in treating people with an intellectual disability.
c. the direct costs of obstetric care, maternity care and counselling, the NIPT and and invasive diagnostics (e.g. chorionic villus testing and amniocentesis) Related costs, such as the cost of medicines, laboratory tests, invasive diagnostics (e.g. chorionic villus sampling and amniocentesis) (B.34 Prenatal screening). Related costs, such as the cost of medicines, laboratory tests (in cases other than NIPT and invasive diagnostics) or patient transport do count towards the deductible;
d. the costs of registering with a general practitioner or with an institution that provides general practitioner care. Registration costs are defined as:
   - the sum that a general practitioner or an institution that provides general practitioner care charges you for registering you as a patient. This will not exceed the rate stipulated as the availability rate in the Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg));
   - reimbursements that are related to the method in which medical care is provided by a general practitioner, at a general practice or in an institution that provides general practitioner care. Or to the characteristics of the patient database or the location of the practice or institution. This applies insofar as we have agreed these reimbursements with your general practitioner or the institution that provides general practitioner care and insofar as a general practitioner or institution is allowed to charge us these costs if you register;
e. the costs of follow-up examinations of a donor after the care period for that donor has expired. This care period lasts, at the most, 13 weeks, or in the event of a liver transplant, six months;
f. any care costs incurred by the donor after the period referred to under e., if such costs are related to the admission for donation;
g. the donor's transport costs if these costs are reimbursed by the donor's own basic insurance;
h. the costs of integrated care that are claimed in accordance with the Policy Regulation on Performance-related funding of the provision of multidisciplinary care for chronic disorders. This policy regulation was established on the basis of the Healthcare Market Regulation Act (Wmg);
i. The costs of nursing and care normally provided by nurses under article B.26 Nursing and care in your own surroundings (extramural);
j. the costs of combined lifestyle interventions as defined in article B.36 Combined lifestyle intervention for insured persons aged 18 or older.

6.3 Mandatory excess exemptions

We have exempted the following costs from the mandatory excess:

a. the direct costs of a medication review of chronic use of prescription drugs conducted by a pharmacy contracted for this purpose;
b. the costs of the stop smoking programme and any pharmacotherapeutic interventions covered by article B.40 Stop smoking programme. This only applies if you purchase the programme from a contracted care provider other than a general practitioner, medical specialist or clinical psychologist;
c. the costs associated with setting up and implementing the coordination role for primary care stay, which are passed on to the insured persons.

6.4 Healthcare costs that we do not reimburse do not count towards the mandatory excess

In some cases you pay for part of the care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. These sums are unrelated to the mandatory excess, which means they do not count towards the € 385 mandatory excess that we deduct.

6.5 The mandatory excess commences when you reach 18 years of age

If you are turning 18 during the course of the calendar year, In that case your mandatory excess commences on the first day of the month that follows the calendar month in which you reach 18 years of age. The amount of your mandatory excess at that moment will depend on the number of days for which we can deduct mandatory excess.

6.6 Mandatory excess if your basic insurance commences later

If your basic insurance commences after 1 January, we calculate your mandatory excess based on the number of days you are insured in that calendar year.

6.7 Mandatory excess if your basic insurance ends sooner

If your basic insurance ends during the course of the calendar year, In that case we calculate your mandatory excess based on the number of days you were insured in that calendar year.

6.8 Mandatory excess in relation to a diagnosis-treatment-combination

What if treatment is invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? the moment at which the treatment started determines the mandatory excess that we have to apply. For more information on reimbursements in the case of DBCs, please see article 5.5 of these terms and conditions. If treatment is invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC)), the treatment date determines the excess we apply.

6.9 Deduction of the mandatory excess

Are you receiving care from a contracted care provider or a care provider with whom we have a payment agreement? In that case we reimburse the care provider or healthcare institution directly. Is part of your mandatory excess still payable? Is part of your voluntarily chosen excess still payable? It can also be set off against claims made under your personal care allowance (persoonsgebonden budget (Zvw-pgb)). We will collect the sum via direct debit collection. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

A.7 What is a voluntarily chosen excess?

7.1 You can opt for a voluntarily chosen excess

Each calendar year, insured persons aged 18 years or older can opt for a voluntarily chosen excess. In relation to your basic insurance you can opt for no voluntarily chosen excess, or a voluntarily chosen excess of € 100, € 200, € 300, € 400 or € 500 per calendar year. Have you opted for a voluntarily chosen excess? In that case you will receive a discount on your premium. The discount for each voluntarily chosen excess is shown in the 2024 Premium Table on our website. This overview is an integral part of this policy.

7.2 Consequence of a voluntarily chosen excess

We deduct the voluntarily chosen excess from your reimbursement. We do this after we have deducted the full amount of the mandatory excess. This applies to costs covered by your basic insurance incurred during the course of the calendar year. Example: in addition to the mandatory excess, you (the policyholder) opt for a voluntarily chosen excess of € 500. This means your total excess is (€ 385 + € 500 =) € 885. If your care provider receives € 950 from us for care that you received, your total excess will be offset against the bill. This € 885 is automatically deducted from the policyholder's account (see also article 6.9).

7.3 The voluntarily chosen excess is not offset against certain healthcare costs

We do not deduct a voluntarily chosen excess from:

a. the costs of care normally provided by general practitioners. The costs of tests or examinations performed as part of this care, which are performed elsewhere and charged for separately, are an exception in this respect. The person or institution that carries out the examination must be authorised to charge the rate fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit) for this examination. Another exception is care normally provided by general practitioners but which, under article B.42 Medical care for specific patient groups, is provided by a geriatrician or a doctor specialised in treating people with an intellectual disability;
b. the direct costs of obstetric care, maternity care and counselling, the NIPT and invasive diagnostics (e.g. chorionic villus testing and amniocentesis) (B.34 Prenatal screening). Related costs, such as the cost of medicines, laboratory tests (in cases other than NIPT and invasive diagnostics) or patient transport do count towards the deductible;
c. the costs of registering with a general practitioner or with an institution that provides general practitioner care. Registration costs are defined as:
   - the sum that a general practitioner or an institution that provides general practitioner care charges you for registering as a patient. This will not exceed the rate stipulated as the availability rate in the Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg));
   - reimbursements that are related to the way in which medical care is provided by a general practitioner, at a general practice or in an institution that provides general practitioner care. Reimbursements that are related to the way in which medical care is provided by a general practitioner, at a general practice or in an institution that provides general practitioner care. This applies insofar as we have agreed these reimbursements with your general practitioner or the institution that provides general practitioner care and insofar as a general practitioner or institution is allowed to charge us these costs if you register;
d. the costs of follow-up examinations of a donor after the care period for that donor has expired. This care period lasts, at the most, 13 weeks, or in the event of a liver transplant, 6 months;
e. any care costs incurred by the donor after the period referred to under d., if such costs are related to the admission for donation;
f. the donor's transport costs if these costs are reimbursed by the donor's own basic insurance;
g. the costs of integrated care claimed in accordance with the Performance-related funding of the multidisciplinary provision of care for chronic disorders Policy Regulation. This policy regulation was established based on the Healthcare Market Regulation Act (Wmg);
h. the costs of nursing and care normally provided by nurses under article B.26 Nursing and care in your own surroundings (extramural).
i. the costs of combined lifestyle interventions as defined in article B.36 Combined lifestyle intervention for insured persons aged 18 or older.

7.4 Voluntarily chosen excess exemptions

We have exempted the following costs from the voluntarily chosen excess:

a. The direct costs of a medication review of chronic use of prescription drugs conducted by a pharmacy contracted for this purpose;
b. the costs of the stop smoking programme and any pharmacotherapeutic interventions covered by article B.40 Stop smoking programme. This only applies if you purchase the programme from a contracted care provider other than a general practitioner, medical specialist or clinical psychologist;
c. the costs associated with setting up and implementing the coordination role for primary care stay, which are passed on to the insured persons.

7.5 Healthcare costs that we do not reimburse do not count towards the voluntarily chosen excess

In some cases you pay for part of the care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. These sums are unrelated to the voluntarily chosen excess, which means they do not count towards the voluntarily chosen excess that we deduct.

7.6 The voluntarily chosen excess commences when you reach 18 years of age

If you are turning 18 during the course of the calendar year, In that case your voluntarily chosen excess commences on the first day of the month that follows the calendar month in which you reach 18 years of age. The size of your voluntarily chosen excess at that moment will depend on the number of days over which we can deduct voluntarily chosen excess.

7.7 Voluntarily chosen excess if your basic insurance commences later

If your basic insurance commences after 1 January, In that case we calculate your voluntarily chosen excess based on the number of days you are insured in that calendar year.

7.8 Voluntarily chosen excess if your basic insurance ends sooner

If your basic insurance ends during the course of the calendar year, In that case we calculate your voluntarily chosen excess based on the number of days you were insured in that calendar year.

7.9 Voluntarily chosen excess in relation to a diagnosis-treatment-combination

What if treatment is invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? the moment at which the treatment started determines the voluntarily chosen excess that we have to apply. For more information on reimbursements in the case of DBCs, please see article 5.5.

7.10 Deduction of a voluntarily chosen excess

Are you receiving care from a contracted care provider or a care provider with whom we have a payment agreement? In that case we reimburse the care provider or healthcare institution directly. Is part of your voluntarily chosen excess still payable? Is part of your voluntarily chosen excess still payable? It can also be set off against claims made under your personal care allowance (persoonsgebonden budget (Zvw-pgb)). We will collect the sum via direct debit collection. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

7.11 Changing your voluntarily chosen excess

Do you want to alter your voluntarily chosen excess? You can do this as of 1 January of the following calendar year. You should inform us about the change to your voluntarily chosen excess by 31 December at the latest. The amendment period is also listed in article 12.5.

A.8 What will you have to pay?

8.1 We determine the premium for insured persons aged 18 or older

We determine the amount of the premium for your basic insurance. The premium you are liable to pay is the basic premium minus any discount due to the voluntarily chosen excess. We calculate the discount according to the premium calculation.

You can also pay your premium per year or half-year in advance. In that case, you will receive a discount on the total premium.

We charge a premium for insured persons aged 18 years or older. Is the insured person about to turn 18? Then you (the policyholder) must pay a premium as of the first of the month following the month in which the insured person becomes 18 years old.

Well before the insured person's 18th birthday, you will receive more information about the possibility of changing the insurance from the insured person's 18th birthday.

8.2 You (the policyholder) pay the premium

You (the policyholder) must pay the premium in advance. You may not offset the premium that you (the policyholder) have to pay against your reimbursement.

You may not offset the premium that you (the policyholder) have to pay against your reimbursement. Then we will refund any premium overpayment. In this case we assume that a month has 30 days. If we terminate your insurance due to fraud or deception (see also article A.20 of these terms and conditions)? we may deduct an administration fee from the premium that we have to refund.

8.3 How you (the policyholder) pay the premium and other costs

We prefer you (the policyholder) to pay the following sums by payment email (iDEAL) or direct debit:

a. premium;
b. mandatory excess and voluntarily chosen excess;
c. statutory personal contributions;
d. personal contributions;
e. any other amounts you owe us.

If you (the policyholder) choose to use a method of payment other than iDEAL or direct debit, you may have to pay administration costs.

8.4 You will be notified of a direct debit 14 days in advance

We send you (the policyholder) advance notice of collection of payment by direct debit. We endeavour to notify you (the policyholder) 14 days before we collect the payment. This does not apply to notification of the new premium. We announce collection of the premium by direct debit once a year on the policy certificate, which is sent to you or made available in Mijn Zilveren Kruis.

A.9 What happens if you do not pay on time?

9.1 Rules apply to how you pay the premium

If you are liable to pay the premium, then you must comply with these rules. This also applies to a third party who pays the premium.

9.2 We set off arrears in premium payments and/or any overdue excess against claims submitted and any personal care allowance (Zvw-pgb)

If you (the policyholder) claim healthcare costs which we have to pay to you, any outstanding premium payments and/or excess will be set off against the payout. We also set off outstanding premium payments and/or excess against claims made under your personal care allowance (Zvw- pgb).

9.3 If you (the policyholder) exceed the payment term

Have you (the policyholder) opted to pay the premium per year or half-year? And have you failed to pay the premium within the period we stipulated? In that case we reserve the right to demand that you (the policyholder) start paying your premium monthly again. The consequence of this is that you no longer have a right to a payment discount.

9.4 You can only cancel your insurance after overdue premiums have been paid

Have we ordered you to pay one or more instalments of the premiums payable? In that case you (the policyholder) may not cancel the basic insurance until you have paid the premium, interest and collection costs due. An exception for this is if we suspend or defer your basic insurance cover or if we confirm your cancellation within two weeks.

9.5 Exception to article A.9.4

Article 9.4 of these terms and conditions does not apply if we confirm the cancellation to you (the policyholder) within 2 weeks.

A.10 What happens if you fall behind with your payments?

10.1 Payment arrangement if you have not paid your premium for 2 months.

If we establish that you have not paid the monthly premium for 2 months, In that case we will send you (the policyholder) a payment arrangement in writing within 10 working days. This payment arrangement means that:

a. you (the policyholder) authorise us to collect new monthly premiums from you (the policyholder) or a third party by direct debit;
b. you (the policyholder) agree to repay us the overdue premiums and health insurance debts in instalments;
c. you (the policyholder) agree to repay us the overdue premiums and health insurance debts in instalments; This does not apply if you (the policyholder) withdraw the authorisation described under a, or if you (the policyholder) fail to comply with the payment agreements stipulated under b.

The letter will state that you (the policyholder) have 4 weeks to accept the arrangement. It will also inform you (the policyholder) what will happen if you (the policyholder) have not paid the monthly premium for 6 months. Furthermore, the letter offering the payment arrangement will provide you (the policyholder) with information about assistance with debts, how you (the policyholder) can obtain such assistance and what debt assistance is available.

10.2 Payment arrangement if you (the policyholder) insure someone else

Have you (the policyholder) insured someone else? And have you (the policyholder) failed to pay that person's monthly premium for the basic insurance for 2 months? In that case the payment arrangement also means that we offer you (the policyholder) the chance to cancel this insurance on the day that the payment arrangement commences. This offer only applies if:

a. the insured person has taken out basic insurance for themselves elsewhere on the date that the payment arrangement enters into effect, and
b. the insured person authorises us to collect new monthly premiums by direct debit if they have taken out basic insurance with us.

10.3 Insured person receives copies of information about the payment arrangement

If article 10.2 of these terms and conditions applies, we will send the insured person(s) copies of the documents mentioned in article 10.1, 10.2 and 10.4 that we send to you (the policyholder). These documents are sent simultaneously.

10.4 What happens if you (the policyholder) have not paid your monthly premium for 4 months?

Have you (the policyholder) failed to pay the monthly premium for 4 months? In that case you (the policyholder) and anyone co-insured with you will be informed that we intend to report you (the policyholder) to the Central Administration Office (Centraal Administratie Kantoor (CAK)) the moment you (the policyholder) have failed to pay monthly premiums for 6 months or longer. What happens if we report you (the policyholder) to the Central Administration Office? In that case the Central Administration Office will collect an administrative premium from you (the policyholder).

You (the policyholder) can also ask us if we are willing to enter into a payment arrangement with you (the policyholder). You (the policyholder) can read about what this payment arrangement entails in article 10.1 of these terms and conditions. If we agree a payment arrangement with you (the policyholder), we will not report you (the policyholder) to the Central Administration Office as long as you (the policyholder) pay the new monthly premiums on time.

10.5 If you (the policyholder) disagree with the payment arrears

If you (the policyholder) disagree with the payment arrears and/or our plan to report you to the Central Administration Office (CAK) as described in article 10.4, you should inform us by sending us a letter of objection. In that case we will not report you (the policyholder) to the Central Administration Office for the time being. We will first investigate whether we calculated your debt correctly. Is our conclusion that we calculated your debt correctly? In that case you (the policyholder) will be informed. If you (the policyholder) disagree with our opinion, then you (the policyholder) can put the matter before the Health Insurance Complaints and Disputes Board (Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ)) or take it to the civil court. You (the policyholder) must do this within 4 weeks of the date on which you (the policyholder) received the letter informing you of our assessment. Also in this case we will not report you (the policyholder) to the Central Administration Office for the time being. See also article A.18 of these terms and conditions regarding complaint handling.

10.6 What happens if you (the policyholder) have not paid your monthly premium for 6 months?

Have we established that you (the policyholder) have not paid the monthly premium for 6 months? Then we will report you (the policyholder) to the Central Administration Office. From this moment on you will no longer pay a flat-rate premium to us. From this moment on you will no longer pay a flat-rate premium to us. We will provide the Central Administration Office with your personal details and those of any person(s) that you (the policyholder) have insured with us for this purpose. We will only provide the Central Administration Office with the personal details it needs to be able to charge you (the policyholder) the administrative premium. You (the policyholder) and the person(s) whom you (the policyholder) have insured will receive notification about this from us.

10.7 Have all the premiums been paid? Then we will terminate your registration with the Central Administration Office (CAK)

If, following the intervention of the Central Administration Office, you (the policyholder) have paid the following amounts, we will terminate your registration with the Central Administration Office:

a. the outstanding premium;
b. the amount owed based on invoices for healthcare costs;
c. the statutory interest;
d. any debt collection costs;
e. any costs of proceedings.

Once we have terminated your (the policyholder's) registration with the Central Administration Office, the collection of the administrative premium will cease. Instead, you will start paying us the flat-rate premium again.

10.8 The information we send you (the policyholder) and the CAK

We inform you (the policyholder and the insured person) and the Centraal Administratie Kantoor (CAK) (Central Administration Office) immediately of the date on which:

a. the debts accumulated with regard to the basic insurance were (or will have been) repaid or annulled;
b. the debt management scheme for natural persons, as defined in the Dutch Bankruptcy Act (Faillissementswet) becomes applicable to you (the policyholder);
c. an agreement was entered into as defined in article 18c, second paragraph, subclause (d.) of the Health Insurance Act (Zorgverzekeringswet (Zvw)). This agreement must have been entered into through the mediation of a debt counsellor, as referred to in article 48 of the Dutch Consumer Credit Act (Wet op het consumentenkrediet (Wck)). Or we will inform you (the policyholder) and the Central Administration Office of the date on which a debt repayment plan has been arranged. Apart from yourself (the policyholder), the debt repayment plan must also involve, at least, your health insurer.

A.11 What happens if your insurance premium and/or conditions change?

11.1 Adjustment of the premium base and conditions

We can change the basis for the premium calculation and the conditions of your basic insurance. For example, because the composition of the basic package has altered. We will send you (the policyholder) a new offer, according to the new basis for the premium calculation and the altered conditions.

11.2 Changes to the basis for your premium calculation

An alteration in the basis for your premium calculation will not come into force earlier than 7 weeks after the day on which we informed you (the policyholder) about it. You (the policyholder) can cancel the basic insurance as of the day on which the alteration comes into force (usually 1 January). This means that you (the policyholder) have in any case 1 month to cancel your basic insurance from the moment that we informed you about the alteration.

11.3 Changes to the conditions and/or your entitlement to care

What if alterations in the conditions and/or entitlement to care are disadvantageous for the insured person? In that case you (the policyholder) are allowed to cancel the basic insurance. This does not apply if this alteration occurs due to an amendment in a statutory provision. You (the policyholder) can cancel the basic insurance as of the day on which the alteration comes into force. This means that you (the policyholder) have 1 month to cancel your basic insurance from the moment we inform you of the alteration.

A.12 When does your basic insurance commence?

12.1 The date of commencement is listed on the policy certificate

The basic insurance commences on the date of commencement that appears on the policy certificate. This date of commencement is the day on which we received the application from you (the policyholder) to take out basic insurance. We tacitly renew the basic insurance every year on 1 January of the following year. This is done for a period of 1 calendar year.

12.2 Are you already insured? In that case, the insurance can commence later

Is the person for whom we provide basic insurance already covered by basic insurance on the day on which we receive your application? Have you (the policyholder) indicated that you want the basic insurance to commence later than the date mentioned in article 12.1 of these terms and conditions? In that case the basic insurance will commence on the later date that you (the policyholder) have indicated.

12.3 Insurance should be taken out within 4 months after the obligation to take out insurance arises

Will the basic insurance commence within 4 months after the obligation to take out insurance arose? In that case we shall keep to the day on which the obligation to take out insurance arose as date of commencement.

12.4 Insurance can have retroactive effect for up to 1 month

Will the basic insurance commence within 1 month of another basic insurance policy being cancelled as of 1 January? In that case the new insurance will commence retroactively from the day on which the previous basic insurance was cancelled. In this matter we can depart from that which is stipulated in article 925, first paragraph, Book 7 of the Dutch Civil Code. The retrospective effect of the basic insurance will also apply if you cancelled your previous insurance because the conditions became unfavourable to you. This is stipulated in article 940, fourth paragraph, Book 7 of the Dutch Civil Code.

12.5 Altering your basic insurance

Have you taken out basic insurance with us? In that case you (the policyholder) can alter this as of 1 January of the next calendar year. You will receive written confirmation of this. You must inform us about the alteration by 31 December at the latest.

12.6 Agreements about the date of commencement in the case of a group discount

The group basic insurance also applies to your family. Does the group contract contain limiting agreements about the age at which your children can take advantage of your group discount? we will inform your children about this in writing.

A.13 When can you cancel your basic insurance?

13.1 Revoking your basic insurance

You (the policyholder) can revoke basic insurance that you have just taken out. This means that you (the policyholder) can cancel the basic insurance within 14 days after you have received your policy certificate or it has been made available to you in Mijn Zilveren Kruis. You can revoke your insurance through Mijn Zilveren Kruis on our website, by letter or by telephone. You (the policyholder) are not required to give reasons for this. In this case we will assume that your basic insurance did not commence.

Have you (the policyholder) revoked your basic insurance with us? In that case you (the policyholder) will receive a refund of any premium that has already been paid. If we have already reimbursed healthcare costs under the policy, then you (the policyholder) must repay the amounts in question.

13.2 Cancelling your basic insurance

You (the policyholder) can cancel your basic insurance:

a. Through Mijn Zilveren Kruis on our website, by letter or by telephone. We must receive notice of cancellation by 31 December at the latest. In this case the basic insurance will end on 1 January of the following year. Have you (the policyholder) notified us that you wish to cancel your basic insurance with us? In that case the cancellation is irrevocable.
b. You (the policyholder) can make use of the cancellation service provided by your new health insurer. Have you (the policyholder) taken out basic insurance for the next calendar year by 31 December of the current calendar year at the latest? Then your new health insurer will cancel your basic insurance with us on your (the policyholder's) behalf.
c. Have you (the policyholder) insured someone other than yourself and has that insured person taken out other basic insurance? This could be the case if, for example, your child turns 18 or leaves home, or if a relationship or marriage is terminated. In that case, you (the policyholder) can cancel the insurance for this person through Mijn Zilveren Kruis on our website, by letter or by telephone. Did we receive this cancellation before the date of commencement of the new insurance? In that case the basic insurance will end on the day that the insured person's new basic insurance commences. In other cases the termination date is the first day of the second calendar month following the day on which you (the policyholder) cancelled.
d. You (the policyholder) may switch from one group basic insurance scheme to another, because you have terminated your employment with one employer and/or commenced employment with a new employer. In that case, you (the policyholder) have up to 30 days from the date on which the old employment ended to cancel the old basic insurance. The cancellation does not take place retrospectively and commences on the first day of the next month.
e. It may also be the case that your participation in a group basic insurance scheme via an authority is terminated. The reason for cancellation may be that you (the policyholder) will start participating in a group basic insurance scheme via an authority that pays your allowance in a different municipality, or that you will start participating in a group basic insurance because you have new employment. You (the policyholder) have up to 30 days from the date on which your participation in the group basic insurance scheme ended to cancel the old basic insurance. The cancellation does not take place retrospectively and commences on the first day of the next month.

Have you notified us that you wish to cancel your insurance? In that case we will notify you (the policyholder) to this effect. The date on which the insurance ends will be specified in the confirmation.

A.14 In what situations will we cancel your basic insurance?

14.1 In some cases, we will cancel your basic insurance

We will terminate your insurance:

a. commencing on the day after the day on which your no longer fulfil the requirements for registering for basic insurance;
b. on the date on which you are no longer insured under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz));
c. if you are a member of the military in active service;
d. in the event of proven fraud as described in article A.20 of these terms and conditions;
e. in the event of death;
f. if we are no longer allowed to offer or implement basic insurance, because our permit to operate as a general insurance company is altered or withdrawn. In that case, we inform you about the matter at least 2 months in advance;
g. if we withdraw our basic insurance from the market for reasons that we consider to be important, we are entitled to terminate your basic insurance unilaterally.

Are we cancelling your insurance? In that case we will notify you (the policyholder) to this effect. The reason for the termination of your insurance and the date on which the insurance terminates will be specified in our letter.

14.2 Basic insurance also lapses in the event of illegal registration

Was an insurance contract issued for you under the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw))? And has it since become apparent that you were not obliged to take out insurance? In that case, the insurance contract will lapse with retroactive effect from the date on which you were no longer obliged to take out insurance. Have you (the policyholder) paid premiums while you were no longer obliged to take out insurance? In that case we will set off the premiums against the reimbursement of care costs that you (the policyholder) subsequently received. If the premiums you (the policyholder) paid exceed the reimbursements you (the policyholder) received, we will refund the difference. Have the reimbursements you (the policyholder) received exceeded what you (the policyholder) have paid in premiums? In that case we shall charge you (the policyholder) the difference. In this case we assume that a month has 30 days.

14.3 Cancellation if you were registered under article 9a to d incl. of the Dutch Health Insurance Act (Zvw)

14.3.1 Insured under the Dutch Health Insurance (Detection and Insurance of Uninsured) Act

Has the Central Administration Office (Centraal Administratie Kantoor (CAK)) insured you with us under the Dutch Health Insurance (Detection and Insurance of Uninsured) Act (Wet opsporing en verzekering onverzekerden zorgverzekering)? In that case you can have this insurance annulled (nullified). This must be done within 2 weeks of the date on which the Central Administration Office informed you that you were insured with us. To be able to nullify the insurance you must prove to the Central Administration Office and to us that you already had other health insurance during the preceding period. This is the period as referred to in article 9d, paragraph 1 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

14.3.2 Annulment of the insurance contract

We are authorised to nullify—on account of error—an insurance contract entered into with you, if it later becomes apparent that you were not, at that moment, obliged to take out insurance. In this matter, we deviate from article 931, Book 7 of the Dutch Civil Code.

14.3.3 You cannot cancel during the first 12 months of the insurance term.

You cannot cancel the basic insurance as referred to in article 9d, paragraph 1 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) during the first 12 months of its term of validity. This deviates from article 7 of the Dutch Health Insurance Act, unless the fourth paragraph of that article applies to you. in which case you are allowed to cancel it.

A.15 When are you entitled to reimbursement of healthcare received abroad?

15.1 Care in a treaty country, EU member state or EEA country

Are you receiving care in a treaty country, EU member state or EEA country? In that case you can choose from entitlement to:

a. care according to the statutory regulations of that country, on the grounds of provisions of the EU social security regulation, or as stipulated in the relevant treaty;
b. reimbursement of the costs of care provided by a hospital or independent treatment centre (ZBC) in another country with whom or with which we have a contract;
c. reimbursement of the costs of care up to our contracted rate in the event that a contracted hospital or ZBC abroad outsources a diagnostic part of the contracted treatment to another care provider with which the contracted hospital or ZBC has a partnership;
d. reimbursement of the costs of care provided by a non-contracted care provider or healthcare institution. In that case you are entitled to reimbursement as specified in the section on 'Care covered by the basic insurance policies' up to:
   - the lower reimbursement if lower reimbursement is specified in the section on 'Care covered by the basic insurance policies';
   - the (maximum) tariff currently set on the basis of the Dutch Healthcare Market Regulation Act (Wet marktverordening gezondheidszorg (Wmg));
   - the prevailing market rate in the Netherlands. This applies if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act.

The reimbursement is reduced by any personal contribution that you are liable to pay.

Please note!

In addition to the provisions of this article, the conditions and exclusions that apply to the healthcare in question in the Netherlands also apply to healthcare received abroad. Do you need a referral, for example? In that case, the same will apply abroad.

15.2 Reimbursement of care in a country that is not a treaty country, an EU country or a member of the EEA

Are you receiving care in a country that is not a treaty country, an EU country or a member of the EEA? In that case you are entitled to reimbursement of the costs of care provided by a non-contracted care provider or healthcare institution as specified in the section on 'Care covered by the basic insurance policies' up to:

a. the lower reimbursement if lower reimbursement is specified in the section on 'Care covered by the basic insurance policies';
b. the (maximum) tariff currently set on the basis of the Dutch Healthcare Market Regulation Act (Wet marktverordening gezondheidszorg (Wmg));
c. the prevailing market rate in the Netherlands. This applies if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act.

The reimbursement is reduced by any personal contribution that you are liable to pay.

Please note!

In addition to the provisions of this article, the conditions and exclusions that apply to the healthcare in question in the Netherlands also apply to healthcare received abroad. Do you need a referral, for example? In that case, the same will apply abroad.

15.3 Conversion rate of foreign currencies

Reimbursement of the costs of care given by a non-contracted care provider is issued to you (the policyholder) in euros. We do this according to the daily conversion rates published by the European Central Bank. We use the rate that was applicable on the date of the invoice. Reimbursements to which you are entitled are always paid to you (the policyholder), by bank transfer to the bank account number (IBAN) known to us. This must be an account number (IBAN) of a bank that has its registered office in the Netherlands.

15.4 Invoices from abroad

Healthcare invoices should preferably be written in Dutch, French, German, English or Spanish. If we feel it is necessary, we may ask you to have an invoice translated by a certified translator. We do not reimburse translation costs.

A.16 Nonliability for damage caused by a care provider or healthcare institution

We are not liable for any damage you suffer as a result of an action or omission by a care provider or healthcare institution. This applies even if the care or assistance provided by the care provider or healthcare institution was covered by the basic insurance.

A.17 What should you do if a third party is liable?

17.1 You must inform us

If a third party is liable for costs resulting from your illness, accident or injury, you must provide us, free of charge, with all information necessary to recover the costs from the responsible party. The right of recovery is based on statutory regulations. This does not apply to liability that results from statutory insurance, health insurance subject to public law or a contract between you and another (legal) person.

17.2 Duty to report

Have you become ill, suffered an accident or sustained an injury in some other way? Did the incident involve a third party, as referred to in article 17.1 of these terms and conditions? In that case you must report this (or have it reported) to us as soon as possible. You must also report the incident (or have it reported) to the police.

17.3 No unauthorised settlement with third parties

You may not enter into an arrangement that undermines our rights. You may only make an arrangement with a third party, their insurer, or a person acting on their behalf, if you have received written permission from us.

A.18 Do you have a complaint?

18.1 You can submit your complaint to our Central Complaints Coordination Department.

If you disagree with a decision we have made or are you dissatisfied with our services, you can submit your complaint to our Central Complaints Coordination Department. You must do this within 6 months of the date on which we informed you of our decision or provided the service. You can notify us of your complaint in a letter, by telephone or through our website.

Complaints must be written in Dutch or English. If you submit a complaint in a language other than Dutch or English, you will have to pay any translation costs.

18.2 What do we do with your complaint?

As soon as we receive your complaint, we enter it in our complaint registration system. You will receive confirmation of receipt. We will then send you a detailed response within 5 working days. If we need more time to process your complaint, we will let you know.

18.3 Do you disagree with our response? You can have your complaint reassessed

Do you disagree with how we dealt with your complaint? In that case you can ask us to reassess your complaint. You can contact the Central Complaints Coordination Department to request a reassessment by post, email, telephone, or through our website. You will receive confirmation of receipt. We will then send you a detailed response within 5 working days. If we need more time to process your complaint, we will let you know.

18.4 You can also submit your complaint to the Health Insurance Complaints and Disputes Board (SKGZ)

Not interested in having your complaint reassessed? Or did our reassessment fail to meet your expectations? In that case, you can submit your complaint to the Health Insurance Complaints and Disputes Board (SKGZ), PO Box 291, 3700 AG Zeist, the Netherlands (skgz.nl). SKGZ will be unable to process your request if a judicial authority is already examining your case or has already ruled on it.

18.5 Recourse to a civil court

Instead of approaching SKGZ, you can also take your complaint to the civil court. You can also turn to a civil court after SKGZ has issued a ruling. In that case the court will determine whether the way in which the ruling was reached is acceptable. You can also take the matter to a civil court if we fail to comply with the ruling issued by SKGZ.

18.6 Complaints about forms

Do you find our forms superfluous or too complicated? In that case you can submit your complaint not only to us, but also to the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)). If the NZa rules on such a complaint, then this is regarded as binding advice.

18.7 Applicable law

This contract is governed by Dutch law.

More information?

Would you like more information about how to submit a complaint to us, how we will deal with it and about the SKGZ procedures? In that case you can download the brochure 'Klachtenbehandeling bij zorgverzekeringen' from our website. You can also request a copy of this brochure from us.

A.19 How do we handle your personal details?

19.1 Achmea B.V. is responsible for processing your data

Zilveren Kruis is part of the Achmea Group. Achmea B.V. is responsible for processing your data. If you apply for insurance or a financial service, we ask you for personal details. The companies that are part of Achmea B.V. use your details:

a. to enter into and execute contracts;
b. to inform you about and offer you relevant products and/or services provided by companies owned by Achmea B.V.;
c. to improve products and services;
d. to guarantee the safety and integrity of the financial services sector;
e. to conduct scientific research and perform statistical analysis;
f. to assess risks;
g. to maintain relationships;
h. to comply with statutory obligations.

For a complete overview of the possible uses of your data, please refer to our Privacy Statement, available at zilverenkruis.nl.

We comply with privacy legislation and regulations when processing your personal data. This includes:

- the General Data Protection Regulation (GDPR);
- the GDPR Implementation Act;
- the Code of Conduct for the Processing of Personal Data by Health Insurers (Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars);
- the Incident Alert System Protocol for Financial Institutions;
- the Personal Investigation Code of Conduct;
- the Telecommunications Act.

For more information, see our Privacy Statement, available at zilverenkruis.nl.

19.2 We consult the Central Information System when processing applications

To ensure responsible acceptance policy, Zilveren Kruis is permitted to consult the data held on you by the Central Information System (CIS) Foundation in Zeist (a foundation that retains insurance data for companies). Members of the CIS Foundation can also exchange data with one another. The purpose of this process is to manage risks and combat fraud. All exchange of information through the CIS Foundation is governed by CIS privacy regulations. For more information, visit stichtingcis.nl.

19.3 We are allowed to forward your details to third parties

From the moment that your basic insurance commences, we are allowed to ask for and pass on your address, insurance and policy details to third parties (including care providers, healthcare institutions, suppliers, Vecozo (the Healthcare Communication Centre), Vektis (the Health Insurer Information Centre) and the Central Administration Office (Centraal Administratie Kantoor (CAK)). We are allowed to do this insofar as is necessary to comply with the obligations based on the basic insurance. Are there urgent reasons why it is imperative that third parties may not have access to your address, insurance and policy details? In that case, you can report this to us in writing. Achmea does not sell your data.

19.4 We register your citizen service number

We are under a statutory obligation to register your citizen service number (BSN) in our administration. Your care provider or healthcare institution is under a statutory obligation to use your BSN on all forms of communication. Other care providers who provide care within the framework of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) are under the same obligation. This means that we use your BSN when we communicate with these parties.

19.5 Information about your rights and how Achmea uses your data

You can find more information in the Privacy Statement published on our website. The Privacy Statement provides information on your rights and how we process personal data.

A.20 What are the consequences of fraud?

20.1 What is fraud?

Fraud is when someone obtains or tries to obtain a reimbursement from an insurer, or an insurance contract with us:

a. under false pretences;
b. on improper grounds and/or in an improper way.

In this contract we define it specifically as one or more of the following activities. You are committing fraud if you and/or someone else who has an interest in the reimbursement have/has:

a. misrepresented the facts;
b. submitted false or misleading documents;
c. made a false statement regarding a claim that has been submitted;
d. have concealed facts that could be important for us in assessing a claim that has been submitted.

20.2 No reimbursement in the event of fraud

In the event of proven fraud, all right to reimbursement of the costs of care covered by the basic insurance ceases to apply. This also applies to situations in which true statements were made and/or the facts were represented correctly.

20.3 Other consequences of fraud

Furthermore, fraud may form a reason for us to:

a. report the matter to the police;
b. cancel your insurance contract(s), in which case you will only be able to take out another insurance contract with us after 5 years;
c. register you in acknowledged signalling systems between insurers (such as CIS);
d. reclaim reimbursement(s) that were paid out and (examination) costs that were incurred.

A.21 Definitions

Terms used in this insurance contract are explained below. What do we mean by the following terms?

Acute care

Care related to a potentially serious or acutely life-threatening condition experienced or observed due to a health problem or injury that has suddenly occurred or been aggravated.

Pharmacy

By pharmacy we are referring to dispensing general practitioners, (internet) pharmacies, chain store pharmacies, hospital pharmacies and pharmacies in outpatient clinics.

Doctor

A person who is competent to carry out the profession of medicine on the grounds of Dutch legislation and is registered as such with the competent government authority within the framework of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Basic insurance

Health insurance as laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

Company doctor

A doctor who is listed as a company doctor in the register, set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Medical Specialists Registration Committee), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society) and who acts on behalf of an employer or on behalf of the Occupational Health and Safety Office (arbodienst) with which the employer is affiliated.

Pelvic physiotherapist

A physiotherapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as a pelvic physiotherapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Proof of diagnosis

A diagnosis established and recorded in your medical record by a general practitioner, a company doctor, a geriatric specialist, a doctor specialised in treating people with an intellectual disability, a doctor who specialises in juvenile health care or another medical specialist. You do not need a referral for the treatment if you can present proof of your diagnosis to the paramedical care provider.

Centre for Exceptional Dentistry

An institution for dental care in special cases, characterised by a partnership of differentiated oral care providers with specific expertise, skills, knowledge and facilities or supported by other disciplines (such as psychology, physical therapy and speech therapy). At a Centre for Exceptional Dentistry, consultation, diagnostics and treatment are provided to patients with special dental problems, often in a multidisciplinary context.

Centre for genetic research

An institution that has a permit on the grounds of the Dutch Special Medical Procedures Act (Wet op bijzondere medische verrichtingen (Wbmv)) for applying clinical genetic research and providing genetic advice.

Contract with preferential policy

We define this as a contract between us and the pharmacy in which specific agreements are made about preferential policy and/or the supply and payment of pharmaceutical care.

Day treatment

Admission lasting less than 24 hours.

Diagnosis-treatment combination (DBC)

A DBC describes a self-contained and validated specialist medical process, by means of a DBC code established by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)) under the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). This includes all or part of the entire care process, from the diagnosis made by the care provider to the completion of any resulting treatment. The DBC process commences the moment the insured submits a request for care and is completed when treatment ends or after 120 days.

Dietitian

A dietitian who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Primary care stay

A medically necessary short stay for medical care normally provided by general practitioners, which may also involve nursing, general care, psychological or paramedical care. The institution must have a formally required authorisation for the provision of primary care accommodation and must demonstrably meet all the conditions for this (unless the law no longer requires this).

Occupational therapist

An occupational therapist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

EU and EEA member state

This includes, apart from the Netherlands, the following countries of the European Union: Belgium, Bulgaria, Cyprus (Greek), Denmark, Germany, Estonia, Finland, France, (including Guadeloupe, French Guiana, Martinique, Mayotte, Saint Martin and La Réunion), Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal (including Madeira and the Azores), Romania, Slovenia, Slovakia, Spain (including Ceuta, Melilla and the Canary islands), the Czech Republic and Sweden. Switzerland is equated with these countries on the grounds of treaty provisions. Members of the EEA (countries that are party to the contract concerning the European Economic Area) are Lichtenstein, Norway and Iceland.

Pharmaceutical care

Pharmaceutical care is defined as:

a. the provision of medicines and dietary preparations designated in this insurance contract, and/or
b. advice and guidance as normally provided by pharmacists when performing a medication review and informing you of responsible use of medication, hereby taking into account our Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).

Physiotherapist

A physiotherapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as a physiotherapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Birth centre

A delivery facility in or on the premises of a hospital, possibly combined with a maternity care facility. A birth centre can be equated with a birthing hotel and a delivery centre.

Behavioural scientist

A behavioural scientist is understood to mean a health psychologist, clinical psychologist, remedial educationalist (-generalist) or a child and youth psychologist or equivalent BIG- registered care provider with a Bachelor of Applied Science or Master's degree.

Geriatric physiotherapist

A geriatric physiotherapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as a geriatric physiotherapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Mental healthcare

Diagnosis and treatment of mental disorders. The GGZ Quality Charter specifies who is qualified to act as a specialist in charge of this care.

Specialised nursing

Specialised nursing is care offered by nurses and specifically aimed at restoring health or preventing worsening of disease or disorder by alleviating suffering and discomfort, among other things. This nursing is related to the need for medical care or a high risk thereof. Observation/monitoring, personal care and guidance interwoven with nursing—including help with chronic health care problems and/or complex care questions—are also included in this care. This includes the direct contact time interwoven with specialised nursing when using home care technology. The same applies to the direction and coordination of multidisciplinary care provision and support and instruction on matters that are directly related to the patient's need for care and, if requested, to the patient's relatives. This care also includes being able to call the care provider concerned outside the agreed fixed times to provide specialised nursing.

Family

One adult, or two married or cohabiting people, and any unmarried biological, step, foster or adopted children under 30 still living at home for whom there is an entitlement to child benefits, benefits under the Wet tegemoetkoming onderwijsbijdrage en schoolkosten (Wtos) or extraordinary expense deductions under tax law.

Healthcare psychologist

A healthcare psychologist registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

GGZ institution

An institution that provides medical care in connection with a psychiatric disorder and which is authorised as such.

Skin therapist

A skin therapist who has been trained in accordance with the Skin Therapists (Professional Training Requirements and Area of Expertise) Decree (Besluit opleidingseisen en deskundigheidsgebied huidtherapeut (Stb. 2002, nr. 626)). This decree is based on article 34 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

General practitioner

A physician listed as a general practitioner in the register of accredited general practitioners established by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) appointed by Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Association), and who practices as a general practitioner in the usual way.

Medical devices

Provisions that fulfil the need of functioning medical devices and bandages designated in the Health Insurance Regulations (Regeling zorgverzekering), taking into account the regulations we have stipulated on permission requirements, terms of use and rules pertaining to volume.

Doctor specialised in juvenile health care

A doctor who is listed as such, with the profile Juvenile health care, in the registers of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society), set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Medical Specialists Registration Committee).

Dental surgeon

A dental specialist listed in the register of specialists in oral diseases and dental surgery of the Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde (KNMT) (Royal Dutch Dental Association).

Calendar year

The period from 1 January up to and including 31 December.

Integrated care

A programme of care that is organised around a given disorder.

Child and youth psychologist

A child and youth psychologist registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and listed in the Child and Youth Psychologists' Register (Register Kinder- en Jeugdpsycholoog) maintained by the Dutch Institute of Psychologists (Nederlands Instituut van Psychologen (NIP)).

Paediatric physiotherapist

A paediatric physiotherapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as a paediatric physiotherapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Paediatric remedial therapist

A paediatric remedial therapist registered as such according to the conditions of the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, and registered as a paediatric Cesar/Mensendieck remedial therapist in the Paramedic Quality Register (KP).

Clinical psychologist

A healthcare psychologist registered as such in accordance with the conditions referred to in article 14 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Maternity centre

An institution that offers obstetric, midwifery and/or maternity care and which fulfils the requirements stipulated by law.

Maternity care

Care provided by a qualified maternity carer or by a nurse who works as such.

Laboratory tests

Tests carried out by a legally accredited laboratory.

Speech therapist

A speech therapist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Informal care

Informal care refers to the provision of unpaid, long-term care for a chronically ill or handicapped person in your immediate social circle.

Manual therapist

A manual therapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as a manual therapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Medical adviser

A doctor who advises us on medical matters.

Medical specialist

A doctor who appears in the Registratiecommissie Geneeskundig Specialisten (RGS) (Register of Specialists, set up by the Medical Specialists Registration Committee), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society).

Oral hygienist

a. An oral hygienist who has been trained in accordance with the training requirements for an oral hygienist, as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and the Decree on Functional Independence (Besluit functionele zelfstandigheid (Stb). 1997, no. 553).
b. A registered dental hygienist who meets the educational requirements as referred to under (a), as well as the educational requirements as included in the Tijdelijk besluit zelfstandige bevoegdheid geregistreerd-mondhygiënist and is registered as such in the relevant temporarily established BIG register.

A registered dental hygienist as referred to in (b) is independently licensed to take X-rays, administer anaesthetics and fill starting cavities. A dental hygienist as referred to in (a) who is not BIG-registered may do so only on the instructions of a dentist.

Multidisciplinary collaboration

An integrated care trajectory that is jointly supplied by numerous care providers with different disciplinary backgrounds and whereby coordination is necessary to provide the care process for the insured person.

Oedema therapist

An oedema therapist registered as such according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and registered as an oedema therapist in the Quality Register for Physiotherapy in the Netherlands (KRF NL) or as a specialist with the Physiotherapy Quality Mark Foundation (SKF).

Cesar or Mensendieck remedial therapist

A remedial therapist that complies with the conditions as referred to in the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree, and registered as a Cesar/Mensendieck remedial therapist in the Paramedic Quality Register (KP).

Admission

Admission to a (psychiatric) hospital, a psychiatric department of a hospital, a convalescence institution, a convalescent home or an independent treatment centre, when and as long as nursing, examination and treatment can only be provided, on medical grounds, in a hospital, convalescence institution or convalescent home.

Optometrist

An optometrist trained in accordance with the Decree governing the professional training requirements and area of expertise of optometrists (Besluit opleidingseisen en deskundigheidsgebied optometrist). This decree is based on article 34 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Orthodontist

A dental specialist listed in the Register of Specialists in dentomaxillary orthopaedics of the Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde (KNMT) (Royal Dutch Dental Association).

General remedial educationalist

A general remedial educationalist listed in the NVO Register of General Remedial Educationalists maintained by Nederlandse Vereniging van pedagogen en onderwijskundigen (NVO) (Association of Educationalists in the Netherlands).

Pedicurist

A professional in paramedical foot care who has completed secondary vocational training and holds a government accredited diploma.

Podiatrist

A podiatrist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Policy certificate

The health insurance policy (deed) recording the basic insurance and supplementary insurances that has been entered into between you (the policyholder) and the health insurer.

Preferred medicines

The preferred medicines designated by us within a group of identical, interchangeable medicines.

Private clinic

A private clinic is a treatment centre without a formally required authorisation for the provision of specialist medical care.

Psychiatrist

A physician listed as a psychiatrist/neuropathist in the Register of Specialists established by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) of the Royal Dutch Medical Association (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)).

Psychotherapist

A psychotherapist who is registered according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Specialist in charge

The care provider who supervises the care process.

GZSP Specialist in charge

The GZSP (medical care for specific patient groups) specialist in charge is a BIG- registered officer (health psychologist, general remedial educationalist, behavioural scientist, geriatric specialist, doctor specialised in treating people with an intellectual disability, clinical psychologist, clinical neuropsychologist or psychiatrist) responsible for implementing the care and treatment plan in a multidisciplinary context.

Rehabilitation

Examination, advice and treatment that involve the provision of specialist medical, paramedic, behavioural and/or rehabilitation care. This care is provided by a multidisciplinary team of experts, under the guidance of a medical specialist, affiliated with an institution authorised to provide rehabilitation care in accordance with the rules laid down by or pursuant to the law.

Geriatric specialist

A doctor who has followed the specialist training in geriatrics and appears in the Register of Medical Geriatric Specialists, set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Commission for the Registration of Medical Specialists), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society).

Emergency care

Care consisting of the identification, stabilisation and resuscitation of all acute medical patients. Emergency care concerns the treatment of urgent conditions and referral to more specialised practitioners.

Urgent medical care

Urgent medical care is the care required if assessment or treatment of symptoms needs to be performed within a matter of hours, or a day at most, to prevent damage to health or possible death. Whether this is the case is determined by the medical advisers at Zilveren Kruis and/or the Zilveren Kruis Emergency Services by Eurocross.

Dentist

A dentist who is registered as such according to the conditions in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Clinical dental technician

A clinical dental technician trained in accordance with the Decree governing the professional training requirements and area of expertise of clinical dental technicians (Besluit opleidingseisen en deskundigheidsgebied tandprotheticus).

Tertiary referral

Patient referral to another healthcare institution for their care need by the medical specialist treating the patient.

You

The insured person. This person's name appears on the policy certificate. When we say 'you (the policyholder)' we are referring to the person who took out the basic insurance and/or supplementary insurances with us.

Exclusions

Exclusions in the insurance contract stipulate that an insured person is not entitled to, or has no right to, reimbursement of costs.

Stay

Admission lasting 24 hours or longer.

Treaty country

Every country with which the Netherlands has entered into a treaty relating to social security that includes regulations for the provision of medical care. This includes Bosnia and Herzegovina, Macedonia, Montenegro, Serbia, Tunisia and Turkey.

In 2020, the United Kingdom (including Gibraltar) entered into a treaty with the EU for the reimbursement of healthcare costs. At the time of establishing these policy conditions for 2024, the UK accepts the EHIC and S2 statement. If laws and regulations change, we will implement such changes as of the effective date.

Obstetrician or midwife

An obstetrician or midwife who is registered as such in accordance with the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Referral/Statement

A referral/statement is valid for up to 1 year, with the exception of a GGZ referral which is valid for up to 9 months.

Insured person

All persons named as such in the policy certificate.

Policyholder

The person who entered into the insurance contract with us.

BIG Act

The Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg). This act describes the expertise and the competencies of the care providers. The corresponding registers list the names of care providers who meet the statutory requirements.

We/us

Zilveren Kruis Zorgverzekeringen N.V..

District nurse

A level-5 nurse (article 3a of the Dutch BIG Act, Bachelor's degree) or nursing specialist (article 14 of the Dutch BIG Act, Master's degree).

Long-term Care Act (Wlz)

Dutch Long-term Care Act (Wet langdurige zorg).

Social Support Act (Wmo)

Dutch Social Support Act (Wet maatschappelijke ondersteuning).

Independent treatment centre (ZBC)

All other institutions offering specialist medical care, other than hospitals.

Hospital

- An institution for specialist medical care for nursing, examination and treatment, in which a stay of 24 hours or longer is allowed and which can also provide acute care, including in any case (but not limited to) emergency care, acute obstetrics and ambulance care. In addition, the institution for specialist medical care also has an intensive care unit in addition to an emergency room;
- An institution for specialist medical care with recognition from the Ministry of Health, Welfare and Sport as an Expertise Centre for Rare Disorders (ECZA).

Care group

A group of care providers from different disciplines who jointly supply integrated care.

Care provider

A care provider or healthcare institution that provides care.

Health insurer

The insurance company that is authorised as such and offers insurance in the sense of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). For implementation of this insurance contract, this is Zilveren Kruis Zorgverzekeringen N.V., whose registered office is in Utrecht, Chamber of Commerce number: 06088185 and which is registered with the AFM under number 12000646.

Care need

The symptoms that led the insured person to seek treatment from a specialist (the specialist in charge). The specialist in charge initiates a care process for this care need. All claims that can be traced back to the original care need and/or care process are regarded as a single care need.

B. Care covered by basic insurance

The care covered by the basic insurance is summarised below. The conditions under which you are entitled to these forms of care are also listed below. If you are unable to find what you are looking for, please refer to the table of contents at the start of these terms and conditions.

Physiotherapy and Cesar or Mensendieck remedial therapy

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.1 Physiotherapy and Cesar or Mensendieck remedial therapy

You are entitled to physiotherapy and/or remedial therapy (Cesar or Mensendieck). The following is a summary of the care involved and the conditions that apply for entitlement to these forms of care.

1.1 Physiotherapy, Cesar/Mensendieck remedial therapy for insured persons aged 18 or older

Are you 18 or older? In that case you are entitled to the 21st treatment (per condition) and subsequent treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. This must involve a disorder that appears on the list approved by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering'). This list can be found on our website or obtained from us. The list drawn up by the Minister of Health, Welfare and Sport also specifies a maximum number of treatments or maximum treatment period for certain disorders.

Do you need manual lymph drainage because you suffer from severe lymphatic oedema, or do you require scar treatment? In that case you can also be treated by a skin therapist.

The nature and extent of care provided is limited to the care normally provided by physiotherapists, Cesar or Mensendieck remedial therapists, and—when manual lymph drainage and/or scar treatment is involved—skin therapists.

Conditions for entitlement to physical therapy and Cesar or Mensendieck remedial therapy

1. Before starting treatment you will need proof of diagnosis from the referring doctor (general practitioner, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist). This proof of diagnosis enables us to determine whether you are entitled to physical therapy and Cesar or Mensendieck remedial therapy under the basic insurance.
2. If you are receiving specialist physical therapy or remedial therapy, we only reimburse the extra costs if the therapist is registered in the corresponding section of the Quality Register for Physical Therapy in the Netherlands (KRF NL), the Physical Therapy Quality Mark Foundation, or in the subspecialisation register of the Paramedic Quality Register (KP). Specialist physical therapy or remedial therapy includes:
   - paediatric physical therapy and remedial therapy
   - pelvic physical therapy and remedial therapy
   - manual therapy
   - oedema therapy
   - geriatric physical therapy and remedial therapy

To find out which therapists provide specialist care eligible for reimbursement, Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

3. If you need several physical therapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day, a specific letter of referral issued by the referring doctor (general practitioner, company doctor, dentist geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

What you are not entitled to under this article

You are not entitled to:

a. the first 20 treatment sessions per condition. If your treatments for this condition continue into the following calendar year, the treatment sessions for the condition received the previous year count towards the 20 treatment sessions to which you are not entitled;
b. individual or group treatment if the only purpose of the treatment is to improve your stamina by working out;
c. pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
d. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports.
e. bandages and medical devices supplied by your physiotherapist, Cesar or Mensendieck remedial therapist or skin therapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Physical therapy related to Parkinson's disease

Do you have Parkinson's disease and require physical therapy for it? We only contract physiotherapists affiliated with the ParkinsonNet network for the treatment of insured persons with Parkinson's disease. If you visit a physiotherapist not contracted to treat insured persons with Parkinson's disease, the reimbursement may be lower than for a contracted physiotherapist. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with Parkinson's disease.

To find out which physical therapists are contracted for treating insured persons with Parkinson's disease, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

Physical therapy for intermittent claudication

Do you suffer from intermittent claudication and require physical therapy for it? We only contract physiotherapists affiliated with the Chonisch ZorgNet network for the treatment of insured persons with intermittent claudication. If you visit a physiotherapist not contracted to treat insured persons with intermittent claudication, the reimbursement may be lower than for a contracted physiotherapist. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with intermittent claudication.

To find out which physical therapists are contracted for treating insured persons with intermittent claudication, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

1.2 Physiotherapy, Cesar/Mensendieck remedial therapy for insured persons up to the age of 18

Are you under the age of 18? And do you have a disorder that appears on the list established by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering')? In that case you are entitled to all treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. The list drawn up by the Dutch Minister of Health, Welfare and Sport specifies a maximum treatment period for a number of disorders. This list can be found on our website or obtained from us.

Do you need manual lymph drainage because you suffer from severe lymphatic oedema, or do you require scar treatment? In that case you can also be treated by a skin therapist.

Do you have a disorder that is not included in the list established by the Dutch Minister of Health, Welfare and Sport? In that case you are entitled to 9 treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. This means 9 treatments per disorder, per calendar year. Do you need more treatments after these 9 treatments because you are still suffering from the disorder? In that case you are entitled to up to 9 extra treatments. This only applies if the extra treatments are medically necessary. In other words, in total, you are entitled to up to 18 treatments.

The nature and extent of care provided is limited to the care normally provided by physiotherapists, Cesar or Mensendieck remedial therapists, and—when manual lymph drainage and/or scar treatment is involved—skin therapists.

Conditions for entitlement to physical therapy and Cesar or Mensendieck remedial therapy

1. Are you receiving treatment for a disorder on the list established by the Dutch Minister of Health, Welfare and Sport (VWS), Annex 1 relating to article 2.6 of the Health Insurance Decree (Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering)? Before starting treatment, you will need proof of diagnosis from the referring professional (general practitioner, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist). This proof of diagnosis enables us to determine whether you are entitled to physical therapy and Cesar or Mensendieck remedial therapy under the basic insurance.
2. Are you receiving specialist physical therapy or remedial therapy? In that case, we only reimburse the extra costs if the therapist is registered in the corresponding section of the Quality Register for Physical Therapy in the Netherlands (KRF NL), the Physical Therapy Quality Mark Foundation, or in the subspecialisation register of the Paramedic Quality Register (KP). Specialist physical therapy or remedial therapy includes::
   - paediatric physical therapy and remedial therapy
   - pelvic physical therapy and remedial therapy
   - manual therapy
   - oedema therapy
   - geriatric physical therapy and remedial therapy

To find out which therapists provide specialist care eligible for reimbursement, Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

3. If you need several physical therapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day, a specific letter of referral issued by the referring doctor (general practitioner, company doctor, dentist geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

What you are not entitled to under this article

You are not entitled to:

a. individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;
b. pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports;
d. bandages and medical devices supplied by your physiotherapist, Cesar or Mensendieck remedial therapist and skin therapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Physical therapy related to Parkinson's disease

Do you have Parkinson's disease and require physical therapy for it? We only contract physiotherapists affiliated with the ParkinsonNet network for the treatment of insured persons with Parkinson's disease. If you visit a physiotherapist not contracted to treat insured persons with Parkinson's disease, the reimbursement may be lower than for a contracted physiotherapist. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with Parkinson's disease.

To find out which physical therapists are contracted for treating insured persons with Parkinson's disease, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

1.3 Pelvic physiotherapy to treat urinary incontinence for insured persons aged 18 or older

Are you 18 or older and do you suffer from urinary incontinence? And would you like to use pelvic physiotherapy to treat it? In that case you are entitled to the first 9 treatment sessions by a pelvic physiotherapist once per medical indication. The nature and extent of the care provided is limited to the care normally provided by physiotherapists.

What you are not entitled to under this article

You are not entitled to:

a. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports;
b. bandages and medical devices supplied by your pelvic physiotherapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

1.4 Physiotherapy or remedial therapy to treat leg pain caused by stage II intermittent claudication (restricted blood supply to the legs) for insured persons aged 18 or older

Are you 18 or older and do you suffer from intermittent claudication? If you want to have it treated by a Cesar/Mensendieck physical or remedial therapist, you are entitled to up to 37 supervised walking exercise treatments over a period of up to 12 months from the first treatment. The nature and extent of the care provided are limited to the care normally provided by physiotherapists and Cesar/Mensendieck remedial therapists.

Conditions for entitlement to physical therapy and Cesar or Mensendieck remedial therapy

If after completing a supervised remedial therapy programme for intermittent claudication, you require a few additional treatments, we must give you permission in advance. In addition to your application, you will be required to submit a supporting statement from your physiotherapist showing the medical necessity for additional treatments. You can download a form from our website which your physiotherapist can complete.

What you are not entitled to under this article

You are not entitled to

a. remedial therapy for restricted blood supply to the legs caused by stage III intermittent claudication. In that case you may be entitled to physical therapy or remedial therapy under article 1.1;
b. surcharges for::
   - appointments outside of regular working hours;
   - missed appointments;
   - reports;
c. bandages and medical devices supplied by your physiotherapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Physical therapy for intermittent claudication

Do you suffer from intermittent claudication and require physical therapy for it? We only contract physiotherapists affiliated with the Chonisch ZorgNet network for this. If you visit a physiotherapist not affiliated with Chronisch ZorgNet, the reimbursement may be lower than for a contracted care provider. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with intermittent claudication.

To find out which physical therapists are contracted for treating insured persons with intermittent claudication, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

1.5 Physiotherapy to treat osteoarthritis of the hip or knee joint for insured persons aged 18 or older

Are you 18 or older and do you have osteoarthritis in your hip or knee joint? And do you want to treat it with remedial therapy supervised by a physiotherapist or remedial therapist? In that case you are entitled to up to 12 supervised remedial therapy treatments over a period of up to 12 months. The nature and extent of the care provided are limited to the care normally provided by physiotherapists and remedial therapists.

What you are not entitled to under this article

You are not entitled to:

a. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports;
b. bandages and medical devices supplied by your physiotherapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

1.6 Physiotherapy to treat chronic obstructive pulmonary disease (COPD) for insured persons aged 18 years or older

Are you 18 years or older and do you suffer from stage II COPD or higher according to the GOLD classification? And do you want to treat it with remedial therapy supervised by a physiotherapist or remedial therapist? Depending on the GOLD classification, you are then entitled to up to the following in the first twelve months:

- 5 supervised remedial therapy treatments for class A
- 27 supervised remedial therapy treatments for class B1*
- 70 supervised remedial therapy treatments for classes B2**, C and D

If treatment is still required after the first 12 months, you are entitled to the following (depending on the GOLD classification):

- 3 supervised remedial therapy treatments per 12 months for class B1*
- 52 supervised remedial therapy treatments per 12 months for classes B2**, C and D

* B1: GOLD classification for symptoms and risk of exacerbations at a moderate disease load and adequate physical capacity.

**B2: GOLD classification for symptoms and risk of exacerbations and at a high disease load and limited physical capacity.

The nature and extent of the care provided are limited to the care normally provided by physiotherapists and remedial therapists.

What you are not entitled to under this article

You are not entitled to:

a. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports;

b. bandages and medical devices supplied by your physiotherapist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

1.7 Fall prevention exercise intervention for the elderly

Has your general practitioner, geriatric specialist or General Practitioner Practice Assistant (POH) elderly care carried out a fall risk assessment after a fall risk test showed that you have a high fall risk? And has it been determined on the basis of the fall risk assessment that you require guidance at the level of a physiotherapist as a result of underlying or additional somatic (physical) or psychological problems? Then you are entitled to a fall-preventing exercise intervention (training program) at most once every twelve months.

Eligibility requirements for a fall-prevention exercise intervention

1. You must have been referred by a GP, geriatrician or geriatric practice nurse;
2. A fall risk test has shown that you have a high risk of falling. Based on a subsequent fall risk assessment, it has been determined that you require supervision by a physiotherapist due to underlying or additional somatic (physical) or psychological problems;
3. The fall risk assessment must have been carried out by the GP, geriatrician or geriatric practice nurse;
4. The fall-prevention exercise intervention must be carried out by a physiotherapist or Cesar or Mensendieck remedial therapist;
5. The physiotherapist or Cesar or Mensendieck remedial therapist must work with a fall-prevention exercise intervention that has been assessed by RIVM and is registered with the RIVM Loket Gezond Leven;
6. You are entitled to one fall-prevention exercise intervention per twelve months if these conditions are met.

What you are not entitled to under this article

You are not entitled to:

a. a fall-prevention exercise intervention if the fall risk test shows that you have a low or medium fall risk;
b. a fall-prevention exercise intervention if the fall risk test shows that you have a high fall risk but the fall risk assessment does not establish that you are in need of supervision by a physiotherapist due to underlying or additional somatic (physical) or psychological problems. You may be able to contact your own municipality in that case.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.2 Occupational therapy

You are entitled to 10 hours of advice, tuition, training or treatment by an occupational therapist. This means 10 hours per calendar year. The occupational therapy must be intended to promote or improve your ability to cope better by yourself. The nature and extent of the care provided is limited to the care normally provided by occupational therapists.

What you are not entitled to under this article

We do not reimburse charges for:

a. appointments outside of regular working hours;
b. missed appointments;
c. reports.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Medical devices

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.3 Medical devices

You are entitled to:

a. supply of functioning medical devices and bandages for personal use (not on loan). A statutory personal contribution or a statutory maximum reimbursement sometimes applies for a medical device;
b. alteration, replacement or repair of medical devices;
c. spare medical devices.

Conditions for entitlement to medical devices

More detailed conditions for reimbursement of medical devices are specified in the Medical Devices Regulations (Reglement Hulpmiddelen). These regulations form part of this policy and can be found on our website or obtained from us. You do not need prior permission for the supply, customisation, replacement or repair of a large number of medical devices. You can contact a contracted supplier directly. The medical devices to which this applies are listed in article 4 of the Medical Devices Regulations (Reglement Hulpmiddelen). You do need our prior permission for the supply, customisation, replacement or repair of a number of medical devices. We assess whether the medical device is necessary, appropriate and not needlessly expensive or complicated. You must always obtain our prior permission when non-contracted suppliers are involved, except in the case of ostomy equipment, catheters and accessories. In some cases medical devices are provided on loan. The devices to which this applies are listed in the Medical Devices Regulations (Reglement Hulpmiddelen). In this case, we depart from the provisions under (a) of this article and article A.2.1 Care entitlement.

What you are not entitled to under this article

Do you need a medical device that forms part of specialist medical care? In that case you are not entitled to medical devices under this article. These medical devices fall under article B.28.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Medicine and dietary preparations

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.4 Pharmaceutical care: medicine and dietary preparations

Pharmaceutical care is defined as:

a. medicines and dietary preparations that are covered in your insurance agreement and with which you are provided by pharmacists;
b. advice and guidance normally provided by pharmacists in terms of doing a medication check and informing you of the responsible use of medicines and dietary preparations as designated in this insurance agreement.

More detailed conditions for pharmaceutical care are specified in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). These regulations form part of this policy and can be found on our website or obtained from us.

You are entitled to the dispensing of and the provision of advice and guidance on:

a. medicines designated for reimbursement by ministerial decree that are included in the GVS insofar these medicines are designated and included in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem). The GVS states which medicines can be reimbursed under the basic insurance and what the maximum reimbursement is. The provision of medicines, advice and guidance must be carried out by a pharmacy that has entered into a contract with us or a pharmacy that does not have a contract with us; and
b. medicines other than registered medicines that may be supplied in the Netherlands according to the Dutch Medicines Act (Geneesmiddelenwet). These must be based on rational pharmacotherapy. We define rational pharmacotherapy as treatment with a medicine in a form suited to the patient, the efficacy and effectiveness of which has been established by scientific research and which is also most economic for your basic insurance. This definition of rational pharmacotherapy includes:
   - medicine prepared on a small scale by or on the orders of a pharmacy;
   - medicines that, according to article 40, third paragraph, under c, of the Dutch Medicines Act, in response to a request by a doctor as referred to in that provision, are prepared in the Netherlands by a manufacturer, as referred to in article 1, first paragraph, under mm, of the Medicines Act;
   - medicines that, according to article 40, third paragraph under c, of the Medicines Act, are marketed in a different member state or in a third country and, at the request of a doctor as referred to in that provision, are imported into the territory of the Netherlands. These medicines must be intended for one of that doctor's patients, who suffers from a disorder that is found in no more than 1 in every 150,000 residents in the Netherlands;
     medicines that, according to Article 40(3)(c) of the Medicines Act, are marketed in a different member state or in a third country and, at the request of a doctor as referred to in that provision, are imported into the territory of the Netherlands, where the medicine is a replacement for a registered medicine which is temporarily unavailable or cannot be supplied in sufficient quantities by the holder of the marketing license or parallel trade permit granted under the Medicines Act or the regulation referred to in Article 1(1)(fff) of that Act, or
   - medicines that, according to Article 52(1) of the Medicines Act, if the medicine serves to replace a registered medicine which temporarily cannot be supplied or cannot be supplied in sufficient quantities by the holder of the marketing license or parallel trade permit granted under to the Medicines Act or under to the regulation referred to in Article 1(1)(ffff) of that Act; and
c. polymer, oligomer, monomer and modular dietary preparations.

Statutory personal contribution

If a medicine is more expensive than the reimbursement limit included in the GVS, you are responsible for the additional costs. The statutory personal contribution for medicine is limited to € 250 per person per calendar year. If you have not been insured with us for a full calendar year, we calculate the maximum statutory personal contribution to medicines according to how many days you were insured with us in that calendar year.

Pharmaceutical care includes a number of (partial) provisions. A description of these (partial) provisions can be found in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). On our website you will also find a summary of the maximum reimbursements we have established for (partial) provisions relating to pharmacy, medicines and dietary preparations. You will also find the registered medicines that we have designated as 'preferred medicines'. You can of course also obtain this information from us.

Conditions for entitlement to medicines and dietary preparations

1. The medicines must be prescribed by a general practitioner, a medical specialist, a dentist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, an obstetrician or midwife or a suitably qualified nurse (once this has been regulated via the ministry).
2. The medicines must be dispensed by a pharmacy. We contract medical specialty stores to supply dietary preparations. Dietary preparations may also be provided by a pharmacy, but they will be reimbursed in accordance with the policy conditions for non-contracted care. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?
3. Are there identical, interchangeable medicines based on active ingredient, strength and method of administration? Then you are only entitled to the medicines we have designated on the basis of the preference policy or the medicine designated by the pharmacy. You are only entitled to a non-designated medicine if there is a medical necessity. The prescriber (see under 1) must indicate on the prescription that there is a medical indication and must be able to substantiate this. You can read more about this in the Glossary of Terms in the Pharmaceutical Care Regulations.
4. You are only entitled to dietary preparations if:
   a. you have a condition that requires the use of these preparations as an essential part of adequate healthcare;
   b. your health problems cannot be managed with an regular adjusted diet and/or dietary products;
   c. the additional conditions for reimbursement listed in Annex 2 (Bijlage 2) of the Health Insurance Regulations (Regeling zorgverzekering) are met. Annex 2 (Bijlage 2) is amended on a regular basis. Also during the course of the current policy year. You can find the latest version of Annex 2 (Bijlage 2) (with the conditions for reimbursement) online at wetten.overheid.nl; type 'Regeling zorgverzekering' (Health Insurance Regulations) in the search box, click on 'Zoeken' (Search). Click on 'Regeling zorgverzekering'. Click on Bijlage 2 (Annex 2) in the contents;
   d. if they have been prescribed by a doctor or dietitian. The pharmacist or medical specialty shop will determine whether the conditions have been met based on the 'Declaration of dietary preparations' filled in by your doctor or dietitian.

Additional provisions that apply for entitlement to specific medicines are listed in article 4.4 of the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). You are only entitled to these medicines if you meet these additional provisions.

Conditions for entitlement to (partial) provisions

We stipulate additional requirements for a number of (partial) provisions relating to the quality of the care provided and/or preconditions regarding which pharmaceutical care you are allowed to declare. You are only entitled to these partial provisions if these additional requirements are met. The (partial) provisions to which these conditions apply are listed in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).

The mandatory excess applies to fitting of a coil for insured persons aged 18 to 21 years

Please note!

If the coil is fitted by a gynaecologist, both the fitting of the coil and the coil itself are reimbursed by the basic insurance. In that case the costs are deducted from your mandatory excess. If the coil is fitted by a general practitioner, obstetrician or midwife, both the fitting of the coil and the coil itself are reimbursed by the basic insurance. In this case the costs of the coil are deducted from your mandatory excess. The costs of the fitting of the coil by the general practitioner, obstetrician or midwife is not deducted from your mandatory excess.

What you are not entitled to under this article

You are not entitled to the following medicines and/or pharmaceutical (partial) provisions:

a. contraceptives for insured persons aged 21 or older, unless there is a medical indication. Within the framework of this article, our definition of a medical indication is endometriosis or menhorragia (severe blood loss);
b. medicines and/or advice on preventing an illness within the framework of travelling abroad;
c. pharmaceutical care listed in the Health Insurance Regulations (Regeling zorgverzekering) as care to which you are not entitled;
d. medicines that appear in article 40, third paragraph, under b of the Dutch Medicines Act (Geneesmiddelenwet);
e. medicines that appear in article 40, third paragraph, under f of the Dutch Medicines Act;
f. medicines that are—or are almost—the equivalent of any non-designated, registered medicine, unless otherwise stipulated by ministerial regulation.
g. non-prescription drugs not listed in the Regeling zorgverzekering (Health Insurance Regulations). Non-prescription drugs are medicines that you can purchase without a prescription;
h. all pharmaceutical (partial) provisions that are not regarded as insured care. All (partial) pharmaceutical provisions are described in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).
i. homeopathic, anthroposophic and/or other alternative medicines and remedies;
j. non-registered allergens, unless treatment with a registered allergen is not possible. You are only entitled to a non-registered allergen on the basis of authorisation issued by us on an individual basis.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Oral health care and dentistry

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

You are entitled to necessary dental care as is normally provided by dentists, clinical dental technicians, dental surgeons, oral hygienists and orthodontists. This is described in further detail in the following articles (articles B.5 to B.12).

B.5 Orthodontics (braces) in exceptional cases

Do you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth or an acquired deformity of the teeth, jaw or mouth? And are you unable to retain or attain a dental function equivalent to the dental function you would have had without the disorder or deformity without orthodontic treatment? Then you are entitled to this treatment.

Please note!

Orthodontic care is not covered by basic insurance in other cases. You can take out supplementary insurance.

NB.

This only applies to insured persons up to the age of 18.

Conditions for entitlement to orthodontic care in exceptional cases

1. The treatment must be carried out by an orthodontist or at a Centre for Exceptional Dentistry.
2. If you are being treated at a Centre for Exceptional Dentistry, you must have been referred by your dentist, general practitioner, a oral surgeon or medical specialist.
3. You have a permanent developmental or growth disorder resulting in a severe functional impairment comparable in severity to a lip, jaw or palate cleft (schisis).
4. This treatment requires a joint diagnosis or must involve other disciplines in addition to dental disciplines.
5. We must give you prior permission. When requesting permission, you must also submit a treatment plan, a cost estimate, photographs and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.

What you are not entitled to under this article

You are not entitled to:

a. the repair or replacement of an existing orthodontic device if you lose or damage it through your own fault or negligence;
b. vacuum-formed orthodontics, aligners.

B.6 Dental care for insured persons up to the age of 18

Are you under the age of 18? Then you are entitled to the following dental treatment:

a. a periodical preventive dental examination once a year (annual check-up), or several times a year, if you are reliant on more frequent check-ups to maintain dental health;
b. an occasional dental consultation;
c. the removal of scale;
d. up to 2 fluoride treatments a year, from the moment permanent teeth appear, unless you are reliant on several fluoride treatments a year to maintain dental health, in which case, we must give you permission in advance;
e. sealing of ridges in molars;
f. periodontal care (treatment of gums);
g. anaesthesia (local anaesthetic);
h. endodontic care (root canal therapy);
i. repairing of dental elements with plastic materials (fillings);
j. gnathological care (treatment of jaw problems);
k. removable dentures (metal frame dentures, partial (plate) dentures or full dentures);
l. surgical dental care. This care does not include the fitting of dental implants;
m. X-rays, with the exception of X-rays performed as part of orthodontic care.

Conditions for entitlement to dental care for insured persons up to the age of 18

1. The treatment must be carried out by a dentist, a oral surgeon, an oral hygienist or a clinical dental technician. This person must be competent and qualified to carry out the treatment involved.
2. Will you be undergoing treatment by a oral surgeon? In that case, you need a referral from your dentist, orthodontist, GP, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care or other medical specialist. You must obtain our advance consent for the following treatments: extraction (pulling of teeth or molars) under anaesthesia, jaw correction in combination with extraction, osteotomy (jaw surgery), genioplasty as a stand-alone operation, preimplantological and perimplantological surgery (bone remodeling) and the implantation of bone anchors for orthodontic treatment.
3. We only reimburse the costs of fitting bone anchors for orthodontic treatment as part of orthodontic care provided in exceptional cases (see Article B.5). We must give you prior permission.
4. If care as defined in article B.5, B.7, B.10, B.11 or B.12 is required, you must obtain our permission in advance. You can read more about this in the articles.
5. You must obtain prior permission:
   - for jaw overview imaging (X21);
   - for autotransplantation (diagnostics and moving one's own tooth or molar to the site of a missing tooth or molar);
   - for dental sealants for baby teeth;
   - for dental sealants for more than 8 permanent teeth and/or molars per year (V30/V35);
   - if more than 1 hour per year of prevention education/evaluation is required (more than 12x (M01 and/or M02));
   - if more than 30 minutes of dental cleaning (more than 6x M03) is required per day;
   - if more than 1.5 hours of dental cleaning (more than 18x M03) is required per year;
   - if more than 6 fillings (V71 to 74, V81 to 84, V91 to 95) are needed per day or more than 10 fillings (V71 to 74, V81 to 84, V91 to 95) are needed per year.

Your care provider can request permission from us on your behalf. We will then assess the appropriateness and legitimacy of the request.

6. Diagnostics and autotransplants must be performed by a dental periodontist accredited by the Dutch Association for Periodontology (NVvP), a dental implantologist accredited by the Dutch Association for Oral Implantology (NVOI) or by an oral surgeon.

What you are not entitled to under this article

You are not entitled to:

a. non-restorative caries treatment in the deciduous teeth (M05) and treatment of white spots (M80 and M81);
b. orthodontic care. With the exception of the orthodontic care in exceptional cases as described in article B.5, this is not covered by the basic insurance. It may be reimbursed under an extra supplementary insurance;
c. implants. These may be covered under articles B.7, B.10, B.12 or D. Tandheelkundige zorg voor verzekerden tot 18 jaar – kronen, bruggen, inlays en implantaten. Dental care for insured persons up to the age of 18 - crowns, bridges, inlays and implants, or may be reimbursed under a supplemental dental insurance;
d. therapeutic botox injection (G44);
e. comprehensive examination for the purpose of formulating, recording, and providing a treatment plan to the patient (C012).

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Please note!

Standard orthodontic treatment is not covered by basic insurance. You can take out supplementary insurance for orthodontic care.

N.B.

This only applies to insured persons up to the age of 18!

B.7 Front tooth replacement for insured persons up to the age of 23

Are you missing one or more permanent incisors or canine teeth that need to be replaced due to hypodontia or because the missing teeth are a direct result of an accident and is there a record of this diagnosis having been made before the age of 18? In that case you are entitled to non- plastic tooth replacement materials. Among other things these include a fixed bridge, an acid-etched or bonded bridge or an implant-retained crown and the fitting of dental implants in the front of the mouth.

Terms and conditions for entitlement for front tooth treatment.

1. The treatment must be carried out by a dentist, an orthodontist or a oral surgeon.
2. Will you be undergoing treatment by a oral surgeon? In that case you need a referral from your dentist.
3. We must give you permission for the treatment in advance. A treatment plan with a cost estimate and available X-rays must be submitted with your request for approval. The treatment plan must be prepared by your dentist, orthodontist or oral surgeon.

What you are not entitled to under this article

You are not entitled to autotransplantation (moving your own tooth or molar to the site of a missing tooth or molar).

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.8 Dental care for insured persons aged 18 or older - dental surgery

You are entitled to specialist dental surgery and the X-rays this involves. This could be combined with a stay in hospital.

You are entitled to nursing and or hospital accommodation if these forms of care are necessary in connection with dental surgery. For more information, see article B.28.

Conditions for entitlement to dental surgery

1. The treatment must be carried out by a dental surgeon.
2. You must be referred by a general practitioner, dentist, orthodontist, dental prosthetist, dental hygienist, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability or another medical specialist. A dental hygienist may only refer you if they suspect oral mucosal disease not caused by with teeth or gum problems. A clinical dental technician may only refer you if he or she suspects pathology in a toothless mouth.
3. We must give you permission in advance for the following treatments:
   - extraction (removal of teeth or molars) under anaesthesia;
   - jaw correction combined with an extraction;
   - osteotomy (jaw surgery);
   - chin plastic surgery as an independent operation;
   - preimplantological and perimplantological surgery (bone remodeling);
   - placing bone anchors for orthodontic treatment.
   - plastic surgery.
4. Have you requested permission for dental treatment? In that case we will assess the cost-effectiveness and legitimacy of your request.

What you are not entitled to under this article

You are not entitled to:

a. periodontal surgery;
b. the fitting of dental implants;
c. an uncomplicated extraction.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.9 Dental care for insured persons aged 18 or older – full set of removable dentures (false teeth) of click dentures with or without implants

You are entitled to the making and fitting of the following dentures or click dentures:

a. a full set of removable dentures for the upper and/or lower jaw (25% statutory personal contribution);
b. a full set of temporary removable dentures (25% statutory personal contribution);
c. a full set of removable overdentures on natural elements (25% statutory personal contribution);
d. a full set of snap-in dentures on implants for the upper and/or lower jaw and fastening materials, such as push buttons and pins (statutory personal contribution of 8% for the upper jaw and 10% for the lower jaw).

A personal contribution of 17% applies for the combination of implant-retained click denture for one jaw and non-implant-retained denture for the other jaw (code J080).

Are you having a full set of dentures (a–d) or click dentures repaired or rebased? Then a statutory personal contribution of 10% applies. We apply maximum amounts for the costs of dental technician services and materials. These amounts can be found on our website or obtained from us.

Conditions for entitlement to a full set of removable dentures and click dentures

1. The treatment must be performed by a dentist or clinical dental technician or at a Centre for Exceptional Dentistry.
2. Are you being treated at a Centre for Exceptional Dentistry? In that case, your dentist or oral surgeon must have referred you.
3. With a dental technician, you are only entitled to repairs (i.e. not rebasing) on removable full dentures for the upper and/or lower jaw. You are only entitled to this if no actions are required inside the mouth. This includes repairing a crack or a simple fracture in the dentures, which can be repaired outside the mouth, or attaching a tooth to the dentures outside the mouth.
4. If the dentures listed under a and c need to be replaced within 5 years, or if emergency dentures (P023) listed under (b) need to be replaced within 6 months, you must obtain our advance permission. We assess the appropriateness and legitimacy of your request.
5. Are you having a full set of upper or lower removable dentures made and fitted, and do the costs of dental technician services and materials exceed the maximum amounts we apply? In that case we must give you permission in advance.
6. Are you having a new full set of upper and/or lower implant-retained click dentures and attachment materials (such as press studs and rods) made? In that case we must give you permission in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. We will then assess the appropriateness and legitimacy of your request. This is not required for the repair and rebasing of removable complete click dentures on implants that are older than 5 years or for a simple repair of click dentures without rod disassembly and without impression (code J104) if performed after 4 months after placement of the click dentures.
7. The severely shrunken jaw supplement (P044) requires our permission in advance. You are only entitled to this if you are entitled to implants (see article B.10) but these are not placed.

What you are not entitled to under this article

You are not entitled to materials that serve to attach the full set of removable overdentures to natural elements (your own tooth roots).

B.10 Implants

Do you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth or an acquired deformity of the teeth, jaw or mouth? And are you unable to retain or attain a dental function equivalent to the dental function you would have had without the disorder or deformity without the fitting of implants? And do you have a severely shrunken, toothless jaw? In that case you are entitled to dental implants that serve to retain a full set of removable click-tight dentures.

We apply maximum amounts for the costs of dental technician services and materials. These amounts can be found on our website or obtained from us.

Conditions for entitlement to implants

1. The treatment must be carried out by a dentist, a oral surgeon, or a Centre for Exceptional Dentistry.
2. Are you attending a Centre for Exceptional Dentistry for treatment? In that case you must be referred by your dentist. A clinical dental technician may only refer you to a dentist.
3. Are you being treated by a oral surgeon? In that case you must be referred by your dentist, a Centre for Exceptional Dentistry or medical specialist.
4. You must obtain our advance permission for the treatment. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. We will then assess the appropriateness and legitimacy of your request.

Please note!

You may also be entitled to implants under article B.12.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.11 Dental care for insured persons with a disability

Do you have a non-dental physical and/or intellectual disability? And are you unable, without dental care, to retain or attain a dental function that is equivalent to the dental function you would have had without the physical and/or intellectual disability? In that case you are entitled to dental care.

Conditions for entitlement to dental care for insured persons with a disability

1. The treatment must be carried out by a dentist, an oral hygienist, a clinical dental technician, an orthodontist, a oral surgeon, or a Centre for Exceptional Dentistry.
2. Are you attending a Centre for Exceptional Dentistry for the care? In that case you must be referred by your dentist, general practitioner, a oral surgeon or medical specialist.
3. Are you being treated by a oral surgeon? In that case you must be referred by your dentist, general practitioner, a Centre for Exceptional Dentistry or medical specialist.
4. You are only entitled to this care if you are not entitled to dental care under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
5. We must give you permission for the care in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.
6. Treatment of jaw complaints (such as pain in joints and chewing muscles) will only be reimbursed if performed by a dentist-gnathologist or centre for special dentistry recognised by the NVGPT.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.12 Dental care in exceptional cases

You are entitled to dental treatment in the following exceptional cases:

a. If you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth, or an acquired deformity of the teeth, jaw or mouth and are unable to retain or attain a dental function equivalent to the dental function you would have had without the condition without dental care.
b. If, without the dental care, medical treatment would have demonstrably insufficient results. And if, without the dental care, you are unable to attain or retain a dental function equivalent to the dental function you would have had without the medical condition.
c. if you suffer from extreme anxiety about dental treatment, according to the validated anxiety scales as described in the guidelines of the Centres for Exceptional Dentistry.

In so far as care is involved that is not directly linked to the indication for exceptional dental care, insured persons aged 18 years or older pay a contribution equal to the sum that would be charged to the insured person concerned if this article did not apply. For instance, do you go to a dentist who specialises in anxiety? In that case you usually pay a higher tariff than for a normal dentist. You are only entitled to the additional costs. You must pay the standard tariff for a normal dentist yourself.

Conditions for entitlement to dental care in exceptional cases

1. The treatment must be carried out by a dentist, an oral hygienist, an orthodontist, a oral surgeon, or a Centre for Exceptional Dentistry.
2. Are you attending a Centre for Exceptional Dentistry for the care? In that case you must be referred by your dentist, general practitioner, a oral surgeon or medical specialist.
3. Are you being treated by a oral surgeon? In that case you must be referred by your dentist, general practitioner, a Centre for Exceptional Dentistry or medical specialist.
4. We must give you prior permission When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.
5. Treatments performed under anaesthesia or nitrous oxide are only reimbursed as a last resort in an anxiety management process. The treatment performed under anaesthetic or nitrous oxide must be carried out at a Centre for Exceptional Dentistry or by a dentist who meets our expertise, organisational and safety requirements for treatments performed under anaesthetic and/or nitrous oxide.
6. Treatment of jaw complaints (such as pain in joints and chewing muscles) will only be reimbursed if performed by a dentist-gnathologist or centre for special dentistry recognised by the NVGPT.
7. Diagnostics and autotransplants must be performed by a dental periodontist accredited by the Dutch Association for Periodontology (NVvP), a dental implantologist accredited by the Dutch Association for Oral Implantology (NVOI), or by an oral surgeon.

Please note!

You may also be entitled to implants under article B.10.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Eyes and ears

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.13 Audiology centre

13.1 Hearing problems

Do you have hearing problems? In that case you are entitled to care in an audiology centre. This care means that the centre:

a. examines your hearing function;
b. advises you about hearing aids you may need to purchase;
c. provides you with information about using any aids;
d. provides you with psychosocial care if this is necessary for your hearing problem.

Condition for entitlement to care in an audiology centre

You must be referred by a general practitioner, company doctor, geriatric specialist, doctor who specialises in juvenile health care, paediatrician, ENT specialist, medical physicist audiologist or triage hearing care professional.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

13.2 Speech and language disorders in children

Does your child have a speech or language disorder? An audiology centre contracted for this purpose can assist in establishing a diagnosis. Do you want to know with which audiology centres we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Condition for entitlement to care in an audiology centre

You must be referred by a general practitioner, company doctor, geriatric specialist, doctor who specialises in juvenile health care, paediatrician, ENT specialist, medical physicist audiologist or triage hearing care professional.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.14 Sensory impairment care

You are entitled to sensory impairment care. This is multidisciplinary care that focuses on learning to cope with, overcoming or compensating for the limitation. This care is designed to enable you to function as independently as possible.

You are eligible for this care if you:

a. have a hearing impairment (you are deaf or hearing impaired) and/or
b. have a visual impairment (you are blind or visually impaired);
c. have a communication impairment (you have significant difficulties with speech and/or language) caused by a primary language development disorder and are under the age of 23. A disorder is considered a communicative disability as a result of a language development disorder if it can be traced back to neurobiological and/or neuropsychological factors. The language development disorder must also be primary. This means that other problems (psychiatric, physiological, neurological) are secondary to the language development disorder.

The multidisciplinary care consists of:

a. diagnostic examination;
b. interventions aimed at teaching mental strategies to help cope with the disability;
c. interventions that alleviate or compensate for the disability and therefore increase self-reliance (the ability to cope independently).

In the case of auditory and communication impairments, the health psychologist is ultimately responsible for the multidisciplinary care and the care plan. This task may also be performed by remedial educationalists or developmental psychologists. In the case of visual impairments the ophthalmologist or a medical physicist who specialises in the visual system is ultimately responsible for the multidisciplinary care when it comes to coordination of the treatment of the 'vision problem'. The healthcare psychologist or a similar behavioural specialist is ultimately responsible for the multidisciplinary care when it comes to coordination of the treatment of mental and/or behavioural problems and learning to cope with the disability. This task may also be performed by practitioners trained in other disciplines.

Conditions for entitlement to sensory impairment care

1. For auditory and communicative impairments, you must be referred by a medical physicist audiologist who works at an audiology centre or a medical specialist who has diagnosed an auditory and/or communicative impairment under the applicable FENAC guidelines.
2. For of visual impairments, you must be referred by an ophthalmologist or another medical specialist who has diagnosed a visual impairment according to the evidence-based NOG Visual Impairment, Rehabilitation and Referral Directive. Was your sensory impairment disorder previously diagnosed by a medical physicist audiologist, ophthalmologist or medical specialist? And has a sensory impairment-related care need arisen without there being any change in the sensory impairment disorder? In that case you can also be referred by a general practitioner or a doctor who specialises in juvenile health care.

You do not need a new referral for simple rehabilitation care (that falls within Care Programme 11*) if: the referral is a repeat referral;

- there has been no change in the sensory impairment disorder; there has been a change in your medical or personal situation that
- necessitates further treatment under your basic insurance;
- the sensory impairment care provider has established that the care needs can be met within Care Programme 11;
- the sensory impairment care provider notifies the general practitioner in writing of the process followed. The general practitioner adds the information to the patient's medical file.

* Care Programme 11 enables fast-track admission for people who have received treatment and/or training in the past and require further treatment. It is also for adults confronted (for the first time) with visual impairment (caused by conditions such as retinitis pigmentosa) whose care needs usually involve being able to make optimal use of their remaining vision, and older people (55+) with an acquired visual impairment who are specifically seeking to retain their independence. The condition is known, the person's vision has been assessed, and the person has one or two specific care needs. These care needs involve learning to compensate for their visual impairment and/or make optimal use of their remaining vision in order to retain their independence. In most cases, these care needs can be met within 10 hours.

What you are not entitled to under this article

You are not entitled to:

a. elements of care designed to support social functioning;
b. complex, long-term and lifewide support for deaf and blind adults and prelingually deaf adults (who became deaf or hard of hearing before the age of 3).

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Mental healthcare

Both with Basis Budget, Basis Zeker and Basis Exclusief, you have arranged care insurance and are entitled to care (arranged by us).

B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare)

If you suffer from a psychological disorder, you are entitled to mental healthcare (GGZ).

If you require hospitalisation for treatment of your psychological disorder, you are also entitled to:

a. stay with nursing and care;
b. paramedical care, medicines, medical devices and dressings that are part of your treatment during your stay.

The nature and extent of the care provided is limited to the care normally provided by psychiatrists and clinical psychologists.

Conditions for entitlement to mental healthcare

1. You must be 18 or older.
2. You must be referred by a general practitioner, a company doctor, a medical specialist (psychiatrist, specialist hospital, a geriatric specialist, a doctor specialised in treating people with an intellectual disability, or a doctor specialised in emergency medicine), a street doctor, an A&E doctor, or the specialist in charge (in case of referral). A referral is not required for acute care.
3. The referral must comply with the "Mental Health Referral Agreements" as published by the Dutch Ministry of Health, Welfare and Sport (VWS).
4. A referral is valid for up to 9 months. This means that you must be registered with the care provider within 9 months of the date the referral is issued. What if it is more than 9 months since the referral was issued? Then you must ask for another referral.
5. Your healthcare provider must have an approved quality statute. Check your care provider's website or ask about the quality charter.
6. Your GGZ treatment requires there to be a specialist in charge. The mental healthcare practitioners allowed to be specialists in charge are described in the applicable sector agreement. You can find this on our website.

What you are not entitled to under this article

Among other things you are not entitled to:

a. treatment of adjustment disorders;
b. assistance with work-related and relationship problems;
c. assistance with psychiatric complaints that do not involve a mental disorder;
d. medical GGZ for insured persons up to the age of 18, with or without stay. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip!

A list of problems and diagnoses not treated under basic insurance, and psychological interventions to which you are not entitled under basic insurance, can be found on our website.

How many days stay with treatment are you entitled to?

In the case of a stay at a psychiatric hospital with treatment you are entitled to an uninterrupted stay at a GGZ institution for a period of up to 1,095 days. The following forms of stay also count towards the calculation of the 1,095 days:

a. stay at a rehabilitation centre or a hospital for the purpose of rehabilitation;
b. a stay in a non-psychiatric hospital;
c. primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Long-term medical stay

If you require a long-term medical stay at a GGZ institution (longer than 365 days), then you need prior permission. Your care provider will request this permission from us in the 9th and/or 21st month of treatment by submitting the completed Long-term Medical Necessity Stay GGZ Checklist via the zk.nl/machtigingggz webpage. The authorisation is valid for a maximum of 12 months.

If your treatment requires you to stay hospitalised for longer than 1,095 days, you can apply for an indication for the Long-Term Care Act in consultation with your healthcare provider.

Additional terms and conditions which apply when the care is provided by a non-contracted care provider

Do you want to use a non-contracted care provider? You need prior approval from us for:

1. psychiatric residency. Your care provider must complete the following application form to apply for approval before your stay: zk.nl/machtigingggz. We will then assess the appropriateness and legitimacy of the request. We will notify your care provider when we authorise or reject your application.
2. for treatment with the medicine Spravato (esketamine) in the case of hard-to-treat depression by a non-contracted care provider. Your care provider must complete the following application form to apply for approval: zk.nl/machtigingggz. We will then assess the appropriateness and legitimacy of the request. We will notify your care provider when we authorise or reject your application.
3. for treatment abroad by a care provider without a Dutch AGB code. Your care provider must complete the following application form to apply for approval: zilverenkruis.nl/consumenten/service/buitenland/formulieren/machtiging-buitenland-ggz. We will then assess the appropriateness and legitimacy of the request. We will notify your care provider when we authorise or reject your application.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Speech and reading

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.16 Speech therapy

You are entitled to treatment sessions with a speech therapist insofar as this care has a medical purpose. Speech therapists treat disorders related to personal communication, voice, language, speech, hearing and swallowing. The nature and extent of the care provided are limited to the care normally provided by speech therapists. This also applies to stutter therapy given by a speech therapist.

What you are not entitled to under this article

You are not entitled to:

a. treatments that we do not define as speech therapy, which include the treatment of dyslexia and of language developmental disorders relating to dialect or speaking a different language;
b. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Transport

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.17 Ambulance transport or patient transport

17.1 Ambulance transport

You are entitled to medically necessary ambulance transport as referred to in Article 1(1)(b) of the Ambulance Services Act:

a. to and from a care provider or institution, if the care provided is partially or entirely reimbursed by the basic insurance;
b. to an institution if the costs of your stay are covered by the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) (this does not apply if care is provided for part of a day only);
c. from a Wlz institution to a care provider or institution where you have to undergo an examination or treatment, the costs of which are fully or partially reimbursed under the Wlz;
d. from a Wlz institution to a care provider or institution that measures you for, fits or adjusts a prosthesis. The costs of the prosthesis must be fully or partially reimbursed under the Wlz;
e. from the above-mentioned care providers or institutions to your home, or to another place of residence if you cannot reasonably receive care in your home.
f. to a care provider from whom or an institution in which an insured person under the age of 18 will receive mental healthcare that is fully or partially reimbursed under the Dutch Youth Act (Jeugdwet).

Conditions for entitlement to ambulance transport

1. Ambulance transport must be approved by the emergency control centre.
2. Ordered ambulance transport must be requested by a general practitioner, medical specialist, geriatric specialist, doctor specialised in treating people with an intellectual disability, or paediatrician. There must be a medical necessity for transport. There is no need to request emergency ambulance transport.
3. You are only entitled to ambulance transport if you do not have to travel more than 200 kilometres to your care provider. This does not apply if we have made a different agreement with you.

17.2 Patient transport

If you regularly travel to and from healthcare providers or healthcare institutions, you may be entitled to reimbursement of the costs of patient transport by public transport (lowest class) or multi-person taxi, or reimbursement of € 0.38 per kilometre for transport by private vehicle. You are entitled to:

a. patient transport if you meet one or more of the following criteria:
   - you are undergoing kidney dialysis or consultations, research or checks that are necessary for these treatments;
   - you are undergoing oncological treatments with radiotherapy, chemotherapy or immunotherapy or are undergoing consultations, examinations or checks that are necessary for these treatments;
   - you have a permanent visual impairment and are unable to travel unaccompanied;
   - you are wheelchair bound;
   - you require geriatric rehabilitation under article 24.2;
   - you are under the age of 18 and entitled to nursing and care for complex somatic problems or a physical disability, involving the need for permanent supervision or the availability of 24-hour-a-day care in the vicinity;
   - you require day treatment provided in a group as part of a care programme for chronic progressive degenerative disease, non-congenital brain injury, or related to an intellectual disability according to article B.42.

b. If you meet one or more of the above criteria, you are entitled to patient transport:
   - to and from a care provider or institution, if the care provided is partially or entirely reimbursed by the basic insurance;
   - to an institution if the costs of your stay are covered by the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) (this does not apply if care is provided for part of a day only);
   - from a Wlz institution to a care provider or institution where you have to undergo an examination or treatment, the costs of which are fully or partially reimbursed under the Wlz;
   - from a Wlz institution to a care provider or institution that measures you for, fits or adjusts a prosthesis. The costs of the prosthesis must be fully or partially reimbursed under the Wlz;
   - from the above-mentioned care providers or institutions to your home, or to another place of residence if you cannot reasonably receive care in your home.

c. transport of a companion if an escort is needed, or to accompany insured persons up to the age of 16. In exceptional cases, we may allow the transport of two companions.

The number of reimbursable kilometres is based on the fastest route between the postcodes of your departure address and destination according to our route planner. For more information, visit zk.nl/vervoer or obtained from us.

Hardship clause for patient transport

If the above-mentioned criteria do not apply to you, you may be entitled to patient transport under the hardship clause. Firstly, you must be dependent on patient transport because you are being treated for a long-term illness or disorder. Secondly, if, in your situation, a lack of patient transport would be grossly unfair. We assess whether you are entitled to reimbursement under the hardship clause. If you are entitled to transport on the basis of this hardship clause, this applies to the treatment itself and any necessary consultations, research or check that you undergo and are required for the treatment.

Personal contribution for patient transport

Patient transport (by public transport, taxi or private car) is subject to a statutory personal contribution of € 118 per person, per calendar year.

Conditions for entitlement to seated patient transport

1. You must obtain advance permission for patient transport and the transport of an escort (by public transport, taxi or private car). You can request permission through the Zilveren Kruis App or the Transport Telephone Line on +31 71 365 41 54. We will determine if you are entitled to transport and, if so, the form of transport to which you are entitled. This person will also determine whether an insured person aged 16 or older needs an escort. For more information about the application process, visit zk.nl/vervoer.
2. The transport must be related to care to which you are entitled under your basic insurance or care reimbursed under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz).
3. If patient transport is not possible by public transport, taxi, private car or ambulance, we must give you permission for a different means of transport in advance.
4. A two-person escort is permitted in exceptional cases. If this is the case, we must also give you permission in advance.
5. You are only entitled to patient transport if you do not have to travel more than 200 kilometres to your care provider. This does not apply if we have made a different agreement with you.

Overnight stay instead of patient transport

If you are entitled to patient transport and need to travel to and from a care provider or care institution for your treatment on 3 or more consecutive days, you may be entitled to reimbursement of 2 or more overnight stays in the vicinity of your treatment location. You will be reimbursed up to € 89 per night. You will also be reimbursed for the outward and return journey from your home to the treatment location on the first and last day of your treatment (subject to the above conditions).

Conditions for overnight stay instead of patient transport:

1. You must obtain advance permission from our Transport Telephone Line (Vervoerslijn) (+31 71 365 41 54). Our Transport Telephone Line staff will determine whether you are entitled to an overnight stay instead of patient transport. They assess whether spending the night will be less stressful for you than travelling back and forth.
2. If you opt for the right to an overnight stay, you will retain the right to patient transport on the first and last day of that treatment period for the outward and return journey from your home to the treatment location. No personal contribution is deducted from the reimbursement for the overnight stay.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

How do I claim my transport costs?

A contracted transport service must send us an invoice for the transport costs. If you use a non-contracted taxi service, public transport or your own transport, please use the claim form to request reimbursement of your transport costs. You can find the claim form on our website. Upon our request, you must be able to provide proof that you incurred the transport costs. To claim the costs of an overnight stay, you must submit the original and clearly specified invoices for your accommodation costs to us. We may request proof of payment, even if you paid the invoice in question in cash.

Feet

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.18 Preventive foot care for insured persons at increased risk of foot ulcers

If you have an increased risk of foot ulcers because of diabetes mellitus or another condition or medical treatment, In that case, you are entitled to foot care. The nature of the foot care you receive will depend on your care profile (care profile 1, 2, 3 or 4). Your care profile is determined by the GP, company doctor, paediatrician, medical specialist, geriatrician, doctor specialised in treating people with an intellectual disability, nursing specialist or physician assistant. To assess this, the physician relies on the siMS score or risk classification.

Once your care profile has been established, a personal treatment plan will be prepared for you. This will be done by a suitably qualified and competent podiatrist. The number of foot inspections and the use of diagnostics will partly depend on the care profile. You are entitled to the care components as included in the applicable care module concerning prevention of foot ulcers by the Nederlandse Vereniging van Podotherapeuten (NVvP), insofar as these have been designated by Zorginstituut Nederland as medical care covered by the basic insurance. The care module can be found on our website or obtained from us.

The foot care to which you are entitled under this policy is arranged as part of integrated care or through care providers outside the healthcare chain. For foot care arranged as part of integrated care, please see article B.38.

Conditions for entitlement to preventive foot care

1. The podiatrist must meet the following conditions:
   - The podiatrist must be registered as such in the Kwaliteitsregister Paramedici;
     The podiatrist may delegate the provision of preventive foot care to a chiropodist. The chiropodist works as a subcontractor for the podiatrist.
     A chiropodist is, when concerning:
     - a diabetic foot:
       - a paramedical chiropodist, medical chiropodist or chiropodist+ with the entry 'foot care for diabetics' (DV), registered in the paramedical foot care register (RPV) of the Stipezo trade association, category 1 (A+B);
       - a medical chiropodist or a chiropodist with the entry 'foot care for diabetics' (DV) registered in the ProCERT KwaliteitsRegister voor Pedicures (KRP);
       - the Kwaliteitsregister Medisch Voetzorgverleners (KMV) maintained by Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ) in partnership with Nederlandse Maatschappij van/voor Medisch Voetzorgverleners (NMMV).
     - a rheumatic foot:
       - a paramedical chiropodist, medical chiropodist or chiropodist+ with the entry 'foot care for diabetics' (RV) registered in the Register Paramedische Voetzorg (RPV) maintained by the Stipezo trade association, category 1 (A+B);
       - a medical chiropodist (MP) or a chiropodist with the entry 'rheumatoid foot' (RV) registered in the ProCERT KwaliteitsRegister voor Pedicures (KRP);
       - the Kwaliteitsregister Medisch Voetzorgverleners (KMV) maintained by Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ) in partnership with Nederlandse Maatschappij van/voor Medisch Voetzorgverleners (NMMV).
     - another indication that leads to an increased risk of foot ulcers:
       - a paramedical chiropodist or medical chiropodist , registered in the Register Paramedische Voetzorg (RPV) maintained by the Stipezo trade association;
       - a medical chiropodist registered in the ProCERT KwaliteitsRegister voor Pedicures (KRP).
2. The podiatrist is the specialist in charge. The podiatrist will claim the costs directly from us quarterly. This also applies if the treatments are provided by a chiropodist
3. You need a statement from the GP, company doctor, paediatrician, medical specialist, geriatrician, doctor specialised in treating people with an intellectual disability, nursing specialist or physician assistant. The statement must specify your care profile. We use the statement to determine if and to what extent you are entitled to preventive foot care under this article.
4. The podiatrist must note the care profile and details of the services provided on the invoice.

What you are not entitled to under this article

You are not entitled to:

a. foot care and treatment by a podiatrist or chiropodist if you have an increased risk of foot ulcers and are entitled to the corresponding integrated care, which includes foot care. These foot care treatments fall under integrated care (see article B.38);
b. medical devices for foot care treatment, such as podiatric insoles and orthoses. More information about this can be found in the Medical Devices Regulations (Reglement Hulpmiddelen). This can be found on our website or obtained from us.
c. foot care services provided by a chiropodist if you have no care profile or Care profile 1 (Zorgprofiel 1). If you have Care Profile 1 (Zorgprofiel 1), you may be entitled to reimbursement under your supplementary insurance;
d. foot screening by a general practitioner. This foot screening falls under GP care (see article B.37).

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Hospital and nursing

Your insurance policies are shown on your policy certificate. If you have Basis Budget or Basis Zeker, you have arranged care insurance and are entitled to care (arranged by us). If you have Basis Exclusief, you have a combined policy and are entitled to reimbursement for the costs of care.

Exception to this is article B.26 for which you are entitled to care (arranged by us).

B.19 Genetic research and advice

Do you want to have genetic research carried out? Or do you want advice? In that case you are entitled to obtain it in a centre for genetic research. This care comprises:

a. research into and on hereditary disorders by means of genealogical analysis;
b. chromosomal research;
c. biochemical diagnostics;
d. ultrasound scanning and DNA research;
e. genetic advice and psychosocial counselling provided as part of this care.

If it is necessary to be able to advise you, the centre will also examine persons other than yourself. The centre can also advise these persons.

Condition for entitlement to genetic research and advice

You must have a referral from your doctor, obstetrician or midwife.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.20 Mechanical respiration

You are entitled to necessary mechanical respiration and the specialist medical care this involves. The care can take place in a treatment centre or at home.

Mechanical respiration at home

Mechanical respiration can be provided at home, under the responsibility of a respiratory centre. In that case:

a. the respiratory centre provides the necessary apparatus – ready-to-use – for every treatment;
b. the respiratory centre provides specialist medical care and the appropriate pharmaceutical care involved in mechanical respiration;
c. electricity costs are reimbursed. You can find the current daily rate on our website.

Condition for entitlement to mechanical respiration

You must be referred by a pulmonologist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.21 Home dialysis

Are you receiving dialysis treatment at home? In that case, you are entitled to reimbursement of the associated costs. These are:

a. any modifications necessary in and around the home and for subsequently returning things back to their original state. We only reimburse the costs of modifications we consider reasonable. Furthermore, we only reimburse these modification costs if they are not already covered by other statutory regulations;
b. other reasonable costs directly related to your dialysis at home (such as the costs of water and electricity). These too will only be reimbursed if they are not covered by other statutory regulations.

Condition for entitlement to reimbursement of these costs

You must obtain our written permission in advance. You must have submitted an estimate of the costs.

Please note!

The regular costs of home dialysis, such as equipment, expert supervision, tests, examinations and treatment, are reimbursed as specialist medical care; see article B.28 for more information.

B.22 Transplantation of organs and tissues

In the case of organ transplants you are entitled to the following treatments:

a. transplantation of tissues and organs in a hospital. The transplant procedure must be performed in:
   - a member state of the European Union;
   - a state that is party to the Agreement on the European Economic Area;
   - another state. In that case, the donor must live in that state and must be your spouse, registered partner or a first, second or third degree blood relative;
b. transplantation of tissues and organs in an independent treatment centre legally qualified and competent to perform these procedures.

In the case of proposed transplantation of an organ you are entitled to reimbursement of the costs of specialist medical care associated with:

a. the choosing of the donor;
b. the surgical removal of the transplant material from the chosen donor;
c. examination, preservation, removal and transportation of postmortem transplant tissue.

You are entitled to reimbursement of the costs of:

a. care to which the donor is entitled in under this policy. The donor is entitled to reimbursement for up to 13 weeks, or 6 months in the case of a liver transplant, from the date of discharge from the hospital. This must be the hospital in which the donor stayed for the selection or removal of the transplant material. Furthermore, you are only entitled to reimbursement of the costs of the care provided if it relates to that hospital stay;
b. transport of the donor by the lowest class of public transport, or, if medically necessary, by car. The transport must be related to the selection process, the stay in hospital, discharge from hospital or the care referred to in point a;
c. Transport of a donor who lives abroad to and from the Netherlands. The donor is only entitled to transport if you are undergoing a kidney, bone marrow or liver transplant in the Netherlands. You are also entitled to other transplant-related costs incurred as a result of the donor residing abroad.

Please note!

This does not include accommodation costs in the Netherlands or any loss of income.

In the case of b and c, if the donor has basic insurance, entitlement to reimbursement of the costs of transport applies under the donor's basic insurance. If the donor does not have basic insurance, these costs will be covered by the recipient's basic insurance.

Conditions for entitlement to this care

1. Are you having the transplant done in a hospital? And is this hospital not contracted by us? You must request our permission in writing before the transplant. Do you want to know with which hospitals we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker.
2. You must obtain advance permission for donor transport from our Transport Telephone Line (Vervoerslijn, +31 71 365 41 54).

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.23 Plastic surgery

You are entitled to plastic surgery procedures performed by a medical specialist at a hospital or independent treatment centre (ZBC) if these procedures help to correct:

a. abnormalities in personal appearance associated with demonstrable physical dysfunction;
b. mutilations that are the result of an illness, an accident or a medical intervention (this includes beard epilation for trans women);
c. the following congenital deformities:
   - cleft lip, jaw and palate;
   - deformities of the facial bones;
   - benign proliferations of blood vessels, lymphatic vessels or connective tissue;
   - birthmarks or
   - deformities of the urinary tract and genital organs;
d. paralysed or weakened upper eyelids if the paralysis or weakening seriously impairs the field of vision (if the lower edge of the upper eyelid, or overhanging skinfold, is within 1 mm of the centre of the pupil), or if the paralysis or weakening is a consequence of a congenital defect or a chronic disorder present at birth;
e. the abdominal wall (abdominoplasty), in the following cases:
   - mutilations whose severity is comparable to third degree burns;
   - untreatable inflammation (intertrigo) in skin folds;
   - an extremely severe limitation in the freedom to move (if your belly covers at least a quarter of your upper legs);
f. primary sexual characteristics in cases of confirmed transsexuality (including epilation of the pubic region as part of vaginoplasty and penile construction);
g. female breast agenesis/aplasia and a similar situation in trans women (also referred to as male-to-female transgender persons).

If a stay is medically necessary, you are entitled to this care in accordance with article B.28.

Conditions for entitlement to plastic surgery

1. You must have been referred by a GP or medical specialist. For plastic surgery for transgender people, a referral is needed from a medical specialist from the multidisciplinary gender team. The multidisciplinary gender team specialises in protocolised treatment of gender incongruence and works together on a structural basis. Within this team, a relevant expert must be in charge throughout the treatment process.
2. We must give you written permission in advance. We reimburse plastic surgery only if the examinations and treatments are carried out in accordance with the 'VAV werkwijzer beoordeling behandelingen van plastisch chirurgische aard' assessment of plastic surgery treatments.

What you are not entitled to under this article

1. Some plastic surgery procedures are not covered by your insurance. You are not entitled to the following procedures:
   a. surgical placement or replacement of breast implants, unless the surgery is performed following a (partial) mastectomy or in the case of female breast agenesis/aplasia;
   b. surgical removal of a breast prosthesis without a medical necessity;
   c. liposuction of the stomach;
   d. treatment to correct paralysed or weakened upper eyelids, unless the paralysis or weakening seriously impairs the field of vision (if the lower edge of the upper eyelid, or overhanging skinfold, is within 1 mm of the centre of the pupil), or if the paralysis or weakening is a consequence of a congenital defect or a chronic disorder present at birth.
2. You are not entitled to: treatments at a private clinic.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted hospitals can also be found on our website or obtained from us.

B.24 Rehabilitation

You are entitled to specialist medical rehabilitation (24.1) and geriatric rehabilitation (24.2).

24.1 Specialist medical rehabilitation

Do you need rehabilitation care? In that case you are only entitled to specialist medical rehabilitation if this is indicated as the most effective method of preventing, reducing or overcoming your handicap. Furthermore, your handicap must be the consequence of:

a. disorders or limitations in your ability to move;
b. a disorder of the central nervous system that leads to limitations in communication, cognition or behaviour.

The rehabilitation care must enable you to achieve or maintain a degree of independence that is reasonably possible given your limitations.

Clinical and non-clinical rehabilitation

You are entitled to clinical or non-clinical (part-time or day-treatment) rehabilitation care. In some cases you are also entitled to clinical rehabilitation care if you are admitted for several days. We only reimburse if rehabilitation care provided during a stay quickly leads to better results than rehabilitation care that does not involve a stay.

Conditions for entitlement to specialist medical rehabilitation

1. You must be referred by a general practitioner, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in youth health care or another medical specialist.
2. The stay must be medically necessary for the purpose of specialist medical rehabilitation.
3. Patients with chronic pain are only eligible for specialist medical rehabilitation when the principles of stepped care are met. With stepped care, a patient is always offered the most effective, least burdensome, cheapest and shortest form of treatment possible given the nature and severity of the problem. And if the minimally necessary intervention has insufficient effect, it is moved to a more intensive intervention.

How many days of clinical stay are you entitled to?

Have you been admitted? In that case you are entitled to an uninterrupted stay in a clinic for a period of up to 1,095 days. The following forms of stay also count towards the calculation of the 1,095 days:

a. (psychiatric) hospital stay;
b. primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Additional terms and conditions which apply when the care is provided by a non-contracted care provider

Do you want to use a non-contracted care provider? Then you need prior approval from us. To apply for permission, your care provider must use the form 'aanvraag machtiging niet-gecontracteerde medisch specialistische revalidatie zorg' (application for authorisation of non-contracted specialist medical rehabilitation care), which can be found on our website. The following must be sent with the application:

- the diagnosis, treatment plan, treatment duration and supporting information;
- completed preliminary phase.

We will then assess the appropriateness and legitimacy of the request. You and/or your care provider will receive a notification from us whether your request has been approved or denied.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted hospitals can also be found on our website or obtained from us.

24.2 Geriatric rehabilitation

You are entitled to geriatric rehabilitation. This care comprises integrated, multidisciplinary rehabilitation care. This applies to care normally provided by geriatric specialists if an acute condition has resulted in acute mobility disorders or reduced self-reliance and specialist medical care has previously been provided for this condition (in connection with vulnerability, complex multimorbidity and reduced learning and training ability). Geriatric rehabilitation focuses on improving functional limitations. The purpose of rehabilitation care is to enable you to return to your home situation.

How many days of geriatric rehabilitation are you entitled to?

You are entitled to geriatric rehabilitation for up to 180 days. In extraordinary cases, we may allow a longer period (your healthcare provider will apply to us for permission).

Conditions for entitlement to geriatric rehabilitation

1. The stay must be medically necessary for the purpose of geriatric rehabilitation.
2. The care must commence within 1 week of a stay in hospital, as defined in article 2.12 of the Health Insurance Decree (Besluit zorgverzekering). In this hospital you must receive medical care as is normally provided by a medical specialist or a similar care provider. You must be referred for the treatment by a medical specialist.
3. You were not residing in a nursing home for treatment before being admitted to this hospital. In this case we are referring to a nursing home as defined in article 3.1.1. of the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)). In this situation, restorative treatment is reimbursed under the Wlz.
4. You are also entitled to geriatric rehabilitation if you did not stay in hospital, but have an acute condition resulting in acute mobility disorders or a decline in self-reliance and you have received prior specialist medical care for your condition. The assessment (geriatric assessment) is carried out by a geriatric specialist at your home or in a primary care residence, or by a clinical geriatrician, internist geriatric specialist or geriatric specialist at the emergency care centre or via an emergency consultation at the geriatric outpatient clinic. The geriatric rehabilitation must be linked to the geriatric assessment within one week. You must be referred by a general practitioner, geriatric specialist, or doctor specialised in treating people with an intellectual disability.
5. In the event of inflow from the home environment or a primary care residence (ELV) without prior specialist medical care, the geriatric specialist can conduct a geriatric assessment in some cases. In that case, the medical stability must be verified to be eligible for geriatric rehabilitation. For acute conditions, the geriatrics specialist will always contact the attending medical specialist or, if in doubt, a medical specialist will be consulted to determine the medical stability.
6. The care must initially involve a stay in a hospital or healthcare institution, as defined in article 2.12 of the Health Insurance Decree.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.25 Second Opinion

Do you want a second opinion? In that case, you are entitled to one. Getting a second opinion means having the diagnosis made by your doctor or treatment proposed by your doctor reassessed. Your doctor can also request a second opinion. The reassessment is performed by a second, independent doctor. The second doctor must possess the same area of expertise and must practice the same profession as the first doctor.

Conditions for entitlement to a second opinion

1. The second opinion must relate to diagnostics or treatment that is covered by the basic insurance.
2. You must be referred by a general practitioner, medical specialist, clinical psychologist or psychotherapist.
3. The second opinion must relate to medical care that is intended for you and which you have discussed with your first doctor.
4. When obtaining a second opinion you give a copy of your first doctor's medical file to the second doctor.
5. You must return to the first doctor with the second opinion. This doctor remains in charge of your treatment.

What you are not entitled to under this article

Insured care does not cover a second opinion if the purpose of the second opinion is to obtain treatment that is not included in the basic insurance.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted hospitals can also be found on our website or obtained from us.

B.26 Nursing and care in your own surroundings (extramural)

Articles B.15, B.27 and B.28 list the conditions for nursing at an inpatient facility (e.g., a hospital). However, you are also entitled to nursing and care in your own surroundings. The nature and extent of the care provided is limited to the care normally provided by nurses and carers, which is specified in the occupational profiles and national quality framework defined by Verpleegkundigen & Verzorgenden Nederland (V&VN) (Netherlands Nurses and Carers Association).

You are entitled to nursing and care related to the need or a high risk of the need for medical care.

For children under the age of 18, nursing and care can also be provided at a medical childcare facility or children's hospice.

Please note!

Under certain conditions, you can apply for a personal care allowance (Zvw-pgb) to pay for nursing and care in your own surroundings. The target groups to which this applies and the conditions that apply are set out in the Reglement Zvw- pgb (Personal Care Allowance Regulations). These regulations form part of this policy and can be found on our website or obtained from us.

Please note!

If you have been diagnosed with dementia and require various types of care and support, you may need someone to coordinate this (a case manager). Depending on your situation, dementia case management may be employed to that end. Together with you and/or your immediate family and your treating physician or case manager, the nurse making the assessment will determine whether dementia case management is necessary.

Conditions for entitlement to nursing and care in your own surroundings

1. a. For adults aged 18 or older, a care needs assessment conducted in your presence by a professionally (at least BA level) qualified, BIG-registered nurse, in accordance with the applicable standards for the assessment of care needs and the organisation of nursing and care in one's own surroundings.
   b. For children under the age of 18, a care needs assessment conducted by a paediatric nurse with a degree from a university of applied sciences or a nurse with specialist training in paediatric nursing. The paediatrician or medical specialist remains ultimately responsible for the treatment. If it becomes apparent that intensive child care is required, the nurse must work for a care provider affiliated with the Intensive Child Care Branch Organisation (BIKZ). If there are capacity problems due to a shortage on the labour market, you can contact us to find a suitable solution with the care provider in question. The care need must be defined in the home environment with you (the child) and your parent(s) or legal guardian(s) present, in accordance with the Guideline for Care Needs Assessment in Childcare and the standards for care needs assessment and organisation of nursing and care in your own surroundings.
2. A professionally qualified (at least BA level), BIG-registered nurse (as stated in 1a and 1b) must conduct a care needs assessment before commencing care. This means that the district nurse will discuss with you what care you need in your particular situation, and the intended results and duration of the care. As part of the care needs assessment, the agreements that have been made are put in a care plan and the need for care is translated into the number of hours of nursing and care required. In the care plan the professionally (HBO) qualified BIG-registered nurse notes the care need and the care that is to be provided. The care plan specifies the number of hours of nursing and the number of hours of care. The care needs must be defined in accordance with the 6 standards listed in the document 'Standards for needs assessment and organisation of nursing and care in one's own surroundings' ('Normen voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving').
3. Nursing and care must be provided by a level 3 nurse or caregiver or higher.
4. In palliative terminal care, the nurse has noted in the medical file that the attending physician (name, specialty, BIG number and date) has determined that the palliative terminal stage has begun. The nature, content and extent of the care must be detailed in the care plan. Provision of care must comply with the quality framework for palliative care.
5. When nursing involves restricted or high-risk procedures, it must be demonstrated that said procedures are performed on the instructions of a physician. The health care provider must also be demonstrably competent and qualified to perform these procedures. In the case of a high-risk procedure, the nature, extent and content of the care must be elaborated in the care plan. In the case of a restricted procedure, a request for execution from a doctor must be present, and work must be carried out in accordance with the 'Manual for restricted procedures in district nursing & care' (ActiZ, 2019).

What you are not entitled to under this article

a. You are not entitled to maternity care under this article. This is reimbursed under article B.32;
b. You are not entitled to personal care under this basic insurance if you are entitled to personal care under the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)).
c. You are not entitled to care through your own network (formerly "usual care"). When making a care needs assessment, the district nurse must assess what you and your network can solve yourself, according to the V&VN Normative Framework for Assessing and Organising Nursing and Care in One's Own Environment. This means that they will identify your network and consider what care may or may not be expected of your network, based on workload and capacity. The care that can be provided by your network may not be included in an indication for district nursing. The indication must include the consideration that the district nurse makes in this regard. The V&VN defines network as: "Next of kin and family caregivers" such as partners, children, roommates, family and friends of the insured. At the time of indication, the district nurse considers how the request for help can be solved or how the intervention can be carried out, taking into account the full context of the insured (care seeker). Self-sufficiency (together with the insured's network) is the starting point of the Standards Framework.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Please note!

We are aware that, when it comes to district nursing services, the quality of care provided varies considerably. We are committed to the principle of quality care. We set high quality standards for our contracted care providers and we ensure that our requirements are met. To ensure that the care provided by non-contracted care providers also meets our requirements, we have an authorisation procedure. If you (wish to) use a non-contracted care provider, the following additional conditions apply. Please be aware that if you use a non-contracted care provider, you will have to wait longer for reimbursement. Please also note that there are plenty of contracted care providers in all regions.

Additional conditions if care is provided by a non-contracted care provider

1. Are you using a non-contracted care provider? In that case, you must request permission from us in advance. To request permission, you must use the 'Authorisation to use non-contracted district nursing care' ('Aanvraag machtiging niet-gecontracteerde wijkverpleegkundige zorg') application form, which can be found on our website. When requesting permission, you need to supply the following:
   - the care needs assessment and the care plan (these must meet the conditions listed above);
   - the nursing diploma held by the professionally (at least BA level) qualified BIG- registered nurse who conducted the care needs assessment;
   - in palliative terminal care, evidence that the nurse has noted in the medical file that the attending physician (name, specialty, BIG number and date) has determined that the palliative terminal stage has begun.

We will then assess the appropriateness and legitimacy of your request. We assess the efficacy by, among other things, comparing your indication with similar indications, and determine whether it is suitable for your care needs. We can also ask the nurse who drew up your indication for further explanation. We will notify you whether your request has been approved or fully or partially denied.

2. You must submit the invoices you receive from your non-contracted care provider to us for reimbursement. Invoices will only be reimbursed if authorisation to use a non-contracted care provider has been requested and approved.

B.27 Primary care stay

You are entitled to primary care stay. The stay must be necessary for medical care and may involve nursing and (paramedical) care. Your general practitioner must consider that recovery is to be expected in the short term. The purpose of the stay is generally to enable you to return to your home situation. Has your doctor indicated that your estimated life expectancy is less than 3 months? In that case you are entitled to palliative terminal care at an institution where patients can stay for primary care.

Primary care stay consists of:

- medically necessary stay in connection with medical care;
- 24-hour availability and provision of nursing and/or care;
- medical care provided by a general practitioner, a geriatric specialist and/or a doctor specialised in treating people with an intellectual disability;
- paramedical care (physiotherapy, Cesar or Mensendieck remedial therapy, speech therapy, dietetic therapy and/or occupational therapy) required in connection with the need for the stay.

The nature and extent of the medical care provided are limited to the care normally provided by general practitioners.

Conditions for entitlement to primary care stay

1. You must be referred by a general practitioner, a medical specialist, a doctor specialised in emergency medicine, a geriatric specialist or a doctor specialised in treating people with an intellectual disability.
2. If your stay will be longer than 3 months, you or your care provider must request permission from us to extend the stay beyond the first 3 months, before the 60th day of your stay. This does not apply for palliative care.
3. You must obtain our advance permission if you wish to stay with a non-contracted primary care provider. For more information about the application, see the bottom of this article.
4. For palliative care, the provision of care must be aligned with the palliative care module or the quality framework for palliative care.
5. The primary nurse must be a level 4 nurse at minimum.

What you are not entitled to under this article

You are not entitled to a primary care stay:

a. if you have been allocated a complete or modular home care package or a personal care allowance (PGB) to pay for care in your own home under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)), or if you receive care through a form of clustered housing. In that case the cost of the stay is covered under the Long-term Care Act (Wlz);
b. in the case of respite care. Respite care is the temporary assumption of full responsibility for the provision of care to provide relief for the usual informal carer. This is paid for by the Social Support Act (Wmo);
c. if you are under the age of 18 and need mental healthcare. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

How many days of clinical stay are you entitled to?

Days of primary care stay count towards the calculation of the maximum of 1,095 days of stay. The following forms of stay also count towards the calculation of the 1,095 days:

a. (psychiatric) hospital stay;
b. stay in a rehabilitation centre or a hospital for the purpose of rehabilitation.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Additional conditions if primary care stay is provided by a non-contracted care provider

1. Do you want to use a non-contracted care provider? Then you need prior approval from us. To apply for approval, you or your healthcare provider must use the Request for Primary Care Stay with Non-Contracted Healthcare Providers application form (Machtigingsformulier ELV niet-gecontrracteerde zorgaanbieders), which can be found on our website.
2. The application must include the referral from the general practitioner, geriatric specialist or medical specialist. The referral must state the care need and the relevant comorbidity. It must be clear from the explanation whether the request concerns a low, high or palliative primary care stay. The referral must also explain that you are expected to be able to return to your home situation after treatment. The latter does not apply to palliative terminal care. Upon receiving your application, we will assess its efficacy and legitimacy. We will notify you and your care provider whether your request is approved or denied.
3. You must submit the invoices you receive from your non-contracted care provider to us for reimbursement. Invoices will only be reimbursed if authorisation to use a non-contracted care provider has been requested and approved.

B.28 Specialist medical care and stay

You are entitled to specialist medical care and stay. This care can be provided at:

a. a hospital;
b. an independent treatment centre; or
c. the home practice of a medical specialist (extramural specialist), if they have an AGB code. You can check this on agbcode.nl. If an extramural specialist is not contracted by us, reimbursement takes place in the same way as for non-contracted independent treatment centres.

The care consists of:

a. specialist medical care;
b. your treatment and possible stay (based on the lowest class accommodation and care) in a hospital or independent treatment centre, including nursing and care, paramedical care, medicines, medical devices and dressings that are part of the treatment.

The nature and extent of the care provided are limited to the care normally provided by medical specialists.

Conditions for entitlement to specialist medical care

1. You must be referred by a general practitioner, a company doctor, geriatric specialist, a doctor specialised in treating people with an intellectual disability, a paediatrician, a physician assistant, a nurse specialist, an emergency department doctor, a doctor assistent, clinical technologist, obstetrician (if it concerns obstetric care or a referral to a paediatrician within the first 10 days after delivery), optometrist (only if it concerns eye care), oral surgeon, dentist (only if it concerns dermatology, neurology, anesthesiology or ENT), GGD doctor (for TBC or an STI) or another medical specialist.
2. A hearing-aid specialist or medical physicist audiologist can also refer you to an ENT specialist.
3. You may also be referred to a paediatrician by the RIVM after a positive/abnormal heel prick screening for a newborn.
4. If you live in a nursing home and do not have your own general practitioner, you may also be referred by a junior doctor working in your nursing home.
5. The referring doctor (see under 1) informs our medical advisor of the reason for your stay. You must authorise the referring doctor to provide this information.
6. Are you being admitted for plastic surgery? In that case you are only entitled to this care if you have requested our permission. This must be done at least 3 weeks before the stay. As proof of our permission, we issue the hospital or independent treatment centre with a guarantee statement.
7. The stay must be medically necessary for specialist medical care.
8. If you are undergoing polysomnography (a comprehensive sleep registration test that measures the quality of your breathing and sleep) with a non-contracted care provider, then you need prior approval from us. To apply for approval, your care provider must submit the authorisation form for non-contracted clinical mental healthcare services (“Aanvraag machtiging niet-gecontracteerde klinische GGZ”), which can be found on our website.

Please note!

The following articles of B. Care covered by basic insurance explain aspects of specialist medical care individually.

The articles in question are:

- Article B.8 Dental care for insured persons aged 18 or older - dental surgery
- Article B.13 Audiology centre
- Article B.15 Mental healthcare for insured persons aged 18 or older (secondary mental healthcare)
- Article B.19 Genetic research and advice
- Article B.20 Mechanical Respiration
- Article B.21 Home Dialysis
- Article B.22 Transplantation of organs and tissues
- Article B.23 Plastic surgery
- Article B.24 Rehabilitation
- Article B.30 Childbirth and obstetric or midwifery care
- Article B.31 In vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI), other fertility enhancing treatments, sperm cryopreservation and oocyte vitrification
- Article B.33 Paediatric Oncology Screening
- Article B.41 Thrombosis Service

What you are not entitled to under this article

You are not entitled to:

a. Specialist medical care and/or stay, as described in this article, if you are treated at a private clinic;
b. treatments for snoring (uvulopalatoplasty);
c. treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis;
d. treatments designed to result in sterilisation;
e. treatments designed to reverse sterilisation;
f. treatments for circumcision without medical necessity.

Mental healthcare (GGZ) does not fall under this article. To find out what mental healthcare you are entitled to, read article B.15.

How many days stay are you entitled to?

Have you been admitted to a hospital or independent treatment centre? In that case you are entitled to an uninterrupted stay in a hospital or independent treatment centre for a period of up to 1,095 days. The following forms of stay also count towards the calculation of the 1,095 days:

a. stay in a rehabilitation centre or a hospital for the purpose of rehabilitation;
b. stay in a psychiatric hospital;
c. primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

The lists of the reimbursement rates that apply to care provided by non-contracted hospitals and independent treatment centres can also be found on our website or obtained from us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.29 Overnight accommodation near a hospital during CAR T-cell therapy

If you are undergoing CAR T-cell therapy and cannot get to the hospital where you are being treated within 60 minutes, you are entitled to reimbursement of the costs of overnight accommodation near the hospital. You will be reimbursed up to € 89 per night.

Condition for reimbursement

If you are undergoing CAR T-cell therapy and cannot get to the hospital where you are being treated within 60 minutes, you are entitled to reimbursement of the costs of overnight accommodation near the hospital during the third and fourth week of treatment. You will stay at the hospital during the first and second week after treatment.

How do I claim my transport costs?

You must submit the invoices for your accommodation costs to us using the claim form on our website.

Pregnancy/baby/child

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.30 Childbirth and obstetric or midwifery care

When assessing your entitlement to obstetric or midwifery care and care during delivery, we distinguish between 'with medical indication' (30.1) and 'without medical indication' (30.2).

30.1 With medical indication

Female insured persons are entitled to:

a. obstetric or midwifery care provided by a medical specialist. This also includes care provided in a hospital and by an obstetrician or midwife supervised by a medical specialist;
b. use of the delivery room if delivery takes place in a hospital.

The nature and extent of the care provided are limited to the care normally provided by medical specialists.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

30.2 Without medical indication

Female insured persons are entitled to:

a. the use of the delivery room if there is no medical indication for giving birth in a hospital or a birth centre. You will be required to pay a statutory personal contribution of € 40 for each day of your stay (€ 20 for the mother and € 20 for the child). If the hospital charges more than € 286 per day (€ 143 for the mother and € 143 for the child), you will also have to pay the amount above € 286 per day in addition to the personal contribution of € 40;
b. obstetric care by a midwife, or by a general practitioner who is active in obstetrics and who is authorized and competent for this purpose.

Example:

The maximum reimbursement for the use of the delivery room is € 246 per day. The calculation for this is as follows: € 286 (or higher amount) -/- € 40 (personal contribution) = up to € 246 per day for mother and child. NB. Birth centres often only charge one day.

The nature and extent of the care provided are limited to the care normally provided by obstetricians and midwives.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Using a non-contracted care obstetrician or midwife. If you wish to use a non-contracted obstetrician or midwife, or if the obstetrician or midwife uses a non-contracted care provider for x-ray and laboratory testing, the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.31 In vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI), other fertility enhancing treatments, sperm cryopreservation and oocyte vitrification

You are entitled to IVF or ICSI (31.1), other forms of fertility-enhancing treatments (31.2), sperm cryopreservation (31.3) and oocyte vitrification (31.4).

31.1 IVF or ICSI

Do you want to undergo an IVF or ICSI treatment? And are you under the age of 43? In that case, per ongoing pregnancy achieved, you are entitled to reimbursement of the first, second and third IVF attempts, including any medicines used. Both IVF and ICSI treatments count towards the three attempts.

What is the definition of an IVF or ICSI attempt to achieve pregnancy?

An IVF or ICSI attempt to achieve pregnancy involves undergoing, at most, the following sequential phases:

a. ripening of oocytes within the woman's body by means of hormonal treatment;
b. retrieval of the ripe oocytes (follicular puncture);
c. oocyte fertilisation and cultivation of embryos in the laboratory;
d. replacement of 1 or 2 of the resulting embryos in the uterus to allow pregnancy to occur. Are you under the age of 38? In that case only 1 embryo may be replaced during the first and second attempts.

From the time of successful follicle puncture, we count the attempt regardless of whether any eggs are obtained. From then on, we count all attempts that are interrupted before an ongoing pregnancy is achieved. A new attempt after an ongoing pregnancy is treated as a first attempt. The replacement of frozen embryos is regarded as part of the IVF or ICSI attempt during which the embryos were created, as long as an ongoing pregnancy has not already been initiated. If an ongoing pregnancy has been initiated, any remaining frozen embryos may be replaced after this pregnancy. If this fails to produce results, further IVF or ICSI treatment can be initiated. This then counts as a first attempt.

What is the definition of an ongoing pregnancy?

A distinction is drawn between 2 different forms of ongoing pregnancy:

a. spontaneous pregnancy lasting at least 12 weeks from the first day of the last menstruation;
b. IVF or ICSI-induced pregnancy lasting at least 10 weeks from the follicular puncture after a non-frozen embryo is replaced. Or at least 9 weeks and 3 days after a frozen embryo was replaced.

Conditions for entitlement to IVF or ICSI

1. The treatment must take place at an institution licenced for IVF and ICSI.
2. You need a statement from your doctor that states the medical indication before submitting your application. The statement must show that you are entitled to IVF or ICSI.
3. We must give you written permission in advance for treatment at an institution abroad.

What you are not entitled to under this article

You are not entitled to medicine required for the fourth or subsequent IVF attempts.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted hospitals can also be found on our website or obtained from us.

31.2 Other fertility-enhancing treatments

Are you under the age of 43? In that case, you are also entitled to reimbursement of fertility-enhancing treatments other than IVF or ICSI and the necessary medicines.

Conditions for entitlement to other fertility-enhancing treatments

For entitlement to other fertility-enhancing treatments the following conditions apply:

1. You need a statement from your doctor that states the medical indication before submitting your application.
2. We must give you written permission in advance for treatment in a hospital abroad.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Selective contracting for Basis Budget

Please note!

Do you have a Basis Budget policy? Then selective contracting applies to the care provided under this article. For more information, please see article A.4.3.2 Arranged care policy with selective contracting (Basis Budget).

Do you want to know which hospitals have been contracted especially for Basis Budget insurance? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted hospitals can also be found on our website or obtained from us.

31.3 Sperm cryopreservation

Are you undergoing specialist medical treatment that may result in unintended infertility? In that case you are entitled to the collection, freezing and storage of semen.

The law stipulates that the freezing of semen must be a part of the oncological care given by a medical specialist. It could also be a comparable treatment that is not oncological. This must involve:

a. major surgery on or close to your genitals;
b. chemotherapy and/or radiotherapy treatment during which your genitals are exposed to radiation.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

31.4 Vitrification (freezing) of human oocytes

Do you want to have human oocytes or embryos frozen? In that case you are entitled to this procedure for the following medical indications:

a. you are undergoing chemotherapy which carries the risk of permanent fertility problems;
b. you are undergoing radiotherapy treatment during which your ovaries are exposed to radiation and could be permanently damaged as a result;
c. you are undergoing surgery during which (large parts of) both of your ovaries will be removed for medical reasons.

Entitlement to freezing procedures also exists for other medical indications

The following medical indications involve an increased risk of you becoming prematurely infertile. This is the case if you suffer from premature ovarian insufficiency (POI) before you reach the age of 40. Also in this instance you are entitled to freezing procedures. The medical indications involved are those relating to the following characteristics of female fertility:

a. fragile X syndrome;
b. Turner syndrome (XO);
c. galactosemia.

For these medical indications, you are entitled to reimbursement of the following parts of the treatment:

a. follicular stimulation;
b. oocyte puncture;
c. oocyte vitrification (freezing).

Entitlement to freezing procedures also exists for IVF or ICSI-related indications

In some cases, you will also be entitled to freezing procedures during an IVF or ICSI attempt based on efficacy considerations. In that case, the attempt must be covered by your basic insurance. This is the case in the following situations:

a. there is an unexpected lack of sperm of sufficient quality;
b. oocytes are frozen instead of embryos;

You are only entitled to the freezing of oocytes for IVF or ICSI-related reasons.

Possibilities after the freezing of oocytes

If you are having your frozen oocytes thawed with the aim of becoming pregnant, you are limited to stages 3 and 4 of an IVF or ICSI attempt (see 31.1).

Please note!

You must be under the age of 43 when the embryo is replaced.

Conditions for entitlement to freezing procedures

1. The freezing procedures must take place in an authorised hospital.
2. Are you being treated in a hospital abroad? In that case we must give you written permission in advance.
3. You are only entitled to freezing procedures for the reasons listed above if you are under the age of 43.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.32 Maternity care

Female insured persons are entitled to maternity care. The nature and extent of care provided is limited to the care normally provided by maternity carers.

Maternity care can be provided:

a. **at home**
   A statutory personal contribution of € 5.10 per hour applies for maternity care provided at home. Maternity care at home is also reimbursed to the newborn's guardian after adoption or if the mother died during or shortly after childbirth.
b. **at a birth or maternity centre**
   A maximum of 8 hours of maternity care is charged per bed-day in a birth or a maternity centre. The statutory personal contribution of € 5.10 per hour also applies in this case. You are entitled to up to 4 bed-days. You are entitled to receive the remainder of the indicated maternity care at home.
c. **at hospital**
   Are you staying at a hospital without a medical indication? In that case, a statutory personal contribution of € 40 applies for each day of your stay (€ 20 for the mother and € 20 for the child). If the hospital charges more than € 286 per day (€ 143 for the mother and € 143 for the child), you will also have to pay the amount above € 286 per day in addition to the personal contribution of € 40.
   You are entitled to the number of hours of maternity care determined in the manner indicated below under the heading 'How much maternity care will you receive?', divided over a maximum of 6 weeks, counting from the day of delivery. If the maternity care has already partly taken place at the hospital, a number of hours of maternity care will be deducted from the aforementioned number of determined hours. For the remaining number of hours you are entitled to maternity care at home.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

How much maternity care are you entitled to?

The number of hours of maternity care to which you are entitled is limited to at least 24 hours to a maximum of 80 hours, spread over a maximum of six weeks, counting from the day of delivery. The birth centre or maternity centre will determine the number of hours you receive. This will be done in accordance with the National Maternity Care Indication Protocol (Landelijk Indicatieprotocol Kraamzorg) or the indication protocol.method that replaces it. The protocol and explanatory notes can be found on our website or contact us.

B.33 Oncological examination of children

You are entitled to care provided by the Dutch Child Oncology Group (Stichting Kinderoncologie Nederland (SKION)). SKION coordinates and registers tissue material it receives and establishes the diagnosis.

B.34 Prenatal screening

As a female insured person you are entitled to:

a. counselling that explains the procedures involved in prenatal screening;
b. Non-Invasive Prenatal Testing (NIPT). You are only entitled to reimbursement of this test if you have a medical indication;
c. invasive diagnostic test (for example a chorionic villus test or an amniocentesis). You are only entitled to reimbursement of this diagnistic if you have a medical indication or if the result of the NIPT is positive. Your care provider will determine this.

Condition for entitlement to prenatal screening

The care provider who carries out the prenatal screening must have a permit as defined in the Population Screening Act (WBO-vergunning) or work in collaboration with a regional centre that has such a permit.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Other

Your insurance policies are shown on your policy certificate. If you have a Basis Zeker or Basis Budget policy, you have arranged care insurance and are entitled to care (arranged by us). If you have a Basis Exclusief policy, you have combined policy and are entitled to reimbursement of the costs of care.

B.35 Dietetic therapy

You are entitled to 3 hours of dietetic therapy by a dietitian. This means 3 hours per calendar year. Dietetic therapy includes information and advice on nutrition and eating habits. Dietetic therapy must have a medical objective. The nature and extent of the care provided is limited to the care normally provided by dietitians.

What you are not entitled to under this article

You are not entitled to:

a. appointments outside of regular working hours;
b. missed appointments;
c. reports.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.36 Combined lifestyle intervention for insured persons aged 18 or older

If you have a moderate, high or extreme weight-related health risk profile (GGR) under the Obesity Care Standard (Zorgstandaard Obesitas) by Partnership Overweight Netherlands (Partnerschap Overgewicht Nederland (PON)), you are entitled to a Combined Lifestyle Intervention (Gecombineerde Leefstijl Interventie (GLI)).

The GLI is a programme aimed at modifying your behaviour. You will receive guidance in improving your eating habits, increasing your exercise activity and maintaining these habits as a sustainable behavioural change. This is a 2-year programme.

Conditions for entitlement to GLI

1. You must be 18 or older. If you are 16 or 17 years old, you are entitled to a Combined Lifestyle Intervention (Gecombineerde Leefstijl Interventie (GLI)) if your general practitioner deems it appropriate.
2. You must be referred by a general practitioner, medical specialist or company doctor.
3. A moderately, strongly or extremely elevated Weight-related Health Risk (Gewichtsgerelateerd GezondheidsRisico (GGR)) must be established by the general practitioner, medical specialist or company doctor. These risks are detailed in PON's Obesity Care Standard.
4. The care provider works with an effective GLI programme registered as such with the Healthy Living Bureau register and designated as insured care.
5. The care provider must at least have the competencies of a lifestyle coach with a degree from a university of applied sciences and be registered with a GLI endorsement in one of the following registries:
   a. the Lifestyle Coaches Registry of the professional association for lifestyle coaches in the Netherlands (Beroepsvereniging Leefstijlcoaches Nederland (BLCN));
   b. the Central Quality Registry (Centraal Kwaliteitsregister (CKR)) or the partial registry of the Physical Therapy Certification Foundation;
   c. or, in the case of dietitians or remedial therapists, the quality registry for paramedics (het kwaliteitsregister Paramedici).

What you are not entitled to under this article

You are not entitled to GLI if your Weight-related Health Risk has been assessed by your general practitioner, medical specialist or company doctor, as slightly elevated according to the Healthcare Standard for Obesity.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

We have contracted GLI care groups that work with care providers who offer the effective GLI. Does your care provider work on behalf of the care group? Then you will receive full reimbursement. The care group invoices the costs directly to us on a quarterly basis; the care provider invoices his or her costs to the care group.

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Please note!

GLI is a new healthcare solution that has never before been offered by healthcare providers in this way. We are committed to the principle of quality care. We set high quality standards for our contracted care providers and we ensure that our requirements are met. To ensure that the care provided by non-contracted care providers also meets our requirements, we have an authorisation procedure. If you (wish to) use a non-contracted care provider, the following additional conditions apply.

Additional terms and conditions which apply when the care is provided by a non-contracted care provider

Do you want to use a non-contracted care provider? Then you need prior approval from us. To apply for approval, your healthcare provider must use the Request for Non-Contracted Combined Lifestyle Interventions application form (aanvraagformulier niet-gecontracteerde Gecombineerde Leefstijlinterventies) on our website. The following must be sent with the application:

- the name of and referral letter from the general practitioner, medical specialist or company doctor, stating that you have a moderately, severely or extremely elevated GGR;
- the name and AGB code of the health care provider supervising the GLI program;
- the name of the GLI programme.

We will then assess the appropriateness and legitimacy of the request. You and/or your care provider will receive a notification from us whether your request has been approved or denied.

B.37 General practitioner care

You are entitled to medical care provided by a general practitioner. The care can also be provided by a care provider under the supervision of the general practitioner. If requested by a general practitioner, you are also entitled to Xrays and laboratory tests. The nature and extent of the care provided is limited to the care normally provided by general practitioners.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Using a non-contracted general practitioner If you wish to use a non-contracted general practitioner, or if your general practitioner uses a non-contracted care provider for x-ray and laboratory testing, the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.38 Integrated care for diabetes mellitus type 2, COPD, asthma and/or VRM

You are entitled to integrated care for diabetes mellitus type 2 (for insured persons aged 18 or older), COPD, asthma or vascular risk management (VRM) if we have made agreements with a care group. In the provision of integrated care the patient with a chronic condition is the primary concern. Care providers from various disciplines play a role in the care programme. We currently purchase integrated care for diabetes mellitus type 2, COPD, asthma and VRM. The content of these programmes is aligned with the current care standards for diabetes mellitus, COPD, asthma and VRM.

Entitlement to integrated care provided by a non-contracted care group

Please note!

Are you receiving integrated care for diabetes mellitus type 2 (for insured persons aged 18 or older), COPD, asthma or VRM provided by a non-contracted care group? In that case the reimbursement may be lower than for a contracted care group. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you have diabetes mellitus type 2 and are you under the age of 18? Or is your care provider not affiliated with a care group? In that case you are only entitled to care normally provided by medical specialists, dietitians and general practitioners. This is the care as defined in articles B.28, B.35 and B.37. In the case of diabetes mellitus type 2, you are also entitled to foot care as defined in article B.18.

To find out with which care providers we have a contract, use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.39 Integrated approach to obesity for insured persons up to 18 years old

If you are younger than 18 and have a moderately elevated weight-related health risk or higher according to the Addendum voor kinderen op de Zorgstandaard Overgewicht en Obesitas by Partnerschap Overgewicht Nederland (PON), you are entitled to care and support within the framework of an integrated approach for obese children that covers two domains (the social domain and the domain of the Health Insurance Act/basic insurance), insofar as such care and support have been designated as basic insurance care by the Dutch National Healthcare Institute (ZINL). Upon determination of a moderately elevated weight-related health risk or higher, you will be referred to a central care provider who will perform a broad history (or comprehensive intake and analysis of the problem) and prepare a plan of action. If the plan of action indicates a combined lifestyle intervention (GLI), you are entitled to the GLI and further supervision and coordination by the central care provider. The central care provider guides and coordinates within the chain to ensure the right support and care for the child and family at the right time by the right professional, and ensures consistency in the integrated approach. The GLI is an intervention aimed at reducing energy intake, increasing physical activity and potentially adding custom psychological interventions to support behavioural change.

Conditions for entitlement to the Integrated approach for obese children

1. Children up to 18 are entitled to a GLI under this article. If you are 16 or 17 years old, you are also entitled to the GLI for adults from B.36 if your GP considers this care appropriate for you. Care under this section and B.36 cannot take place at the same time.
2. You must have been referred by a GP, paediatrician, or paediatric nurse, although a paediatric nurse may not refer patients to themselves, given point 8 below.
3. A moderately, severely, or extremely elevated weight-related health risk must be determined by a GP, paediatrician, or paediatric nurse according to the Addendum voor Kinderen to PON's Zorgstandaard Overgewicht en Obesitas.
4. You are entitled to a GLI and further support and coordination by a central care provider if you have a moderately elevated weight-related health risk or higher and a GLI programme is indicated and substantiated in the care plan.
5. The GLI programme has a maximum duration of 24 consecutive months.
6. The deployment of the central care provider within this integrated approach can last up to 3.5 years in its entirety.
7. The phase between taking the history and starting the GLI (intermediate phase) must be no more than 6 months. The intermediate phase can only be extended if there are clear arguments for it and we have given our prior consent. To that end, the central care provider must submit an application with the reasoning via our website.
8. The central care provider must be a paediatric nurse with an HBO+ education supplemented by specific training to become a central care provider with a focus on knowledge of the social and care domains, specifically aimed at youth and family. The central care provider must have proof of successful completion of their training and education.
9. The GLI must be conducted by an HBO-trained paediatric lifestyle coach. The required competencies for the paediatric lifestyle coach are still being elaborated by Beroepsvereniging Leefstijlcoaches Nederland (BLCN). BLCN must clarify what additional requirements apply to paediatric lifestyle coach training compared to adult lifestyle coach training (e.g., the 'systemic' approach), accredit training for this purpose and establish a register for paediatric lifestyle coaches. Once the BLCN has established such a register, paediatric lifestyle coaches must be registered in it.
10. Paediatric lifestyle coaches must work with paediatric GLI programmes whose effectiveness has been established and proven at a sufficient level by the RIVM and which have been designated as insured care by Zorgverzekeraars Nederland/Zorginstituut Nederland and us.

What you are not entitled to under this article

You are not entitled to:

a. an anamnesis and plan of action when your GP or paediatrician has determined your weight-related health risk to be slightly elevated according to the Addendum voor Kinderen to the Zorgstandaard Overgewicht en Obesitas by Partnerschap Overgewicht Nederland (PON).
b. a GLI and further support and coordination by the central care provider if the GLI—despite having a moderately elevated weight-related health risk or higher—is not indicated by the central care provider in the plan of action.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.40 Stop smoking programme

You are entitled to up to 1 stop smoking programme designed to help you give up smoking per calendar year. The stop smoking programme must consist of medical and possibly pharmacotherapeutic interventions that support behavioural change, the objective of which is to stop smoking. This involves support such as that normally provided by general practitioners, medical specialists and clinical psychologists.

Conditions for entitlement to a stop smoking programme

1. You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, an obstetrician or midwife or a medical specialist.
2. Pharmacotherapy with nicotine-replacement medicines, nortriptyline, bupropion and varenicline is only reimbursed in combination with support that focuses on behaviour.
3. The programme must have been drawn up in accordance with the description and frameworks set out in the 'Stoppen met Roken' (Stop smoking) care module and comply with the CBO Tobacco Addiction (Tabaksverslaving) guideline.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.41 Thrombosis Unit

Do you suffer from thrombosis? In that case you are entitled to care from a thrombosis service. The care provided by this service includes:

a. taking regular blood samples;
b. carrying out the necessary laboratory tests in order to determine the coagulation time of your blood. The thrombosis service may also arrange for a third party to carry out these tests. The thrombosis service remains accountable;
c. providing you with apparatus and equipment so you can measure the coagulation time of your blood yourself;
d. training you to use this equipment and supervising you when you carry out measurements;
e. advising you on the use of medicines to influence the coagulation time of your blood.

Condition for entitlement to care from a thrombosis service

You must be referred by a general practitioner, an obstetrician or midwife (in case of pregnancy or delivery), a geriatric specialist, a doctor for the mentally handicapped or a medical specialist.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

B.42 Medical care for specific patient groups

Medical care for specific patient groups (GZSP) is a collection of forms of care for vulnerable people who still live at home. Care needs are multifaceted and may be somatic, psychological and/or behavioural. This concerns:

- elderly people with complex disorders (somatic and/or psychological);
- people with chronic, progressive, degenerative disorders such as Parkinson's, Huntington's and multiple sclerosis;
- people with non-congenital brain injuries;
- people with intellectual disabilities.

The care consists of:

- generalist medical care aimed at vulnerable patients such as the elderly and people with an intellectual disability. The treatment focuses on teaching the patient skills or behaviour to help them deal with the implications of their condition, disorder or disability.
- care which is no longer focused on recovery, but on dealing with the problems and limitations arising from the condition.

The care you receive is determined by the care needs and professional considerations that apply to the specific interventions offered. The care may be provided by a doctor specialised in treating people with an intellectual disability or a geriatric specialist (monodisciplinary care). The treatment may also be provided by a multidisciplinary team led by the GZSP director. In both cases, the treatment will be laid out in a treatment plan. The care may be provided individually or in groups. The provided care must comply with the GZSP "Group Care" basic principles (Uitgangspunten 'Zorg in een groep' Geneeskundige Zorg voor Specifieke Patiëntgroepen (GZSP)) and the GZSP "Individual Performance" basic principles (Uitgangspunten 'Individuele prestaties' Geneeskundige Zorg voor Specifieke Patiëntgroepen (GZSP)). These basic principles have been jointly drawn up by various care providers, professional associations and Zorgverzekeraars Nederland. You can view the basic principles at zn.nl/publicaties.

The nature and extent of the care provided is limited to the care normally provided by general practitioners, clinical psychologists and paramedics.

Conditions for entitlement to medical care for specific patient groups

You must be referred by a general practitioner or a medical specialist.

What you are not entitled to under this article

1. You are not entitled to care if the treatment goals have been met or if there are no more treatment goals.
2. You are not entitled to care if an indication for the Long-term Care Act (Wlz) has been issued.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

Do you want to know with which care providers we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

C. Terms and conditions supplementary insurances

The terms and conditions that apply to your basic insurance also apply to your supplementary insurances. Exceptions to this are article A.1.1 This insurance contract is based on: paragraph a–d and article A.4.3 Non-contracted care providers. In other words, these articles of the 'Terms and conditions of the basic insurance policies' do not apply to your supplementary insurances.

There are also articles that apply specifically to your supplementary insurances. These articles are listed below.

C.1 How do you apply for the supplementary insurance?

1.1 Applying for supplementary insurance

Everyone who is entitled to take out our basic insurance can also apply for supplementary insurance should they wish to do so. You can choose one insurance policy from Basis Vitaal, Vitaal 1, 2, 3 and Vitaal Premium. You can also choose one insurance policy from Tand 1, Tand 2, Tand 3 and Tand 4. You can also take out Ziekenhuis Ontzorgpakket. You (the policyholder) can apply for supplementary insurance by signing and returning an application form that you have completed in full. You can also complete the application form on our website. But you can only do this if you are applying for our basic insurance at the same time. We only provide supplementary insurance with retroactive effect if a situation as referred to in article 6.1 of these terms and conditions applies.

1.2 We cannot always provide supplementary insurance

There are some situations in which we cannot provide supplementary insurance. We will reject your application if:

- you (the policyholder) have an overdue premium payment for an existing insurance with us;
- you have been found guilty of fraud as defined in article A.20 What are the consequences of fraud?;
- your oral health condition gives cause to do so;
- you need some form of healthcare when you apply. if you are likely to need some form of healthcare which, due to its nature and extent, would be covered by the supplementary insurance;
- you have taken out a ZieZo basic insurance policy;
- you have had to pay an administrative fine imposed by the Central Administration Office (Centraal Administratie Kantoor (CAK)) because you failed to take out health insurance. You cannot take out supplementary insurance with us during the 12 months that you are officially insured.

1.3 Children have the same supplementary insurance as their parents

Are your children also covered by your basic health insurance? Then you can take out supplementary insurance for your children, if you also have a supplementary insurance. You do not have to pay a premium for supplementary insurance for children under 18. So it is not possible to arrange supplementary insurance for children that is more extensive than the supplementary insurance arranged for yourself or a partner covered by the same policy.

Please note!

Does your partner have their own basic and supplementary insurance policies, either with us or with another insurer? In that case you must indicate whether your children are to be added to your policy or your partner's policy. You can take out supplementary insurance for your children, if you also have a supplementary insurance.

C.2 What does the supplementary insurance cover?

2.1 What we reimburse

You are entitled to reimbursement of expenses under your supplementary insurance if the expenses in question were incurred during the period covered by the supplementary insurance. In this respect the determining factor is the date on which treatment and/or care was/were provided. The date of treatment is the date of treatment noted on the bill, not the date on which the bill was issued. Are you claiming for treatment provided within the context of a Diagnosis Treatment Combination (DBC) care product? Then the start date of your treatment is the determining factor.

Reimbursement for non-contracted care providers or healthcare institutions

In the case of some of the reimbursements listed under 'Reimbursements covered by supplementary insurance policies', we only reimburse the costs if you are treated by a contracted care provider. You can read about this in the respective article. It may also be the case that we do not fully reimburse a non-contracted care provider or healthcare institution. You can also read about this in the respective article.

Reimbursement after interruption of the insurance term

In the event of a temporary interruption of the insurance of up to twelve months, the insurance period will be deemed not to have been interrupted and the duration of the interruption will count in determining the term of the reimbursement period specified in the coverage.

2.2 Reimbursement of the costs of medical treatment abroad

Reimbursement of the costs of medical treatment abroad is subject to certain conditions and exclusions. These are listed in the articles under 'Reimbursements covered by supplementary insurance policies'. The foreign care provider or healthcare institution must be recognised by the local authorities in the country in question. The foreign care provider or healthcare institution must also meet requirements equivalent to the statutory requirements that must be met by Dutch healthcare providers and institutions, as defined by the conditions of your insurance. Article A.15 When are you entitled to reimbursement of healthcare received abroad? of the basic insurance terms and conditions also applies to medical treatment abroad.

Please note!

Do our conditions mention 100% or full reimbursement? Then, in the context of the article in question, expenses will be reimbursed up to 100% of the fee normally charged for the same treatment in the Netherlands.

This article does not apply to articles listed in the conditions of your insurance as pertaining specifically to the situation that applies in the Netherlands, This article also does not apply to article D.4 Healthcare abroad. We only reimburse the costs of medical treatment abroad if these costs would be covered by your supplementary insurances if the treatment were provided in the Netherlands.

2.3 What we do not reimburse (concurrent insurance)

You are only entitled to reimbursement of expenses that are not, or only partially, reimbursed by statutory regulations. The expenses in question must also be covered by your supplementary insurance. Your supplementary insurance does not include cover that compensates for:

a. a lower reimbursement covered by your basic insurance for care provided by non-contracted care providers;
b. expenses offset against the excess of your basic insurance, unless we are providing group supplementary insurance that covers the mandatory excess;
c. statutory personal contributions and amounts over and above the statutory maximum reimbursement, unless the reimbursement in question is explicitly listed as being covered by the supplementary insurance.

Medical expenses covered by law or a travel insurance policy, irrespective of which policy was issued first, or medical expenses that would been covered by law or a travel insurance policy if this supplementary insurances did not exist, are not covered by this supplementary insurances. If the costs of your treatment are fully or partially eligible for reimbursement by another insurer, we will reimburse them and recover some or all of the costs from the insurer concerned. To this end, we share your medical information with the insurer concerned.

2.4 Costs incurred as a result of terrorism

Have costs been incurred as a result of terrorism? In that case your supplementary insurance will reimburse these costs up to the maximum amount listed in the clause sheet on terrorism cover issued by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT)). This clause sheet and the corresponding claim handling protocol form an integral part of these policy conditions. You can find the protocol at nht.vereende.nl. The policy sheet can be found on our website or obtained from us.

2.5 Sequential application of multiple policies

If you have multiple policies with us, we will reimburse the invoices you submit by applying the policies in the following order:

- Basic insurance;
- Tand 1, 2, 3 and 4;
- Basis Vitaal, Vitaal 1, 2, 3, Premium and Aanvullend +;
- Ziekenhuis Ontzorgpakket.

C.3 Is there a mandatory and voluntarily chosen excess?

The mandatory excess and any voluntarily chosen excess that you have opted to take out only apply to the basic insurance. In other words, the excess does not apply to reimbursements covered by your supplementary insurances.

C.4 What will you have to pay?

4.1 Premium calculation

The premium you have to pay is determined by your age. Do you have to pay a higher premium because you have entered a new age bracket? Then the premium will change on 1 January following the year in which you enter the new age bracket.

If you are a parent who has taken out basic and supplementary insurance with us, children under 18 who are covered by your insurance do not have to pay a premium for the supplementary insurance. What happens when these children reach the age of 18? Then you (the policyholder) must pay a premium as of the first of the month following the month in which the child reaches the age of 18.

4.2 Late payment

Did you (the policyholder) fail to pay your premium on time? In addition to article A.9 What happens if you do not pay on time? and A.10 What happens if you fall behind with your payments?, the following will occur. We will terminate any supplementary insurance, if you (the policyholder) do not pay your premium within the grace period specified in our third written demand for payment. Your right to reimbursement will then automatically cease to apply from the first day of the month following the expiry of the stipulated term of payment. The payment obligation continues to apply.

Have you paid all outstanding premiums? Then you can reapply for supplementary insurance from 1 January of the following year. You may be required to undergo a preliminary medical assessment.

C.5 What if your insurance premium and/or conditions change?

5.1 We may change your insurance premium and/or conditions

We have the right to change the premium and/or the conditions of our supplementary insurances for all policyholders or certain groups of policyholders. Any such changes will be effective from a date specified by us. These changes will apply to both new and existing supplementary insurance with us.

5.2 If you do not agree to the changes

Are you not prepared to pay the higher premium or do you not accept more restrictive terms and conditions? You can notify us through Mijn Zilveren Kruis on our website, by letter or by telephone within 30 days after we have announced the change. We will then cancel your supplementary insurance on the date on which the new premium and/or new conditions take effect.

5.3 You cannot always cancel your insurance if we change the premium and/or conditions

In some cases, you cannot cancel your insurance prior to the expiry date if we change the premium and/or the conditions. This is the case if:

- the higher premium and/or more restrictive conditions or reimbursements are stipulated by statutory regulations;
- your premium increases due to reaching an age limit.

In the situations listed above, you can cancel your insurance by following one of the procedures described in article C.7 of these terms and conditions.

5.4 Agreements about the group insurance

The collective insurance also applies to your family. Does the group contract contain limiting agreements about the age at which your children can take advantage of your group discount? we will inform your children about this in writing.

C.6 When does your supplementary insurance commence? And how do you change it?

6.1 Your supplementary insurance commences on 1 January

You (the policyholder) can take out supplementary insurance in addition to your basic insurance with us. You can do this up until 31 January of the current calendar year. If your application is approved, the supplementary insurance will be retroactively effective from 1 January. We must agree to this in writing. If you apply for supplementary dental insurance, you may be required to undergo a preliminary medical assessment. In addition, the reimbursement of the costs of orthodontics may be subject to a waiting period of 1 year.

6.2 Changing your supplementary insurance

If you (the policyholder) want to change your supplementary insurance with us, you can apply for supplementary insurance up until 31 January of the current calendar year. This means you are choosing a higher or lower variant of the supplementary (dental) insurance you already have. We will change your supplementary insurance with retroactive effect from 1 January. We must agree to this in writing. You may be required to undergo a preliminary medical assessment.

Have you (the policyholder) changed your supplementary insurance with us? Then any reimbursements that you have already received will count towards the new supplementary insurance policy. This applies to periods that apply for certain healthcare entitlements and the calculation of the (maximum) reimbursement. In addition, the reimbursement of the costs of orthodontics may be subject to a waiting period of 1 year.

Did you have a set of full removable dentures fitted prior to this calendar year? And have you yet to submit a claim under your supplementary dental insurance in the current calendar year? Then you are entitled to alter or cancel your supplementary dental insurance, in which case the change will apply from the first day of the month that follows the calendar month in which we received the request to change or cancel the insurance.

C.7 Cancelling your supplementary insurance?

7.1 Ways to cancel your supplementary insurance

You (the policyholder) can cancel your supplementary insurance in the following ways:

a. through Mijn Zilveren Kruis on our website, by letter or by telephone. We must receive notice of cancellation by 31 December at the latest. We will then cancel your supplementary insurance on 1 January of the following year. Once you have asked us to cancel your supplementary insurance, the cancellation is irrevocable.
b. By using the cancellation service provided by your new health insurer. Have you (the policyholder) taken out supplementary insurance for the next calendar year with another health insurer prior to 31 December of the current calendar year? Then your new health insurer will cancel your supplementary insurance with us on your (the policyholder's) behalf. If you (the policyholder) do not wish to make use of this cancellation service, you must state this on your new health insurer's application form.

7.2 You can terminate your supplementary insurance throughout the year if you are admitted to a Wlz institution for treatment.

If you are admitted to and receiving treatment at a Wlz institution, the care covered by your supplemental or dental insurance may also be reimbursed from the Wlz. This may result in double insurance. If you are admitted to a Wlz institution where you are receiving treatment, you can cancel your supplemental and dental insurance if you have not used any reimbursement from the supplemental or dental insurance in the current year. Please contact our Customer Service department for more information. The termination will take effect from the first day of the month after the calendar month in which we received the request to terminate the insurance.

Visit on the website of the Zorginstituut Nederland for more information on care reimbursed through the Wlz if you live in a Wlz institution and receive treatment from the same institution.

C.8 In what situations will we cancel your supplementary insurance?

We will terminate your supplementary insurance on a date to be determined by us. This applies to both your own supplementary insurance and the supplementary insurance provided for any other persons covered by your policy. We will do this if you (the policyholder) do not pay your premium within the grace period specified in our third written demand for payment.

We will terminate your supplementary insurance on a date to be determined by us if we decide, for reasons that we consider to be compelling, to no longer offer supplementary insurance.

We will also cancel your supplementary insurance with immediate effect if:

a. you do not respond on time to a request for information (which may need to be supplied in writing), if the requested information is required to enable efficient administration of our supplementary insurance;
b. if it subsequently transpires that you failed to complete the application form correctly and in full, Or if it subsequently transpires that you failed to disclose circumstances that are important to us;

c. it has been established that you have committed fraud. Our definition of fraud is listed in article A.20 What are the consequences of fraud?.

Please note!

On termination of your membership of a group supplementary insurance scheme, you will cease to benefit from the reduced rate for group insurance and other advantages. These include, for example, additional reimbursements covered by the group supplementary insurance scheme.

C.9 How do we check the legitimacy and cost-effectiveness of the submitted invoices?

We check the legitimacy and cost-effectiveness of the invoices submitted to us. In checking legitimacy we verify that the care provider actually provided the care. In checking cost-effectiveness we verify that the care provided was the most appropriate care given the state of your health. Our monitoring procedures are conducted in accordance with the provisions of, or pursuant to, the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) as this applies to the basic insurance.

C.10 Definitions

Terms used in these conditions that relate specifically to your supplementary insurances are explained below. What do we mean by the following terms?

Supplementary insurance

The supplementary insurances (policies) you have taken out in addition to your basic insurance. These include:

- the supplemental dental insurance;
- the supplemental insurance;
- Ziekenhuis Ontzorgpakket.

Accident

A sudden violent impact on the body of the insured person, that is not of their volition and beyond their control, causing medically demonstrable physical injury.

Insurance period

The period during which an insurance agreement concerning a Zilveren Kruis supplementary insurances is in continuous force between us and the insured person.

We/us

Achmea Zorgverzekeringen N.V.

Health insurer

Achmea Zorgverzekeringen N.V. is the health insurer that provides your supplementary insurance policies. In other words, Achmea Zorgverzekeringen N.V. administers your supplementary insurance for you. Achmea Zorgverzekeringen N.V. is registered with the Chamber of Commerce under number 28080300 and with the Netherlands Authority for the Financial Markets (AFM) under number 12000647.

D. Reimbursements covered by Basis Vitaal, Vitaal 1, 2, 3, Premium and Aanvullend +

Alternative therapy

D.1 Alternative forms of treatment, therapies and medicines

We reimburse the costs of consultations and treatments provided by alternative healers or therapists. To find out which treatments we reimburse, see the overview of professional associations and treatments. The list of professional associations and treatments can be found on our website or obtained from us.

In addition, we reimburse the costs of homeopathic and anthroposophic medicines.

Conditions for reimbursement

1. Your alternative healer or therapist must be a member of a professional association that satisfies the requirements of our alternative medicine policy. The alternative medicine policy and the list of professional associations that meet our criteria are part of this policy. We only reimburse consultations and treatments included in the overview of reimbursable treatments. The list of professional associations and treatments can be found on our website or obtained from us.
2. The invoice must state the alternative healer's valid AGB code issued for the care being provided, as well as which professional association the alternative healer or therapist is affiliated with.
3. The consultation must be conducted within the context of medical treatment.
4. The consultation must be provided on an individual basis. In other words, it must be only for you.
5. The homeopathic and anthroposophic medicines must be listed as homeopathic or anthroposophic medicines in the Netherlands and in the G-standaard of the Z-Index. The G-standaard is a database which lists all of the medicines available from pharmacies. The G-standaard is a dynamic list that can be amended throughout the year. The reimbursement may also change throughout the year if the registration is amended.
6. The homeopathic and/or anthroposophic medicines must be supplied by a pharmacy. We reimburse these products up to the limit published in the G-Standaard (Z-index) and known to your pharmacy.
7. We only reimburse the costs of homeopathic and anthroposophic medicines if they have been prescribed by a doctor.

What we do not reimburse under this article

We do not reimburse the costs of:

a. care if your alternative healer or therapist is also your general practitioner;
b. (laboratory) tests;
c. manual therapy provided by a physiotherapist;
d. treatments, examinations and courses of a social nature or designed to promote well-being (the extent to which a person feels good physically, mentally and socially) and/or prevention;
e. work or school-related coaching;
f. care reimbursed under another article, e.g. the Mindfulness article;
g. psychosocial care for insured persons up to the age of 18.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: up to € 45 per day. Maximum of € 250 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.
Vitaal 3	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: up to € 45 per day. Maximum of € 500 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.
Vitaal Premium	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: up to € 45 per day. Maximum of € 750 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.

Abroad

D.2 Transport of the insured person or mortal remains to the Netherlands (repatriation)

We reimburse the costs of:

a. medically necessary patient transport by ambulance or aircraft from abroad to a healthcare institution in the Netherlands;
b. transport of mortal remains (body or remains of the body) from the place of death to the insured person’s home in the Netherlands.

Conditions for reimbursement

1. Patient transport must be required in connection with urgent medical treatment abroad.
2. Zilveren Kruis Emergency Services by Eurocross must give you permission in advance and must also arrange the transport.

Reimbursement	Coverage
Basis Vitaal	100%
Vitaal 1	100%
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

D.3 Vaccinations and preventive medication required for foreign travel

Are you travelling abroad? In that case, we reimburse the costs of consultations, necessary vaccinations and/or preventive medication required for a stay abroad. By 'necessary vaccinations and/or preventive medication' we mean vaccinations and/or preventive medication identified as necessary by the Landelijk Coördinatiecentrum Reizigersadvisering (LCR) (National Coordination Centre for Travel Advice). The vaccinations recommended by the LCR for each country are listed on their website, lcr.nl/landen

Conditions for reimbursement

1. We only reimburse consultations, medication and vaccinations required to prevent rabies if you will be staying in a country where rabies is endemic (permanently present as a disease in certain areas) for a prolonged period and where adequate medical aid is not easily accessible. You must also meet at least one of the following conditions:
   - you will be taking a multi-day hiking or cycling trip outside of tourist resorts; you will be spending time or staying with the local population for more than three months;
   - you will be staying outside of a resort or protected environment;
   - you are under the age of 12.
2. Preventive medication (such as malaria tablets) must be prescribed by a doctor affiliated with LCR.
3. Preventive medication must be supplied by a pharmacy.

What we do not reimburse under this article

We do not reimburse the costs of non-prescription drugs not listed in the Regeling zorgverzekering (Health Insurance Regulations). Non-prescription drugs are drugs that can be purchased over the counter in the Netherlands.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	100%
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

D.4 Healthcare abroad

We reimburse the costs of medical treatment abroad. The conditions for reimbursement are listed below.

4.1 Emergency medical treatment abroad

We reimburse the costs of medically-necessary healthcare during a stay in a country other than your country of residence for a holiday, study or business trip. The need for care must have been unforeseeable when you travelled abroad. And the medical care must be immediately necessary in an emergency situation resulting from an accident or illness. This reimbursement covered by your supplementary insurance only applies in addition to the reimbursement covered by your basic insurance.

We reimburse the costs of:

a. treatment by a general practitioner or medical specialist;
b. hospital accommodation and surgery;
c. treatments, examinations, medicines and dressings prescribed by a doctor;
d. medically-necessary ambulance transportation to and from the nearest doctor and/or the nearest hospital;
e. dental care for insured persons up to the age of 18.

Please note!

We only reimburse dental care for insured persons aged 18 or older if you have supplementary dental insurance. these costs are covered by supplementary dental insurance.

Conditions for reimbursement

1. Zilveren Kruis Emergency Services by Eurocross/Zilveren Kruis' medical advisers will assess whether the care in question was unforeseeable on departure abroad and whether it concerns an acute situation that arose as a result of an accident or illness and for which medical care is immediately necessary. This assessment is decisive for the question of whether the care qualifies for reimbursement on the basis of this article.
2. The costs will only be reimbursed if these costs would be covered by your basic insurance if the treatment were provided in the Netherlands.
3. If you stay in a hospital abroad, you must notify us immediately through Zilveren Kruis Emergency Services by Eurocross.

Reimbursement	Coverage
Basis Vitaal	supplementary coverage up to 100% for a stay abroad of up to 365 days
Vitaal 1	supplementary coverage up to 100% for a stay abroad of up to 365 days
Vitaal 2	supplementary coverage up to 100% for a stay abroad of up to 365 days
Vitaal 3	supplementary coverage up to 100% for a stay abroad of up to 365 days
Vitaal Premium	supplementary coverage up to 100% for a stay abroad of up to 365 days

4.2 Overnight stay and transport costs for specialist treatment provided abroad

Have we approved a non-urgent treatment requiring particular expertise that can only be provided abroad? In that case we reimburse:

a. overnight accommodation in the vicinity of the hospital;
b. return transport between the Netherlands and the hospital;
c. transport and/or accommodation expenses for 1 specialist escort if an escort is medically necessary;
d. transport and/or accommodation expenses for 1 family member, or 2 family members for insured persons up to the age of 16.

Specialist treatment is a medical treatment abroad that meets the conditions listed in articles A.1.2 This insurance contract is also based on established medical science and medical practice, A.2.1 Care entitlement and A.2.4 The nature and extent of the care to which you are entitled is determined by the Dutch Health Insurance Act and is not provided in the Netherlands. Our medical adviser will determine whether a treatment qualifies as a treatment requiring particular expertise.

Conditions for reimbursement

1. We must give you written permission in advance.
2. You must be referred for the treatment by a medical specialist.
3. You must provide us with a specification of the incurred costs.
4. The medical necessity of an escort and the type of escort (such as a nurse for example) will be determined by us.

Reimbursement	Coverage
Basis Vitaal	accommodation expenses: up to € 75 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, private transport: taxi € 0.38 per kilometre We reimburse accommodation expenses and transport costs up to € 5,000 for you and your family members combined.
Vitaal 1	accommodation expenses: up to € 75 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, private transport: taxi € 0.38 per kilometre We reimburse accommodation expenses and transport costs up to € 5,000 for you and your family members combined.
Vitaal 2	accommodation expenses: up to € 75 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, private transport: taxi € 0.38 per kilometre We reimburse accommodation expenses and transport costs up to € 5,000 for you and your family members combined.
Vitaal 3	accommodation expenses: up to € 75 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, private transport: taxi € 0.38 per kilometre We reimburse accommodation expenses and transport costs up to € 5,000 for you and your family members combined.

Reimbursement	Coverage
Vitaal Premium	accommodation expenses: up to € 75 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, private transport: taxi € 0.38 per kilometre We reimburse accommodation expenses and transport costs up to € 5,000 for you and your family members combined.

4.3 Non-urgent medical care in Europe

We reimburse the cost of medical care in EU/EEA countries during a temporary stay.

Conditions for reimbursement

These costs are only reimbursed if they would also be covered by basic insurance in the Netherlands and the costs exceed the reimbursement provided by our basic insurance.

What we do not reimburse under this article

We do not reimburse the costs of:

a. patient transportation to and from a foreign country
b. patient transportation in a foreign country

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	no reimbursement
Vitaal Premium	Supplement up to 200% of the maximum rate set at the time of treatment under the terms of the Healthcare Market Regulation Act (Wmg) for the same care in the Netherlands. If no (maximum) tariffs have been established in accordance with the Dutch Healthcare Market Regulation Act, you are entitled to reimbursement of up to a maximum of 200% of the prevailing market rate in the Netherlands during a stay of up to 365 days abroad.

Physiotherapy and Cesar or Mensendieck remedial therapy

D.5 Physiotherapy and Cesar or Mensendieck remedial therapy

We reimburse the costs of treatment by a physiotherapist and/or a Cesar or Mensendieck remedial therapist. The conditions for reimbursement are listed below.

5.1 Physiotherapy and/or Cesar or Mensendieck remedial therapy

We reimburse the costs of treatment by a physiotherapist and/or a Cesar or Mensendieck remedial therapist. We also reimburse the costs of lymphatic drainage for serious lymphoedema and scar therapy if the treatment is given by a skin therapist.

Are you under the age of 18? Are you entitled to physiotherapy or Cesar or Mensendieck remedial therapy under your basic insurance? Then the reimbursement covered by your supplementary insurance applies in addition to the reimbursement covered by your basic insurance (see article B.1 Physiotherapy and Cesar or Mensendieck remedial therapy).

Are you 18 or older? Are you entitled to physiotherapy or Cesar or Mensendieck remedial therapy under your basic insurance? In that case, the first 20 treatments per disorder are not always covered by your basic insurance (see article B.1 Physiotherapy and Cesar or Mensendieck remedial therapy). The reimbursement provided by your supplementary insurance applies to these first 20 treatment sessions.

Conditions for reimbursement

1. Are you receiving specialist physiotherapy or remedial therapy? In that case, we only reimburse the extra costs if the therapist is registered in the corresponding section of the Quality Register for Physiotherapy in the Netherlands (KRF NL), the Physiotherapy Quality Mark Foundation, or in the subspecialisation register of the Paramedic Quality Register (KP). By 'specialist physiotherapy or remedial therapy' we mean:
   - paediatric physiotherapy and remedial therapy
   - pelvic physiotherapy and remedial therapy
   - manual therapy
   - oedema therapy
   - geriatric physiotherapy and remedial therapy
   - psychosomatic physiotherapy and remedial therapy

   To find out which therapists provide specialist care eligible for reimbursement, Use Zorgzoeker on zk.nl/zorgzoeker or contact us.
2. If you are receiving treatment related to intermittent claudication (restricted blood supply to the legs), the treatment must be carried out by a physiotherapist affiliated with the Chronisch ZorgNet network for intermittent claudication.
3. If you are receiving treatment from a physical therapist in relation to Parkinson's disease, the treatment must be carried out by a physiotherapist affiliated with the ParkinsonNet network.
4. What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day? In that case, a specific letter of referral issued by the referring doctor (general practitioner, company doctor, dentist geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which skin therapists, physiotherapists and Cesar or Mensendieck remedial therapists we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Physical therapy related to Parkinson's disease

Do you have Parkinson's disease and require physical therapy for it? We only contract physiotherapists affiliated with the ParkinsonNet network for the treatment of insured persons with Parkinson's disease. If you visit a physiotherapist not contracted to treat insured persons with Parkinson's disease, the reimbursement may be lower than for a contracted physiotherapist. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with Parkinson's disease.

To find out which physical therapists are contracted for treating insured persons with Parkinson's disease, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

Physical therapy for intermittent claudication

Do you suffer from intermittent claudication and require physical therapy for it? We only contract physiotherapists affiliated with the Chonisch ZorgNet network for the treatment of insured persons with intermittent claudication. If you visit a physiotherapist not contracted to treat insured persons with intermittent claudication, the reimbursement may be lower than for a contracted physiotherapist. For more information, see A.4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?.

Please note:

A physiotherapist may have a contract for regular physical therapy but not for treating insured persons with intermittent claudication.

To find out which physical therapists are contracted for treating insured persons with intermittent claudication, use the Zorgzoeker at zk.nl/zorgzoeker or contact us.

What we do not reimburse under this article

We do not reimburse the costs of:

a. individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;
b. pregnancy gymnastics and postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c. surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - reports.
d. bandages and medical devices supplied by your physiotherapist, Cesar or Mensendieck remedial therapist or skin therapist;
e. individual treatment if you are already taking part in an exercise programme for the same ailment, as described in article D.7.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	up to 6 treatments per person per calendar year
Vitaal 2	up to 12 treatments per person per calendar year (up to 9 manual therapy treatments per indication)
Vitaal 3	up to 21 treatments per person per calendar year (up to 9 manual therapy treatments per indication)
Vitaal Premium	up to 30 treatments per person per calendar year (up to 9 manual therapy treatments per indication)

Reimbursement Aanvullend + for insured persons with:	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	up to 3 additional treatments per person per calendar year
Vitaal 2	up to 3 additional treatments per person per calendar year
Vitaal 3	up to 3 additional treatments per person per calendar year
Vitaal Premium	up to 3 additional treatments per person per calendar year

5.2 Post-care physiotherapy

We reimburse the costs of post-care physiotherapy as part of:

1. post-oncology care: treatment to maintain or improve fitness during or following medical treatment of cancer and recovery-oriented treatment designed to reduce or eliminate symptoms of lymphoedema or imminent lymphoedema, scar tissue or other problems caused by medical treatment of cancer. If you need manual lymph drainage because you suffer from severe lymphatic oedema, or if you require scar treatment, you can also be treated by a skin therapist;
2. post-CVA care: physiotherapy treatment following a stroke or cerebrovascular accident (CVA) by a physiotherapist who specialises in recovery-oriented physiotherapy;
3. cardiovascular disease management by a physiotherapist specialised in recovery-oriented physiotherapy.

If you are entitled to physiotherapy under your basic insurance, Then the reimbursement covered by your supplementary insurance applies in addition to the reimbursement covered by your basic health insurance (see article B.1 Physiotherapy and Cesar or Mensendieck remedial therapy).

Condition for reimbursement

Before starting post-care physiotherapy, you will need proof of diagnosis from the referring doctor (general practitioner, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist).

What we do not reimburse under this article

We do not reimburse the cost of physiotherapy follow-up care when treatment takes place in a hospital or independent treatment center.

We only reimburse contracted care

Please note!

Do you want to receive reimbursement for all treatments? In that case, post-care physiotherapy must be provided by a contracted physiotherapist; treatment of serious lymphoedema and/or scar therapy must be provided by a contracted skin therapist. What if you choose a non-contracted care provider? In that case, you are only entitled to reimbursement for physiotherapy under article 5.1.

To find out with which care providers we have a contract, use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	100% with a maximum duration of 2 years for the duration of the supplementary insurance
Vitaal 1	100% with a maximum duration of 2 years for the duration of the supplementary insurance
Vitaal 2	100% with a maximum duration of 2 years for the duration of the supplementary insurance
Vitaal 3	100% with a maximum duration of 2 years for the duration of the supplementary insurance
Vitaal Premium	100% with a maximum duration of 2 years for the duration of the supplementary insurance

D.6 Occupational therapy

Is reimbursement of the costs of 10 hours of occupational therapy covered by your basic insurance? Then, in addition to this reimbursement, we also reimburse the costs of additional hours of occupational therapy.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which occupational therapists we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	5 hours per person per calendar year
Vitaal 2	5 hours per person per calendar year
Vitaal 3	5 hours per person per calendar year
Vitaal Premium	5 hours per person per calendar year

D.7 Exercise programmes

We reimburse the costs of exercise programmes. Exercise programmes are designed for people who need to exercise more to manage their disease or condition but are unable to do so. During the exercise programme a physiotherapist and/or a Cesar or Mensendieck remedial therapist will teach you to move without assistance so you can continue to exercise on your own on completion of the programme.

We reimburse the costs of exercise programmes if you:

a. are recovering from earlier heart failure;
b. suffer from rheumatoid arthritis (we use the definition of rheumatoid arthritis established by ReumaNederland (Dutch Arthritis Association));
c. have type 2 diabetes;
d. have stage I or II COPD according to the GOLD Classification;
e. suffer, or are recovering, from an oncological condition.

Condition for reimbursement

Before starting the exercise programme, you will need proof of diagnosis from the referring doctor (general practitioner, company doctor, geriatric specialist, doctor specialised in treating people with an intellectual disability, doctor specialised in juvenile health care, physician assistant, nursing specialist or medical specialist).

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	up to € 350 per person per disorder for the duration of the supplementary insurance
Vitaal Premium	up to € 350 per person per disorder for the duration of the supplementary insurance

Skin

D.8 Skin care

We reimburse the costs of skin treatment provided by a beautician or skin therapist. The conditions for reimbursement are listed below.

8.1 Acne treatment

We reimburse the costs of (facial) acne treatment provided by a beautician or skin therapist;

Conditions for reimbursement

1. The skin therapist must be registered as 'quality registered' in the Quality Register for Paramedics.
2. The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS), De Huidprofessional or the SKIN register as an acne treatment specialist.
3. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

What we do not reimburse under this article

We do not reimburse the costs of:

a. cosmetics;
b. laser treatment.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	up to € 200 per person per calendar year
Vitaal 2	up to € 300 per person per calendar year
Vitaal 3	up to € 400 per person per calendar year
Vitaal Premium	up to € 450 per person per calendar year

8.2 Camouflage lessons

We reimburse the costs of lessons in camouflage taught by a beautician or skin therapist and the necessary fixatives, ointments and powders (etc.).

Conditions for reimbursement

1. Camouflage therapy must relate to the treatment of scars, naevi or pigment marks on the neck or face.
2. The skin therapist must be registered as 'quality registered' in the Quality Register for Paramedics.
3. The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS), De Huidprofessional or the SKIN register as a skin camouflage specialist.
4. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 300 per person for the duration of the supplementary
Vitaal 3	up to € 400 per person for the duration of the supplementary
Vitaal Premium	up to € 500 per person for the duration of the supplementary

8.3 Electrical epilation, IPL or laser epilation

We reimburse the costs of:

a. electrical epilation and Intense Pulsed Light (IPL) hair removal treatments provided by a beautician or skin therapist for women with unsightly facial and/or neck hair;
b. laser hair removal treatments performed by a skin therapist or at an institution with an associate dermatologist for women with extremely unsightly facial and/or neck hair.

Conditions for reimbursement

1. The skin therapist must be registered as 'quality registered' in the Quality Register for Paramedics.
2. The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS), De Huidprofessional or the SKIN register as a specialist in electrical hair removal or hair removal techniques.
3. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

What we do not reimburse under this article

We do not reimburse the costs of cosmetic treatments.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	maximaal € 150 per kalenderjaar
Vitaal 3	maximaal € 250 per kalenderjaar
Vitaal Premium	maximaal € 300 per kalenderjaar

Medical devices

D.9 Medical devices

We reimburse the costs of medical devices, or the personal contribution that applies for these products. The medical devices covered by your insurance and the conditions under which reimbursement is provided are listed below.

9.1 Personal contribution for toupim or wig

We reimburse the personal contribution for a toupim or wig.

Condition for reimbursement

You must be entitled to reimbursement for a toupim of your own hair or a wig under your basic insurance (see article B.3 Medical devices).

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 100 per person per calendar year
Vitaal 3	up to € 200 per person per calendar year
Vitaal Premium	up to € 300 per person per calendar year

9.2 ADL medical devices

We reimburse the costs of medical devices required by insured persons with a permanent physical disability to help them perform daily living activities (so-called ADL medical devices), to the extent that the device in question does not fall under the Medical Devices Regulations (Reglement Hulpmiddelen), the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) or the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)).

Conditions for reimbursement

1. The device must be supplied by Vegro or Medipoint|Harting-Bank.
2. The device must be recognised as an ADL medical device by Vegro or Medipoint| Harting-Bank.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 100 per person per calendar year
Vitaal 3	up to € 100 per person per calendar year
Vitaal Premium	up to € 100 per person per calendar year

9.3 Statutory personal contribution towards the costs of a hearing aid

We reimburse the statutory personal contribution towards the costs of a hearing aid.

Condition for reimbursement

You must be entitled to reimbursement under your basic insurance (see article B.3 Medical devices).

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 100 of the statutory personal contribution per hearing aid
Vitaal 3	up to € 200 of the statutory personal contribution per hearing aid
Vitaal Premium	up to € 300 of the statutory personal contribution per hearing aid

Medicine and dietary preparations

D.10 Pharmaceutical care

We reimburse the costs of certain medication. The conditions for reimbursement are listed below.

10.1 Contraceptives

We reimburse the costs of hormonal contraceptives and coils (IUDs) for female insured persons aged 21 or older. The reimbursements for these contraceptives are subject to the maximum reimbursements set by us.

1. In the case of the contraceptive pill, a prescription issued by a general practitioner, a doctor in a centre for sexuality, an obstetrician or midwife, or a medical specialist must be submitted the first time the pill is dispensed. (This is not necessary thereafter.)
2. For reimbursement, the contraceptive must be listed in the GVS. GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem).

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know which pharmacies we have a contract with? use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

What we do not reimburse under this article

We do not reimburse the costs of:

a. contraceptives like these are reimbursed by your basic insurance on the basis of a medical indication. Within the framework of this article, our definition of a medical indication is endometriosis or menhorragia (severe blood loss);
b. the statutory personal contribution (the upper limit GVS price), if the contraceptives are reimbursed by your supplementary insurance. The statutory personal contribution does not apply if you are entitled to reimbursement under your basic health insurance.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	100%
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

10.2 Statutory personal contribution (upper-limit GVS price)

You yourself have to pay part of the costs of some medicines. The remainder of the costs is covered by your basic insurance. The part that you have to pay is the statutory personal contribution. We reimburse this statutory personal contribution (the upper limit GVS price) if the pharmaceutical care in question is covered by your basic insurance or supplementary insurance. GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem). The GVS states which medicines can be reimbursed under the basic insurance.

What we do not reimburse under this article

We do not reimburse the costs of:

a. the personal contribution you must pay for exceeding the maximum limit set for reimbursement of pharmacy-dispensed medicines and dietary preparations;
b. the statutory personal contribution (upper limit GVS price) that applies for medicines prescribed to treat Attention Deficit Hyperactivity Disorder (ADHD) that are reimbursed by your basic insurance.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 150 per calender year
Vitaal 3	up to € 250 per calender year
Vitaal Premium	up to € 250 per calender year

Oral health care and dentistry

We reimburse the costs of necessary dental care normally provided by a dentist, clinical dental technician, dental surgeon, oral hygienist or orthodontist. This is discussed in the following articles. If you have also taken out dental insurance, we reimburse the bills you submit by applying the policies in the following order: first your supplementary dental insurance, then your supplementary insurance.

D.11 Orthodontics

11.1 Orthodontic treatment for insured persons up to the age of 18

We reimburse the costs of orthodontic treatment (correction of dental misalignment) for insured persons up to the age of 18. We also reimburse the costs of a second opinion by an orthodontist or dentist. Costs are claimed using treatment codes for orthodontic care stipulated by the Nederlandse Zorgautoriteit (NZa) (Dutch Healthcare Authority) which end with the letter 'A'. We also reimburse the implantation of bone anchors by a dental surgeon.

If the orthodontic treatment has not ended before reaching the age of 18 and the maximum reimbursement has not yet been reached, then the current treatment will be reimbursed under this article.

What we do not reimburse under this article

Have you lost or damaged existing orthodontic appliances through your own fault or negligence? Then we do not reimburse the costs of repair or replacement.

Waiting period for orthodontic care

There is a waiting period of 1 year for the reimbursement of orthodontic care costs. This means that you will pay the premium during the waiting period but will not be entitled to or receive reimbursement for orthodontic expenses incurred during the waiting period. The waiting period applies if you take out Vitaal 3 or Vitaal Premium and did not have supplemental insurance with orthodontics coverage with us for the entire year of 2023. Your waiting period also applies if you switch from one of the other Achmea health insurers.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	up to € 2,000 for the duration of the supplementary insurance
Vitaal Premium	up to € 2,500 for the duration of the supplementary insurance

11.2 Orthodontic treatment for insured persons aged 18 or older

We reimburse the costs of orthodontic treatment (correction of dental misalignment) for insured persons aged 18 or older. We also reimburse the costs of a second opinion by an orthodontist or dentist. Costs are claimed using treatment codes for orthodontic care stipulated by the Nederlandse Zorgautoriteit (NZa) (Dutch Healthcare Authority) which end with the letter 'A'. We also reimburse the implantation of bone anchors by a dental surgeon.

What we do not reimburse under this article

Have you lost or damaged existing orthodontic appliances through your own fault or negligence? Then we do not reimburse the costs of repair or replacement.

Waiting period for orthodontic care

There is a waiting period of 1 year for the reimbursement of orthodontic care costs. This means that you will pay the premium during the waiting period but will not be entitled to or receive reimbursement for orthodontic expenses incurred during the waiting period. The waiting period applies if you take out Vitaal Premium and did not have supplemental insurance with orthodontics coverage with us for the entire year of 2023. Your waiting period also applies if you switch from one of the other Achmea health insurers.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	no reimbursement
Vitaal Premium	up to € 1,500 for the duration of the insurance for insured persons aged 18 or older

D.12 Dental care required as a result of an accident

We reimburse the costs of dental care by a dentist, clinical dental technician, orthodontist or dental surgeon. The treatment must be aimed at repairing direct damage to the teeth caused by an accident that occurred during the insurance period. To qualify for reimbursement, the treatment must be performed within 1 year of the accident, unless it is necessary to defer the (definitive) treatment because the jaw is not yet fully formed. If you have permission to have the direct damage to the teeth resulting from the accident repaired with an implant and the teeth are not yet mature, temporary treatment should be performed until implantation can be performed. Our advising dentist will assess whether or not temporary (i.e., not yet permanent) treatment is required and whether or not the teeth are mature. Cover must be provided by this insurance both when the accident occurs and when treatment is provided.

Conditions for reimbursement

1. We must give you permission in advance. Before approving your request for treatment we will assess whether the treatment is appropriate and legitimate.
2. We reimburse the costs to the extent they are aimed at repairing the teeth as cheaply and simply as possible. You are not entitled to reimbursement if the indication for the requested treatment existed before the accident or if there is pre-existing damage or deferred care to the teeth. The treatment must not result in a better dental situation than the situation immediately prior to the accident. This is at the discretion of our consulting dentist.
3. We only reimburse the costs of dental care if there is no reimbursement from the basic insurance.
4. A treatment plan with a cost estimate and available X-rays must be submitted with your request for approval. The treatment plan must be prepared by your dentist, clinical dental technician, orthodontist or dental surgeon.
5. For insured persons age 18 or older, autotransplantation must performed by a dental periodontist accredited by the Dutch Association for Periodontology (NVvP), or an implantologist accredited by dental the Dutch Association for Oral Implantology (NVOI).

What we do not reimburse under this article

We do not reimburse the cost of dental treatment in the case of:

a. gross negligence or wilful intent on the part of the insured person;
b. the use of narcotics and/or excessive use of alcohol by the insured person;
c. engagement in physical fighting by the insured person other than for the purpose of self-defence.

Reimbursement	Coverage
Basis Vitaal	up to € 10,000 per accident
Vitaal 1	up to € 10,000 per accident
Vitaal 2	up to € 10,000 per accident
Vitaal 3	up to € 10,000 per accident
Vitaal Premium	up to € 10,000 per accident

Eyes and ears

D.13 Spectacles and contact lenses

We reimburse the costs of spectacles frames with prescription lenses and prescription or overnight contact lenses per period of 2 calendar years. A period of 2 calendar years is seen as 3 years that run from 1 January to 31 December. The 3-year period commences on 1 January of the year of the first purchase.

Condition for reimbursement

The spectacles and/or contact lenses must be supplied by an optician or optical retailer.

What we do not reimburse under this article

We do not reimburse the costs of:

a. non-prescription sunglasses, spectacles and contact lenses;
b. prism spectacles;
c. the statutory personal contribution for spectacles and/or contact lenses reimbursed under your basic insurance (see article B.3 Medical devices);
d. separate spectacle frames and/or accessories;
e. coloured contact lenses.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 100 per person per 2 calendar years for spectacles and contact lenses combined
Vitaal 3	up to € 200 per person per 2 calendar years for spectacles and contact lenses combined
Vitaal Premium	up to € 300 per person per 2 calendar years for spectacles and contact lenses combined

D.14 Refractive eye surgery and lens implants

This article explains the conditions for reimbursement of the costs of refractive surgery (14.1) and lens implantation (14.2).

14.1 Refractive surgery

We reimburse the costs of refractive eye surgery.

Condition for reimbursement

The ophthalmologist performing the treatment must be registered as a refractive surgeon with the Netherlands Ophthalmological Society (NOG) A specialist who is not registered with the NOG must meet the quality criteria established by the society and follow the guidelines set out in the Consensus on Refractive Surgery (Consensus Refractiechirurgie) published by the society.

Please note!

Ophthalmologists not registered as refractive surgeons are also listed in the NOG register. However, treatment only qualifies for reimbursement when performed by an ophthalmologist who is registered as a refractive eye surgeon.

14.2 Lens implantation

We reimburse the additional costs of a lens other than a standard monofocal intraocular lens.

Condition for reimbursement

You must be entitled to reimbursement of lens implantation with a standard monofocal intraocular lens under your basic insurance.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	up to € 500 for the duration of the supplementary insurance for costs reimbursed under articles 14.1 and 14.2 combined
Vitaal Premium	up to € 750 for the duration of the supplementary insurance for costs reimbursed under articles 14.1 and 14.2 combined

D.15 Optometrist

We reimburse the costs of early detection of ocular disease by an optometrist.

Condition for reimbursement

The optometrist must be a member of the Dutch Optometrists Association (OVN) or meet the quality criteria established by the association.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	maximum of 1 examination per person per 2 calendar years
Vitaal Premium	maximum of 1 examination per person per 2 calendar years

D.16 Ear position correction (without medical necessity) for insured persons up to the age of 18

For insured persons up to the age of 18 we reimburse the costs of a cosmetic surgery procedure designed to correct the position of the ear performed by a medical specialist.

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which care providers we have a contract? use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	100%
Vitaal Premium	100%

Transport

D.17 Personal contribution for transport costs

If you are entitled to reimbursement of transport costs under article B.17 Ambulance transport or patient transport, Then we reimburse the statutory personal contribution you are required to pay towards the costs of patient transport.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	no reimbursement
Vitaal Premium	100%

Feet

D.18 Chiropodic care for rheumatoid, diabetic and medical foot conditions

We reimburse the costs of chiropodic care for rheumatoid (18.1), diabetic (18.2) or other medical foot conditions (18.3). The conditions for reimbursement are listed below.

18.1 Chiropodic care for a rheumatoid foot condition

If you suffer from a rheumatoid foot condition and have Care Profile 1, we reimburse the costs of foot care services provided by a chiropodist.

Conditions for reimbursement

1. You must submit a statement issued by a general practitioner or medical specialist. (You are only required to submit this statement once.) The statement must state that you require foot care services because you suffer from:
   - arthritis associated with intestinal disease (joint inflammation in addition to intestinal disease)
   - psoriatic arthritis (inflammation of the joints in people suffering from psoriasis)
   - Bechterew's disease (increasing joint inflammation, often starting in the spine)
   - chondrocalcinosis (crystal deposition disease)
   - juvenile rheumatoid arthritis
   - chronic gout in one or both feet
   - Paget's disease (chronic bone disease)
   - polyneuropathy (inflammation of the nerve)
   - chronic reactive arthritis (joint inflammation, often in response to infection)
   - rheumatoid arthritis (inflammation of the joints)
   - scleroderma (rheumatic condition in which connective tissue thickens or hardens due to an inflammatory process)
   - Still's disease (juvenile rheumatoid arthritis)
   - severe osteoarthritis of the foot with misalignment and/or deformity.
2. The chiropodist must be listed in one of the following registers:
   - the ProCERT Quality Register for Chiropodists (KRP) with the designation 'rheumatoid foot' (RV) or medical chiropodist (MP).
   - the Register Paramedische Voetzorg (RPV) maintained by trade organisation Stipezo (Stichting pedicure in de zorg), category 1 (A+B), if it concerns a paramedical chiropodist, medical chiropodist or chiropodist+ with the entry 'foot care for rheumatoid arthritis patients' (RV).
   - the Quality Register for Medical Foot Care Providers (KMV) maintained by the Health Professional Registration and Accreditation Agency (KABIZ) in partnership with the Dutch Medical Foot Care Provider Association (NMMV).
3. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with. If a care profile has been established or can be established, the provider must indicate the care profile on the invoice.
4. The invoice should state whether it relates to an examination, treatment or special technique and specify the nature of the medical foot condition.

What we do not reimburse under this article

We do not reimburse the costs of:

a. preventive foot care covered by basic insurance (B.18 Preventive foot care for insured persons at increased risk of foot ulcers);
b. the removal of calluses for cosmetic reasons;
c. non-medically necessary trimming of toenails.

18.2 Chiropodic care for a diabetic foot condition

If you suffer from a diabetic foot condition and your care profile has been established as Care Profile 1 (Zorgprofiel 1), we reimburse the costs of foot care services provided by a chiropodist.

Conditions for reimbursement

1. The chiropodist must be listed in one of the following registers:
   - the ProCERT Quality Register for Chiropodists (KRP) with the designation 'foot care for diabetics' (DV) or medical chiropodist (MP).
   - the Quality Register for Medical Foot Care Providers (KMV) maintained by the Health Professional Registration and Accreditation Agency (KABIZ) in partnership with the Dutch Medical Foot Care Provider Association (NMMV).
   - the Register Paramedische Voetzorg (RPV) maintained by trade organisation Stipezo (Stichting pedicure in de zorg), category 1 (A + B), if it concerns a paramedical chiropodist, medical chiropodist or chiropodist+ with the entry 'foot care for rheumatoid arthritis patients' (DV).
2. The care provider must note the care profile on the invoice. The invoice must also state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

What we do not reimburse under this article

We do not reimburse the costs of:

a. preventive foot care covered by basic insurance (B.18 Preventive foot care for insured persons at increased risk of foot ulcers);
b. the removal of calluses for cosmetic reasons;
c. non-medically necessary trimming of toenails.

18.3 Chiropodic care for a medical foot condition

If you suffer from a medical foot condition and have Care Profile 1, we reimburse the costs of foot care services provided by a medical chiropodist. You are considered to suffer from a medical foot condition if you have one of the disorders listed below and develop medical complaints if you are not treated.

Conditions for reimbursement

1. You must submit a statement issued by a general practitioner or medical specialist. (You are only required to submit this statement once.) The statement must state that you require foot care because you suffer from:
   - peripheral neuropathy (nerve disorder in arms or legs)
   - hereditary motor and sensory neuropathies (HMSN; aka Charcot-Marie-Tooth disease, an inherited muscle disease)
   - foot paresis (due to cardio-vascular disease (CVA) for example)
   - paraplegia (damage to the spinal cord)
   - Sudeck's dystrophy/post-traumatic dystrophy (pain syndrome of feet, hands and/or shoulders)
   - arteriosclerosis obliterans (artery calcification)
   - chronic thrombophlebitis (vein inflammation)
   - thromboangiitis obliterans (aka Buerger's disease, chronic inflammation of arteries and/or veins in arms or legs)
   - arterial insufficiency (deteriorated arterial blood flow)
   - severe malpositioning (resulting in the development of excessive calluses and corns)
   - hammer toes
   - palmoplantar keratoderma (thickening of the skin on the inside of the hands and under the feet)
   - tylotic eczema (form of eczema in which there is thick scaling on the palms and/or soles of the feet)
   - recurrent erysipelas (acute inflammation of the skin)
   - psoriatic nails
   - chemotherapy involving problems of the nails and feet
   - problems of the nails and feet due to MS, ALS, spasm, Kahler's disease (a form of leukemia), Parkinson's disease or epidermolysis bullosa (blister disease).
2. The chiropodist must be listed in one of the following quality registers:
   - the ProCERT Quality Register for Chiropodists (KRP) with the designation medical chirpodist (MP).
   - the Register Paramedische Voetzorg (RPV) maintained by trade organisation Stipezo (Stichting pedicure in de zorg), category 1 (A+B), if it concerns a paramedical chiropodist or medical chiropodist.
3. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with. If a care profile has been established or can be established, the provider must indicate the care profile on the invoice.
4. The invoice should state whether it relates to an examination, treatment or special technique and specify the nature of the medical foot condition.

What we do not reimburse under this article

We do not reimburse the costs of:

a. preventive foot care covered by basic insurance (B.18 Preventive foot care for insured persons at increased risk of foot ulcers);
b. the removal of calluses for cosmetic reasons;
c. non-medically necessary trimming of toenails.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 150 per person per calendar year for costs reimbursed under articles 18.1, 18.2 and 18.3 combined
Vitaal 3	up to € 200 per person per calendar year for costs reimbursed under articles 18.1, 18.2 and 18.3 combined

Reimbursement	Coverage
Vitaal Premium	up to € 250 per person per calendar year for costs reimbursed under articles 18.1, 18.2 and 18.3 combined

D.19 Podiatry/podology/podopostural therapy and arch supports

We reimburse the costs of treatment provided by a (sports) podiatrist, podologist or podopostural therapist and/or (sport) arch supports. The consultation and the costs of fitting, manufacturing, supplying and repairing podiatry or podology insoles and orthoses are included in the treatment.

Conditions for reimbursement

1. The podiatrist must be registered in the Paramedics Quality Register (Kwaliteitsregister Paramedici).
2. The sports podiatrist who provides the treatment must be accredited by the Dutch Sports Health Care Professionals Certification Association (Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS)).
3. The podologist who provides the treatment must be registered in the KABIZ Quality Register and affiliated with National Umbrella Body for Podiatry (LOOP) or meet the quality criteria established by LOOP.
4. The podopostural therapist who provides the treatment must be registered in the KABIZ Quality Register (Kwaliteitsregister KABIZ) and affiliated with National Umbrella Body for Podiatry (Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP)) or meet the quality criteria established by LOOP.
5. The arch supports must be supplied or repaired by an arch support supplier in possession of the SEMH certificate Orthotist-Prosthetist (Orthopedische InstrumentMakerijen (OIM)) or Orthopaedic Shoe Company (Orthopedische Schoentechnische Bedrijven (OSB)). Sports arch supports must be supplied by a sports podiatrist accredited by the Dutch Sports Health Care Professionals Certification Association (Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS)) or the VSO-Netwerk (a network that specialises in corrective arch supports). For an overview of SCAS-accredited sports podiatrists, visit sportzorg.nl/zoek-een-sportzorgprofessional. For an overview of VSO-Netwerk members, visit vsonetwerk.nl. Arch supports may also be supplied or repaired by an arch support supplier that meets the quality criteria established by SEMH or the VSO-Netwerk.
6. The invoice must specify the nature of the service(s) provided (examination, treatment, supply of a medical device and/or use of a special technique). The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

What we do not reimburse under this article

We do not reimburse the costs of:

a. footwear and alterations of footwear;
b. preventive foot care covered by basic insurance (B.18 Preventive foot care for insured persons at increased risk of foot ulcers);

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 150 per person per calendar year, including up to 1 pair of orthotics
Vitaal 3	up to € 200 per person per calendar year, including up to 1 pair of orthotics
Vitaal Premium	up to € 250 per person per calendar year, including up to 1 pair of orthotics

Hospital and nursing

D.20 Overnight guest house accommodation and transport for visitors in the case of a stay in a hospital, mental healthcare institution or hospice

Are you staying in a hospital, a mental healthcare institution or hospice in the Netherlands, Belgium or Germany? Then for your visitors we reimburse the costs of:

a. overnight stay at a Ronald McDonald House or another guesthouse that is located in the vicinity of the hospital, the mental healthcare institution or the hospice;
b. private transport or transport by taxi from and to the home address and the hospital, mental healthcare institution, hospice or guesthouse; and the costs of transport between the guesthouse and the hospital, the mental healthcare institution or the hospice. We reimburse € 0.38 per kilometre;
c. transport by public transport (lowest class) from and to the home address and the hospital, mental healthcare institution, hospice or guesthouse; and the costs of public transport between the guesthouse and the hospital, the mental healthcare institution or the hospice.

The number of reimbursable kilometres is based on the fastest route between the postcodes of your departure address and destination according to our route planner. For more information, visit zk.nl/vervoer or contact us.

Conditions for reimbursement

1. Use the claim form to request reimbursement of your costs. You can find the claim form on our website.
2. You must be able to provide proof that you incurred the transport and/or accommodation expenses during your stay.
3. The guesthouse must be a non-commercial undertaking affiliated with:
   - a hospital in the Netherlands; or
   - a contracted hospital outside the Netherlands.

Personal contribution for transport

A personal contribution of €100 per calendar year applies for transport by public transport, taxi or private car.

What we do not reimburse under this article

We do not reimburse the costs of air transport.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	Accommodation expenses: up to € 35 per night. Transport and/or accommodation expenses: up to € 300 per calendar year for all visitors combined
Vitaal 2	Accommodation expenses: up to € 35 per night. Transport and/or accommodation expenses: up to € 400 per calendar year for all visitors combined
Vitaal 3	Accommodation expenses: up to € 35 per night. Transport and/or accommodation expenses: up to per calendar year for all visitors combined
Vitaal Premium	Accommodation expenses: up to € 35 per night. Transport and/or accommodation expenses: up to per calendar year for all visitors combined

D.21 Overnight guest house accommodation during an outpatient treatment cycle

Are you receiving outpatient treatment? Then we reimburse the costs of overnight accommodation in a Ronald McDonald guest house, or another guest house, in the vicinity of the hospital. You must receive outpatient treatment on 2 or more consecutive days without staying in the hospital.

What we do not reimburse under this article

We do not reimburse the costs of:

a. overnight accommodation instead of patient transport, if you are entitled to reimbursement from the basic insurance (see article B.17.2 Patient transport);
b. accommodation the night before the start of treatment.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 35 per day, up to € 400 per calendar year
Vitaal 3	up to € 35 per day, up to € 500 per calendar year
Vitaal Premium	up to € 35 per day, up to € 600 per calendar year

D.22 Hospice care

We reimburse the personal contributions an insured person is required to pay while staying in a hospice. The hospice must form part of the palliative care network within the region. The hospice must not be part of a healthcare institution, such as a nursing home, retirement home or care home.

What we do not reimburse under this article

We do not reimburse the personal contribution payable under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) for a stay in a hospice.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 35 per day
Vitaal 3	up to € 35 per day
Vitaal Premium	up to € 35 per day

D.23 Sterilisation

We reimburse the costs of sterilisation.

Conditions for reimbursement

The treatment must be performed at:

1. the practice of a general practitioner qualified to perform the procedure if the insured person is male;
2. a hospital or independent treatment centre (outpatient or day treatment).

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which medical specialists we have a contract? use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

What we do not reimburse under this article

We do not reimburse the costs for a sterilisation reversal operation.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	100%
Vitaal Premium	100%

D.24 Second opinion arranged through Royal Doctors

We reimburse the costs of a second opinion arranged through Royal Doctors. The second opinion will be provided by a specialist from the Royal Doctors network. The assessment will be based on your medical records. You will not be examined by a Royal Doctors specialist.

Condition for reimbursement

You must request a second opinion in advance by calling the Personal Care Coach on +31 71 364 02 80.

Reimbursement	Coverage
Basis Vitaal	100%
Vitaal 1	100%
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

Pregnancy/baby/child

D.25 Personal contribution towards the costs of childbirth and obstetric or midwifery care

Did you give birth in a hospital or birth centre as an outpatient under the supervision of a midwife, obstetrician or general practitioner without having a medical reason? Then you are required to pay a statutory personal contribution towards the costs under your basic insurance. We reimburse the statutory personal contribution payable by female insured persons.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

D.26 Maternity package

We will deliver a maternity package to the home of a female insured person well in advance of the anticipated delivery date.

Condition for reimbursement

You must request the maternity package at least 2 months in advance of the anticipated delivery date.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

D.27 Maternity care

The conditions under which reimbursement of the statutory personal contribution and/or personal payment towards the costs of maternity care is covered by your supplementary insurance are listed below.

27.1 Personal contribution towards the costs of maternity care provided at home or at a birth or maternity centre

Are you required to pay a statutory personal contribution towards the costs of maternity care provided at home or at a birth or maternity centre under your basic insurance? Then we reimburse the statutory personal contribution payable by female insured persons.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

27.2 Personal contribution towards the costs of maternity care at a hospital without medical indication

Are you required to pay a statutory personal contribution towards the costs of non-medically indicated maternity care provided at a hospital under your basic insurance? Then we reimburse the statutory personal contribution payable by female insured persons.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	100%
Vitaal 3	100%
Vitaal Premium	100%

27.3 Postponed maternity care

For female insured persons we reimburse the costs of postponed maternity care provided by a maternity centre. Postponed maternity care is maternity care provided from the 11th day after the birth onwards

Conditions for reimbursement

1. Postponed maternity care must be provided by a contracted maternity centre.
2. The maternity centre must consider the postponed maternity care to be medically necessary.

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which maternity centres we have a contract? use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	up to 12 hours per pregnancy
Vitaal 2	up to 12 hours per pregnancy

Reimbursement	Coverage
Vitaal 3	up to 12 hours per pregnancy
Vitaal Premium	up to 12 hours per pregnancy

D.28 Lactation care

We reimburse the costs of advice and assistance provided by a lactation expert for insured women having problems with breastfeeding after a birth.

Condition for reimbursement

1. The lactation expert must be a member of the Dutch Association of Lactation Experts (NVL) or meet the quality criteria established by the association. Alternatively, the lactation expert must be employed by one of our contracted maternity centres.
2. The invoice must state the lactation expert's valid AGB code issued for the care being provided, and must clearly state that it is for lactation care.

To find out with which care providers we have a contract, use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	no reimbursement
Vitaal 3	no reimbursement
Vitaal Premium	up to € 200 per person per calendar year

D.29 “Slimmer Zwanger” pregnancy self-help programme

We reimburse the costs of a subscription to the Slimmer Zwanger self-help programme for a healthy pregnancy. A subscription to the Slimmer Zwanger programme lasts 26 weeks and the programme can be followed both before and during the pregnancy.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	1 subscription for the duration of the supplementary insurance
Vitaal 3	1 subscription for the duration of the supplementary insurance
Vitaal Premium	1 subscription for the duration of the supplementary insurance

D.30 Antenatal classes

For female insured persons we reimburse the costs of:

a. antenatal courses during pregnancy that help prepare you for and/or guide you through the delivery process;
b. courses that promote physical recovery following delivery.

Conditions for reimbursement

1. You must provide us with proof of registration for the classes and payment of the fees.
2. The classes must be run by:
   - a home nursing agency or maternity care institution;
   - a midwife or obstetrician practice or a health centre;
   - a qualified care provider who is a member of the Samen Bevallen antenatal classes association and meets the quality criteria established by the association;
   - a physiotherapist or a remedial therapist qualified to teach the Cesar or Mensendieck postural correction system;
   - a qualified hypnobirthing practitioner;
   - a qualified care provider who is a member of the Zwanger en Fit pregnancy fitness association;
   - a care provider qualified to teach the psychoprophylaxis method (to help reduce fear of childbirth);
   - Mom in Balance (motherhood support organisation).

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 50 per person per pregnancy

Reimbursement	Coverage
Vitaal 3	up to € 75 per person per pregnancy
Vitaal Premium	up to € 100 per person per pregnancy

Preventive healthcare

We reimburse the costs of preventive healthcare. Prevention focuses on improving or maintaining your health in the fields of Nutrition (D.31), Getting or staying fit (D.32), Mental Resilience (D.33) and Other courses (D.34). The conditions for reimbursement are listed below.

Preventie budget

Voor de in artikel D.31 t/m D.34 genoemde kosten tezamen geldt een maximale vergoeding van:

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	up to € 300 per person per calendar year
Vitaal 2	up to € 500 per person per calendar year
Vitaal 3	up to € 600 per person per calendar year
Vitaal Premium	up to € 700 per person per calendar year

D.31 Nutrition

31.1 Nutrition education by a weight management consultant or sports nutritionist

We reimburse the costs of nutrition education by a weight management consultant or (sports) nutritionist. Nutrition education involves the provision of information about, and advice on, nutrition and eating habits, without medical indication.

Conditions for reimbursement

1. The weight management consultant must be a member of the Beroepsvereniging Gewichtsconsulenten Nederland (BGN) (Dutch professional association for Weight Consultants) or must meet the quality criteria established by the association.
2. The sports nutritionist must be accredited by the Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS) (Dutch Sports Health Care Professionals Certification Association). A list of SCAS-accredited sports dieticians can be found at sportzorg.nl/zoek-een-sportzorgprofessional.
3. The invoice must specify: that the care professional is affiliated with the BGN or SCAS-certified.

What we do not reimburse under this article

We do not reimburse the costs of both dietetic therapy and nutrition education (D.35) for the same diagnosis.

31.2 Weight loss course

We reimburse the costs of a course provided by Happy Weight. The programme lasts 15 weeks.

Condition for reimbursement

You must provide us with the original confirmation of registration for the course.

D.32 Getting or staying fit

32.1 Health check or lifestyle check

Reimbursement of the costs of an online health check performed to gain insight into your health. The health check consists of:

- an online questionnaire;
- a checkbox with a home test (finger-prick test) to measure cholesterol and blood sugar levels.

Upon completion, you will receive an online health report.

You can also opt for the lifestyle check involving a more extensive health check that includes an online lifestyle consultation with a lifestyle coach. The aim is to gain insight into your health and lifestyle.

Conditions for reimbursement

a. We reimburse one check per calendar year.
b. We only reimburse health checks or lifestyle checks performed by &niped.

32.2 Medical examination by a sports doctor

We reimburse the costs of the following examinations by a sports doctor at a Sports Medicine Centre:

a. medical examination by a sports doctor;
b. a sports check-up;
c. an exertion test.

Condition for reimbursement

1. The sports doctor or Sports Medicine Centre must be accredited by the Dutch Sports Health Care Professionals Certification Association (SCAS). For an overview of SCAS-accredited Sports Medicine Centres, visit sportzorg.nl/zoek-een-sportzorgprofessional.
2. The Diving Physician performing the diving medical examination must be certified by the Nederlandse Vereniging voor Duikgeneeskunde (NVD). For an overview of NVD-accredited diving physicians, visit duikgeneeskunde.nl/vereniging/voor-duikers.

What we do not reimburse under this article

We do not reimburse the costs of a sports doctor if they are reimbursed under the basic insurance. This is usually the case if you have been referred by your GP or a medical specialist.

32.3 Sports medical advice and guidance

We reimburse the costs of sports medical advice and guidance (advice on sports training and a personal training programme based on the results of the sports medical examination) provided by a sports doctor at a sports medical institution.

Condition for reimbursement

1. A medical examination for sports must be performed by a sports doctor at a Sports Medicine Centre before the advice is provided.
2. The sports doctor or Sports Medicine Centre must be accredited by the Dutch Sports Health Care Professionals Certification Association (SCAS). A list of SCAS-accredited Sports Medicine Centres can be found at sportzorg.nl/zoek-een-sportzorgprofessional.

32.4 Flu vaccination

Are you under the age of 60? Then we reimburse the costs of a flu vaccination.

What we do not reimburse under this article

We do not reimburse the costs of vaccinations given to risk groups as part of the national flu prevention programme covered by the Long Term Care Act (Wlz).

D.33 Mental resilience

33.1 Mindfulness training

We reimburse the cost of an 8- or 9-week group course

- Mindfulness Based Cognitive Therapy (S-MBCT),
- Mindfulness Based Stress Reduction (MBSR),
- Mindfulness Based Childbirth & Parenting-Fear (MBCP-fear),
- Mindfulness Based Compassionate Living (MBCL).

These are courses to develop skills to better cope with stressful situations.

Conditions for reimbursement

1. The mindfulness training must be provided by a trainer who is registered with the Mindfulness Register or the VVM. You can find registered trainers on mindfulnessregister.nl or verenigingvoormindfulness.nl
2. The invoice must state the Mindfulness trainer's AGB code and member Mindfulness Register or VVM.

D.34 Other courses

34.1 First aid and resuscitation courses

We reimburse the costs of the following courses:

a. A **basic resuscitation course** offered by a training institute registered with the Dutch Resuscitation Council (Nederlandse Reanimatieraad (NRR)) or in accordance with the Dutch First Aid Guidelines.
b. A **first aid course** that results in an Oranje Kruis First Aid diploma or a Dutch Red Cross First Aid certificate. (We do not reimburse the costs of emergency response training for companies, including child first aid courses required to qualify for registration under the Dutch Childcare Act (Wet kinderopvang (Wk)).
c. A **course on first aid for children's accidents** that results in an Oranje Kruis or Dutch Red Cross first aid certificate. We do not reimburse the costs of emergency response training for companies, including child first aid courses required to qualify for registration under the Dutch Childcare Act.

Condition for reimbursement

You must provide us with the original confirmation of registration for the course.

34.2 Care for women

We reimburse the costs of health advice: Menopause complaints, Getting pregnant & Pregnancy, Menstruation problems, Contraception and Breast self-examination.

Conditions for reimbursement

1. The consultation must be provided by a consultant who is a member of Care for Women. In the case of menopause complaints the consultation can also be provided by a menopause consultant who is a member of the Vereniging Verpleegkundig Overgangsconsulenten (VVOC) (Association of Medical Menopause Consultants). Or a care provider who meets the quality criteria established by one of these organisations.
2. The invoice must state the care provider's valid AGB code issued for the care being provided, as well as which professional association they are affiliated with.

What we do not reimburse under this article

We do not reimburse the costs of food supplements or medicines.

34.3 Sleep improvement course

We reimburse the costs of:

a. an online sleep therapy course which provides professional advice and practical solutions online to help improve your sleep. The course must be organised by Somnio.
b. a course to learn to sleep. The course must be organised by a home care agency.

Condition for reimbursement

You must provide us with the original confirmation of registration for the course.

34.4 Online informal care courses

We reimburse the costs of one or more online courses through Samen Beter Thuis. The online courses help you improve your informal care knowledge and skills.

Condition for reimbursement

The informal care course(s) must be taught by Samen Beter Thuis.

34.5 Course on dealing with a medical condition

We reimburse the costs of the following courses:

a. For insured persons suffering from **heart problems**, we reimburse the costs of a course that teaches patients how to cope with heart problems. The course must be organised by a home care agency. We do not reimburse the costs of a sports club or fitness centre.
b. For insured persons suffering from **lymphoedema**, we reimburse the costs of a lymphoedema awareness and/or self-management course that teaches patients how to be proactive in helping to prevent, detect and/or treat lymphoedema. The course must be organised by a qualified instructor who has completed the lymphoedema self-management training course run by the Dutch Paramedical Institute (Nederlands Paramedisch instituut (NPi)). A list of qualified instructors can be found on our website or obtained from us.
c. For insured persons suffering from **rheumatoid arthritis, osteoarthritis or Bechterew's disease**, we reimburse the costs of a course to teach patients how to cope with their condition. The course must be organised by ReumaNederland or a home care agency.
d. For insured persons suffering from **type 2 diabetes**, we reimburse the costs of a patient- basic- or follow-up educational course organised by the Dutch Diabetes Association (DVN) or a home care agency.
e. **Courses organised by patient associations** The course must be organised by a patient association affiliated with Patiëntenfederatie Nederland (Dutch Federation of Patient Associations) or the Ieder(in) network for those with physical or mental disability or chronic illness.

Condition for reimbursement

You must provide us with the original confirmation of registration for the course.

34.6 Online self-help modules to treat psychological complaints

We reimburse the costs of the voucher (annual subscription fee) for online (self-help) modules offered by Stichting mirro, which explain how to identify, deal with and prevent mental health issues.

Condition for reimbursement

Do you want to refer to one or more of the online self-help modules offered by Stichting mirro? In that case you need vouchercode 128746ybjsi0. You can use the code to register at mirro.nl/account.

What we do not reimburse under this article

We do not reimburse the cost of vouchers purchased by you.

Other

D.35 Dietetic therapy by a dietitian

We reimburse the costs of dietetic therapy by a dietitian. Dietetic therapy involves the provision of information about, and advice on, nutrition and eating habits for medical reasons. Are you entitled to dietetic therapy under your basic insurance? Then the reimbursement covered by your basic insurance applies in addition to the reimbursement covered by your basic insurance.

What we do not reimburse under this article

We do not reimburse the costs of both dietetic therapy and nutrition education (31.1) for the same diagnosis.

Lower reimbursement for treatment provided by a non-contracted care provider

Please note!

If you use a non-contracted care provider, we will reimburse the costs of care up to the maximum rate at the time of treatment under the Dutch Healthcare Market Regulation Act (Wmg). If no maximum tariff has been established on the basis of the Healthcare Market Regulation Act, we will reimburse the costs of care up to the prevailing market rate in the Netherlands. You can ask us about the insured amount.

Do you want to know with which dietitians we have a contract? Use the Zorgzoeker on zk.nl/zorgzoeker or contact us.

Reimbursement	Coverage
Basis Vitaal	no reimbursement

Reimbursement	Coverage
Vitaal 1	up to 1 hours per person per calendar year
Vitaal 2	up to 2 hours per person per calendar year
Vitaal 3	up to 3 hours per person per calendar year
Vitaal Premium	up to 4 hours per person per calendar year

D.36 Informal care support

Informal care can be quite a burden for you, especially if you provide long-term and intensive informal care. If you are an informal caregiver, we offer temporary reimbursement for necessary support services to ensure that you can keep providing care and enable you to apply for substitute informal care (respite care via the Wmo) through the care recipient's municipal authority. The conditions for reimbursement are listed below.

Informal care refers to the provision of unpaid, long-term care for a chronically ill or handicapped person in your immediate social circle.

36.1 Substitute informal care

We reimburse the cost of temporary substitute informal care to give the informal caregiver time off. You can use substitute informal care if you are receiving informal care or if you are an informal caregiver.

Conditions for reimbursement

a. You must request substitute informal care in advance by calling the Personal Care Coach on +31 71 364 02 80. They will refer you to the appropriate organisation.
b. In a family with multiple insured persons, this reimbursement can only be granted for the benefit of one insured person.

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to 40 hours of substitute informal care per person for 3 consecutive months, once per calendar year
Vitaal 3	maximaal 80 uur vervangende mantelzorg per persoon maximaal 1 keer per kalenderjaar voor 3 aaneengesloten maandenuur
Vitaal Premium	up to 120 hours of substitute informal care per person for 3 consecutive months, once per calendar year

36.2 Informal care agent

The informal care agent provides temporary professional support for the informal caregiver by taking over various organisational tasks relating to care, welfare, finance, etc. The efforts of the informal care agent help the informal caregiver feel better and enable them to combine care duties with work and personal life for longer.

You can use the informal care agent if you are receiving informal care or if you are an informal caregiver.

Conditions for reimbursement

a. The services provided by an informal care agent are eligible for reimbursement once. The services provided cannot be claimed by both the informal caregiver and the informal care recipient.
b. The informal care agent must be registered in the national Centraal Kwaliteitsregister van Mantelzorgmakelaars maintained by Beroepsvereniging voor Mantelzorgmakelaars (BMZM).

Reimbursement	Coverage
Basis Vitaal	no reimbursement
Vitaal 1	no reimbursement
Vitaal 2	up to € 250 per calender year
Vitaal 3	up to € 500 per calender year
Vitaal Premium	up to € 750 per calender year

E. Reimbursements covered by Tand 1, 2, 3 and 4

E.1 Dental care for insured persons aged 18 or older

Are you 18 or older? And do you have Tand 1, 2, 3 or 4? In that case we reimburse the costs of dental treatment by a dentist, a dental surgeon, an oral hygienist or a clinical dental technician.

What is reimbursed?

We reimburse 100% of the costs of consultations and check-ups (C-codes), oral hygiene (M-codes), fillings (V-codes) and extractions (H-codes).

We reimburse up to 80% of the costs of other treatments.

What is a dental hygienist allowed to claim?

You are entitled to checks, X-rays, anaesthetics, oral hygiene, treatment of gum disease and small fillings insofar as these belong to the area of expertise of the dental hygienist.

What is a dental prosthetician allowed to claim?

You are entitled to have partial dentures (plates or frames) made, repaired and filled in to the extent that these fall within the area of expertise of the dental prosthetician.

What is a dental surgeon allowed to claim?

You are entitled to periodontal surgery, the fitting of a dental implant and an uncomplicated extraction (pulling a tooth or molar) by a dental surgeon if these costs are not reimbursed under your basic insurance (see article B.7 Front tooth replacement for insured persons up to the age of 23B.8 Dental care for insured persons aged 18 or older - dental surgery, B.10 Implants, B.11 Dental care for insured persons with a disability and B.12 Dental care in exceptional cases).

What is a dental technician allowed to claim?

You are entitled to minor repairs of a partial denture (plate or frame) performed by a dental technician if no oral treatment is required and insofar as they fall within the dental technician's area of expertise. These include the reattachment or replacement of a tooth or molar and the repair of a crack in the partial denture. What if there is a break in your denture? Then the repair must be performed by a dentist and not by a clinical dental technician. A crack in your denture means that the denture is broken but still in one piece. A break in your denture means that the denture has broken into 2 or more pieces.

Please note!

We only reimburse the costs of dental care if the maximum reimbursement of your supplementary dental insurance has not yet been reached.

What we do not reimburse under this article

We do not reimburse the costs of:

a. dental check-up reports and dental statements;
b. missed appointments (C90);
c. non-restorative caries treatment in the deciduous teeth (M05);
d. a fluoride treatment (M40);
e. external bleaching of teeth and molars (E97);
f. cosmetic oral care (K001, K002, K003 and K004);
g. a mandibular advancement splint (MAS: a brace used to prevent snoring), and the related diagnostic and follow-up care (G71, G72 and G73);
h. orthodontic care;
i. general anaesthetic and nitrous oxide.
j. a complicated extraction by a dental surgeon. (This is reimbursed under the basic insurance.)
k. partially completed work;
l. autotransplantation (H38 and H39);
m. therapeutic botox injection (G44).

Maximum reimbursements

The maximum total reimbursement depends on your package. The reimbursements provided by the different packages are listed below.

Reimbursement	Coverage
Tand 1	• We reimburse 100% of C-codes, M-codes, V-codes and H-codes. • We reimburse 80% of the costs of other codes. • The maximum total reimbursement is € 250 per person per calendar year.
Tand 2	• We reimburse 100% of C-codes, M-codes, V-codes and H-codes. • We reimburse 80% of the costs of other codes. • The maximum total reimbursement is € 500 per person per calendar year.

Reimbursement	Coverage
Tand 3	• We reimburse 100% of C-codes, M-codes, V-codes and H-codes. • We reimburse 80% of the costs of other codes. • The maximum total reimbursement is € 1,000 per person per calendar year.
Tand 4	• We reimburse 100% of C-codes, M-codes, V-codes and H-codes. • We reimburse 80% of the costs of other codes. • The maximum total reimbursement is € 1,500 per person per calendar year.

F. Ziekenhuis Ontzorgpakket supplemental insurance

With our Ziekenhuis Ontzorgpakket, you are entitled to reimbursement of the costs of a private or twin room without medical indication during a hospital stay.

Please note!

The following policy conditions only apply to insured persons who have taken out the Ziekenhuis Ontzorgpakket. You can take out this insurance if you are 18 or older. If you have taken out Ziekenhuis Ontzorgpakket, it will be listed on your policy schedule.

You must demonstrate the right to reimbursement of the claims listed in this supplemental insurance by submitting a certified original invoice from which we can establish the reimbursement to be made.

F.1 Added-comfort facilities during a hospital stay in Belgium or Germany

Are you 18 or older and staying at a healthcare institution in Belgium or Germany? Are you receiving contracted medical treatment at the institution? In that case, we reimburse the additional fees charged by the healthcare institution for accommodation in a private room or twin room. We also reimburse any fee surcharge that may apply. If a private room or twin room is not available, we issue a so-called daily allowance of € 70 for each day you spend in the hospital. The maximum allowance is €4,900 per calendar year.

Are you staying at a healthcare institution in Belgium or Germany? Are you receiving non-contracted medical treatment at the institution? Then we issue a so-called daily allowance of up to € 70 for each day you spend in the hospital. The daily allowance is set off against the additional fees charged by the healthcare institution for accommodation in a private room or twin room. We also reimburse the fee surcharge, if applicable. We reimburse up to €4,900 per calendar year for the daily fee and the fee surcharge combined.

You are not entitled to reimbursement of added-comfort facilities during a hospital stay in Belgium Germany for contracted or non-contracted medical treatment.

What we do not reimburse

We do not reimburse the costs of added-comfort facilities during a stay in the rehabilitation or psychiatric department of a hospital or psychiatric hospital.

Reimbursement	Coverage
Ziekenhuis Ontzorgpakket	maximum of € 70 per day, up to € 4,900 per calendar year

F.2 Taxi transport to and from the hospital

Will you or did you have to pay for taxi transport to and from hospital on the first and last day of a hospital stay in the Netherlands? In that case, we reimburse the costs of return transport between your home address and the hospital. Did someone accompany you in the taxi? In that case, we also reimburse the costs of their taxi trip both ways between the hospital and your home address. We reimburse up to a maximum of 4 taxi journeys per hospital stay.

Condition for reimbursement

You must obtain our prior permission for transport through the Transport Telephone Line, telephone number +31 71 365 41 54

Reimbursement	Coverage
Ziekenhuis Ontzorgpakket	up to 4 taxi journeys per hospital stay

F.3 Domestic help

We reimburse the costs of domestic help provided by a designated care provider for up to 10 hours per admission of the insured person receiving medically necessary nursing in a hospital, the costs of which are reimbursed in full or in part by the health insurer under the basic health insurance or supplementary insurance. Nursing is understood to mean a stay of 24 hours or longer, in this case.

What we do not reimburse under this article

We do not reimburse admission to a psychiatric institution, psychiatric hospital, psychiatric ward of a hospital, rehabilitation institution, sanatorium or the Dutch Asthma Centre in Davos.

Reimbursement	Coverage
Ziekenhuis Ontzorgpakket	up to 10 hours per hospital admission

F.4 Child care during and after a parental hospital stay

If you are a parent insured with us and you will be admitted to hospital, you can receive childcare outside the hours your child normally spends at daycare from the fourth day of your hospital stay. This applies to children up to the age of 12 living at home.

Condition for reimbursement

Do you want to arrange child care? Then you need prior approval from us. Please contact us to request approval.

What we do not reimburse under this article

We do not reimburse the costs of:

a. child care during admission to a psychiatric institution, psychiatric hospital, psychiatric ward of a hospital, rehabilitation institution, sanatorium or the Dutch Asthma Centre in Davos;
b. the hours at the day care centre you would normally use.

Reimbursement	Coverage
Ziekenhuis Ontzorgpakket	up to € 20 per child per business day, up to 60 working days

We are happy to help you

Visit zk.nl/contact

for an overview of all contact options

Would you prefer to speak to someone in person?

You can contact us on 071 751 00 51

- From 8.00 - 20.00 on working days
- On Saturdays from 9.00 - 13.00
  (**Extra:** Saturday 11 November and 30 December from 9.00 - 17.30
  Sunday 31 December from 9.00 to 17.00)

You can also write to us at

Zilveren Kruis Achmea, PO box 444, 2300 AK Leiden

Documents regarding your health insurance can be downloaded at zk.nl/informatiedocument.
If you have any questions, telephone 071 751 00 51.

Visit zilverenkruis.nl for a list of contracted care providers, reimbursement tariffs for non-contracted care providers, Medical Devices Regulations, Pharmaceutical Care Regulations, Personal Care Allowance Regulations, professional associations of alternative healthcare professionals that meet our criteria, policy conditions, brochures, forms and other information about our insurance policies.
You can also obtain the information from us.

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