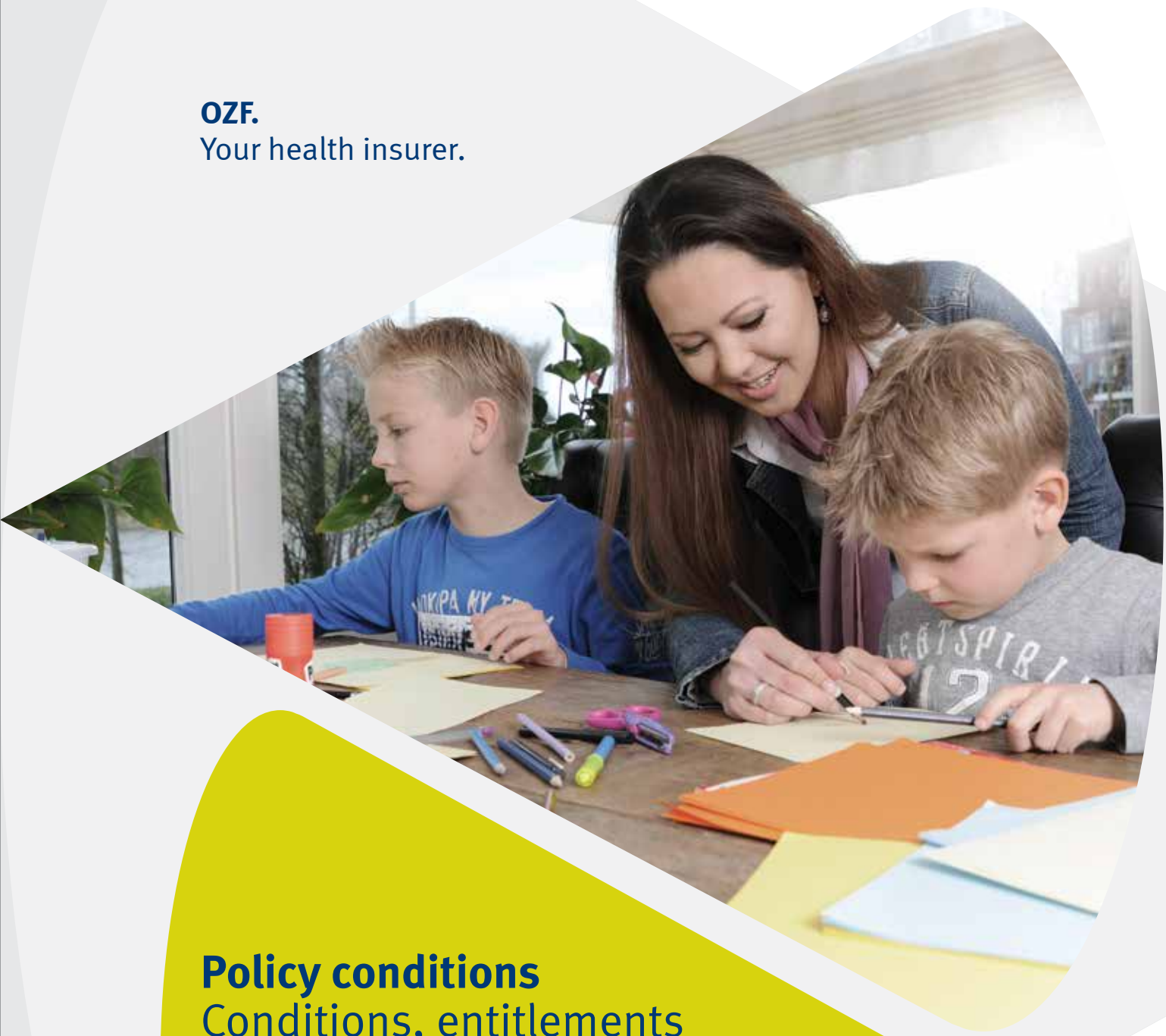
These conditions apply from 1 January 2019 and replace all previous versions.

OZF.
Your health insurer.

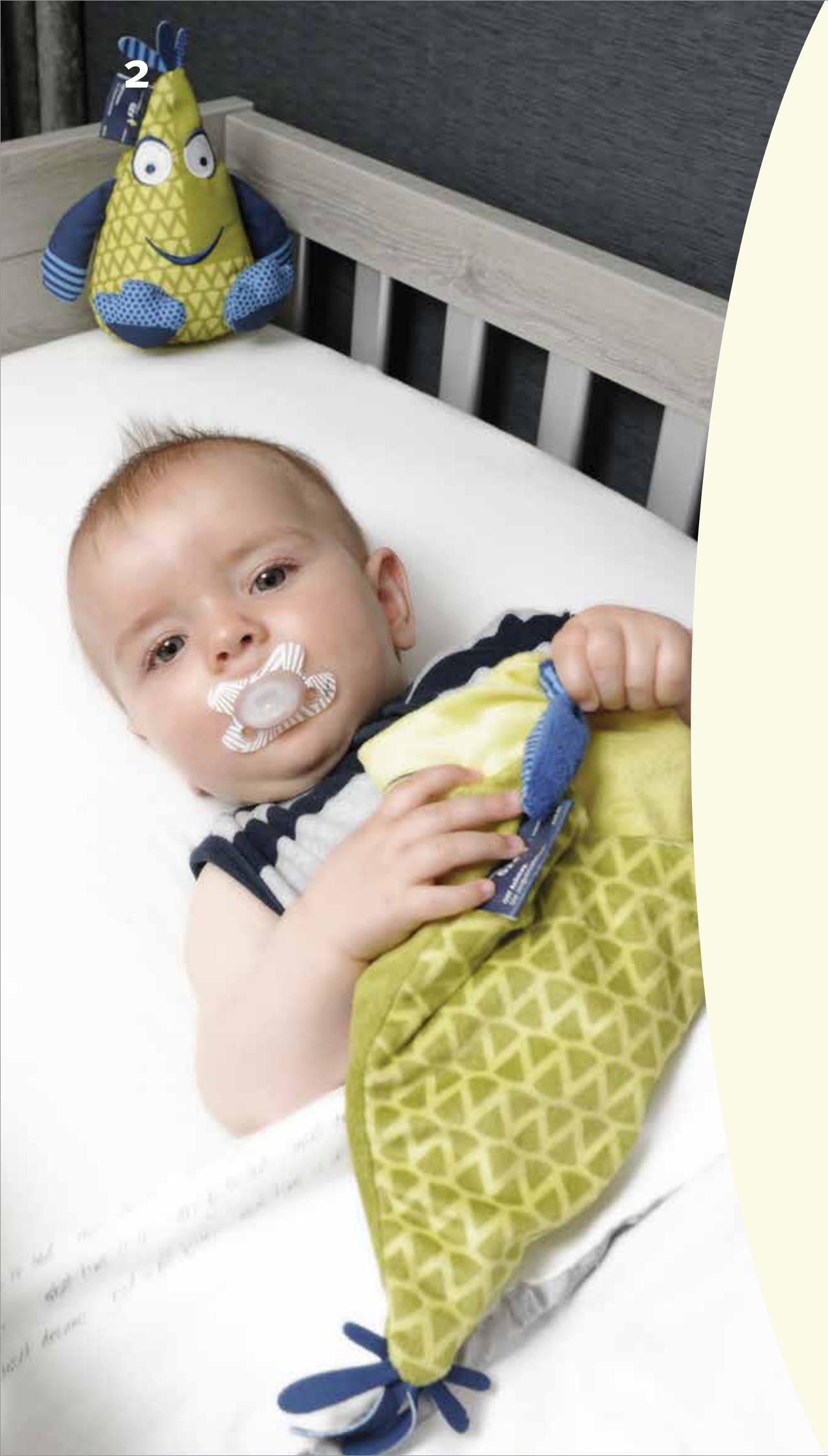


Policy conditions
Conditions, entitlements and reimbursements 2019

Basic insurance, Supplementary insurance policies &
Dental insurance policies

70602/2018-11

ZORGVERZEKERAAR OZF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These are the conditions of your basic and supplementary (dental) insurance policies
We call our basic insurance OZF Zorgpolis. This is an arranged care policy. This means that in most cases you are entitled to arranged care. But you are also entitled to reimbursement of the costs of care. For non-contracted care, we reimburse up to 75% of the average tariff we purchased this care for (from contracted care providers). You can supplement your basic insurance with 1 or more supplementary (dental) insurance policies: AV Compact, AV Royaal, Tand Compact and Tand Royaal. You can find the documents on your health insurance via ozf.nl/informatiedocument.

The government determines the contents of the basic insurance
The government stipulates the conditions of the basic insurance. These are laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the corresponding legislation. Every health insurer must comply with these conditions.

How do you find the reimbursement you are looking for?
We may reimburse your care under your basic insurance and/or your supplementary (dental) insurance (policies). First check if we reimburse the care under your basic insurance: 'OZF Zorgpolis Entitlements and Reimbursements' are listed on pages 21 to 44. The table of contents is on page 20. What if there is no (or only partial) reimbursement under your basic insurance? In that case, check whether the care is reimbursed by our supplementary (dental) insurance (policies): Reimbursements covered by our supplementary (dental) insurance (policies) are listed on pages 51 to 70. The table of contents is on pages 49 and 50.
Please note! It is also possible that your care may be reimbursed by both your basic and supplementary (dental) insurance (policies). In that case, you will need to refer to several sections of these conditions to work out the total reimbursement.

Do you need permission?
You will see that for certain reimbursements we must give permission in advance. You can request our permission by post or email. You can find more information about requesting permission on our website, ozf.nl. The application forms can also be found on our website.

Advantages of contracted care
We have entered into contracts with a large number of care providers and healthcare institutions. Contracted care providers send the bill directly to us. This means that you do not receive a bill from the care provider. If you are entitled to full reimbursement under the policy conditions, the bill is paid in full. However, this does not include your (mandatory and/or voluntarily chosen) excess or any (statutory) personal contributions that may apply. We collect these payments from you.

Lower reimbursement for non-contracted care
Do you want to use a non-contracted care provider or healthcare institution? And does the care meet the policy conditions? In that case, you are entitled to reimbursement of 75% of the average tariff we pay for this care (provided by contracted care providers). If this is the case, it will say so next to the reimbursement.
Please note! Our supplementary insurance sometimes only coverscontracted care. If this is the case, it will say so next to the reimbursement.
Do you want to know with which care providers and healthcare institutions we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

You can also find a complete overview on ozf.nl
On our website, you will find details of our contracted care providers, our reimbursement tariffs for non-contracted care providers, policy conditions and brochures. You will also find claim forms, Medical Devices Regulations (Reglement Hulpmiddelen), Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg), Personal Care Allowance Regulations - Nursing and Care (Reglement PGB verpleging en verzorging) and other information about our health insurance policies.

Mandatory excess
For everyone aged 18 or older basic insurance involves a mandatory excess. The government determines the amount of the mandatory excess. For 2019 this is €385.

This mandatory excess does not apply to:
- Care reimbursed by our supplementary (dental) insurance (policies).
- The costs of care or other services incurred in 2019 but for which the invoices are not received until after 31 December 2020.
- Care provided by a general practitioner (with the exception of the costs of tests performed as part of this care, such as laboratory tests, which are carried out elsewhere and charged for separately).
- The costs of registering with a general practitioner or with an institution that provides general practitioner care.
- Care provided for children up to the age of 18.
- Direct costs for obstetric and/or midwifery care and maternity care (with the exception of medicines, blood pressure tests, chorionic villus sampling and patient transport).
- Integrated care.
- After-care for a donor.
- The donor's transport costs if these costs are reimbursed by the donor's own basic insurance.
- The costs of nursing and care provided by nurses in your own surroundings.

You can find out more about the mandatory excess in article 6 of the 'OZF Zorgpolis General conditions'.

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. When do you not pay a voluntarily chosen excess?
A voluntarily chosen excess does not apply to the care listed in the paragraph on the mandatory excess, with the exception of the 2nd bullet point in that list. You can find out more about the voluntarily chosen excess in article 7 of the 'OZF Zorgpolis General conditions'.

What can be found where?
These policy terms and conditions are organised as follows:

Contents General conditions
OZF Zorgpolis

General conditions

OZF Zorgpolis

Article 1 What is the regulatory basis for basic health insurance?

1.1 This insurance contract is based on:

- The Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the accompanying explanatory notes.
- The Health Insurance Decree (Besluit zorgverzekering) and the accompanying explanatory notes.
- The Health Insurance Regulations (Regeling zorgverzekering) and the accompanying explanatory notes.
- The application form that you (the policyholder) completed.

1.2 It is also based on established medical science and medical practice

The contents of 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 and/or reimbursement of the costs of care is/are 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). This article can be found at: http://wetten.overheid.nl/BWBR0018715/Hoofdstuk2/1/11/Artikel22/.

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. Insofar as these agreements are relevant they are incorporated in the policy conditions. If you receive care services provided both by the municipality and by us, please contact us.

Article 2 What does the basic insurance cover (entitlements and reimbursements) and for whom is it intended?

2.1 This basic insurance entitles you to healthcare, and/or reimbursement of the costs of care

The government decides which care is insured. The insurance can be taken out with or for:

- People living in the Netherlands who are obliged to take out insurance.
- People living in a country other than the Netherlands who are obliged to take out insurance.

The forms of care covered by your basic insurance are listed under 'OZF Zorgpolis Entitlements and Reimbursements'. For each form of care, this section tells you whether you are entitled to the care itself or (partial) reimbursement of the costs of care.

2.2 Procedures for taking out insurance

You (the policyholder) apply to us for the basic insurance by completing, signing and returning an application form. Or by completing the application form on our website.

2.3 Application and registration

When you apply to us for insurance, we determine whether you meet the registration conditions stipulated by the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). Do you meet the registration conditions? Then we send you a policy certificate. The insurance contract is specified in the policy certificate. We also provide you with a healthcare card. You need to present your healthcare card or the policy certificate to your care provider when seeking healthcare. You are then entitled to care and/or reimbursement of the costs of care in accordance with the Health 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 and/or reimbursement of the costs of 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.

2.5 Concessions

In special cases, and insofar as it does not contravene the Dutch Health Insurance Act, the Health Insurance Decree or the relevant Health Insurance Regulations including the explanatory notes, we may make a concession if (full) reimbursement is not covered by the policy. No rights can be derived from the awarding of a concession.

Article 3 What is not insured (exclusions)?

3.1 You are not entitled to (reimbursement of the costs of) care if care is required as a consequence of 1 of the following situations in the Netherlands:

- Armed conflict.
- Civil war.
- Uprising.
- Civil disturbance.
- Riot and mutiny.

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

3.2 You are not entitled to (reimbursement of the costs of):

- Check-ups.
- Flu vaccinations.
- Treatments for snoring (uvulopalatoplasty).
- Treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis.
- Treatments designed to result in sterilisation.
- Treatments designed to reverse sterilisation.
- Treatments for circumcision without medical necessity.
- The issuing of doctors' statements.

Please note! In some cases, you are entitled to (reimbursement of the costs of) this care. For this to apply, the policy conditions must explicitly state that the care is reimbursed.

3.3 Missed appointments and prescribed medicines that are not collected

You are not entitled to (reimbursement of the costs of) care, if you:

- Fail to turn up for care appointments.
- 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 Laboratory tests requested by a doctor who practices alternative medicine

You are entitled to (reimbursement of the costs of) laboratory tests and/or X-rays requested by a general practitioner, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor specialising in juvenile health care, an obstetrician or midwife or a medical specialist.
You are not entitled to (reimbursement of the costs of) 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 treatment carried out by you or a member of your family

You may not claim the costs of self-administered or self-referred care against your own insurance. You are not entitled to (reimbursement of the costs of) this 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 treatment 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 Entitlements or reimbursements resulting from terrorism

3.6.1 Care needed as a consequence of 1 or more terrorist acts

Is care needed as a consequence of 1 or more terrorist acts? In that case you may have a right to reimbursement of some of the costs 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 person will only receive a percentage of their claim. In other words: is the total amount claimed in a calendar year from (non-)life insurers or benefits-in-kind funeral insurers governed by the Dutch Financial Supervision Act (Wet op het financieel toezicht (Wft)) for damage (resulting from terrorist acts) expected to exceed the maximum sum that the insurance company reinsures per calendar year?
In that case, you are only entitled to (reimbursement of the costs of) 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 Terrorismeschade N.V. (NHT)).

3.6.2 Precise 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. The protocol can be found at terrorismeverzekerd.nl. The clause sheet can be downloaded from our website or obtained from us.

3.6.3 Possibility of an additional payment following a terrorist act

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 Long-term Care Act (Wet langdurige zorg (Wlz)), Youth Act (Jeugdwet), 2015 Social Support Act (Wet maatschappelijke ondersteuning (Wmo)) or other statutory regulations

You are not entitled to (reimbursement of the costs of) forms of care or other services that qualify for reimbursement under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)), Youth Act (Jeugdwet), 2015 Social Support Act (Wet maatschappelijke ondersteuning (Wmo) 2015) or any other statutory regulations. What if you and we differ in our opinions on this? Then we reserve the right to discuss the matter with all parties involved (Centrum Indicatiestelling Zorg (CIZ) (Care Assessment Centre), the municipal authorities, the informal caregiver(s), you and ourselves) in order to determine the act or provisions under which entitlement to (reimbursement of the costs of) care exists. If this consultation leads to the conclusion that entitlement to care exists under an act or provisions other than the Health Insurance Act (Zorgverzekeringswet (Zvw)), there is no entitlement to care under your basic insurance.

Article 4 What is reimbursed? And from which care providers and healthcare institutions can you seek treatment?

4.1 This basic insurance entitles you to (reimbursement of the costs of) care

We reimburse the part of these costs that does not fall under personal contributions (including your mandatory excess). The extent of the reimbursement will depend on, among other things, which care provider or healthcare institution you choose.
You can choose from:

- Care providers or healthcare institutions that have a contract with us (contracted care providers or healthcare institutions).
- Care providers or healthcare institutions that do not have a contract with us (non-contracted care providers or healthcare institutions).

4.2 Contracted care providers or healthcare institutions

Do you need care that is covered by the basic insurance? In that case, you can choose to receive care from any care provider or healthcare institution in the Netherlands that has a contract with us. The care provider or healthcare institution 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(s).

Do you want to know with which care providers and healthcare institutions we have a contract? Or what care and/or treatments hospitals or independent treatment centres are contracted to provide? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

Remuneration ceiling

- We agree 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.

- 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.
- We reserve the right to (temporarily) remove certain care providers from the list of contracted care providers in the Medical Provider Search Tool 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 2019 may be removed from the list during the course of the year. So you may find that there is more choice on 1 January 2019 than on 1 December 2019 (for example). It is important to bear this in mind.

4.3 Non-contracted care providers or healthcare institutions

4.3.1 Do you want to receive care from a non-contracted care provider or healthcare institution?

In that case, it may affect the reimbursement tariff. If this is the case, it will say so in the policy conditions under 'OZF Zorgpolis Entitlements and Reimbursements' next to the form of care you are seeking. We reimburse up to 75% of the average contracted rate we pay for this care. 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.

What if we purchased insufficient care and/or a contracted care provider is unable to supply the care on time? In that case, we reimburse the costs of care up to, at the most, the current (maximum) tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). What 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 a maximum of the prevailing market rate in the Netherlands.

Is there a maximum reimbursement for non-contracted care providers based on 75% of the average contracted tariff or the Dutch Healthcare Market Regulation Act tariff? In that case, you will find a list with the amount of these maximum reimbursements on our website. You are also welcome to contact us.

Is there a maximum reimbursement based on market value in the Netherlands? Then you can request an indication of this amount from us.

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

The lower reimbursement tariff for a non-contracted hospital (referred to in article 4.3.1) does not apply in the case of:

- Urgent medical care.
- Obstetric or midwifery care.
- Dental surgery.
- Treatments for which you are referred to another healthcare institution by a specialist treating you (tertiary referral).
- Care that comes under the Dutch Special Medical Procedures Act (Wet op bijzondere medische verrichtingen (Wbmv)).
- Follow-up treatments in the first 4 cases listed above, if the follow-up treatments treat 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)). What 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 a maximum of the prevailing market rate in the Netherlands.

With the exception of urgent medical care, this article does not apply to treatments abroad. See article 3 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Is there a maximum reimbursement for non-contracted care providers based on 75% of the average contracted tariff or the Dutch Healthcare Market Regulation Act tariff? In that case, you will find a list with the amount of these maximum reimbursements on our website. You are also welcome to contact us.

Is there a maximum reimbursement based on market value in the Netherlands? Then you can request an indication of this amount from us.

Please note! After receiving one of these treatments are you starting a new plannable treatment? Then first check the list of contracted hospitals. In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. That way you can avoid possibly having to pay part of the bill yourself.

4.4 Occasionally you will 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 using the agreed method of payment.

4.5 If you need healthcare and/or waiting list mediation services

You are entitled to healthcare and/or waiting list 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. You are also entitled to healthcare mediation services 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 a care provider or healthcare institution.
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 and arrange an appointment for you. We call this waiting list mediation.

Do you want healthcare and/or waiting list mediation services? You can call our Transport Telephone Line (Vervoerslijn) on (071) 364 0 280. Lines are open from 08.00 tot 18.00 on working days.

Article 5 What are your obligations?

5.1 Your obligations are listed below.

Have you harmed our interests by failing to fulfil these obligations? In that case, you are not entitled to (reimbursement of the costs of) care.

5.2 General obligations

Do you wish to receive care and/or reimbursement of the costs of care? In that case you must fulfil the following obligations:

- Are you obtaining care from a hospital or outpatient clinic? In that case, you must present 1 of the following valid documents as proof of identity:
  - Driving licence.
  - Passport.
  - Dutch identity card.
  - Foreign national's document.
- Does our medical adviser want to know why you were admitted? In that case, you must ask your doctor or medical specialist to inform our medical adviser.
- You must provide us with all the information we need. This is for our medical advisers or for people responsible for monitoring or investigation. Naturally, we always comply with the requirements of privacy legislation.
- You must cooperate if we want to recover costs from an accountable third party.
- You are obliged to inform us of (possible) irregularities or fraud by care providers (in claims for example).
- You are obliged to hand over a referral or statement in cases in which this is required. The referral or statement is only valid if it was issued less than 1 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.
- 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

- Are you being detained in custody? In that case, you must inform us within 30 days of being taken into custody to specify when the detention started (date of commencement) and how long it will last.
- Have you been released? In that case, you must notify us of the date on which you were released within 2 months of being released.

5.4 Obligations if you submit invoices yourself

Do you receive invoices from a care provider or healthcare institution? In that case send us the original and clearly specified invoices (keep a copy for your own files). You can do this in 2 ways:

- Online: ozf.nl/declareren.
- By post: Zorgverzekeraar OZF, Claims Service Department, P.O. box 94, 7550 AB Hengelo - NL.

We do not accept copies of invoices, reminders, pro-forma invoices, (cost) estimates or any other such documents. We will only be able to reimburse your care costs if we have an original and clearly specified invoice, issued to the patient or insured person, which notes the treatment code. The treatment codes are established by the Nederlandse Zorgautoriteit (NZa, Dutch Healthcare Authority).

Do you submit invoices online? Then you are obliged to keep the original invoices for a period of 1 year after we receive them. We may ask you to submit these original invoices.

The care provider who treats you must issue invoices in their 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. Any claim you have on us may not be transferred to a third party. 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 reimbursement of the costs of care. In other words, the invoice date, which is the date on which the invoice was drawn up, is not the determining factor.

Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie, (DBC))? In that case, the moment at which the treatment (or DBC) starts determines the right to reimbursement. You must be insured with us on the date on which treatment starts. Do you want to know what applies in your case? Please contact us.

What happens if you submit invoices more than 12 months after the end of thecalendar year in which you were treated? In that case, the reimbursement you receive may be lower than the reimbursement to which you were originally entitled. Are you submitting invoices more than 3 years after the date of treatment and/or the date on which care was provided? Then we will not process these invoices. This is stipulated in 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 1 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 obligation to take out insurance, a change of employer, a change in your bank account number (IBAN), a change of address, 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 (the policyholder).

Please note! Are you moving within the Netherlands? Inform your municipality on time. The Municipal Personal Records Database (Basisregistratie personen (BRP)) is leading for our administration.

Article 6 What is your mandatory excess?

6.1 Are you 18 or older and are you required to pay a premium?

In that case there is a mandatory excess for your basic insurance. The government determines the amount of the mandatory excess. In 2019, the mandatory excess is €385 per insured person per calendar year.

6.2 You pay the first €385 of your healthcare costs yourself

We deduct the mandatory excess from your entitlement to (reimbursement of the costs of) care. These are costs incurred throughout the calendar year which are covered by your basic insurance.
For example: you are admitted to a hospital and the invoice is sent to us. In that case, we reimburse the hospital directly. We then send you (the policyholder) a summary of the claim. The summary informs you of the care that will be deducted from your mandatory (and/or any voluntarily chosen) excess. And the manner in which you choose to pay us the respective amount of excess. This will depend on the agreed method of payment.

Please note! Physiotherapy for a disorder on the by the Dutch Minister of Health, Welfare and Sport (VWS) approved list found in Annex 1 of article '2.6 of the Health Insurance Decree' (Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering) (article 4.1 on pages 22 and 23 of 'OZF Zorgpolis Entitlements and Reimbursements'), is always deducted

from your excess. Do the treatments continue into the following calendar year? Then the treatments in the following calendar year are deducted from your excess for that year.

6.3 There is no mandatory excess for some healthcare costs
We do not deduct mandatory excess from:

- The costs of care or other services incurred in 2019 but for which the invoices are not received until after 31 December 2020.
- The costs of care 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 tariff fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)) for this examination.
- The direct costs of obstetric and/or midwifery care and maternity care.
- 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 tariff stipulated as the availability tariff in the Dutch 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. 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.
- The costs of follow-up examinations of a donor after the period of caring for that donor has expired. This period of care lasts, at the most, 13 weeks, or in the event of a liver transplant, 6 months.
- The donor's transport costs if these costs are reimbursed by the donor's own basic insurance.
- The costs of integrated care claimed in accordance with the policy rule on performance-related funding of the provision of multidisciplinary care for chronic disorders. This policy regulation was established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)).
- The costs of nursing and care normally provided by nurses (in accordance with article 32 of 'OZF Zorgpolis Entitlements and Reimbursements').

6.4 Exemption from the mandatory excess
We have exempted the following costs from the mandatory excess:

- The direct costs of a medication review of chronic use of prescription drugs executed by a pharmacy contracted for this purpose.
- The costs of the Stop smoking programme (in accordance with article 41 of 'OZF Zorgpolis Entitlements and Reimbursements'). This only applies if you purchase the programme from a contracted care provider other than a general practitioner, medical specialist or clinical psychologist.

6.5 Healthcare costs that we do not reimburse do not count towards the mandatory excess
In some cases you pay part of the costs of care to which you are entitled and/or part of the reimbursement of the costs of care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. Or if you are entitled to a lower reimbursement for non-contracted care. These sums are unrelated to the mandatory excess, which means they do not count towards the €385 mandatory excess that we deduct.

6.6 Mandatory excess commences when you reach 18 years of age
Will you be 18 during the course of the calendar year? In that case, your mandatory excess commences on the 1st day of the month that follows the calendar month in which you turn 18. We calculate your mandatory excess based on the number of days you are insured in that calendar year from that day onwards.

6.7 Mandatory excess if your basic insurance commences later
Will your basic insurance commence after 1 January? In that case we calculate your mandatory excess based on the number of days you are insured in that calendar year.

6.8 Mandatory excess if your basic insurance ends earlier
Will your basic insurance end during the course of the calendar year? In that case we calculate your mandatory excess based on the number of days you are actually insured in that calendar year.

6.9 Mandatory excess in the case of a diagnosis-treatment-combination (DBC)
What if treatment is invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? In that case, the moment at which the treatment (or DBC) starts determines the mandatory excess that we have to apply. You can find more information about reimbursements in the case of DBCsin article 5.5 of these General Conditions.

6.10 Deduction of the mandatory excess
Are you receiving care from a contracted care provider, healthcare institution or a care provider with whom we have an agreement? In that case we reimburse the care provider or healthcare institution directly. Is part of your mandatory excess still payable? Then we will subsequently send you (the policyholder) a summary of the claim. The summary informs you of the care that will be deducted from your mandatory (and/or any voluntarily chosen) excess. We can offset the amount you owe against invoices you submit, including those submitted under your personal care allowance (persoonsgebonden budget (PGB)) for nursing and care. We will collect the amount owed by you using the agreed method of payment.

What if you (the policyholder) fail to pay mandatory excess on time? Then we may charge you additional costs, such as administration fees, debt collection costs and statutory interest.

Article 7 What is a voluntarily chosen excess?

7.1 Are you 18 or older? Then you can opt for a voluntarily chosen excess per calendar year
You can opt not to include a voluntarily chosen excess for your basic insurance. Or you can opt to include 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. You can find out how much discount you will receive on our website, ozf.nl/premie. Or you can obtain this information from us.

7.2 Consequence of a voluntarily chosen excess
We deduct the voluntarily chosen excess from your entitlement to (reimbursement of the costs of) care. 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. If, for example, in addition to the mandatory excess, you opt for a voluntarily chosen excess of €500, this means your total excess is €885 (€385 + €500). We pay your care provider €950 for the care you have received. We will subsequently send you (the policyholder) a summary of the claim. The summary informs you of the care that will be deducted from your mandatory (and/or any voluntarily chosen) excess and on the payment method by which you will be required to pay this excess - €885 in this example. This will depend on the agreed method of payment.

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

We do not deduct a voluntarily chosen excess from:

- The costs of care 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 tariff fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)) for this examination.
- The direct costs of obstetric and/or midwifery care and maternity care.
- 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 tariff stipulated as the availability tariff in the Dutch 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. 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.
- The costs of follow-up examinations of a donor after the period of caring for that donor has expired. This period of care lasts, at the most, 13 weeks, or in the event of a liver transplant, 6 months.
- The donor's transport costs if these costs are reimbursed by the donor's own basic insurance.
- The costs of integrated care claimed in accordance with the policy rule on performance-related funding of the provision of multidisciplinary care for chronic disorders. This policy rule was established on the basis of the Dutch Healthcare Market Regulation Act (Wmg).
- The costs of nursing and care normally provided by nurses (in accordance with article 32 of 'OZF Zorgpolis Entitlements and Reimbursements').

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

In some cases you pay part of the costs of care to which you are entitled and/or part of the reimbursement of the costs of care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. Or if you are entitled to a lower reimbursement for non-contracted care. These sums are unrelated to the voluntarily chosen excess, which means they do not count towards your voluntarily chosen excess.

7.5 Voluntarily chosen excess commences when you reach 18 years of age

Will you be 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 become 18 years of age. We calculate your voluntarily chosen excess based on the number of days you are insured in that calendar year from that day onwards.

7.6 Voluntarily chosen excess if your basic insurance commences later

Will your basic insurance commence 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.

7.7 Voluntarily chosen excess if your basic insurance ends earlier

Will your basic insurance end during the course of the calendar year? 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 in the case of a diagnosis-treatment-combination (DBC)

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 determines the voluntarily chosen excess we have to apply. You can find more information about reimbursements in the case of DBCsin article 5.5 of these General Conditions.

7.9 Deduction of a voluntarily chosen excess

Are you receiving care from a contracted care provider, healthcare institution or a care provider with whom we have an agreement? In that case, we reimburse the care provider or healthcare institution directly. Is part of your voluntarily chosen excess still payable? In that case, you will be invoiced for the amount you owe. We can also offset the amount you owe against invoices you submit, including those submitted under your personal care allowance (persoonsgebonden budget (PGB)) for nursing and care. We will collect the amount owed by you using the agreed method of payment. What if you (the policyholder) fail to pay the voluntarily chosen excess on time? Then we may charge you additional costs, such as administration fees, debt collection costs and statutory interest.

7.10 Altering the 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 need to inform us of the change in your voluntarily chosen excess by 31 December at the latest. This alteration notification period is also specified in article 12.5 of these General conditions.

Article 8 What will you have to pay?

8.1 We determine your premium

8.1.1 The amount of your premium

We determine the amount of the premium for your basic insurance. The premium you have to pay is the basic premium, minus any discount for a voluntarily chosen excess and/or any group discount that may apply. We calculate both discounts according to the basis for the premium calculation.

8.1.2 Premium up to the age of 18.

We charge a premium for insured persons aged 18 years or older. Is an insured person about to turn 18? Then you (the policyholder) must pay a premium from the 1st day of the month following the calendar month in which the insured person turns 18.

8.1.3 If you (the policyholder) are no longer part of a group scheme

Are you (the policyholder) no longer part of a group scheme? Then you (the policyholder) are no longer entitled to the discount offered by the scheme.

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 entitlement to (reimbursement of the costs of) care.

Has your basic insurance been terminated prematurely by you (the policyholder) or by us? Then we will refund any premium overpayment. In this case, we assume that a month has 30 days. Have we terminated your insurance due to fraud or deception (see also article 20 of these General conditions)? In that case 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 direct debit:

- Premium.
- Mandatory excess and voluntarily chosen excess.
- Statutory personal contributions.
- Personal contributions.
- Any other amounts you owe us.

What if you (the policyholder) choose to use a method of payment other than direct debit? In that case, you (the policyholder) may have to pay additional costs.

8.4 Prior notice of direct debit collection

We announce the collection of the premium by direct debit on the policy certificate we send you once a year.

Article 9 What happens if you do not pay the premium on time?

9.1 Rules apply to how you pay the premium

If you are required to pay a premium, then you must comply with the applicable rules. This also applies if someone other than you (the policyholder) pays the premium.

9.2 We set off premium arrears and/or excess against reimbursement of the costs of care

Do you (the policyholder) still have to pay premium and/or deductible excess to us? And have you submitted a claim for costs of care that we have yet to pay you (the policyholder)? In that case, we will deduct the overdue premium and/or the deductible excess from the reimbursement. This also applies to the reimbursement of claims submitted under your personal care allowance (persoonsgebonden budget (PGB)) for nursing and care. What if you (the policyholder) fail to pay on time? Then we may charge you (the policyholder) additional costs, such as administration fees, debt collection costs and statutory interest.

9.3 If you (the policyholder) do not comply with the terms of payment

Have you (the policyholder) opted to pay the premium annually or biannually? 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. This will mean that you are no longer entitled to a payment discount.

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

Have we ordered you to pay 1 or more overdue premiums? In that case you (the policyholder) may not cancel the basic insurance until you have paid the premium owed and any additional costs, such as administration fees, debt collection costs and statutory interest. This does not apply if we suspend the cover provided by your basic insurance.

9.5 Exception to article 9.4

Article 9.4 of these General conditions does not apply if we inform you (the policyholder) within 2 weeks that we confirm the cancellation.

Article 10 What happens if you fall behind with your payments?

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

Have we established 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:

- You (the policyholder) authorise us to collect new monthly premiums from you (the policyholder) or a third party by direct debit.
- You (the policyholder) agree to repay us the overdue premiums and health insurance debts in instalments.
- We will not terminate the basic insurance due to the existence of the debts referred to in the 2nd bullet point, nor will we suspend the cover provided by the basic insurance for this reason as long as the payment arrangement continues. This does not apply if you (the policyholder) withdraw the authorisation described in the 1st bullet point, or if you (the policyholder) fail to comply with the payment agreements referred to in the 2nd bullet point.

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 the monthly premium for that person's 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:

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

10.3 Insured person(s) receive(s) copies of information about the payment arrangement

If article 10.2 of these General conditions applies, we send the insured person(s) copies of the documents referred to in articles 10.1, 10.2 and 10.4 that we send 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 (excluding additional costs such as administration fees, debt collection costs and statutory interest)? In that case, we will notify you (the policyholder) and the persons you insure that we intend to report you (the policyholder) to the Central Administration Office (Centraal Administratie Kantoor (CAK)). If you (the policyholder) have not paid your monthly premium for 6 months or more, we will 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 General 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

Do you (the policyholder) disagree with the payment arrears and/or our intention to report you to Centraal Administratie Kantoor (CAK) (Central Administration Office) as described in article 10.4? Then 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 we will notify you (the policyholder) to this effect. If you (the policyholder) disagree with our assessment, then you (the policyholder) can submit the matter to Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) (Health Insurance Complaints and Disputes Board) 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 article 18 of these General conditions regarding complaint handling for more information.

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

Have we established that you (the policyholder) have not paid the monthly premium (excluding additional costs such as administration fees, debt collection costs and statutory interest) for 6 months? Then we will report you (the policyholder) to the Centraal Administratie Kantoor (CAK) (Central Administration Office). From that point on you will no longer pay us a flat-rate premium. Instead the Central Administration Office will impose an administrative premium on you (the policyholder).
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 (the policyholder's) registration with the Central Administration Office (CAK).

We will terminate your (the policyholder's) registration with the Central Administration Office, if, following the intervention of the Central Administration Office, you (the policyholder) have paid the following amounts:

- The outstanding premium(s).
- The amount owed based on invoices for healthcare costs.
- The statutory interest.
- Any debt collection costs that may apply.
- Any litigation costs that may apply.

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

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

We inform you (the policyholder and persons covered by the insurance) and the Centraal Administratie Kantoor (CAK) (Central Administration Office) immediately of the date on which:

- The debts accumulated with regard to the basic insurance were (or will have been) repaid or annulled.
- The debt management scheme for natural persons, as defined in the Dutch Bankruptcy Act (Faillissementswet) becomes applicable to you (the policyholder).
- An agreement was entered into as defined in article 18c, 2nd paragraph, part (d.) of the Dutch 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.

Article 11 What if your premium and/or conditions alter?

11.1 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 If the basis for your premium calculation alters

An alteration in the basis for your premium calculation will not come into force earlier than 6 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 (the policyholder) about the alteration.

11.3 If the conditions, entitlements and/or reimbursements alter

What if alterations in the conditions, entitlements and/or reimbursements are disadvantageous for you as 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 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 (the policyholder) about the alteration.

Article 12 When does your basic insurance commence?

12.1 The date of commencement of the basic insurance appears on the policy certificate

The date of commencement is the day on which we received the application from you (the policyholder) to take out basic insurance. As of the next 1 January, we extend the basic insurance each year automatically. We do this each time for a period of 1 calendar year.

12.2 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? And have you (the policyholder) indicated that you want the basic insurance to commence later than on the day mentioned in article 12.1 of these General 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 will treat the day on which the obligation to take out insurance arose as the date of commencement.

12.4 Insurance can commence retroactively from 1 January for a period of 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 respect we may deviate from the provision of article 925, 1st paragraph, Book 7 of the Dutch Civil Code. The retroactive effect of the basic insurance will also apply if you cancelled your previous insurance because the conditions became less favourable for you. This is stipulated in article 940, 4th 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 need to inform us about the alteration by 31 December at the latest.

12.6 Agreements regarding group discounts
The group discount on the basic insurance also applies to your family.

Article 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. Send us a letter or an email in which you cancel the insurance. You (the policyholder) are not required to state your 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 in the following ways:

- You (the policyholder) can notify us that you wish to cancel your basic insurance by post or email. 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.
- 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.
- Have you (the policyholder) insured someone other than yourself and has that insured person taken out other basic insurance? In that case, you (the policyholder) can send a letter or email to cancel this insurance for the insured person. 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.
- You (the policyholder) may switch from one group basic insurance scheme to another, because you (the policyholder) 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. Cancellation is not applied retroactively but commences on the 1st day of the next month.
- It may also be the case that your participation in group basic insurance through an authority that pays your allowance 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 (the policyholder) will start participating in a group basic insurance because you (the policyholder) 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. Cancellation is not applied retroactively but commences on the 1st 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) in writing of the date on which the insurance ends.

Article 14 In what situations will we cancel your basic insurance?

14.1 In some cases we will cancel your basic insurance:
We will do this:

- Commencing on the day after the day on which you no longer fulfil the registration requirements for basic insurance.
- On the date on which you are no longer insured under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
- If you are a member of the military in active service.
- In the event of proven fraud as described in article 20 of these General conditions.
- In the event of death.
- 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 will inform you about this at least 2 months in advance.
- 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 offset these 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. Did the reimbursements you (the policyholder) received exceed what you (the policyholder) 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 Cancelling if you were registered under article 9a to d incl. of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw))

14.3.1 Has the Central Administration Office (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 (Centraal Administratie Kantoor(CAK)) 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 We are authorised to nullify an insurance contract issued to you in error if it later emerges that you were not, at that moment, obliged to take out insurance. In this matter we depart from article 931, Book 7 of the Dutch Civil Code.

14.3.3 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 would deviate from article 7 of the Dutch Health Insurance Act, unless the 4th paragraph of that article applies. In that case you are able to cancel.

Article 15 What if there is a medical emergency outside the country of residence?

In that case, please call our emergency response centre Eurocross Assistance on +31 71 364 1 282. This telephone number is also printed on your healthcare card. Has there been an admission to a healthcare institution in a foreign country? In that case, please notify Eurocross Assistance by telephone as soon as possible and certainly within 48 hours. The country of residence is the country where you reside for a period of 3 months or longer. Eurocross Assistance can be contacted by telephone 24 hours a day to report admission to a healthcare institution and to seek advice or assistance in an emergency. It also provides payment guarantees in the event of admission to a healthcare institution and maintains contact with you (the insured person), family members and/or the doctors in charge of treatment.
What if a medicine cannot be obtained locally? In that case, Eurocross can send the medicine for you. What if the medical costs exceed the maximum cover provided by this policy? In that case we do not reimburse the costs. What if Eurocross has already paid these medical costs? In that case, the costs shall be deemed to have been paid at the expense of the insured person and you will be deemed to have authorised us to collect the repayment of the uninsured costs by direct debit.

Article 16 Non-liability 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.

Article 17 What should you do if (a) third party/ parties is/are liable?

17.1 Is a third party liable for costs that are a consequence of your illness, accident or injury?
In that case you must provide us, free of charge, with all information required to recover the costs from the person responsible. 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 You are obliged to report
Have you become ill, suffered an accident or sustained an injury in some other way? And did this involve a third party, as referred to in article 17.1 of these General 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 arrangement with third parties without permission
You may not enter into an arrangement that is prejudicial to our rights. You may only (instruct another party to) make an arrangement with a third party, or their insurer, or a person acting on their behalf, if you have received written permission from us.

Article 18 Do you have a complaint?

18.1 Do you disagree with a decision we have made?
Or are you dissatisfied with our services? In that case you can submit your complaint to our Complaints and Disputes 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 or email, by telephone, through our website or by fax. Complaints must be written in Dutch or English. If you write your complaint in another language, you pay any translation costs.

18.2 What will we do with your complaint?
We will send you confirmation of receipt of your complaint within 3 working days of having received your complaint. We will enter the details of your complaint in our complaint registration system. We will send you a detailed response within 10 working days of receipt of your complaint. What if we need more time to look into your complaint? In that case we will notify you to this effect.

18.3 Do you disagree with our response? In that case 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 our Complaints and Disputes Department to request a reassessment by post, email, telephone, through our website or by fax. We will send you confirmation of receipt of your request within 3 working days of having received your request. And we will send you a detailed response within 10 working days of receipt of your reassessment request. What if we need more time to reassess your complaint? In that case, we will notify you to this effect.

18.4 What if our reassessment fails to meet your expectations?
In that case you can submit your complaint to Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) (Health Insurance Complaints and Disputes Board), Postbus 291, 3700 AG Zeist, The Netherlands. You can find information about SKGZ at skgz.nl. SKGZ will be unable to review your complaint if a judicial authority is already examining, or has already ruled on, your case.

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 Nederlandse Zorgautoriteit (NZa) (Dutch Healthcare Authority). If the NZa rules on such a complaint, the ruling is regarded as binding advice.

18.7 This contract is governed by Dutch law.
Would you like more information about how to submit a complaint to us, how we will deal with it and about SKGZ and/or civil court procedures? On our website you will find the brochure 'Klachtenbehandeling' which explains complaint handling procedures (in Dutch). You can also request a copy of this brochure from us.

Article 19 What do we do with your personal details?

19.1 If you apply for insurance or a financial service, we ask you for personal details.
OZF is part of the Achmea Group. Achmea B.V. is responsible for the processing of your data and uses your details:

- To enter into and execute contracts.
- To inform you about and offer you relevant products and/or services provided by companies owned by Achmea B.V.
- To improve products and services.
- To guarantee the safety and integrity of the financial services sector.
- To assess risks.
- To conduct scientific research and perform statistical analysis.
- To maintain relationships.
- To comply with statutory obligations.

When using your personal data we are required to comply with the 'Code of Conduct for the Processing of Personal Data by Health Insurers' (Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars). We process your data in accordance with the requirements of the General Data Protection Regulation (GDPR) and according to any resulting legislation and regulations. The above-mentioned data processing is registered with the Dutch Data Protection Authority (Autoriteit Persoonsgegevens).

19.2 If you do not want to receive information about our products and services

Would you prefer not to receive information about our products and/or services? Or do you want to withdraw your permission for us to use your email address? In that case, you can inform us in writing. Zorgverzekeraar OZF, Customer Privacy Department, P.O. Box 94, 7550 AB Hengelo - NL.

19.3 We refer to the Central Information System when processing applications

To ensure responsible acceptance policy, we are 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. You can find more information at stichtingcis.nl.

19.4 We are allowed to pass your details on to third parties

From the moment 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 Zorginstituut Nederland (National Health Care Institute). We are allowed to do this insofar as is necessary in order 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.

19.5 We register your citizen service number (BSN)

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

19.6 More information about your rights and about how Achmea uses your data

You can find more information in the Privacy Statement published on our website. Here you can find out about the grounds for processing personal data and your rights.

Article 20 What are the consequences of fraud?

20.1 What is fraud?

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

- Under false pretences.
- On improper grounds and/or in an improper way.

In this contract, fraud is specifically defined as 1 or more of the following activities. You are committing fraud if you and/or someone else who has an interest in the entitlement and/or reimbursement:

- Misrepresented the facts.
- Submitted false or misleading documents.
- Made a false statement regarding a claim that has been submitted.
- Concealed facts that could be important for us in assessing a claim that has been submitted.

20.2 No entitlement to reimbursement in the event of fraud

In the event of proven fraud, all entitlement 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:

- Report the matter to the police.
- Cancel your insurance contract(s). In which case you will only be able to take out another insurance contract with us after 5 years.
- Register you in recognised fraud detection systems used by insurers (such as the CIS).
- Reclaim reimbursement(s) that were paid out and (examination) costs that were incurred.

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Definition of terms

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

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

Doctor
A person who is competent to practice medicine under Dutch law 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)).

Doctor specialising in juvenile health care
A doctor practising as referred to in the Dutch Youth Care Act (Wet op de jeugdzorg (Wjz)).

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

Company doctor
A doctor listed as a company doctor in the register 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 acts on behalf of an employer or the Occupational Health and Safety Office ('arbodienst') with which the employer is affiliated.

Pelvic physiotherapist
A physiotherapist 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)) and who is also registered as a pelvic physiotherapist in the pelvic physiotherapy section of the Central Quality Register (Centraal Kwaliteitsregister (CKR)) maintained by Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF) (Royal Dutch Association for Physiotherapy) or with Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Youth Care Agency (Bureau Jeugdzorg)
An agency as referred to in article 10 of the Dutch Youth Care Act (Wet op de jeugdzorg (Wjz)).

Centre for Exceptional Dentistry
A university centre, or a centre that we deem the equivalent thereof, that provides dental care in exceptional cases, whereby treatment requires a team approach and/or exceptional expertise.

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 pharmacist 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, 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)), a self-contained and validated process of specialist medical and/or mental health care (GGZ). This includes (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 person submits a request for care and is completed when treatment ends, or after 120 days in the case of specialist medical care, or 365 days in the case of specialist mental health care (GGZ).

Dietitian
A dietitian who meets the requirements of 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, mental care and (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 country and a member of the EEA
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, the United Kingdom (including Gibraltar) 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:

- The provision of medicines and dietary preparations designated in this insurance contract, and/or
- Advice and guidance 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).

Fraud
Fraud is when someone obtains an entitlement and/or a reimbursement from an insurer or an insurance contract under false pretences and/or on improper grounds and/or in an improper way.

Physiotherapist
A physiotherapist 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)). A physiotherapist also includes a physiotherapeutic masseur as referred to in article 108 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

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.

General Basic GGZ
Diagnosis and treatment of mild to moderate non-complex mental health problems or stable chronic problems. The GGZ Quality Charter specifies who is qualified to act as the specialist in charge of this care. The involvement of a healthcare psychologist, psychiatrist, clinical psychologist, psychotherapist or a nursing specialist (this only applies for the product chronic Basic GGZ (BC) at an institution or practice contracted to provide Basic GGZ) is required.

Geriatric physiotherapist
A geriatric physiotherapist 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)) and who is also registered as a geriatric physiotherapist in the Central Quality Register (Centraal Kwaliteitsregister (CKR)) maintained by Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF) (Royal Dutch Association for Physiotherapy) or with Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Specialist mental health care
Diagnosis and specialist treatment of (very) complex mental health disorders. The GGZ Quality Charter specifies who is qualified to act as the 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 interwovenwith specialised nursing in video communication and pharmaceutical telecare. 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
1 adult, or 2 persons who are married or cohabiting, and their unmarried biological, step, foster or adopted children up to the age of 30, for whom entitlement to child benefits allowance, an allowance based on the Dutch Fees and Educational Expenses (Allowances) Act (Wet tegemoetkoming onderwijsbijdrage en schoolkosten (Wtos)) or special deduction of expenses under tax legislation still exists.

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 (Government Gazette 2002, no. 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.

Care in the form of 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.

IDEA contract
IDEA stands for Integral Cost-effectiveness Contract for Excellent Pharmacies. This is the contract between us and a pharmacy in which specific agreements have been made about pharmaceutical care.

Doctor specialised in juvenile health care
A doctor who is listed as such, with the profile Juvenile healthcare, 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 maintained by 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 Nederlands Instituut van Psychologen (NIP) (Dutch Institute of Psychologists).

Paediatric physiotherapist
A paediatric physiotherapist 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)) and who is also registered in the Central Quality Register (Centraal Kwaliteitsregister (CKR)) or with the Dutch Quality Physiotherapy Certification Foundation (Stichting Keurmerk Fysiotherapie).

Paediatric remedial therapist
A paediatric remedial therapist who is registered as such in accordance with the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and who is also registered in the register designated by Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists) and Zorgverzekeraars Nederland (the Association of Dutch Health Insurers).

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 the 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 meets the requirements of 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
An manual therapist 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)) and who is also registered as a manual therapist in the Central Quality Register for Physiotherapy (Centraal Kwaliteitsregister (CKR)) or with the Dutch Quality Physiotherapy Certification Foundation (Stichting Keurmerk Fysiotherapie).

Medical adviser
A doctor who advises us on medical matters.

Medical specialist
A doctor listed in the Register of Specialists established by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) appointed by Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)) (Royal Dutch Medical Society).

Oral hygienist
An oral hygienist who has been trained in accordance with the training requirements for an oral hygienist, as stipulated in 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 (Government Gazette 1997, no. 553)).

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 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)) and who is also registered as an oedema therapist in the Central Quality Register (Centraal Kwaliteitsregister (CKR)) or with Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Cesar or Mensendieck remedial therapist
A remedial therapist who meets the requirements of the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

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 maintained by Nederlandse Maatschappij tot bevordering der Tandheelkunde (NMT) (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 meets the requirements of 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 (dental) insurance agreed 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 in the Register of Specialists established by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) appointed by 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.

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 who is listed in the Register of Medical Geriatric Specialistsestablished by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) appointed by Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Association).

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, prevent damage to health or possible death. Whether this is the case is determined by Zilveren Kruis and/or Eurocross' medical advisers.

Dentist
A dentist registered as such in accordance with 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).

'Taxe' price
The 'taxe' price of a medicine is the price listed by a supplier in the G-Standaard database (a national price list). The price excludes VAT and applies per purchase unit.

Tertiary referral
Patient referral to another healthcare institution for the original 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 (dental) insurance 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 to a (psychiatric) hospital, a psychiatric department of a hospital, a rehabilitation hospital, or a primary care facility, for a period of 24 hours or more, if and as long as nursing, examination and treatment can only be provided, on medical grounds, in a (rehabilitation) hospital or primary care facility.

Treaty country
Any country other than an EU or EEA member state with which the Netherlands has signed a social security treaty that sets out regulations regarding the provision of medical care. These include Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Montenegro, Serbia, Tunisia and Turkey.

Obstetrician or midwife
An obstetrician or midwife 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)).

Referral/statement
A referral/statement is valid for a maximum of 1 year.

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 Health insurance N.V., OZF's insurer.

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).

Dutch Healthcare Market Regulation Act
Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)).

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

Independent treatment centre
A specialist medical care institution (IMSZ) that provides nursing care, examinations and treatment in accordance with the rules stipulated by or pursuant to the law, and is authorised to do so.

Hospital
An institution for specialist medical healthcare (IMSZ) that provides nursing care, examinations and treatment in accordance with the rules stipulated by or pursuant to the law, and is authorised to do so.

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 Health Insurance Act (Zorgverzekeringswet (Zvw)). For the purposes of the implementation of this insurance contract this is Zilveren Kruis Zorgverzekeringen N.V., which has its registered office in Utrecht registered at the Chamber of Commerce under number 06088185 and with the Netherlands Authority for the Financial Markets (AFM) under number 12000646.

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

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.

Entitlements and Reimbursements - Contents

OZF Zorgpolis

Entitlements and Reimbursements - Contents

OZF Zorgpolis

Entitlements and Reimbursements

OZF Zorgpolis

The care covered by the basic insurance and the conditions that apply are summarised below. Unable to find what you are looking for? Then first refer to the contents page of 'OFZ Zorgpolis Entitlements and Reimbursements' on page 20.

Bones, muscles and joints

Article 1 Occupational therapy

You are entitled to reimbursement of the costs of 10 hours of advice, tuition, training or treatment by an occupational therapist. 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.

Condition for reimbursement

You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to reimbursement of the costs of occupational therapy under the basic insurance.

Sometimes no statement is needed for treatment provided by contracted occupational therapists.

In some cases no statement is needed for reimbursement. This is because we have entered into agreements with a number of contracted occupational therapists about direct access. These occupational therapists can treat you without a statement from the referring doctor. We call this Direct Access Occupational Therapy (Directe Toegang Ergotherapie (DTE)). Use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted occupational therapists who offer DTE.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted occupational therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which occupational therapists we have a contract? In that case use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse surcharges for:

- Appointments outside of regular working hours.
- Missed appointments.
- Simple, brief reports or more complicated, time-consuming reports.

Article 2 Foot care for insured persons with diabetes mellitus

Do you have diabetes mellitus? In that case, you are entitled to foot care.

The nature of the foot care you receive will depend on your care profile. Your care profile is determined by a general practitioner, an internist or a geriatric specialist. The doctor will base the assessment of your care profile on the Simm's score and any other medical risks that may apply.

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. The elements of care to which you are entitled are stipulated in the care module Prevention of Diabetic Foot Ulcers 2014 (Preventie Diabetische Voetulcera 2014).

Care Profile 1 (Zorgprofiel 1):

- 1 podiatric foot inspection by a podiatrist per calendar year.

Care Profile 2 (Zorgprofiel 2):

- 1 podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year.
- Foot inspection appointments, education and encouragement of self-management.
- Preventive foot care designed to prevent the development of ulcers. The podiatrist may delegate the provision of this care to a pedicure qualified to provide it.

Care Profile 3 (Zorgprofiel 3):

- 1 podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year.
- Use of podiatric treatment(s) and a podiatric monitoring consultation with a podiatrist.
- Preventive foot care and, if problems are caused by pressure and chafing, instrumental treatment to minimise the risk of an ulcer. The podiatrist may delegate the provision of this care to a pedicurist qualified to provide it.

Care Profile 4 (Zorgprofiel 4):

- 1 podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year.
- Preventive foot care and, if problems are caused by pressure and chafing, instrumental skin and nail treatment to keep the skin structure intact in order to reduce the risk of an ulcer. The podiatrist may delegate the provision of this care to a pedicure qualified to provide it.
- Use of podiatric treatment(s) and a podiatric monitoring consultation with a podiatrist.

The foot care that we reimburse 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, we refer you to article 39 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Conditions for reimbursement

- We stipulate that the podiatrist must meet the following conditions:
  - The podiatrist must be registered in the Paramedics Quality Register (Kwaliteitsregister Paramedici).
  - The podiatrist may delegate the provision of preventive foot care to a pedicure. The pedicurist works as a subcontractor for the podiatrist. A pedicurist is:
    - A medical pedicurist or a pedicurist with the entry 'foot care for diabetics' (DV) who is registered in the ProCERT Quality Register for Pedicurists (KRP).
    - A paramedical chiropodist, medical pedicurist or pedicurist+ with the entry 'foot care for diabetics' (DV), registered in the paramedical foot care register (Register Paramedische Voetzorg, (RPV)) of the Stipezo trade association (Stichting pedicure in de zorg), category 1 (A+B).
    - A medical foot care provider registered in the KABIZ registry of Medical Foot Care Providers (Quality Registration and Accreditation of Care Professionals).

The podiatrist is the specialist in charge. The podiatrist declares the costs (quarterly) even if the treatments are performed by a pedicurist.
- You need a statement from a general practitioner, internist or geriatric specialist. The statement must specify your care profile. This statement enables us to determine whether you are entitled to foot care under the basic insurance.
- The podiatrist must note the care profile and details of the services provided on the invoice.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

What we do not reimburse according to this article:
- If you have diabetes mellitus and are entitled to reimbursement of the corresponding integrated care, which includes foot care. In that case, you are not entitled to reimbursement of foot inspection and treatment by a podiatrist or pedicurist under this article. In this case, these foot care treatments are covered by the entitlement within integrated care (see article 40 of 'OZF Zorgpolis Entitlements and Reimbursements').
- 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). These regulations can be found on our website or obtained from us. Podiatric insoles and orthoses are reimbursed under AV Royaal supplementary insurance under certain conditions: see article 7 of 'Reimbursements covered by supplementary insurance policies'.
- Foot care (treatment by a pedicurist) if you do not have a care profile or if you have Care Profile 1 (Zorgprofiel 1). Do you have Care Profile 1 (Zorgprofiel 1)? Then foot care is reimbursed under AV Royaal supplementary insurance under certain conditions: see article 3 of 'Reimbursements covered by supplementary insurance policies'.
- Foot screening by a general practitioner. Foot screening by a general practitioner falls under general practitioner care (see article 39 of 'OZF Zorgpolis Entitlements and Reimbursements').

Abroad

Article 3 When are you entitled to (reimbursement of) medical treatment abroad?

3.1 Are you receiving care in a treaty country, EU country or EEA country?

In that case you can choose from entitlement to:
- 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.
- Care and/or reimbursement of the costs of care given by a contracted care provider or healthcare institutionabroad.
- Reimbursement of the costs of care provided by a non-contracted care provider or healthcare institution. In that case, you are entitled to reimbursement in accordance with 'OZF Zorgpolis Entitlements and Reimbursements' up to a maximum of:
  - The lower reimbursement if it is mentioned next to an entitlement in the OZF Zorgpolis insurance.
  - 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.

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

Do you receive 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 given by a non-contracted care provider or healthcare institution in accordance with 'OZF Zorgpolis Entitlements and Reimbursements' up to a maximum of:
- The lower reimbursement if it is mentioned next to an entitlement in the OZF Zorgpolis insurance.
- 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.

3.3 Conversion rate of foreign currencies

Reimbursement of the costs of care given by a non-contracted care provider or healthcare institution 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 applies 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.

3.4 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.

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.

Physiotherapy and Cesar or Mensendieck remedial therapy

Article 4 Physiotherapy and Cesar or Mensendieck remedial therapy

We reimburse the costs of physiotherapy and Cesar or Mensendieck remedial therapy The following is a summary of the care involved and the conditions that apply for reimbursement.

4.1 Physiotherapy and/or Cesar or Mensendieck remedial therapy for insured persons aged 18 or older

Are you 18 or older? In that case, we reimburse (per condition) the costs of the 21st and subsequent treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. This must involve a disorder that appears on the 'Annex 1 relating to article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering') list approved by the Minister of Health, Welfare and Sport (VWS). The list, which is drawn up by the Minister of Health, Welfare

and Sport, also specifies a maximum treatment period for a number of disorders.

Please note! The first 20 treatment sessions are not reimbursed under the basic insurance. Do you have AV Royaal insurance? In that case, we reimburse the first 20 treatment sessions under AV Royaal. Do you have AV Compact insurance? In that case, we reimburse a maximum of 12 of the 20 treatments through AV Compact. In other words, you are responsible for paying for treatment sessions 13 to 20. See article 11.1 of 'Reimbursements covered by supplementary insurance policies'.

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

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

Conditions for reimbursement

- Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to reimbursement of the costs of physiotherapy and Cesar or Mensendieck remedial therapy under the basic insurance.
- Are you receiving specialist physiotherapy or remedial therapy? In that case, we only reimburse the costs if the therapist is registered in the corresponding section of the Central Quality Register (Centraal Kwaliteitsregister (CKR)), or with the Quality Physiotherapy Certification Foundation (Stichting Keurmerk Fysiotherapie), or in the subspecialisation register maintained by Association of Cesar and Mensendieck Remedial Therapists (Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM)). By 'specialist physiotherapy or remedial therapy' we mean:
  - Paediatric physiotherapy.
  - Pelvic physiotherapy.
  - Manual therapy.
  - Oedema therapy.
  - Geriatric physiotherapy.
  - Paediatric remedial therapy.

  Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
- 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 (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted physiotherapist, remedial therapist or skin therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which physiotherapists, Cesar or Mensendieck remedial therapists and skin therapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse:

- The first 20 treatment sessions, per disorder. Do treatments for this disorder continue into the following calendar year? In that case, the treatment sessions for the condition received the previous year count towards the first 20 treatment sessions which we do not reimburse. Under certain conditions these treatments may be (partially) reimbursed under AV Compact or AV Royaal: see article 11.1 of 'Reimbursements covered by supplementary insurance policies'.
- Individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training.
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.

4.2 Physiotherapy and Cesar or 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 is included in the 'Annex 1 of article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering') list approved by the Dutch Minister of Health, Welfare and Sport (VWS)? In that case, we reimburse all treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. The list, which is drawn up by the Minister of Health, Welfare and Sport, also specifies a maximum treatment period for a number of disorders.

Do you need manual lymph drainage because you suffer from severe lymphatic oedema? 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, we reimburse the costs of 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, we reimburse a maximum of 9 extra treatments. This only applies if the extra treatments are medically necessary. In other words, we reimburse a maximum of 18 treatments for insured persons up to the age of 18.

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

Conditions for reimbursement

- Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to reimbursement of the costs of physiotherapy and Cesar or Mensendieck remedial therapy under the basic insurance.
- Are you receiving specialist physiotherapy or remedial therapy? In that case, we only reimburse the costs if the therapist is registered in the corresponding section of the Central Quality Register (Centraal Kwaliteitsregister (CKR)), with the Quality Physiotherapy Certification Foundation (Stichting Keurmerk Fysiotherapie), or in the subspecialisation register maintained by the Association of Cesar and Mensendieck Remedial Therapists (Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM)). By 'specialist physiotherapy or remedial therapy' we mean:

- Paediatric physiotherapy.
- Pelvic physiotherapy.
- Manual therapy.
- Oedema therapy.
- Geriatric physiotherapy.
- Paediatric remedial therapy.

Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

- 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 (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

In some cases, no statement is needed from the referring doctor for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists. These physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a referral. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Remedial Therapy (Directe Toegang Oefentherapie (DTO)). Use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted care providers who offer DTF or DTO. You are also welcome to contact us.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted physiotherapist, Cesar or Mensendieck remedial therapist or skin therapist? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which physiotherapists, Cesar or Mensendieck remedial therapists and skin therapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse:

- Individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training.
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.

4.3 Pelvic physiotherapy 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, we reimburse, once per indication, the costs of the first9 treatments by a pelvic physiotherapist.

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

Conditions for reimbursement

- Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to reimbursement of the costs of pelvic physiotherapy under the basic insurance.
- Are you receiving pelvic physiotherapy to treat urinary incontinence? In that case, we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register), or with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation). Do you want to know which pelvic physiotherapists provide specialist care that qualifies for reimbursement? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted pelvic physiotherapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which pelvic physiotherapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse:

- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Dressings, bandages and medical devices supplied by your pelvic physiotherapist.

4.4 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? And do you want to treat it with remedial therapy supervised by a physiotherapist? In that case you are entitled to a maximum of 37 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.

Condition for reimbursement

Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to supervised remedial therapy for stage II intermittent claudication (restricted blood supply to the legs) under the basic insurance.

What we do not reimburse

We do not reimburse:

- Remedial therapy for restricted blood supply to the legs caused by stage III intermittent claudication. In that case, you may be entitled to physiotherapy or remedial therapy under article 4.1 of 'OZF Zorgpolis Entitlements and Reimbursements'.
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Dressings, bandages and medical devices supplied by your pelvic physiotherapist.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted occupational therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

4.5 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 a maximum of 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.

Condition for reimbursement
Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to supervised remedial therapy treatments for osteoarthritis of the hip or knee joint under the basic insurance.

What we do not reimburse
We do not reimburse:
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Dressings, bandages and medical devices supplied by your pelvic physiotherapist.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists
In some cases, no statement is needed from the referring doctor for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists. These physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a referral. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Remedial Therapy (Directe Toegang Oefentherapie (DTO)). Use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted care providers who offer DTF or DTO. You are also welcome to contact us.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

4.6 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 a maximum of the following in the first twelve months:
- 5 supervised remedial therapy treatments for class A.
- 27 supervised remedial therapy treatments for class B.
- 70 supervised remedial therapy treatments for classes 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 B.
- 52 supervised remedial therapy treatments per 12 months for classes C and D

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

Conditions for reimbursement
Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to supervised remedial therapy treatment for COPD under the basic insurance.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists
In some cases, no statement is needed from the referring doctor for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists. These physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a referral. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Remedial Therapy (Directe Toegang Oefentherapie (DTO)). Use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted care providers who offer DTF or DTO. You are also welcome to contact us.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted physiotherapist, remedial therapist or skin therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
We do not reimburse:
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.

Medical devices

Article 5 Medical devices

We reimburse:

- The supply of functioning medical devices and dressings for personal use (not on loan).
  Please note! A statutory personal contribution or a statutory maximum reimbursement sometimes applies for a medical device.
- Alteration, replacement or repair of medical devices.
- Spare medical devices.

Conditions for reimbursement

More detailed conditions for reimbursement of medical devices are specified in the Medical Devices Regulations (Achmea Reglement Hulpmiddelen). These regulations form an integral part of this policy. These regulations 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 always have to ask for our prior permission when non-contracted suppliers are involved. 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 respect we deviate from article 2.1 of the 'OZF Zorgpolis General conditions'.

Lower reimbursement for a non-contracted supplier

Are your medical devices supplied by a non-contracted supplier? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted suppliers).
Do you want to know which suppliers we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

Do you need a medical device that forms part of specialist medical care? In that case, the costs are not reimbursed under this article. These medical devices fall under article 26 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Medicines and dietary preparations

Article 6 Pharmaceutical care: medicines and dietary preparations

Pharmaceutical care is defined as:

- Medicines and dietary preparations covered by your insurance contract dispensed to you.
- Advice and guidance normally provided by pharmacists when performing a medication review and informing you of the responsible use of medicines and dietary preparations designated in this insurance contract.

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

We reimburse the costs of the dispensing of and the provision of advice and guidance on:

- All medicines designated for reimbursement by ministerial decree that are included in the GVS. 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. Medicines must be dispensed and advice and guidance must be provided by a pharmacy that has an IDEA contract with us.
- 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). Medicines must be dispensed and advice and guidance must be provided by a pharmacy that has a preferential policy contract with us or a pharmacy that does not have a contract with us.
- Medicines other than registered medicines that may be supplied in the Netherlands according to the 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 you or for your basic insurance. This definition of rational pharmacotherapy includes:
  - Medicines prepared on a small scale in a pharmacy by or under the orders of the pharmacist.
  - Medicines prepared in the Netherlands by a manufacturer, as defined in article 1, paragraph 1, subclause (mm.), of the Dutch Medicines Act (Geneesmiddelenwet), in accordance with article 40, paragraph 3, subclause (c.), of the Act at the request of a doctor as referred to in that provision.
  - Medicines marketed in another member state, or in a third country, in accordance with article 40, paragraph 3, subclause (c.), of the Dutch Medicines Act (Geneesmiddelenwet), and imported into the territory of the Netherlands at the request of a doctor as referred to in that provision. 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.
- Polymer, oligomer, monomer and modular dietary preparations.

Statutory personal contributions

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 medicines has a limit of €250 per person per 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. You can of course also obtain this information from us.

Conditions for reimbursement of medicines and dietary preparations

- 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).

- The medicines must be dispensed by a pharmacy. Dietary preparations may also be supplied by other specialised medical suppliers.
- Are there identical interchangeable medicines? In that case, we only reimburse medicines designated by us, or in the case of a pharmacy with an IDEA contract, the medication designated by the pharmacy. Is there no designated medicine? Then you are entitled to the cheapest medicine. Your pharmacist can tell you which medicine is the cheapest. You are only entitled to a non-designated medicine or a more expensive medicine in the event of a medical emergency. The prescriber (see the 1st bullet point below) must state on the prescription that the medicine is medically indicated and must be able to substantiate this. More information about this can be found in the list of definitions in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).
- You are only entitled to reimbursement of dietary preparations if:
  - You have a condition that requires the use of these preparations as an essential part of adequate healthcare.
  - Your health problems cannot be managed with an adjusted normal diet and/or dietary products.
  - 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. This can also occur during the current calendar year. You can find the latest version of Annex 2 (Bijlage 2) (with the conditions for reimbursement) online at http://wetten.overheid.nl. Type 'Regeling zorgverzekering' (Health Insurance Regulations) in the search box, click on 'Zoeken' (Search). Click on 'Regeling zorgverzekering', then click on Bijlage 2 (Annex 2) in the list.
  - If they are prescribed by a doctor or a dietitian.

Additional provisions that apply for reimbursement of specific medicines are listed in article 4.4 of the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). The costs of these medicines are only reimbursed if these additional conditions are met.

Conditions for reimbursement of (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. We only reimburse the costs of these (partial) provisions if these supplementary requirements are met. The (partial) provisions to which these conditions apply are listed in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).

Lower reimbursement for a non-contracted pharmacy

Are you receiving pharmaceutical care from a non-contracted pharmacy? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers). Do you want to know which pharmacies we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Please note! Application of the mandatory excess in the case of the fitting of a coil for insured persons aged 18 to 21 years: If the coil is fitted by a gynaecologist, both the fitting of the coil and the coil itself are reimbursed by the basic insurance. It is possible that excess will be deducted. 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. You are not required to pay an excess if the coil is fitted by a general practitioner or obstetrician.

What we do not reimburse

We do not reimburse the following medicines and/or (partial) pharmaceutical provisions:

- Contraceptives for insured persons aged 21 or older, unless there is a medical indication of: endometriosis or menorrhagia (abnormally heavy menstrual periods).
- Medicines and/or advice intended to prevent an illness while travelling abroad.
- Pharmaceutical care that we are not permitted to reimburse under the Health Insurance Regulations (Regeling zorgverzekering).
- Investigational medicinal products listed in article 40, paragraph 3, subclause (b.) of the Dutch Medicines Act (Geneesmiddelenwet).
- Medicines listed in article 40, paragraph 3, subclause (f.) of the Dutch Medicines Act (Geneesmiddelenwet).
- Medicines that are (almost) the therapeutic equivalent of a non-designated, registered medicine.
- Non-prescription drugs not listed in the Health Insurance Regulations (Regeling zorgverzekering). Non-prescription drugs are medicines that you can purchase without a prescription.
- All (partial) pharmaceutical provisions that are not regarded as insured care. All (partial) pharmaceutical provisions are described in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).
- Homeopathic, anthroposophic and/or other alternative medicines and remedies.
- Non-registered allergens, unless treatment with a registered product is not possible. In that case, you can request authorisation for reimbursement of a non-registered allergen. We only reimburse on the basis of authorisation issued by us and on an individual basis.

Oral health care and dentistry

We reimburse necessary dental care such as that normally provided by dentists, clinical dental technicians, dental surgeons, oral hygienists and orthodontists. The dental care to which this applies is described in detail in articles 7 to 14.

Article 7 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 we reimburse the costs of this treatment.

Please note! Orthodontic care is not covered by basic insurance in other cases. Insured persons up to the age of 18 can take out Tand Royaal insurance for orthodontic care: see article 52 of 'Reimbursements covered by supplementary insurance policies'. Orthodontic care in Tand Royaal has a 12-month waiting period.

Conditions for reimbursement

- The treatment must be carried out by an orthodontist or at a Centre for Exceptional Dentistry.
- Are you being treated at a Centre for Exceptional Dentistry? In that case you must be referred by your dentist, dental specialist or general practitioner.
- This treatment requires joint diagnosis or the involvement of other disciplines in addition to dental disciplines.
- 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.
  The treatment plan, cost estimate and X-rays will be prepared by your care provider. We will then assess the appropriateness and legitimacy of your request.

What we do not reimburse

- The repair or replacement of an existing orthodontic device if you lose or damage it through your own fault or negligence.
- Category 0 orthodontics (braces) (Myobracetrainers).
- Category 7 orthodontics (braces) (vacuum-formed orthodontics, aligners).

Article 8 Front tooth replacement for insured persons up to the age of 23

Are you missing 1 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.

Conditions for reimbursement

- The treatment must be carried out by a dentist or dental surgeon.
- Are you being treated by a dental surgeon? In that case, you need a referral from your dentist or dental specialist.
- We must give you permission 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 or dental surgeon.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Do you want to use a non-contracted dental surgeon? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted dental surgeons).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 9 Dental care for insured persons up to the age of 18 years

Are you under the age of 18? In that case, we reimburse the following dental treatments:

- 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.
- An occasional dental consultation.
- The removal of scale.
- A maximum of 2 fluoride treatments a year, from the moment permanent teeth appear. Are you reliant on this dental care more than twice a year? In that case, we must give you permission in advance.
- Sealing of ridges in molars.
- Periodontal care (treatment of gums).
- Anaesthesia.
- Endodontic care (root canal therapy).
- Repair of dental elements with plastic materials (fillings).
- Gnathological care (treatment of jaw problems).
- Removable dentures (metal frame dentures, partial (plate) dentures or full dentures).
- Surgical dental care. This care does not include the fitting of dental implants.
- X-rays, with the exception of X-rays performed as part of orthodontic care.

Conditions for reimbursement

- The treatment must be carried out by a dentist, dental surgeon, oral hygienist or clinical dental technician. This person must be competent and qualified to carry out the treatment involved.
- Are you being treated by a dental surgeon? In that case you need a referral from your dentist, dental specialist or a general practitioner.
- We only reimburse the costs of the fitting of bone anchors as part of orthodontic care provided in exceptional cases (see Article 7 of the 'OZF Zorgpolis Entitlements and Reimbursements '). We must give you permission in advance.
- Do you need care as described in articles 7, 8, 13 or 14 of 'OZF Zorgpolis Entitlements and Reimbursements'? In that case, we will give you permission in advance. You can read more about this in the respective articles.
- We must give you permission in advance for an X-ray of the whole jaw (code X21). Your care provider can request permission from us on your behalf. We will then assess the appropriateness and legitimacy of the request.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Do you want to use a non-contracted dental surgeon? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

- Non-restorative caries treatment in the deciduous teeth (M05).
- Orthodontic treatment. Under certain conditions orthodontic treatment may be reimbursed under article 7 of 'OZF Zorgpolis Entitlements and Reimbursements'. Or, for insured persons up to the age of 18, under Tand Royaal: see article 52 of 'Reimbursements covered by dental insurance policies'. Reimbursement of orthodontics is subject to a 12-month waiting period from the effective date of Tand Royaal.
- Implants. Under certain conditions, implants may be reimbursed under article 12 or article 14 of 'OZF Zorgpolis Entitlements and Reimbursements'. Or under Tand Royaal: see article 51 of 'Reimbursements covered by dental insurance policies'. For Tand Royaal you have to undergo a medical assessment.

Article 10 Dental care for insured persons aged 18 or older - dental surgery

We reimburse dental surgery that is of a specialist nature, and the X-rays involved,, where necessary in combination with a stay in hospital.

Are you being treated by a dental surgeon? In that case, you are also entitled to nursing and/or stay if these forms of care are necessary. See article 26 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Conditions for reimbursement

- The treatment must be performed by a dental surgeon.
- You must be referred by a general practitioner, a dentist, an orthodontist, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor who specialises in juvenile health care or another medical specialist. A clinical dental technician may only refer you if he or she suspects pathology in a toothless jaw.
- We must give you permission in advance for the following treatments:
  - Extraction (removal of teeth or molars) under anaesthesia.
  - Correction of the jaw combined with an extraction.
  - Osteotomy (jaw surgery).
  - Chin plastic surgery as an independent procedure.
  - Pre- and post- implant surgery (bone reconstruction).
  - Placing bone anchors for orthodontic treatment.
  - Plastic surgery.

Have you requested permission for dental treatment? In that case, we will assess the cost-effectiveness and legitimacy of your request.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Do you want to use a non-contracted dental surgeon? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse:

- Periodontal surgery.
- Implants. Under certain conditions, implants may be reimbursed under article 12 or article 14 of 'OZF Zorgpolis Entitlements and Reimbursements'. Or under Tand Royaal: see article 51 of 'Reimbursements covered by dental insurance policies'. For Tand Royaal you have to undergo a medical assessment.
- An uncomplicated extraction (removal of a tooth or molar).

Article 11 Dental treatment for insured persons aged 18 or older - full set of (implant-retained) removable dentures (false teeth)

Are you 18 or older? Then we reimburse the making, fitting, repair and rebasing of following dentures:

- A full set of removable dentures for the upper and/or lower jaw.
- A full set of removable initial dentures.
- A replacement set of full removable dentures.
- A full set of removable overdentures on natural elements.
- A full set of upper and/or lower implant-retained (click-tight) dentures (false teeth) and attachment materials (such as press studs and rods).

A statutory personal contribution of 25% applies for the dentures described in the first 4 bullet points. A statutory personal contribution of 8% for the upper jaw and 10% for the lower jaw applies for the implant-retained denture and attachment materials (press studs and rod) (5th bullet point). A statutory personal contribution of 17% applies for a combination of an implant-retained denture for one jaw and a non-implant-retained denture for the other jaw (code J50).

Are you having a full set of initial dentures, an existing full set of removable dentures or overdentures, or an implant-retained denture repaired or rebased? Then a statutory personal contribution of 10% applies. We do not reimburse this statutory personal contribution under 'Reimbursements covered by dental insurance policies'.

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 reimbursement

- The treatment must be performed by a dentist or clinical dental technician or at a Centre for Exceptional Dentistry.
- Are you being treated at a Centre for Exceptional Dentistry? In that case, your dentist, dental specialist, clinical dental technician or general practitioner must have referred you. A clinical dental technician can only refer you to a Centre for Exceptional Dentistry if you have a set of removable full denture for both the upper and lower jaw.
- Does a full upper and/or lower denture, a replacement set of full removable dentures, or a full set of overdentures need to be replaced within 5 years? Or does an initial denture need to be replaced within 6 months? In that case, we must give you permission in advance. We will assess the appropriateness and legitimacy of your request.
- We apply maximum amounts for the costs of dental technician services and materials. These maximum amounts can be found on our website or obtained from us. 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.
- Are you having a new full set of upper and/or lower implant-retained (click-tight) dentures (false teeth) and/or 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 necessary for the repair and rebasing of a full set of removable implant-retained dentures that are more than 5 years old.
- We reimburse repairs to a full set of removable dentures for the upper and/or lower jaw, a full set of removable initial dentures or a replacement set of full removable dentures by a clinical dental technician if no oral treatment is required. This applies to the extraoral repair of a crack or simple break in the dentures such that the parts of the dentures fit together easily. Or the extraoral attachment of a tooth or molar to the denture.

What we do not reimburse

We do not reimburse materials that serve to attach the full set of removable overdentures to natural elements (your own tooth roots).

Article 12 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 without the disorder or deformity without the fitting of implants? And do you have a severely shrunken, toothless jaw? In that case, we reimburse the dental implants needed for a full set of removable dentures (click-tight dentures), including the press studs or rod (the click-on system attached to the implants). You must have a severely shrunken, toothless jaw and the implants you have fitted must be used to retain the removable dentures (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 reimbursement

- The treatment must be carried out by a dentist, dental surgeon or at a Centre for Exceptional Dentistry.
- Are you being treated at a Centre for Exceptional Dentistry or by a dental surgeon? In that case, you must be referred by your dentist or dental implantologist. A clinical dental technician may only refer you to a dentist or dental implantologist.
- We must give you permission in advance for this 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 a reimbursement of implants under article 14 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon
Do you want to use a non-contracted dental surgeon? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 13 Dental care for insured persons with a handicap

Do you have a non-dental physical and/or mental handicap? And are you unable to retain or attain a dental function equivalent to the dental function you would have without the physical and/or mental handicap without dental care? In that case, you are entitled to the reimbursement of dental care.

Conditions for reimbursement
- The treatment must be carried out by a dentist, oral hygienist, clinical dental technician, orthodontist, dental surgeon or at a Centre for Exceptional Dentistry.
- Are you being treated at a Centre for Exceptional Dentistry? Or are you being treated by a dental surgeon? In that case, you must be referred by your dentist, dental specialist or general practitioner.
- 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)).
- We must give you permission in advance for this treatment. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays.
  The treatment plan, cost estimate and x-rays will be prepared by your care provider. We will then assess the appropriateness and legitimacy of your request.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon
Do you want to use a non-contracted dental surgeon? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 14 Dental care in exceptional cases

In the following exceptional cases you are entitled to dental treatment:
- 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 without dental care, you would be unable to retain or attain a dental function equivalent to the dental function you would have had without the medical condition.
- If, without the dental care, medical treatment would have demonstrably insufficient results. And if without the (additional) dental care you would be unable to retain or attain a dental function equivalent to the dental function you would have had without the medical condition.
- If you suffer from extreme anxiety about dental treatment, according to the validated anxiety scales as described in Centre for Exceptional Dentistry guidelines.

Insofar as the care involved is not directly related to an indication requiring exceptional dental treatment, insured persons aged 18 or older pay a contribution equal to the amount they would be charged if this article did not apply. For instance, do you go to a dentist who specialises in treating anxious patients? 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 reimbursement
- The treatment must be carried out by a dentist, oral hygienist, orthodontist, dental surgeon or a Centre for Exceptional Dentistry.
- Are you being treated at a Centre for Exceptional Dentistry? Or are you being treated by a dental surgeon? In that case, your dentist, dental specialist, clinical dental technician or general practitioner must have referred you. A clinical dental technician can only refer you to a Centre for Exceptional Dentistry if you have a set of removable full denture for both the upper and lower jaw.
- We must give you permission in advance. When requesting our permission, you must also submit a treatment plan and a cost estimate. 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.
- Treatments performed under anaesthetic or nitrous oxide are only reimbursed as a last resort in an anxiety management process. The treatment performed under anaesthetic 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. We must give you permission for the treatment in advance. We assess entitlement to reimbursement each time the treatment is requested.

Please note! You may also be entitled to a reimbursement of implants under article 12 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon
Do you want to use a non-contracted dental surgeon? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dental surgeons we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Eyes and ears

Article 15 Audiology centre

15.1 Hearing problems
Do you have hearing problems? In that case, you are entitled to reimbursement of care in an audiology centre. This care means that the centre:
- Examines your hearing function.
- Advises you about hearing aids you may need to purchase.
- Provides you with information about using any aids.
- Provides you with psychosocial care if this is necessary for your hearing problem.

Condition for reimbursement
You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in juvenile health care, a paediatrician, an ENT specialist or a hearing-aid specialist.

Lower reimbursement for a non-contracted audiology centre
Do you want to use a non-contracted audiology centre? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which audiology centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

15.2 Speech and language disorders in children
Does your child have a speech or language disorder? Then an audiology centre can help make a diagnosis.

Condition for reimbursement
Your child must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in juvenile health care, a paediatrician, an ENT specialist or a hearing-aid specialist.

Lower reimbursement for a non-contracted audiology centre
Do you want to use a non-contracted audiology centre? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which audiology centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 16 Sensory disability care

We reimburse sensory impairment care (zintuiglijke gehandicaptenzorg (ZG)). This is multidisciplinary care that focuses on learning to cope with the overcoming of or compensation for the limitation. This care is designed to enable you to function as independently as possible.

You are eligible for this care if you:
- Have a hearing impairment (you are deaf or hearing impaired).
- Have a visual impairment (you are blind or visually impaired).
- 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.

The multidisciplinary care consists of:
- Action-oriented diagnostics.
- Interventions that help a person learn mental strategies for coping with the disability.
- Interventions that overcome or compensate for the disability and therefore increase self-reliance (the ability to cope independently).

In the case of hearing and communication impairments, the healthcare 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 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 reimbursement
- In the case of hearing and communication impairment, you must be referred by a medical physicist audiologist who works at an audiology centre or a medical specialist.
- In the case of visual impairment, you must be referred by an ophthalmologist or another medical specialist.

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, but there has been a change in the medical or personal situation that necessitates further treatment under your basic insurance.
- The sensory impairment care provider has established that the care need(s) can be met within Care Programme 11*.
- The sensory impairment care provider notifies the general practitioner in writing of the process that has been followed. The general practitioner adds the information to the patient's medical file.

* Care Programme 11: Among other things, this care programme enables 'fast-track' admission for people who have received treatment and/or training in the past who need further treatment or training. It is also for adults who are (for the first time) confronted 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 1 or 2 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.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
We do not reimburse:
- Elements of care designed to support social functioning.
- Complex, lifelong and life-wide support for deaf and blind adults and prelingually deaf adults (who became deaf or hard of hearing before the age of 3).

Psychological care

Article 17 General basic mental health care for insured persons aged 18 or older

Do you have mild to moderate non-complex mental health problems or stable chronic problems? In that case, we reimburse the costs of general basic mental health care (hereafter referred to as 'Basic GGZ').

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

Conditions for reimbursement

- You are 18 or older.
- You must be referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped or a doctor who specialises in emergency medicine. The referral must comply with the 'Mental Health Referral Agreements' (‘Afspraken verwijzing Geestelijke gezondheidszorg’) established by the Dutch Minister of Health, Welfare and Sport (VWS). A referral is valid for a maximum of 9 months. This means that your treatment must commence within 9 months of the date on which the referral is issued. What if it is more than 9 months since the referral was issued? Then you must ask for another referral.
- Your care provider must have a quality charter registered with ggzkwaliteitsstatuut.nl. You can request a copy of the quality charter or view it on your care provider's website.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers or institutions we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

Among other things, we do not reimburse:

- Treatment of adjustment disorders.
- Assistance with work-related and relationship problems.
- Assistance with psychiatric complaints that do not involve a mental disorder.
- Basic GGZ care for insured persons up to the age of 18. This falls under the Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of other problems and diagnoses not treated under basic insurance, and psychological interventions to which you are not entitled under basic insurance, can be found at ozf.nl/ggz.

Please note! The doctor treating you can only arrange 1 Basis GGZ service for you per year. The doctor treating you may only arrange a second Basis GGZ service for you within the same year if you suffer a relapse or if, counter to expectations, you return with the same or other symptoms after the previous treatment has been completed.

Article 18 Non-clinical specialist mental health care for insured persons aged 18 or older (secondary mental health care)

Do you suffer from a complex mental disorder? Then we reimburse the costs of specialist mental health care.

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

Conditions for reimbursement

- You are 18 or older.
- You must be referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped or a doctor who specialises in emergency medicine. The referral must comply with the 'Mental Health Referral Agreements' (‘Afspraken verwijzing Geestelijke gezondheidszorg’) established by the Dutch Minister of Health, Welfare and Sport (VWS).
- A referral is valid for a maximum of 9 months. This means that your treatment must commence within 9 months of the date on which the referral is issued. What if it is more than 9 months since the referral was issued? Then you must ask for another referral.
- Your care provider must have a quality charter registered with ggzkwaliteitsstatuut.nl. You can request a copy of the quality charter or view it on your care provider's website.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers and institutions we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse:

- Treatment of adjustment disorders.
- Assistance with work-related and relationship problems.
- Assistance with psychiatric complaints that do not involve a mental disorder.
- Non-clinical specialist medical care for insured persons up to the age of 18. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of other problems and diagnoses not treated under basic insurance, and psychological interventions to which you are not entitled under basic insurance can be found at ozf.nl/ggz.

Article 19 Stay in a psychiatric hospital for insured persons aged 18 or older

Have you been admitted to a GGZ institution, such as a psychiatric hospital, a psychiatric university clinic or the psychiatric ward of a hospital? In that case we reimburse In these policy conditions:

- Specialist mental health care in accordance with article 18 of 'OZF Zorgpolis Entitlements and Reimbursements'.
- Your stay with or without nursing and care.
- Paramedical care, medicines, medical devices, dressings and bandages that are part of your treatment during your stay.

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

How many days stay with treatment do we reimburse?

In the case of a psychiatric stay with treatment, we reimburse an uninterrupted stay in a GGZ institution for a period of up to 1,095 days. The following forms of admission also count towards the calculation of the 1,095 days:

- Stay in a rehabilitation centre or a hospital for the purpose of rehabilitation.
- A stay in a non-psychiatric hospital.
- 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 do count these days when calculating the 1,095 days.

Conditions for reimbursement
- You are 18 or older.
- You have been referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped or a doctor who specialises in emergency medicine. The referral must comply with the most recent national agreements regarding cooperation between mental health services.
- A referral is valid for a maximum of 9 months. This means that your treatment must commence within 9 months of the date on which the referral is issued. What if it is more than 9 months since the referral was issued? Then you must ask for another referral.
- The stay must be medically necessary for the purpose of medical care.
- Your care provider must have a quality charter registered with ggzkwaliteitsstatuut.nl. You can request a copy of the quality charter or view it on your care provider's website.

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. Your care provider must use the 'Request Authorisation non-contracted clinical GGZ' ('Aanvraag machtiging niet-gecontracteerde klinische GGZ') form to apply for approval. This form can be found on our website. The following must be sent with the application:
- Referral letter (from a general practitioner, company doctor, medical specialist, geriatric specialist, doctor, a doctor who specialises in treating the mentally handicapped, or a doctor who specialises in emergency medicine).
- Treatment plan.
- Justification of the planned activities or methods of treatment during the stay.
- Quote including services to be provided (DBC + stay x number of days).

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 if treatment is provided by a non-contracted care provider
Are you receiving treatment at a non-contracted GGZ institution? Then, if we have approved the treatment, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which GGZ institutions we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
What we do not reimburse:
- Treatment of adjustment disorders.
- Assistance with work-related and relationship problems.
- Assistance with psychiatric complaints that do not involve a mental disorder.
- A stay in a psychiatric hospital for insured persons up to the age of 18. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of other problems and diagnoses not treated under basic insurance, and psychological interventions to which you are not entitled under basic insurance, can be found at ozf.nl/ggz.

Speech and reading

Article 20 Speech therapy
We reimburse your treatment sessions with a speech therapist insofar as this care has a medical purpose and can be expected to restore or improve the ability to speak.

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.

Conditions for reimbursement
- You will need a statement from the referring doctor (general practitioner, medical specialist, or dentist). This statement enables us to determine whether you are entitled to reimbursement of the costs of speech therapy under the basic insurance.
- Are you receiving treatment at school? In that case, we only reimburse your costs if we have entered into agreements about this with your care provider.

Sometimes no statement is necessary for contracted speech therapists
In some cases, no statement is needed for reimbursement. This is because we have entered into agreements with a number of contracted speech therapists about direct access. These speech therapists can treat you without a referral. We call this Direct Access Speech Therapy (Directe Toegang Logopedie (DTL)).
Do you want to know which contracted care providers offer DTL? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

Are you unable to travel for treatment because of your symptom(s)? Then you will not be able to obtain DTL. In that case you will need a statement from a referring doctor. The referring doctor should indicate on the statement that treatment must be provided at home.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted speech therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which speech therapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
We do not reimburse:
- 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.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.

Transport

Article 21 Ambulance transport or seated patient transport
21.1 Ambulance transport
We reimburse the following forms of ambulance transport:
- Ordered ambulance transport requested via the ambulance dispatch centre.

- Ordered ambulance transport requested via our Transport Telephone Line (Vervoerslijn) (in the case of transport for patients on waiting lists).

Please note! Do you need emergency ambulance transport? This is usually called in via 112. In that case, you do not need a referral. Nor do you need our prior permission. Emergency ambulance transport falls under the basic insurance. This means that your excess applies.

You are entitled to ambulance transport:
- To and from a care provider or a healthcare institution, if the care provided is partially or entirely reimbursed under 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 an institution that provides care covered by the Long-term Care Act ('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 Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
- From the above-mentioned care providers or institutions to your home, or to a another place of residence if you cannot reasonably receive care in your home.
- To a care provider from whom or an institution in which an insured person under the age of 18 will receive mental health care that is fully or partially reimbursed under the Dutch Youth Act (Jeugdwet).

Conditions for reimbursement
- Ordered ambulance transport must be requested by a general practitioner, medical specialist, geriatric specialist, doctor for the mentally handicapped or paediatrician and be approved by the control room. There must be a medical necessity for horizontal transport. There is no need to request emergency transport.
- Our Transport Telephone Line (Vervoerslijn) must authorise ordered ambulance transport for patients on waiting lists in advance. You can call our Transport Telephone Line (Vervoerslijn) on (071) 365 4 154. Lines are open from 08:00 to 18:00 on working days. One of our Transport Telephone Line (Vervoerslijn) staff will determine whether you are entitled to reimbursement.
- We only reimburse the costs of transport if the distance to the care provider does not exceed 200 kilometres. This does not apply if we have made a different agreement with you.

21.2 Seated patient transport

Do you regularly travel to and from healthcare providers or healthcare institutions? If so, you may be entitled to reimbursement of the costs of seated patient transport by public transport (lowest class), (multi-person) taxi or a kilometre allowance of €0.30 per kilometre for transport by private car.

We reimburse the costs of seated 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 are visually impaired and unable to travel without an escort.
- You are wheelchair dependent.
- 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.

Do you meet one or more of the above mentioned medical indications? In that case, we reimburse seated patient transport:
- To and from a care provider or a care-providing institution, if the care provided is partially or entirely reimbursed under 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 an institution that provides care covered by the Dutch Long-term Care Act ('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 Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
- From the above-mentioned care providers or institutions to your home, or to a another place of residence if you cannot reasonably receive care in your home.
- Transport of a companion if an escort is needed, or to accompany insured persons up to the age of 16.

The number of reimbursable kilometres is based on the fastest route between the postcodes of your departure address and destination.

Hardship clause for seated patient transport

What if you do not meet the criteria listed above? In that case, you may be entitled to reimbursement under the hardship clause. Firstly, you must depend upon seated patient transport for a prolonged period because you are being treated for a long-term illness or disorder. Secondly, the fact that we are not reimbursing transport must be regarded as a case of extreme inequity. We assess whether you are entitled to reimbursement under the hardship clause. Are you entitled to reimbursement of transport costs based on the hardship clause? Then this also applies to any consultations, examinations or checks you must undergo in the course of the treatment.

Statutory personal contribution for seated patient transport

A statutory personal contribution applies for seated patient transport (by public transport, (multi-person) taxi or private car). This is €103 per person per calendar year.

Conditions for reimbursement
- Seated patient transport (by public transport (multi-person) taxi or private car) and/or transport of a companion must be approved in advance by our Transport Telephone Line (Vervoerslijn). You can call our Transport Telephone Line (Vervoerslijn) on (071) 365 4 154. Lines are open from 08:00 to 18:00 on working days. One of our Transport Telephone Line (Vervoerslijn) staff will determine whether you are entitled to reimbursement of transport and the form of transport to which you are entitled. Are you 16 or older? Then the person who assists you will also determine whether an escort is needed.
- The transport must be related to care that we reimburse under the basic insurance or under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
- Is seated patient transport by public transport, (multi-person) taxi, private car or ambulance not possible? In that case we must give you permission in advance for a different means of transport.
- A two-person escort is permitted in exceptional cases. Also, in this case, we must give you permission in advance.
- We only reimburse the costs of transport if the distance to the care provider does not exceed 200 kilometres. This does not apply if we have made a different agreement with you.
- What if you use a non-contracted taxi service, public transport or your own transport? In that case, use the ‘Reiskosten zittend ziekenvervoer’ (Seated Patient Transport) claims form. 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.

Lower reimbursement for non-contracted taxi services
Do you use a non-contracted taxi service? In that case we reimburse up to 75% of the average tariff we pay for this care (provided by contracted taxi services).
Do you want to know with which taxi services we have a contract? Then call our Transport Telephone Line (Vervoerslijn) on (071) 365 4 154. Lines are open from 08:00 to 18:00 on working days.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Hospital, treatment and stay

Article 22 The Asthma Centre in Davos (Switzerland)

Do you suffer from asthma? In that case, you are entitled to reimbursement of treatment at the Dutch Asthma Centre in Davos.

Conditions for reimbursement
- Similar treatment in the Netherlands was unsuccessful and we consider the treatment in Davos to be appropriate.
- You must be referred by a lung specialist or paediatrician.
- We must give you written permission in advance.

Article 23 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 must be to enable you to return to your home situation. Has your doctor indicated that 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:
- A stay that is medically necessary for the purpose of 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 who specialises in treating the mentally handicapped.
- 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.

How many days of clinical stay do we reimburse?
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:
- (Psychiatric) hospital stay.
- 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.

Conditions for reimbursement
- You must be referred by a general practitioner, a medical specialist, a doctor who specialises in emergency medicine, a geriatric specialist or a doctor who specialises in treating the mentally handicapped.
- If your stay is longer than 3 months, you 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 in the case of palliative care.
- For palliative care, the provision of care must be aligned with the Palliative Care care module (adopted nationally in 2013) or the quality framework for palliative care.
- The primarily responsible nurse is a nurse with expertise level 4 at minimum.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
You are not entitled to primary care stay:
- 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).
- 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).
- If you are under the age of 18 and need mental health care. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Article 24 Genetic research and advice

We reimburse the costs of genetic research and advice at a centre for genetic research. This care includes:
- Research into and about hereditary disorders by means of genealogical analysis.
- Chromosome research.
- Biochemical diagnosis.
- Ultrasound scanning and DNA research.
- 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 reimbursement
You must have a referral from your doctor, obstetrician or midwife.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know which centres we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 25 Mechanical respiration

You are entitled to reimbursement of necessary mechanical respiration and the care this involves as provided by medical specialists. 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:
- The respiratory centre provides the necessary apparatus - ready-to-use - for every treatment.
- The respiratory centre supplies the care of medical specialists and the appropriate pharmaceutical care involved in mechanical respiration.

Condition for reimbursement
You must be referred by a lung specialist.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 26 Specialist medical care and hospital accommodation

You are entitled to specialist medical care and stay. This care can be provided in:
- A hospital.
- An independent treatment centre.
- The home practice of a medical specialist (extramurally working specialist), if this medical specialist has an AGB code. You can check this via www.agbcode.nl.

The care consists of:
- Specialist medical care.
- 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.
Please note! The Dutch Minister of Health, Welfare and Sport is entitled to designate treatments as 'conditionally admitted' treatments 4 times a year. So we cannot give you a current overview of the treatments to which this applies in these policy conditions. For the most recent overview we refer you to article 2.2 of the Health Insurance Regulations (Regeling zorgverzekering). This article can be found at: http://wetten.overheid.nl/BWBR0018715/Hoofdstuk2/1/11/Artikel2.2/.

How many days of clinical stay do we reimburse?
Have you been admitted to a hospital or independent treatment centre? In that case we reimburse an uninterrupted stay in the hospital or independent treatment centre for a period up to 1.095 days. The following forms of stay also count towards the calculation of the 1,095 days:
- Stay in a rehabilitation centre or a hospital for the purpose of rehabilitation.
- Stay in a psychiatric hospital.
- 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 do count these days when calculating the 1,095 days.

Conditions for reimbursement
- You must be referred by a general practitioner, a company doctor, a sports physician, a geriatric specialist, a doctor for the mentally handicapped, a paediatrician, a physician assistant, a nurse specialist, an emergency department doctor, doctor-assistant, clinical physicist audiologist, obstetrician (if it concerns obstetric care or if it concerns a referral to a paediatrician within the first 10 days after delivery), optometrist (only if it concerns eye care), dental surgeon or another medical specialist.
- A hearing-aid specialist can also refer you to an ENT specialist.
- If TB is suspected, a GGD doctor may refer you to a lung specialist.
- The referring doctor (see the first bullet point) must inform our medical adviser of the reason for your stay. You must authorise the referring doctor to provide this information.
- Are you being admitted for plastic surgery? In that case, you are only entitled 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.
- The stay must be medically necessary for the purpose of specialist medical care.

Please note! Forms of specialist medical care are described separately in the following articles of 'OZF Zorgpolis Entitlements and Reimbursements'. The articles in question are:

Article 10	Dental care for insured persons aged 18 or older - dental surgery
Article 15	Audiology centre
Article 19	Stay in a psychiatric hospital (mental health care) for insured persons aged 18 or older
Article 22	The Asthma Centre in Davos (Switzerland)
Article 24	Genetic research and advice
Article 25	Mechanical respiration
Article 27	Plastic surgery
Article 28	Rehabilitation
Article 30	Home dialysis
Article 31	Transplantation of organs and tissue
Article 33	Childbirth and obstetric or midwifery care
Article 34	In vitro fertilisation (IVF), other fertility-enhancing treatments, sperm cryopreservation and oocyte vitrification
Article 36	Oncological examination of children
Article 42	Thrombosis service

Lower reimbursement if treatment is provided by a non-contracted care provider
We may not have contracted some care providers. And some care providers may only be contracted to provide treatment for certain disorders. Are you being treated by a care provider whom we have not contracted (to treat your condition)?In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract and for which conditions? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
You are not entitled to:
- Specialist medical care and/or stay, as described in this article, if you are treated at a private clinic.
- Treatments for snoring (uvulopalatoplasty).
- Treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis.

- Treatments designed to result in sterilisation.
- Treatments designed to reverse sterilisation.
- Treatments for circumcision without medical necessity.

Mental health care (GGZ) does not fall under this article. Entitlement to reimbursement of GGZ is described in articles 18 and 19 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Article 27 Plastic surgery

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

- Abnormalities in personal appearance associated with demonstrable physical dysfunction.
- Mutilations that are the result of an illness, an accident or a medical intervention.
- 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.
  - Deformities of the urinary tract and genital organs.
- 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.
- The abdominal wall (abdominoplasty), in the following cases:
  - Mutilations the severity of which is comparable with that of 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).
- Primary sexual characteristics in cases of confirmed transsexuality (including epilation of the pubic region and beard).
- 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, we reimburse the costs under article 26 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Conditions for reimbursement

- You must be referred by a general practitioner or medical specialist.
- We must give you written permission in advance.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse the following plastic surgery procedures under the basic insurance:

- 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.
- Surgical removal of a breast prosthesis without medical necessity.
- Liposuction of the stomach.
- 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.
- Plastic surgery procedures at a private clinic.

Article 28 Rehabilitation

We reimburse specialist medical rehabilitation (28.1) and geriatric rehabilitation (28.2).

28.1 Specialist medical rehabilitation

Do you need rehabilitation care? In that case, we only reimburse the costs of specialist medical rehabilitation indicated as the most effective method of preventing, reducing or overcoming your handicap.
Furthermore, your handicap must be the consequence of:

- Disorders or limitations in your ability to move.
- 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 care

We reimburse the costs of non-clinical (part-time or day-treatment) rehabilitation care. In some cases, we also reimburse 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.

How many days of clinical stay do we reimburse?

Have you been admitted? In that case, we reimburse an uninterrupted stay for a period up to 1,095 days. Stays at (psychiatric) hospitals and primary care facilities also count towards this total.
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 do count these days when calculating the 1,095 days.

Conditions for reimbursement

- You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a physician assistant, a doctor who specialises in juvenile health care or another medical specialist.
- The stay must be medically necessary for the purpose of specialist medical rehabilitation.

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. Your care provider must use the 'Request Authorisation non-contracted clinical GGZ' ('Aanvraag machtiging niet-gecontracteerde klinische GGZ') form to apply for approval. This form can be found on our website. The following must be sent with the application:

- The diagnosis, treatment plan, treatment time and justification.
- The 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 if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? Then, if we have approved the treatment, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

28.2 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 motility 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 months of geriatric rehabilitation do we reimburse?
We reimburse geriatric rehabilitation for a maximum of 6 months. In exceptional cases, we may allow a longer period.

Conditions for reimbursement
- You must be referred by a general practitioner, a doctor who specialises in treating the mentally handicapped or a medical specialist.
- The stay must be medically necessary for the purpose of geriatric rehabilitation care.
- The care must commence within 1 week of a stay in a hospital, as defined in article 2.12 of the Health Insurance Decree (Besluit zorgverzekering). In this hospital, you must receive medical care normally provided by a medical specialist or a similar care provider.
- 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)).
- The care must initially involve a stay in a hospital or healthcare institution, as defined in article 2.12 of the Health Insurance Decree (Besluit zorgverzekering).

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 29 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 reimbursement
- The second opinion must relate to diagnostics or treatment that is covered by the basic insurance.
- You must be referred by a general practitioner, medical specialist, clinical psychologist or psychotherapist.
- The second opinion must relate to medical care that is intended for you and which you have discussed with your first doctor.
- When obtaining a second opinion, you give a copy of your first doctor's medical file to the second doctor.
- You must return to the first doctor with the second opinion. This doctor remains in charge of your treatment.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
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.

Article 30 Home dialysis

Are you receiving dialysis treatment at home? In that case we reimburse the costs involved. These are:
- Necessary modifications in and around the home and subsequent reversal of these modifications. 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.
- Other reasonable costs directly related to your dialysis at home (such as the costs of water and electricity). These will also only be reimbursed if they are not covered by other statutory regulations.

Condition for reimbursement
We must give you 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 26 of 'OZF Zorgpolis Entitlements and Reimbursements'.

Article 31 Transplantation of organs and tissue

In the case of organ transplants you are entitled to reimbursement of the following treatments:
- The transplantation of tissues and organs in a hospital.
  A transplantation can be performed in:
  - A member state of the European Union.
  - A country that is party to the Agreement on the European Economic Area.
  - Another country. In that case, the donor must live in that country and must be your spouse, registered partner or a 1st, 2nd or 3rd-degree blood relative.
- Transplantation of tissues and organs in an independent treatment centre legally authorised to perform these procedures.

In the case of a proposed organ transplant we reimburse specialist medical care associated with:
- The choosing of the donor.
- The surgical removal of the transplant material from the chosen donor.
- Examination, preservation, removal and transportation of post-mortem transplant material.

You are entitled to reimbursement of the costs of:
- Care to which the donor is entitled in accordance with this policy. The donor is entitled to this care for a maximum of 13 weeks from the date of discharge from the hospital. In the case of a liver transplant, the donor is entitled to this care for a period of 6 months 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 care provided if it relates to that hospital stay.
- Transport of the donor by the cheapest form of public transport, or, if medically necessary, by car. The transport must relate to the selection process, the hospital stay, discharge from hospital or the care referred to in the 1st bullet point.
- 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! If the donor has basic insurance, entitlement to reimbursement of the costs of the transport referred to in the 2nd and 3rd bullet points is covered by the donor's insurance. What if the donor does not have basic insurance? In that case, these costs will be covered by the recipient's basic insurance. This does not include accommodation costs in the Netherlands or any loss of income.

Conditions for reimbursement
Is the transplant procedure being performed in a non-contracted institution? In that case, you must request our permission in writing in advance.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated at a healthcare institution that we have not contracted (to treat your condition)? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract and for which conditions? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 32 Nursing and care in your own surroundings (extramural)

The conditions that apply for entitlement to nursing care in an intramural institution (such as a hospital for example) are set out in articles 18, 19, 26 and 33 of 'OZF Zorgpolis Entitlements and Reimbursements'. However, you are also entitled to nursing and care in your own surroundings. You are entitled to nursing and care related to (a high risk of) the need for medical care. The nature and extent of the care provided are 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 (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! If you fall within in a particular target group you can apply for a personal care allowance (persoonsgebonden budget (Zvw-pgb)) that you can use to purchase nursing and care in your own surroundings. The target groups to which this applies and the conditions that apply are set out in the Dutch Health Insurance Act (Zvw) Personal Care Allowance Regulations - Nursing and Care (Reglement PGB verpleging en verzorging). These regulations form an integral part of this policy. These regulations can be found on our website or obtained from us.

Conditions for reimbursement
- For adults aged 18 or older, a care needs assessment conducted in accordance with the standards that apply to the assessment of care needs and the organisation of nursing and care in one's own surroundings must be carried out by a professionally (HBO) qualified BIG-registered nurse.
- For children under the age of 18 you are in possession of an indication provided by a paediatric nurse with a degree from a university of applied sciences or a nurse who has completed specialist training in paediatric nursing. The paediatrician or medical specialist remains ultimately responsible for the treatment. If it becomes apparent that this is intensive child care, the paediatric nurse with a degree from a university of applied sciences or nurse who has completed specialist training in paediatric nursing must work for a care provider affiliated to the Intensive Child Care Branch Organisation (BIKZ). The care needs assessment must be conducted in your home with you present. A professionally qualified (HBO), BIG-registered nurse must conduct a care needs assessment in advance to providing care. This means that the district nurse will discuss your needs with you and determine what care you need in your particular situation and the intended results. 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').
- In the case of palliative terminal care, you need a statement from the referring doctor. The statement must confirm that the estimated life expectancy is less than 3 months. The nature, content and extent of the care must be detailed in the care plan.
- For specialist nursing, a request must be issued by a medical specialist in advance. Specialist nursing must be provided by a BIG-registered nurse who is competent and qualified to provide the necessary care for the condition in question. The nature, content and extent of the care must be detailed in the care plan. Provision of care must be aligned with the Palliative Care care module (adopted nationally in 2013) or the quality framework for palliative care.

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 also note that there are plenty of contracted care providers in all regions.

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

- 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 wijk-verpleegkundige zorg') Request form, which can be found on our website. When requesting permission, you need to supply:
  - The care needs assessment and the care plan (these must meet the conditions listed above).
  - The nursing diploma held by the professionally (HBO) qualified BIG-registered nurse who conducted the care needs assessment.
  - And, in the case of palliative terminal care, a statement confirming that the estimated life expectancy is less than 3 months.

  We will then assess the appropriateness and legitimacy of your request. We will notify you whether your request has been approved or denied.
- You submit the invoices you receive from your non-contracted care provider to us. What if non-contracted care has not been approved? Then your invoices will not be reimbursed.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? Then, if we have approved the treatment, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

- You are not entitled to maternity care under this article. Reimbursement of maternity care is described in article 35 of 'OZF Zorgpolis Entitlements and Reimbursements'.
- 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)).
- You are not entitled to usual care. We define 'usual care' as care that which, according to generally acceptable views, can reasonably be expected from household members, such as the partner, parents, children and others with whom the insured person occupies a home on a permanent basis.

Pregnancy/baby/child

Article 33 Childbirth and obstetric or midwifery care

With respect to the reimbursement of obstetric or midwifery care and care during delivery, we distinguish between 'with medical indication' (33.1) and 'without medical indication' (33.2).

33.1 With medical indication

For female insured persons we reimburse:

- Use of the delivery room if delivery takes place in a hospital (in the hospital itself or in the outpatient department).
- Obstetric or midwifery care provided by a medical specialist. This also includes care provided in a hospital by an obstetrician or midwife supervised by a medical specialist.
- You are not entitled to usual care. We define 'usual care' as care that which, according to generally acceptable views, can reasonably be expected from household members, such as the partner, parents, children and others with whom the insured person occupies a home on a permanent basis.

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

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

33.2 Without a medical indication

For female insured persons we reimburse:

- Obstetric or midwifery care by an obstetrician or midwife or, if an obstetrician or midwife is not available, by a general practitioner.
- Use of the delivery room if there is no medical indication for giving birth in a hospital or a birth centre. For this you will be required to pay a statutory personal contribution of €35 for each day of stay (€17.50 for the mother and €17.50 for the child). Does the hospital charge more than €250 per day (€125 for the mother and €125 for the child)? In that case, in addition to the €35, you will also have to pay the amount over €250 per day.

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

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 34 In vitro fertilisation (IVF), other fertility-enhancing treatments, sperm cryopreservation and oocyte vitrification

You are entitled to reimbursement of IVF treatment (34.1), other fertility-enhancing treatments (34.2), sperm cryopreservation (34.3) and oocyte vitrification (34.4).

34.1 IVF

Are you under the age of 43? In that case, per ongoing pregnancy achieved, you are entitled to reimbursement of the 1st, 2nd and 3rd IVF attempts, including any medicines used.

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

An IVF attempt to achieve pregnancy involves undergoing, at most, the 4 following sequential phases:

1. Ripening of oocytes within the woman's body by means of hormonal treatment.
2. Retrieval of the ripe oocytes (follicular puncture).
3. Oocyte fertilisation and cultivation of embryos in the laboratory.
4. Replacement of 1 or 2 of the resulting embryos in the uterus to allow a pregnancy to develop. Are you under the age of 38? In that case, only 1 embryo may be replaced during the 1st and 2nd attempts.

The process only counts as an attempt if follicular puncture (phase 2) is successful. 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 1st attempt. The replacement of frozen embryos (or the replacement of an embryo obtained following the thawing of an unfertilised oocyte) is regarded as part of the IVF attempt during which they were created, as long as an ongoing pregnancy has not already been initiated. If an ongoing pregnancy has been initiated, any remaining frozen embryos (or an embryo obtained following the thawing of an unfertilised oocyte) may be replaced after this pregnancy. If this fails to produce results, further IVF treatment can be initiated. This then counts as a 1st attempt.

ICSI treatment (intracytoplasmic sperm injection) is the equivalent of an IVF attempt.

What is the definition of an ongoing pregnancy

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

- Physiological pregnancy: a (spontaneous) pregnancy lasting at least 12 weeks from the 1st day of the last menstruation.
- IVF-induced pregnancy lasting at least 10 weeks from the follicular puncture after a non-frozen embryo was replaced. Or at least 9 weeks and 3 days after a frozen embryo was replaced.

Conditions for reimbursement

- The treatment must take place in an authorised hospital.
- You need a statement from your doctor that states the medical indication before submitting your application.
- We must give you written permission in advance for treatment in a hospital abroad.

Maximum reimbursement for medicines

We reimburse medicines that are necessary for an IVF attempt. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of our maximum reimbursements for medicines can be found on our website.

What we do not reimburse

We do not reimburse the costs of a 4th and subsequent IVF attempts. This also applies to the medicines needed for a 4th and subsequent IVF attempts.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

34.2 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 and the medicines involved.

Conditions for reimbursement

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

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

Maximum reimbursement for medicines

We reimburse medicines that are necessary for a fertility treatment. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of our maximum reimbursements for medicines can be found on our website.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

34.3 Sperm cryopreservation

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

Conditions for reimbursement

The freezing of sperm must be a part of specialist oncological care or an equivalent non-oncological treatment. This must involve:

- Major surgery on or close to your genitals.
- Chemotherapy and/or radiotherapy treatment during which your genitals are exposed to radiation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers). Do you want to know with which care providers we have a contract?
In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

34.4 Oocyte vitrification

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

- You are undergoing chemotherapy which carries the risk of permanent fertility problems.
- You are undergoing radiotherapy treatment during which your ovaries are exposed to radiation and could be permanently damaged as a result.
- 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:

- Fragile X syndrome.
- Turner syndrome (XO).
- Galactosemia.

If these medical indications are present, you are entitled to reimbursement of the following parts of the treatment:
- Follicular stimulation.
- Oocyte puncture.
- Vitrification (freezing) of the oocytes.

Entitlement to freezing procedures also exists for IVF-related reasons
In some cases, you will also be entitled to freezing procedures during an IVF attempt based on (cost-)effectiveness considerations. For this to apply, the attempt must be covered by the basic insurance. This is the case in the following situations:
- There is an unexpected lack of sperm of sufficient quality.
- Oocytes are frozen instead of embryos.

You are only entitled to the freezing of oocytes if IVF-related reasons apply.

Possibilities after the freezing of oocytes
Are you having your frozen oocytes thawed with the aim of becoming pregnant? In that case, you are limited to phases 3 and 4 of an IVF attempt (see article 34.1 of 'OZF Zorgpolis Entitlements and Reimbursements').

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

Conditions for reimbursement
- The freezing procedure must be performed at an authorised hospital.
- Are you being treated in a hospital abroad? In that case, we must give you written permission in advance.
- You are only entitled to freezing procedures for the reasons listed above if you are under the age of 43.

Maximum reimbursement for medicines
We reimburse medicines needed for the freezing of oocytes. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of our maximum reimbursements for medicines can be found on our website.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 35 Maternity care

For female insured persons, we reimburse maternity care. The nature and extent of the care provided are limited to the care normally provided by maternity carers.

Maternity care can be provided:
- **At home**
  A statutory personal contribution of €4.40 per hour applies for maternity care provided at home.
- **At a birth or a maternity centre**
  A maximum of 8 hours of maternity care is charged per bed-day in a birth or a maternity centre. Also in this case, a statutory personal contribution of €4.40 per hour applies. You are entitled to a maximum of 4 bed-days. You are entitled to receive the remainder of the indicated maternity care at home.
- **In hospital**
  Are you staying in a hospital without a medical indication? In that case, a statutory personal contribution of €35 applies for each day of stay (€17.50 for the mother and €17.50 for the child). Does the hospital charge more than €250 per day (€125 for the mother and €125 for the child)? In that case, in addition to the €35, you will also have to pay the amount over €250 per day. You are entitled to a maximum of 10 days' maternity care, calculated from the day of the delivery. What if the mother and child leave the hospital together before the 10th day? In that case, they are entitled to maternity care at home for the remaining days. Entitlement will only be allocated for days 9 and 10 on the basis of a reassessment by an obstetrician or midwife.

How many hours of maternity care do we reimburse?
The number of hours of maternity care to which you are entitled depends on your personal situation following delivery. The birth centre or maternity centre will determine this in consultation with you. This will be done in accordance with the National Maternity Care Indication Protocol (Landelijk Indicatieprotocol Kraamzorg). The protocol and explanatory notes can be found on our website or obtained from us.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 36 Oncological examination of children

You are entitled to reimbursement of care provided by the Dutch Foundation for Pediatric Oncology (Stichting Kinderoncologie Nederland, SKION). SKION coordinates and registers tissue material it receives and establishes the diagnosis.

Article 37 Prenatal screening

As a female insured person you are entitled to reimbursement of:
- Counselling that explains the procedures involved in prenatal screening.
- A structural echoscopic examination, also known as the 20-week ultrasound scan.
- A combined test (a nuchal scan combined with a blood test) for congenital disorders during the 1st trimester of pregnancy. You are only entitled to these forms of care if you have been referred for medical reasons by a general practitioner, obstetrician, midwife or medical specialist.
- Non-Invasive Prenatal Testing (NIPT). You are only entitled to NIPT if you have a medical indication or if the result of the combined test is positive. Is the result of the combined test 1 in 200 or higher? In that case, the result of the test is considered to be positive.
  Please note! An excess may apply for NIPT.
- Invasive diagnostics. You are only entitled to these diagnostic procedures if you have a medical indication or if the result of the combined test or Non-Invasive Prenatal Testing is positive. Is the result of the combined test or Non-Invasive Prenatal Testing 1 in 200 or higher? In that case the result of the combined test is considered to be positive.

Condition for reimbursement
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 if treatment is provided by a non-contracted care provider
Is your prenatal screening being performed by a non-contracted care, provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Other questions

Article 38 Dietetic therapy

We reimburse 3 hours of dietetic therapy by a dietitian 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.

Condition for reimbursement
You will need a statement from the referring doctor (general practitioner, company doctor, dentist or medical specialist). This statement enables us to determine whether you are entitled to reimbursement of the costs of dietetic therapy under the basic insurance.

Sometimes no statement is needed for treatment provided by contracted dietitians
In some cases you do not need a statement from the referring doctor for reimbursement. This is because we have entered into agreements with a number of contracted dietitians about direct access: these dietitians can advise you without a referral. We call these Direct Access Dietitians (Directe Toegang Diëtist (DTD)). You can use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted dietitians who offer DTD. You are also welcome to contact us.
Are you unable to travel for advice because of your symptom(s)? Then you will not be able to obtain DTD. In that case, you will need a statement from a referring doctor. The referring doctor should indicate on the statement that advice must be provided at home.

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you obtaining advice from a non-contracted dietitian? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which dietitians we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse
We do not reimburse:
- Appointments outside of regular working hours.
- Missed appointments.
- Simple, brief reports or more complicated, time-consuming reports.

Article 39 General practitioner care

You are entitled to reimbursement of medical care provided by a general practitioner, company doctor or a similar doctor or care provider under the supervision of the general practitioner. If requested by a general practitioner, you are also entitled to X-rays and laboratory tests.

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

Lower reimbursement if treatment is provided by a non-contracted care provider
Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 40 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 and/or vascular risk management (VRM) if we have reached agreements about this 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 have currently purchased integrated care for COPD, diabetes mellitus type 2, asthma and VRM. The content of these programmes is aligned with the current care standards for diabetes mellitus, COPD, asthma and VRM.

Reimbursement of integrated care provided by a non-contracted care group
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 reimbursement tariff that applies, can be found in article 4 of the OZF Zorgpolis General conditions.

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 26, 38 and 39 of 'OZF Zorgpolis Entitlements and Reimbursements'. In the case of diabetes mellitus type 2 you are also entitled to foot care as defined in article 2 of 'OZF Zorgpolis Entitlements and Reimbursements'.
Do you want to know with which care groups we have a contract? Our contracted care groups are listed on our website. You are also welcome to contact us.

Article 41 Stop smoking programme

Do you want to stop smoking? In that case, we reimburse, a maximum of 1 stop smoking programme designed to help you give up smoking per calendar year. This stop smoking programme must consist of medical and, possibly, pharmacotherapeutic interventions that support behavioural change, whereby the objective is to stop smoking. This involves support such as that normally provided by general practitioners, medical specialists and clinical psychologists.

Conditions for reimbursement

- 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.
- Pharmacotherapy with nicotine-replacement medicines, nortriptyline, bupropion and varenicline is only reimbursed in combination with support that focuses on behaviour.
- The programme must be drawn up in accordance with the description and frameworks set out in the Care module 'Stop Smoking' and comply with the CBO directive 'Tobacco addiction'.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 42 Thrombosis service

In the case of thrombosis, you are entitled to reimbursement of care provided by a thrombosis service. The care provided by this service includes:

- Taking regular blood samples.
- Carrying out the necessary laboratory tests in order to determine the coagulation time of your blood. The thrombosis service can also arrange for a third party to perform these tests, in which case the thrombosis service remains responsible.
- Providing you with equipment and accessories so you can measure the coagulation time of your blood yourself.
- Training you to use this equipment and supervising you when you carry out measurements.
- Advising you on the use of medicines to influence the coagulation time of your blood.

Condition for reimbursement

You must be referred by a general practitioner, midwife (in the event of pregnancy or childbirth), geriatric specialist, doctor for the mentally handicapped or a medical specialist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Are you being treated by a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Article 43 Combined lifestyle intervention for insured persons aged 18 or older

Do you have a moderately or strongly increased risk profile according to the Obesity Care Standard (Zorgstandaard Obesitas) by Partnership Overweight Netherlands (Partnerschap Overgewicht Nederland (PON))? And are you 18 or older? In that case, we reimburse a Combined Lifestyle Intervention (Gecombineerde Leefstijl Interventie (GLI)).

The GLI is a programme aimed at reducing the health risks brought on by your weight. 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 reimbursement

- You must be referred by a general practitioner.
- A moderately or strongly increased Weight-related Health Risk (Gewichtsgerelateerd GezondheidsRisico (GGR)) must be established by the general practitioner. These risks are detailed in PON's Obesity Care Standard.
- The care provider works with an effective GLI programme that is registered as such in the Healthy Living Bureau quality registry.
- 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:
  - The Lifestyle Coaches Registry of the professional association for lifestyle coaches in the Netherlands (Beroepsvereniging Leefstijlcoaches Nederland (BLCN)).
  - The Central Quality Registry (Centraal Kwaliteitsregister (CKR)) or the partial registry of the Physiotherapy Certification Foundation.
  - Or, in the case of dietitians or remedial therapists, the quality registry for all health professions (het kwaliteitsregister Paramedici).

What we do not reimburse

We do not reimburse GLI if your weight-related health risk (GGR) has been assessed by your general practitioner as slightly increased or extremely increased according to the Obesity Care Standard.

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. Do you want to use a non-contracted care provider? Then the following 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. Your care provider must use the 'Request Authorisation non-contracted clinical GGZ' ('Aanvraag machtiging niet-gecontracteerde klinische GGZ') form to apply for approval. This form can be found on our website. The following must be sent with the application:

- The name and referral letter of the general practitioner stating that you have a moderate or strongly increased GGR.
- The name and the AGB code of the healthcare provider who supervises the GLI programme.
- And 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.

Lower reimbursement if treatment is provided by a non-contracted care provider

Do you want to use a non-contracted care provider? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which care groups we have a GLI contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

Contents General conditions
Supplementary (dental) insurance

General conditions

Supplementary (dental) insurance

The General conditions that apply to your basic insurance also apply to your supplementary (dental) insurance with the exception of article 1.1 (This insurance contract is based on), points 1 to 3, and article 4.3 (non-contracted care providers or healthcare institutions). In other words, these articles of the General conditions of OZF Zorgpolis, which is an arranged care policy, do not apply to your supplementary (dental) insurance. There are also articles that apply specifically to your supplementary (dental) insurance. These articles are listed below.

Article 1 How do you apply for supplementary (dental) insurance?

1.1 Applying for supplementary insurance

Everyone who is entitled to take out our basic insurance can also apply for supplementary (dental) insurance should they wish to do so. 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. We only provide supplementary (dental) insurance with retroactive effect if the situation referred to in article 6.1 on page 47 of these General conditions applies.

1.2 We cannot always provide supplementary insurance

There are some situations in which we cannot provide supplementary (dental) insurance. We will reject your application if:

- A premium payment for an existing insurance you (the policyholder) have with us is overdue.
- You have committed fraud as defined in article 20 of the 'OZF Zorgpolis General conditions'.
- The state of your health warrants such a decision.
- When you submit your application, you are already receiving, or expect to need, some form of care that is covered by our supplementary (dental) insurance.
- 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 (dental) insurance with us during the 12 months that you have an ex-officio health insurance.

1.3 Insured persons under the age of 18

Are your children covered by your basic insurance? And are they under the age of 18? Then you can take out supplementary (dental) insurance (policies) for your children if you or your co-insured partner also have/has a supplementary (dental) insurance with us. You do not have to pay a premium for supplementary (dental) insurance for children under 18. It is not possible to take out a more extensive supplementary (dental) insurance for your children than your own or your co-insured partner's supplementary (dental) insurance.

Article 2 What does the supplementary (dental) insurance cover?

2.1 What we reimburse

You are entitled to reimbursement of expenses covered by your supplementary (dental) insurance that are incurred during the period covered by the supplementary (dental) 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 invoice, not the date on which the invoice was issued.

Please note! In some cases we will only reimburse the costs under the supplementary (dental) insurances if you go to a contracted care provider or healthcare institution. You can read about this in the respective article. We may also issue a lower reimbursement if you use a non-contracted care provider or healthcare institution. You can also read about this in the respective article.

2.2 Reimbursement of medical treatment during a stay abroad

Are you receiving medical care abroad? In that case, the reimbursement of this care is subject to conditions and exclusions. These conditions and exclusions are detailed in articles 8 and 9 of 'Reimbursements covered by AV Compact and AV Royaal supplementary insurance'. 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 15 of the 'OZF Zorgpolis General 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 a maximum of 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 9 of 'Reimbursements covered by AV Compact and AV Royaal supplementary insurance'. We only reimburse the costs of medical treatment abroad if these costs would be covered by your supplementary insurance if the treatment were provided in the Netherlands.

2.3 What we do not reimburse (non-reimbursement of related expenses)

You are not entitled to reimbursements under the supplementary (dental) insurance that are provided via a statutory regulation. The expenses in question must also be covered by your supplementary (dental) insurance. Your supplementary (dental) insurance does not include cover that compensates for:

- Lower reimbursements covered by your basic insurance if you use non-contracted care.
- Expenses offset against the (mandatory and/or voluntarily chosen) excess of the basic insurance. This does not apply to the mandatory excess if you have chosen to pay the mandatory excess in instalments.
- 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 (dental) insurance.

Medical expenses covered by a law or some other provision or other insurance (including travel insurance), irrespective of which policy was issued first, are not covered by this supplementary (dental) insurance. This also includes medical expenses that would have been covered if this supplementary (dental) insurance did not exist.

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 Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT) (Netherlands reinsurance company for losses from terrorism). This clause sheet and the corresponding claim handling protocol are an integral part of these policy conditions. The protocol can be found at terrorismeverzekerd.nl. The clause sheet can be downloaded from our website or obtained from us.

2.5 Sequential application of multiple insurance policies
Do you have several insurance policies with us? Then we will reimburse the bills you submit by applying the policies in the following order:
- The basic insurance.
- AV Compact / AV Royaal supplementary insurance.
- Tand Compact / Tand Royaal supplementary dental insurance.

Article 3 Is there a mandatory and/or 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, there is no excess for supplementary (dental) insurance.

Article 4 What will you have to pay?
4.1 The amount of your premium
The premium is determined by OZF. The premium you have to pay is shown on your policy certificate. We apply age categories for our supplementary (dental) insurance. What if you enter a new age bracket in 2019? Then you pay the premium for the new age bracket from 1 January 2020.

Are you a member of a group insurance scheme that charges an average premium? And will you turn 65 in 2019? Then you pay the premium for the new age bracket from 1 January 2020.

Insured persons up to the age of 18 do not pay a premium for our supplementary (dental) insurance policies. However, conditions apply. These conditions are listed in article 1.3, on page 46 of these General conditions. Is an insured person about to turn 18? Then you (the policyholder) must pay a premium as of the 1st of the month following the month in which the insured person turns 18.

4.2 If you do not pay the premium on time
Did you (the policyholder) fail to pay your premium on time? Then, in addition to applying articles 9 and 10 of the 'OZF Zorgpolis General conditions', we will also terminate your supplementary (dental) insurance (policies). We will do this if you (the policyholder) do not pay your premium within the grace period specified in our 2nd written demand for payment. Your right to reimbursement will then automatically cease to apply from the 1st 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 will be able to take out new supplementary (dental) insurance (policies) as of 1 January of the following year. You may be required to undergo a preliminary medical assessment.

4.3 Settlement
Premiums payable for insurance and other amounts owed to us may not be offset against reimbursements to be received from us. This is only possible if we have given you written permission in advance.

We may deduct amounts owed by you for OZF Zorgpolis insurance and any supplementary (dental) insurance (policies) you have taken out from amounts payable to you. This also applies to debt collection costs and bailiff's fees.

Article 5 What if your premium and/or conditions alter?
5.1 We may alter your premium and/or the conditions of your insurance
We have the right to alter the premium and/or the conditions of our supplementary (dental) insurance policies 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 your (existing) insurance (policies) with us.

5.2 If you do not agree to the alterations
Are you not prepared to pay the higher premium or do you not accept more restrictive terms and conditions? Then please notify us to this effect by post or email within 30 days of the date on which we announced the change(s). We will then cancel your insurance on the date on which the new premium and/or new conditions become effective.

5.3 Sometimes it is not possible to cancel your insurance if we alter the premium and/or the conditions of your insurance
You cannot cancel your insurance prior to the expiry date if the higher premium and/or more restrictive conditions and/or reimbursements are stipulated by statutory regulations. In the situations listed above, you can cancel your insurance by following one of the procedures described in article 7 of these General conditions.

Article 6 When does your supplementary (dental) insurance commence? And how do you change this?
6.1 Your supplementary (dental) insurance commences on 1 January
You (the policyholder) can take out supplementary (dental) insurance in addition to your basic insurance with us. You can apply for supplementary insurance up until 31 January of the current calendar year. If your application is approved, the supplementary (dental) insurance will be retroactively effective from 1 January. We must agree to this in writing. For Tand Royaal you have to undergo a medical assessment. In addition, a waiting period of 12 months applies for the reimbursement of:
- Refractive eye surgery or lens implantation under AV Royaal (see article 19 of 'Reimbursements covered by supplementary insurance policies').
- Orthodontics under Tand Royaal (see article 52 of 'Reimbursements covered by dental insurance policies'.

6.2 To change your supplementary (dental) insurance
Do you (the policyholder) want to change your supplementary (dental) insurance with us? Then you can do this up until 31 January of the current calendar year. If your application is approved, 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 (dental) insurance with us? Then any reimbursements that you have already received will count towards the new supplementary (dental) insurance policy. This applies to both the (reimbursement) periods of the healthcare entitlements and the calculation of the (maximum) reimbursement.

Article 7 How do you cancel your supplementary (dental) insurance?

You (the policyholder) can cancel your supplementary (dental) insurance:

- By sending us a letter or email. Online through Mijn OZF. Or by calling our Customer Service Department. We must receive notice of cancellation by 31 December at the latest. We will then cancel your supplementary (dental) insurance on 1 January of the following year. Have you asked us to cancel your supplementary insurance? In that case, the cancellation is irrevocable.
- From the date on which your basic insurance with us is cancelled. If you wish you can continue your supplementary (dental) insurance with us after cancelling your basic insurance with us.
- By using the cancellation service provided by your new health insurer. Have you (the policyholder) taken out supplementary (dental) 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 (dental) insurance with us on your (the policyholder's) behalf. Do you (the policyholder) not wish to make use of the cancellation service provided by your new health insurer? In that case, you (the policyholder) must note this on the application form submitted to your new health insurer.

Article 8 In what situations will we cancel your supplementary (dental) insurance?

We will cancel both your supplementary (dental) insurance and the supplementary (dental) insurance provided for any other persons covered by your policy:

- On a date to be determined by us:
  - If you (the policyholder) do not pay the outstanding amounts within the grace period specified in our 2nd written demand for payment.
  - If we withdraw our supplementary (dental) insurance from the market for reasons that we consider to be important.
- With immediate effect:
  - If 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 your supplementary (dental) insurance.
  - 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.
  - If it has been established that you have committed fraud. What we mean by 'fraud' is defined in article 20 of the 'OZF Zorgpolis General conditions'.

Article 9 How do we check the legitimacy and appropriateness of the submitted invoices?

We check the legitimacy and appropriateness 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.

Definition of terms

Terms used in these conditions that relate specifically to your supplementary (dental) insurance are explained below. What do we mean by the following terms?

Supplementary (dental) insurance (policies)
The supplementary (dental) insurance (policies) you have taken out in addition to your basic insurance:

- AV Compact or AV Royaal.
- Tand Compact or Tand Royaal.

Accident
A sudden and unexpected event that is beyond the control of the insured person, which causes medically demonstrable, externally inflicted, physical injury.

We/us
Achmea Zorgverzekeringen N.V., OZF's insurer.

Health insurer
Achmea Zorgverzekeringen N.V. is the health insurer that provides your supplementary (dental) insurance policies.
Achmea Zorgverzekeringen N.V. is the company that provides the 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.

Reimbursements covered by supplementary insurance policies - Contents

AV Compact and AV Royaal

Reimbursements covered by dental insurance policies - Contents

Tand Compact and Tand Royaal

Services

Reimbursements covered by supplementary insurance policies

AV Compact and AV Royaal

You can take out various supplementary (dental) insurance policies with us: AV Compact, AV Royaal, Tand Compact and Tand Royaal. The insurance (policies) you have taken out is/are listed on your policy certificate. The following care is reimbursed under the supplementary insurance policies AV Compact and AV Royaal. You can find details of the care covered by Tand Compact and Tand Royaal dental insurance from page 69 onwards. The elements of care covered by the insurance and the extent of the reimbursement are listed for each type of care. The specified reimbursement of care applies per person unless stated otherwise next to each type of medical care. The conditions for reimbursement and for what is not reimbursed are also listed below. Unable to find what you are looking for? Then first refer to the contents of 'Reimbursements covered by supplementary insurance policies' on pages 49 and 50.

Alternative therapies

Article 1 Alternative forms of treatment, therapies and medicines

We reimburse the costs of consultations and treatments provided by alternative healthcare professionals (doctors and non-doctors) who offer the following therapies:

Alternative therapies
- Acupuncture.
- APS therapy.
- Ayurvedic medicine.
- Craniosacral therapy.
- Homeopathy.
- Kinesiology.
- Mesology therapy.
- Natural health therapies.
- Neural therapy.
- Orthomolecular medicine.
- Reflex zone therapy.
- Shiatsu therapy.

Alternative therapies (musculoskeletal system)
- Chiropractic treatment.
- Haptotherapy.
- Manual medicine / orthomanipulation.
- Neuromuscular therapy.
- Orthopaedic medicine.
- Osteopathy.

Alternative therapies (mental health modalities)
- Gestalt therapy.
- Haptotherapy.
- Hypnosis and regression therapy.
- Integrative and/or body-oriented therapy.
- Expressive arts therapy.

Anthroposophic medicine
- Anthroposophic medical treatment carried out by an anthroposophical doctor.
- Eurythmy therapy.
- Art therapy.
- Psychological care.

In addition, we reimburse the costs of homeopathic and anthroposophic medicines.

Conditions for reimbursement
- Your alternative healer or therapist must have a valid AGB code (to be checked via agbcode.nl) and be a member of a professional association that meets our criteria. The list of professional associations that meet our criteria can be found on our website ozf.nl/alternatief or obtained from us.
- We only reimburse consultations and treatments that fall within the specific field for which the professional association is listed.
- The consultation must be conducted within the context of medical treatment.
- The consultation must be provided on an individual basis. In other words, it must be only for you.
- The homeopathic and anthroposophic medicines must be listed as homeopathic or anthroposophic medicines in the Netherlands and in the Z-Index G-standaard database. The G-standaard is a database which lists all of the medicines available from pharmacies.
- We only reimburse the costs of homeopathic and anthroposophic medicines if they have been prescribed by a doctor.

We only reimburse contracted care

We only reimburse alternative medicines if they are supplied by a contracted pharmacy. What if you choose a non-contracted pharmacy? Then you will receive no reimbursement.
Do you want to know which pharmacies we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

What we do not reimburse

We do not reimburse:
- If the alternative healthcare professional is also your general practitioner.
- Laboratory tests requested by the alternative healthcare professional.
- Manual therapy provided by a physiotherapist.
- Treatments, examinations and courses of a social nature or designed to promote well-being and/or prevention.
- Work or school-related coaching.
- Healthcare that is reimbursed from another article. Examples of this are Mindfulness training and Counselling.

AV Compact
A maximum of €40 per day for consultations with alternative healers or therapists Homeopathic and anthroposophic medicines: 100% A maximum of €350 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.
AV Royaal
A maximum of €40 per day for consults with alternative healers or therapists Homeopathic and anthroposophic medicines: 100% A maximum of €550 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.

Bones, muscles and joints

Article 2 Remedial therapy in a hot water pool for rheumatoid arthritis

Do you suffer from rheumatoid arthritis? Then we reimburse remedial therapy in a hot water pool.

Conditions for reimbursement

- You must provide us with a one-time statement issued by a general practitioner or a medical specialist. The statement must state that you require remedial therapy in a hot water pool because you suffer from rheumatoid arthritis.
- The remedial therapy must be provided in a group session under the responsibility of a physiotherapist, a Cesar or Mensendieck remedial therapist and/or a rheumatoid arthritis patients association.

AV Compact
No reimbursement
AV Royaal
A maximum of €200 per calendar year

Article 3 Pedicure care for rheumatoid, diabetic and medical foot conditions

3.1 Pedicure care for a rheumatoid foot condition

Do you suffer from a rheumatoid foot condition? Then we reimburse the costs of foot care services provided by a medical pedicurist, medical chiropodist or healthcare pedicurist.

Conditions for reimbursement

- You must provide us with a one-time statement issued by a general practitioner or a medical specialist. The statement must state that you require foot care services because you suffer from:
  - Arthritis associated with an intestinal disease.
  - Psoriatic arthritis (inflammation of the joints in people suffering from psoriasis).
  - Ankylosing spondylitis (Bechterew's disease).
  - Chondrocalcinosis (crystal deposition disease).
  - Juvenile rheumatoid arthritis.
  - Chronic gout in one or both feet.
  - Paget's disease (bone disease).
  - Polyneuropathy.
  - Chronic reactive arthritis.
  - Rheumatoid arthritis.
  - Scleroderma.
  - Still's disease (juvenile rheumatoid arthritis).
  - Severe osteoarthritis of the foot with misalignment and/or deformity.
- The pedicure must be listed in the ProCert Quality Register for Pedicurists (KwaliteitsRegister voor Pedicures (KRP)) as being qualified to treat 'rheumatoid foot' conditions (RV) or as a medical pedicurist (MP).
- What if the foot care is provided by a (medical) chiropodist or a healthcare pedicurist? Then the care provider must be listed in the Stipezo Register for Paramedical Foot Care (Register Paramedische Voetzorg (RPV)).
- The invoice must state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.
- The invoice must specify the nature of the service(s) provided (examination, treatment and/or use of a special technique) and the nature of the rheumatoid foot condition.

What we do not reimburse

We do not reimburse:

- The removal of calluses for cosmetic reasons.
- Non-medically necessary trimming of toenails.

AV Compact
No reimbursement
AV Royaal
A maximum of €25 per treatment up to a maximum of €150 per calendar year for pedicure care for rheumatoid and/or diabetic and/or medical foot conditions combined

3.2 Pedicure care for a diabetic foot condition

Do you suffer from a diabetic foot condition and has your care profile been established as Care Profile 1 (Zorgprofiel 1)? Then we reimburse the costs of foot care services provided by a medical pedicure, (medical) chiropodist or healthcare pedicure.

Conditions for reimbursement

- You must give the pedicurist a statement from a general practitioner, an internist or a geriatric specialist. This statement must confirm that you fall under Care Profile 1 (Zorgprofiel 1). This profile is described in article 2 of 'OZF Zorgpolis Entitlements and Reimbursements'.
- The pedicurist must be listed in the ProCert Quality Register for Pedicurists (KwaliteitsRegister voor Pedicures (KRP)) as being qualified to treat 'diabetic foot' conditions (DV) or as a medical pedicurist (MP).
- What if the foot care is provided by a (medical) chiropodist or a healthcare pedicurist? Then the care provider must be listed in the Stipezo Register for Paramedical Foot Care (Register Paramedische Voetzorg (RPV)).
- The Care Profile (Zorgprofiel) must be specified on the invoice.
- The invoice must state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.

What we do not reimburse

We do not reimburse:

- The annual foot examination. From Care Profile 1 (Zorgprofiel 1) onwards this is covered by your basic insurance (see articles 2 and 40 of 'OZF Zorgpolis Entitlements and Reimbursements').
- Treatments, from Care Profile 2 (Zorgprofiel 2) onwards. These are covered by your basic insurance (see articles 2 and 40 of 'OZF Zorgpolis Entitlements and Reimbursements').
- The removal of calluses for cosmetic reasons.
- Non-medically necessary trimming of toenails.

AV Compact
No reimbursement
AV Royaal
A maximum of €25 per treatment up to a maximum of €150 per calendar year for pedicure care for rheumatoid and/or diabetic and/or medical foot conditions combined

3.3 Pedicure care for a medical foot condition

Do you suffer from 1 of the following conditions and develop medical problems if you are not treated? Then we reimburse the costs of foot care services provided by a medical pedicure, (medical) chiropodist or healthcare pedicure.

Conditions for reimbursement

- You must provide us with a one-time statement issued by a general practitioner or a medical specialist. The statement must state that you require foot care services because you suffer from:
  - Peripheral neuropathy.
  - Hereditary motor and sensory neuropathies (HMSN).
  - Paresis of the foot (due to a cerebrovascular accident (CVA) for example).
  - Paraplegia.
  - Sudeck's dystrophy/post-traumatic dystrophy.
  - Arteriosclerosis obliterans.
  - Chronic thrombophlebitis.
  - Thromboangiitis obliterans (Buerger's disease).
  - Arterial insufficiency.
  - Severe malpositioning (resulting in the development of excessive calluses and corns).
  - Hammer toes.
  - Palmoplantar keratoderma.
  - Tylotic eczema.
  - Recurrent erysipelas.
  - Psoriatic nails.
  - Problems of the nails and feet caused by chemotherapy.
  - Problems of the nails and feet due to MS, ALS, spasm, multiple myeloma (Kahler's disease), Parkinson's disease or epidermolysis bullosa.
- The pedicurist must be listed in the ProCert Quality Register for Pedicurists (KwaliteitsRegister voor Pedicures (KRP)) as being qualified to treat 'rheumatoid foot' conditions (RV) or as a medical pedicure (MP).
- What if the foot care is provided by a (medical) chiropodist or a healthcare pedicure? Then the care provider must be listed in the Stipezo Register for Paramedical Foot Care (Register Paramedische Voetzorg (RPV)).
- The invoice must state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.
- The invoice must specify the nature of the service(s) provided (examination, treatment and/or use of a special technique) and the nature of the medical foot condition.

What we do not reimburse

We do not reimburse:

- The removal of calluses for cosmetic reasons.
- Non-medically necessary trimming of toenails.

AV Compact
No reimbursement
AV Royaal
A maximum of €25 per treatment up to a maximum of €150 per calendar year for pedicure care for rheumatoid and/or diabetic and/or medical foot conditions combined

Article 4 Podiatry/podology/podopostural therapy

We reimburse podiatric treatment by a (sports) podiatrist, podologist or podopostural therapist.

Conditions for reimbursement

- The podiatrist who provides the treatment must be registered in the Paramedics Quality Register (Kwaliteitsregister Paramedici).
- The sports podiatrist who provides the treatment must be accredited by Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS) (Dutch Sports Health Care Professionals Certification Association). A list of SCAS-accredited sports podiatrists can be found at sportzorg.nl/zoek-een-sportzorgprofessional.
- The podologist who provides the treatment must be registered in the Kwaliteitsregister KABIZ (KABIZ Quality Register) and affiliated with Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry) or must meet the quality criteria established by LOOP.
- The podopostural therapist who provides the treatment must be registered in the Kwaliteitsregister KABIZ (KABIZ Quality Register) and affiliated with Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry) or must meet the quality criteria established by LOOP.
- The invoice must specify the nature of the service(s) provided(examination, treatment and/or use of a special technique).

What we do not reimburse

We do not reimburse:

- Footwear and alterations to footwear.
- Foot examination and treatment of diabetic feet.
- Pedicures carried out by a podiatrist, podologist or podopostural therapist.
- Instrumental treatments such as the removal of calluses and the trimming of (fungally infected) nails, or treatment of corns, warts, verrucas or ingrown toenails.

AV Compact
No reimbursement
AV Royaal
A maximum of €100 per calendar year

Article 5 Sports medical examination by a sports physician

We reimburse the costs of the following sports medical examinations by a sports physician at a Sports Medical Institution:

- A sports medical examination.
- A sports check-up.
- An exertion test.

Condition for reimbursement

The Sports Medical Institution or sports physician must be accredited by the Dutch Sports Health Care Professionals Certification Association (Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS). A list of SCAS-accredited Sports Medical Institutions can be found at sportzorg.nl/zoek-een-sportzorgprofessional.

AV Compact
A maximum of €200 per calendar year
AV Royaal
A maximum of €200 per calendar year

Article 6 Sports medical advice and guidance by a sports physician

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.

Conditions for reimbursement

- A sports medical examination must be performed by a sports physician at a Sports Medical Institution before the advice is provided.
- The Sports Medical Institution or sports doctor 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 Medical Institutions can be found at sportzorg.nl/zoek-een-sportzorgprofessional.

AV Compact
A maximum of €150 per calendar year
AV Royaal
A maximum of €150 per calendar year

Article 7 Arch supports

We reimburse (sport) arch supports and/or orthoses. Or the repair of these devices.

Conditions for reimbursement

The (sport) arch supports must be made and supplied or repaired by:

- An arch support supplier affiliated with NVOS Orthobanda (the professional association for suppliers of orthopaedic devices) or an arch support supplier who meets the quality criteria of NVOS Orthobanda.
- 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). Or a sports podiatrist who meets the quality criteria of SCAS or the VSO-Netwerk. A list of SCAS-accredited sports podiatrists can be found at sportzorg.nl/zoek-een-sportzorgprofessional. Members of the VSO-Netwerk are listed at vsonetwerk.nl.
- A podiatrist who is registered in the Paramedics Quality Register (Kwaliteitsregister Paramedici).
- A podologist who provides the treatment must be registered in the Kwaliteitsregister KABIZ (KABIZ Quality Register) and affiliated with Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry) or must meet the quality criteria established by LOOP.
- The podopostural therapist who provides the treatment must be registered in the Kwaliteitsregister KABIZ (KABIZ Quality Register) and affiliated with Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry) or must meet the quality criteria established by LOOP.
- An orthopaedic shoe maker.
- The invoice must specify the nature of the devices made, supplied and/or repaired.

AV Compact
No reimbursement
AV Royaal
A maximum of €125 per calendar year

Abroad

Article 8 Transport of the insured person and mortal remains (repatriation)

We reimburse:

- Medically-necessary patient transport by ambulance or aircraft from abroad to a healthcare institution in your country of residence.
- Transport of mortal remains from the place of death to the place of residence in your country of residence.

Conditions for reimbursement

- The patient transport must be required in connection with urgent medical treatment in a country other than your country of residence.
- Our emergency response centre Eurocross Assistance must approve the transport in advance and must also arrange the transport.

AV Compact
100%
AV Royaal
100%

Article 9 Medical treatment abroad

We reimburse medical treatment abroad. We do this in the case of urgent medical treatment abroad (9.1), transport costs following healthcare mediation if care is provided in Belgium or Germany (9.2), overnight stay and transport costs of family members following healthcare mediation if care is provided in Belgium or Germany (9.3). The reimbursements we provide and the conditions that apply are summarised below.

9.1 Urgent medical treatment abroad

We reimburse 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. Furthermore, it must be impossible to postpone the medical treatment until you return to your country of residence. Reimbursement under this article only applies in addition to the reimbursement we provide under OZF Zorgpolis.

We reimburse:

- Treatment by a general practitioner or medical specialist.
- Hospital stay and surgery.
- Treatments, examinations, medicines and dressings prescribed by a doctor.
- Medically necessary ambulance transportation to and from the nearest doctor and/or the nearest hospital.
- Dental treatment for insured persons up to the age of 18.

Please note! Are you 18 or older? In that case, we only reimburse dental treatment abroad if you have Tand Compact or Tand Royaal supplementary dental insurance. These costs are covered by one of these supplementary dental insurance policies.

Conditions for reimbursement

- Eurocross' and/or OZF's medical advisor assess whether the care in question could not have been foreseen when leaving for a foreign country. And the medical care must be immediately necessary in an emergency situation resulting from an accident or illness. This assessment is decisive for the question of whether the care qualifies for reimbursement on the basis of this article.

- The costs will only be reimbursed if these costs would be covered by your basic insurance if the treatment were provided in the Netherlands.
- Hospitalisation must be reported immediately to our emergency response centre Eurocross Assistance.

AV Compact

Supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days

AV Royaal

Supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days

9.2 Transport costs following healthcare mediation if care is provided in Belgium or Germany

Did our Healthcare Mediation team arrange a hospital stay in a health-care institution in Belgium or Germany? Then we reimburse transport from and to the Netherlands by a contracted taxi service, private car or public transport.

Conditions for reimbursement

- The service provided by our Healthcare Mediation team must have reduced the waiting time for treatment.
- Our Transport Telephone Line (Vervoerslijn) must approve the transport in advance. The Transport Telephone Line (Vervoerslijn) will determine if you are entitled to reimbursement of the transport and the form of transport to which you are entitled. You can call our Transport Telephone Line (Vervoerslijn) on (071) 365 4 154. Lines are open from 08:00 to 18:00 on working days.
- Taxi transport must be provided by a contracted taxi service. A contracted taxi service must send us the invoice. What if you choose a non-contracted taxi service? Then you will receive no reimbursement.
- What if you use public transport or your own transport? In that case, use the 'Reiskosten zittend ziekenvervoer' (Seated Patient Transport) claim form to submit your transport costs. You can find the claim form on our website.

AV Compact

Contracted taxi service: 100%
Public transport (lowest class): 100%
Own transport: €0.30 per kilometre

The maximum total reimbursement is €1,000 per calendar year

AV Royaal

Contracted taxi service: 100%
Public transport (lowest class): 100%
Own transport: €0.30 per kilometre

The maximum total reimbursement is €1,000 per calendar year

9.3 Overnight stay and transport costs of family members following healthcare mediation if care is provided in Belgium or Germany

Do you have to travel from the Netherlands to be admitted to a foreign healthcare institution for treatment in accordance with article 9.2 of 'Reimbursements covered by supplementary insurance policies'? Then we reimburse the following for your family members:

- The overnight guest house accommodation in the vicinity of the hospital.
- The taxi transport, own transport or public transport to and from the hospital.

Conditions for reimbursement

- Use the 'Vervoers- en/of overnachtingskosten' (Transport and/or Accommodation) claim form to submit your expenses. You can find the claim form on our website.
- You must be able to provide proof that you incurred the transport and/or accommodation expenses if we ask for it.

AV Compact

Accommodation expenses: a maximum of €35 per night.
A maximum of €0.30 per kilometre, irrespective of the method of transport
Transport and/or accommodation expenses: a maximum of €500 per calendar year for all family members combined

AV Royaal

Accommodation expenses: a maximum of €35 per night.
A maximum of €0.30 per kilometre, irrespective of the method of transport
Transport and/or accommodation expenses: a maximum of €500 per calendar year for all family members combined

Physiotherapy and remedial therapy

Article 10 Exercise programmes

We reimburse exercise programmes. Exercise programmes are designed for people who are supposed 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 upon completion of the programme.

We reimburse exercise programmes if you:

- Suffer from obesity (BMI > 30).
- Are recovering from earlier heart failure.
- Suffer from rheumatoid arthritis (we use the definition of rheumatoid arthritis established by Reumafonds (Dutch Arthritis Association).
- Have type 2 diabetes.
- Suffer from mild to moderate COPD with a pulmonary function value of FEV1/VC < 0.7, a distress score of >2 on the MRC scale and a health score of >1 to 1.7 based on the CCQ scale.
- Are suffering or recovering from an oncological condition.

Conditions for reimbursement

- You must be referred by a general practitioner, company doctor or medical specialist.
- The exercise programme must be taught in the practice room of the physiotherapist or Cesar or Mensendieck remedial therapist who is treating you.
- The duration of the exercise programme must be at least 3 months.

We only reimburse contracted care

The exercise programme must be given by a physiotherapist or Cesar/Mensendieck remedial therapist that we have contracted for this purpose. What if you choose a care provider who we have not contracted for this purpose? Then you will receive no reimbursement. You can use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find a contracted physiotherapist or Cesar/Mensendieck remedial therapist. You are also welcome to contact us.

What we do not reimburse

If you are using a combination of lifestyle interventions (see article 43 or 'OZF Zorgpolis Entitlements and Reimbursements'). and suffer from obesity, we do not reimburse the costs of an exercise programme.

AV Compact
A maximum of €175 per condition for the duration of the supplementary insurance
AV Royaal
A maximum of €350 per condition for the duration of the supplementary insurance

Article 11 Physiotherapy and Cesar or Mensendieck

11.1 Physiotherapy and Cesar or Mensendieck remedial therapy for insured persons aged 18 or older

We reimburse treatment by a physiotherapy and Cesar or Mensendieck remedial therapist. We also reimburse manual lymphatic drainage by a skin therapist if the treatment is prescribed for serious lymphoedema. Is reimbursement of physiotherapy or Cesar or Mensendieck remedial therapy covered by your basic insurance (see article 4.1 of 'OZF Zorgpolis Entitlements and Reimbursements')? In that case, the costs of the first 20 treatment sessions per condition are not reimbursed under the basic insurance. Of these first 20 treatment sessions:

- We reimburse 12 if you have AV Compact supplementary insurance. In other words, you must pay for 8 of these first 20 sessions yourself (treatment sessions 13 to 20).
- We reimburse all 20 if you have AV Royaal supplementary insurance.

Conditions for reimbursement

- You must be referred by a general practitioner, company doctor or medical specialist.
- Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF)), with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
  - Paediatric physiotherapy.
  - Pelvic physiotherapy.
  - Manual therapy.
  - Oedema therapy.
  - Geriatric physiotherapy.
  - Paediatric remedial therapy.

  Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
- What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar/Mensendieck remedial therapist on the same day? In that case, a specific letter of referral issued by the referring doctor (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

Lower reimbursement if treatment is provided by a non-contracted Cesar or Mensendieck remedial therapist

Are you being treated by a non-contracted physiotherapist, Cesar or Mensendieck remedial therapist or skin therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).

Do you want to know with which physiotherapists, Cesar or Mensendieck remedial therapists and skin therapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists: these physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a statement from the referring doctor. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Cesar or Mensendieck Remedial Therapy (Directe Toegang Oefentherapie Cesar/Mensendieck (DTO)). Use the Medical Provider Search Tool on www.ozf.nl/zorgzoeker to find contracted therapists that offer DTF or DTO. You are also welcome to contact us.

What we do not reimburse

We do not reimburse:

- Individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training.
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.
- Individual treatment if you are already taking part in an exercise programme, as described in article 10 of 'Reimbursements covered by supplementary insurance policies', for the same condition.

AV Compact
A maximum of 12 treatments per calendar year, with a maximum of 9 manual therapy treatments
AV Royaal
A maximum of 27 treatments per calendar year, with a maximum of 9 manual therapy treatments

11.2 Physiotherapy and Cesar or Mensendieck remedial therapy for insured persons up to the age of 18

We reimburse treatment by a physiotherapist or Cesar or Mensendieck remedial therapist. We also reimburse manual lymphatic drainage by a skin therapist if the treatment is prescribed for serious lymphoedema.

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 4.2 of 'OZF Zorgpolis Entitlements and Reimbursements').

Conditions for reimbursement

- You must be referred by a general practitioner, company doctor or medical specialist.
- Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR)

(Central Quality Register) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF)), with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
- Paediatric physiotherapy.
- Pelvic physiotherapy.
- Manual therapy.
- Oedema therapy.
- Geriatric physiotherapy.
- Paediatric remedial therapy.

Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

- 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 (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

Lower reimbursement if treatment is provided by a non-contracted Cesar or Mensendieck remedial therapist

Are you being treated by a non-contracted physiotherapist, Cesar or Mensendieck remedial therapist or skin therapist? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).
Do you want to know with which physiotherapists, Cesar or Mensendieck remedial therapists and skin therapists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

This is because we have entered into agreements with a number of contracted physiotherapists and Cesar or Mensendieck remedial therapists about direct access: these physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a statement from the referring doctor. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Cesar or Mensendieck Remedial Therapy (Directe Toegang Oefentherapie Cesar/Mensendieck (DTO)). Use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find contracted therapists that offer DTF or DTO. You are also welcome to contact us.

What we do not reimburse

We do not reimburse:
- Individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training.
- Antenatal and postnatal fitness classes, (medical) fitness, (sports) massage and work and activity therapy.
- Surcharges for:
  - Appointments outside of regular working hours.
  - Missed appointments.
  - Simple, brief reports or more complicated, time-consuming reports.
- Bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.
- Individual treatment if you are already taking part in an exercise programme, as described in article 10 of 'Reimbursements covered by supplementary insurance policies', for the same condition.

AV Compact
Unlimited number of treatments, with a maximum of 9 manual therapy treatments
AV Royaal
Unlimited number of treatments, with a maximum of 9 manual therapy treatments

Article 12 Post-care physiotherapy

We reimburse post-care physiotherapy as part of:
- Post-oncology care: treatment designed to maintain or improve fitness during or following medical treatment of cancer and recovery-oriented treatment designed to reduce or eliminate symptoms of (imminent) lymphoedema, scar tissue or other problems caused by medical treatment of cancer.
- (Post-)CVA care: physiotherapy treatment following a stroke or cerebrovascular accident (CVA) by a physiotherapist who specialises in recovery-oriented physiotherapy.
- Cardiovascular disease management by a physiotherapist who specialises in recovery-oriented physiotherapy. Are you 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 insurance (see article 4 of 'OZF Zorgpolis Entitlements and Reimbursements').

Condition for reimbursement

You must be referred by a general practitioner, company doctor or medical specialist.

We only reimburse contracted care

The post-care physiotherapy treatment must be provided by a PlusPraktijk physiotherapy practice contracted for this purpose. What if the post-care physiotherapy treatment is provided by a non-contracted care provider? Then you will receive no reimbursement. Do you want to know with which PlusPraktijk physiotherapy practices we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
100%
AV Royaal
100%

Skin

Article 13 Acne treatment

We reimburse (facial) acne treatments provided by a beautician or skin therapist and the products and/or materials used to carry out the treatment.

Conditions for reimbursement

- You must be referred by a general practitioner or medical specialist.
- The beautician must be registered with Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty Therapy Industry Association) as specialising in acne treatment.
- The skin therapist must be affiliated with Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch Association of Skin Therapists) or comply with the relevant quality criteria established by NVH.

What we do not reimburse
We do not reimburse:
- Camouflage therapy for the same indication (see article 14 of 'Reimbursements covered by supplementary insurance policies').
- Laser treatment for couperose skin, pigmentation or age spots, wine spots or thread veins.

AV Compact
No reimbursement
AV Royaal
A maximum of €350 per calendar year

Article 14 Camouflage therapy

We reimburse camouflage therapy performed (on the face and/or neck) by a beautician or skin therapist and the products and/or materials used to carry out the treatment.

Conditions for reimbursement
- You must be referred by a general practitioner or medical specialist.
- The camouflage therapy must relate to the treatment of scars, port wine stains or pigment marks on the neck and/or face.
- The beautician must be registered with Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty Therapy Industry Association) as specialising in camouflage therapy.
- The skin therapist must be affiliated with Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch Association of Skin Therapists) or comply with the relevant quality criteria established by NVH.

What we do not reimburse
We do not reimburse:
- Acne treatment for the same indication (see article 13 of 'Reimbursements covered by supplementary insurance policies').
- Laser treatment for couperose skin, pigmentation or age spots, wine spots or thread veins.

AV Compact
No reimbursement
AV Royaal
A maximum of €350 per calendar year

Article 15 Epilation treatment

For female insured persons we reimburse electrical epilation and Intense Pulsed Light (IPL) hair removal treatments provided by a beautician or skin therapist. Or laser hair removal treatments performed at a laser treatment clinic recognised by us.

Conditions for reimbursement
- The treatment must be performed to remove extremely unsightly facial hair.
- You must be referred by a general practitioner or medical specialist.
- The beautician must be registered with Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty Therapy Industry Association) as specialising in electrical epilation or hair removal techniques.
- The skin therapist must be affiliated with Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch Association of Skin Therapists) or comply with the relevant quality criteria established by NVH.
- Laser treatment must be provided in a qualified institution with which a dermatologist is affiliated.

What we do not reimburse
We do not reimburse cosmetic treatments.

AV Compact
No reimbursement
AV Royaal
A maximum of €545 for the duration of the supplementary insurance

Medical devices

Article 16 Medical devices

We reimburse medical devices and/or the (statutory) personal contribution that applies to these devices. The medical devices covered by your insurance and the conditions under which reimbursement is provided are listed below.

16.1 Personal contribution for wigs
We reimburse the statutory personal contribution that applies for a wig.

Condition for reimbursement
You must be entitled to reimbursement of a wig under OZF Zorgpolis (see article 5 of 'OZF Zorgpolis Entitlements and Reimbursements').

AV Compact
No reimbursement
AV Royaal
A maximum of €200 per calendar year

16.2 Hand splint
We reimburse the costs of a hand splint needed for post-care physiotherapy in the case of hand problems that require specialist treatment.

Condition for reimbursement
The hand splint must be supplied by a CHT-NL-qualified hand therapist. CHT-NL-qualified hand therapist are listed at handtherapie.com/zoek-uw-handtherapeut.

AV Compact
A maximum of €40 per calendar year for 1 finger or small thumb splint A maximum of €60 per calendar year for 1 wrist, hand or large thumb splint A maximum of €90 per calendar year for 1 dynamic or static splint
AV Royaal
A maximum of €40 per calendar year for 1 finger or small thumb splint A maximum of €60 per calendar year for 1 wrist, hand or large thumb splint A maximum of €90 per calendar year for 1 dynamic or static splint

16.3 Headwear during oncology treatment
Are you undergoing oncology treatment? In that case, we reimburse a Toupim (a headband wig), scarf, hat, peaked cap or bandana.

Conditions for reimbursement
- A statement issued by a general practitioner or medical specialist must confirm that you are undergoing oncology treatment.
- The headwear must be purchased from a specialist supplier recognised by us.

AV Compact
No reimbursement
AV Royaal
A maximum of €150 per calendar year

16.4 Personal alert system required for medical reasons
We reimburse the subscription fee associated with the use of a personal alert system.

Conditions for reimbursement
- You must be entitled to reimbursement of a personal alert system under OZF Zorgpolis (see article 5 of 'OZF Zorgpolis Entitlements and Reimbursements').
- If you use a non-contracted supplier, we must give you permission in advance.

Lower reimbursement for a non-contracted supplier
What if the alert system is supplied by a non-contracted service? Then the maximum reimbursement is €60 per calendar year.
Do you want to know with which suppliers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
Contracted: 100% Non-contracted service: maximum of €60 per calendar year
AV Royaal
Contracted: 100% Non-contracted service: maximum of €60 per calendar year

16.5 Adhesive strips for breast prosthesis
Do you wear an external breast prosthesis after having a mastectomy? Then we reimburse the adhesive strips used to attach the prosthesis.

AV Compact
100%
AV Royaal
100%

16.6 Bedwetting alarm
We reimburse the purchase or hire of a bedwetting alarm. We also reimburse the pants that go with the alarm system.

AV Compact
A maximum of €100 for the duration of the supplementary insurance
AV Royaal
A maximum of €100 for the duration of the supplementary insurance

16.7 Sports or ice pack brace
We reimburse the costs of a sports or ice pack brace.

AV Compact
A maximum of €50 for 1 sports or ice pack brace per calendar year
AV Royaal
A maximum of €50 for 1 sports or ice pack brace per calendar year

16.8 Support pessary
We reimburse the costs of a support pessary used to prevent or alleviate the symptoms of bladder or uterine prolapse.

Condition for reimbursement
The support pessary must be supplied by your general practitioner. Or by a pharmacy to which you are referred by your general practitioner.

AV Compact
No reimbursement
AV Royaal
100%

16.9 Incontinence therapy
We reimburse the hire of a TRANS therapy (nerve stimulation) device for the treatment of incontinence.

Condition for reimbursement
You must be referred by a doctor, pelvic-floor physiotherapist or incontinence nurse.

We only reimburse contracted care
The device must be supplied by a contracted supplier. What if you choose a non-contracted supplier? Then you will receive no reimbursement.
Do you want to know with which suppliers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
100%
AV Royaal
100%

16.10 IncoCure self-help programme
For female insured persons who suffer from incontinence, we reimburse the costs of the therapeutic online process offered by IncoCure.

This self-help programme consists of an online questionnaire that diagnoses the type of incontinence. You are given personal advice on treatment. To complete the questionnaire, you can go straight to the website incocure.com.

AV Compact
A maximum of €15 per calendar year
AV Royaal
A maximum of €15 per calendar year

Medicines

Article 17 Pharmaceutical care

We also reimburse melatonin (17.1) and contraceptives (17.2). The conditions for reimbursement are listed below.

17.1 Melatonin

We reimburse generic melatonin tablets.

Conditions for reimbursement

- The melatonin tablets must be prescribed by a (child) psychiatrist, paediatrician or (paediatric) neurologist associated with a contracted healthcare institution. Do you want to know with which institutions we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
- Are Concerta or Methylphenidate being taken at the same time? Then the melatonin tablets can also be prescribed by a general practitioner.

We only reimburse contracted care

We only reimburse melatonin tablets supplied by:

- The eFarma online pharmacy.
- One of our other contracted pharmacies. Then the maximum reimbursement is €100 per calendar year. Anything over and above this must be paid by you. What if you choose a non-contracted pharmacy? Then you will receive no reimbursement.
  Do you want to know with which pharmacies we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
If supplied by the eFarma online pharmacy: 100% If supplied by a contracted pharmacy: maximum of €100 per calendar year

17.2 Contraceptives for insured persons aged 21 or older

For female insured persons aged 21 or older we reimburse hormonal contraceptives and coils (IUDs).

Conditions for reimbursement

- The contraceptive must be prescribed by a general practitioner, a doctor at a sexual health clinic, an obstetrician or midwife, or a medical specialist.
- In the case of the contraceptive pill, a prescription issued by a general practitioner, a doctor at a sexual health clinic, an obstetrician or midwife, or a medical specialist must be submitted the first time the pill is dispensed. (This is not necessary thereafter).
- The contraceptive must be listed in the Medicinal Products Reimbursement System (GVS). The GVS states which medicines can be reimbursed under the basic insurance.
- The contraceptive must be supplied by a contracted pharmacy.

We only reimburse contracted care

The contraceptive must be supplied by a contracted pharmacy. What if you choose a non-contracted pharmacy? Then you will receive no reimbursement. Do you want to know which pharmacies we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

Application of the mandatory excess in the case of fitting a coil for insured persons between the ages of 18 and 21.

If the coil is fitted by a gynaecologist, both the fitting and the coil itself are reimbursed by the basic insurance. It is possible that excess will be deducted. If the coil is fitted by a general practitioner, both the fitting 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 fitting of the coil by the general practitioner is not deducted from your excess.

What we do not reimburse

Contraceptives prescribed to treat a medical condition covered by your basic insurance (endometriosis or menorrhagia (abnormally heavy menstrual periods)).

AV Compact
100%
AV Royaal
100%

Eyes and ears

Article 18 Spectacles and/or contact lenses

We reimburse spectacles and/or contact lenses per period of 2 calendar years. In this respect, the determining factor is the date on which the spectacles and/or contact lenses are supplied. This period commences on 1 January of the year of the first purchase.

Conditions for reimbursement

- The spectacles and/or contact lenses must be supplied by an optician or optical retailer.
- The (contact) lenses must be prescription lenses.

What we do not reimburse

- Eye tests, measuring of the eyes or optometric eye examinations by an optician or optometrist.
- Contact lens solutions, spectacle case or other eyewear accessories.
- Repair, maintenance or check of spectacles and/or contact lenses.

AV Compact
A maximum of €100 per 2 calendar years for spectacles and contact lenses combined
AV Royaal
A maximum of €200 per 2 calendar years for spectacles and contact lenses combined

Article 19 Refractive eye surgery or lens implantation

We reimburse refractive eye surgery. Or the additional costs of a lens implant with an intraocular lens other than a (standard) monofocal intraocular lens.

Conditions for reimbursement

- We have not reimbursed spectacles or contact lenses in the 6 months prior to the refractive eye surgery or insertion of lens implants.
- Entitlement to reimbursement of spectacles and/or contact lenses (see article 18 of 'Reimbursements covered by supplementary insurance policies') ceases to apply for a period of 10 years from the date of refractive eye surgery or insertion of lens implants.

- The ophthalmologist who performs the treatment must be registered as a refractive surgeon with the Nederlands Oogheelkundig Genootschap (NOG) (Netherlands Ophthalmological Society). What if the specialist is not registered with the NOG? Then the specialist must follow the guidelines published by the society and meet the criteria set out in the Consensus on Refractive Surgery (Consensus Refractiechirurgie).
- Is the refractive eye surgery or lens implant procedure being performed abroad? In that case, we must give you permission in advance.

Refractive eye surgery or lens implantation waiting period
Newly insured persons have a 12-month waiting period. This means that you will be paying the insurance premium during the waiting period, but cannot yet receive reimbursement for refractive eye surgery or lens implantation. The waiting period commences when you take out an AV Royaal insurance policy.

AV Compact
No reimbursement
AV Royaal
A maximum of €500 per eye for the duration of the supplementary insurance

Article 20 Hearing aid (statutory personal contribution) for insured persons aged 18 or older

Have you purchased a hearing aid that qualifies for reimbursement under OZF Zorgpolis? In that case, we reimburse the 25% statutory personal contribution towards the costs of a hearing aid.

Conditions for reimbursement
- You must be entitled to reimbursement under OZF Zorgpolis (see article 5 of 'OZF Zorgpolis Entitlements and Reimbursements').
- You are 18 or older.

Lower reimbursement for a non-contracted supplier
Did you purchase the hearing aid from a non-contracted supplier? In that case we reimburse the statutory personal contribution of 25% up to a maximum of €100 per hearing aid. (The statutory personal contribution may be less than €100).
Do you want to know with which hearing aid suppliers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
Contracted: 100% Non-contracted supplier: a maximum of €100 per hearing aid

Preventive healthcare

Article 21 FysioRunning coaching programme

We reimburse the costs of the FysioRunning online coaching programme. The process consists of a screening questionnaire and coaching for a maximum of 13 weeks.

Condition for reimbursement
To register and complete the screening questionnaire, go to the FysioRunning website, fysiorunning.nl.

AV Compact
1 FysioRunning online coaching programme per calendar year
AV Royaal
1 FysioRunning online coaching programme per calendar year

Article 22 Consultations, vaccinations and medicines if you travel abroad

Are you travelling abroad? In that case, we reimburse consultations, necessary vaccinations and/or preventive medication required for or during 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 for each country are listed on their website, lcr.nl/landen.

Are you using a non-contracted care provider or healthcare institution?
- A maximum reimbursement per calendar year applies to consultations and vaccinations via a non-contracted care provider. Anything over and above this must be paid by you.
- We do not reimburse preventive medicines via non-contracted pharmacies.

Do you want to know with which care providers we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
Contracted: 100% for consultations and vaccinations and/or preventive medicines Non-contracted: a maximum of €75 per calendar year for consultations and vaccinations
AV Royaal
Contracted: 100% for consultations and vaccinations and/or preventive medicines Non-contracted: a maximum of €100 per calendar year for consultations and vaccinations

Article 23 Course designed to reduce alcohol consumption

We reimburse the costs of a (preventive) course designed to reduce alcohol consumption.

Condition for reimbursement
You must provide us with the original confirmation of registration for the course and payment of the fees.

AV Compact
A maximum of €300 per calendar year
AV Royaal
A maximum of €300 per calendar year

Article 24 Flu vaccinations

We reimburse flu vaccinations.

Condition for reimbursement

The flu vaccination must not be provided by the national vaccination programme.

AV Compact
No reimbursement
AV Royaal
100%

Article 25 Health Check

We reimburse the costs of a Health Check (a preventive health test).

We only reimburse contracted care

We only reimburse a Health Check performed by a Care for Human nurse. Do you want to make an appointment with a Care for Human nurse? Then go to careforhuman.nl.

AV Compact
1 Health Check per calendar year
AV Royaal
1 Health Check per calendar year

Article 26 (Preventive) courses

We reimburse the following (preventative) courses:

- For insured persons suffering from heart problems: 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.
- For insured persons suffering from lymphoedema: 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 taught by an instructor who has completed the lymphoedema self-management training course run by Stichting Lymfologie Centrum Nederland (SLCN) (Dutch Lymphology Centre Foundation). A list of qualified instructors can be found on our website or obtained from us.
- For insured persons suffering from rheumatoid arthritis, osteo-arthritis or Bechterew's disease: a course that teaches patients how to cope with their disease. The course must be organised by the Dutch Arthritis Association (Reumafonds) or a home care agency.
- For insured persons suffering from type 2 diabetes: a patient-oriented, basic or follow-up educational course organised by Diabetesvereniging Nederland (DVN) (Dutch Diabetes Association) or a home care agency.
- For insured persons who want to lose weight by following the dietary advice offered by the following courses:
  - One of the print and online programmes organised by Happy Weight.
  - The range of courses provided by Biamed Nederland.
  - The range of courses provided by Lekker Puh!.
  - The range of courses provided by Weight Watchers.
  - The course 'Sportief afvallen' provided by a home care agency.
  - A course on healthy nutrition for the elderly organised by a home care agency.
- A basic resuscitation course offered by a training institute registered with Nederlandse Reanimatieraad (NRR) (Dutch Resuscitation Council).
- 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)).
- 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 (Wet kinderopvang (Wk)).
- A course on feeling good about your body. The course must be organised by a home care agency.
- 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.
- A course on self-respect for kids. The classes must be run by licensees affiliated with Instituut voor Kanjertrainingen B.V. (Institute for Self-Respect for Kids Training Courses).
- The programme offered by Meer Bewegen voor Ouderen (MBvO) (More Exercise for the Elderly).
- Fall prevention course ('In Balans' or 'Vallen Verleden Tijd'). This course must be given by a contracted physiotherapist or Cesar or Mensendieck remedial therapist who offers this course. Do you want to know which physiotherapy and/or remedial therapy practices offer this course? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us. You can also take a fall prevention course taught by a home care agency.

Condition for reimbursement

You must provide us with the original confirmation of registration for the course and payment of the fees.

AV Compact
A maximum of €100 per course per calendar year
AV Royaal
A maximum of €100 per course per calendar year

Article 27 'Slaapcoach' online sleep improvement course

We reimburse the costs of:

- A 'Slaapcoach' online sleep improvement course, which provides professional advice and practical solutions online to help improve your sleep. The course must be organised by Somnio.
- A 'You can learn to sleep' course. 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 and payment of the fees.

AV Compact
A maximum of €150 per calendar year
AV Royaal
A maximum of €150 per calendar year

Article 28 'Afvallen en Afblijven' diet and exercise programme

We reimburse the costs of the 12-week diet and exercise programme 'Afvallen en Afblijven' (losing weight and keeping it off).

Conditions for reimbursement

- The programme must be organised by an agency with which we have agreements. Do you want to know with which agency or agencies we have agreements? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
- You must provide us with the original confirmation of registration for the course and payment of the fees.

AV Compact
A maximum of €250 per calendar year
AV Royaal
A maximum of €250 per calendar year

Article 29 Bowel cancer screening self-test

We reimburse an iFOB test for the purpose of bowel cancer screening. You can perform this test at home. The test kit is also used in the national screening programme. Do you want to know from which suppliers you can order the iFOB test? Then please contact us.

Conditions for reimbursement

- You must be 50 or older.
- You are not entitled to take part in the national bowel cancer screening programme.

AV Compact
No reimbursement
AV Royaal
A maximum of €25 per calendar year

Psychological care

Article 30 Counselling

We reimburse the costs of counselling. Counselling is a short-term form of individual psychosocial support.

Conditions for reimbursement

- The counsellor who works with you must be a member of the Algemene Beroepsvereniging voor Counselling (ABvC) (General Professional Association for Counselling).
- The invoice must clearly state that it concerns counselling.

AV Compact
A maximum of €300 per calendar year
AV Royaal
A maximum of €300 per calendar year

Article 31 Mindfulness training

We reimburse the costs of mindfulness training.

Condition for reimbursement

The mindfulness training must be provided by a trainer who is a member of the Community of Mindfulness-Based Trainers in the Netherlands and Flanders (Vereniging Mindfulness Based Trainers in Nederland en Vlaanderen (VMBN)). VMBN-affiliated trainers are listed on the website, vmbn.nl.

AV Compact
A maximum of €250 per calendar year
AV Royaal
A maximum of €250 per calendar year

Transport

Article 32 Transport and overnight guest house accommodation

We reimburse the costs of accommodation costs in a guesthouse for an outpatient treatment cycle (32.1) and of accommodation and transport costs for family members for a stay in a hospital or GGZ institution (32.2). The conditions for reimbursement are listed below.

32.1 Overnight guest house accommodation during outpatient treatment

Are you receiving outpatient treatment? In that case, we reimburse overnight accommodation in a Ronald McDonald guest house or another guest house in the Netherlands 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

The costs of overnight accommodation on the night before the 1st day of treatment.

AV Compact
A maximum of €35 per night
AV Royaal
A maximum of €35 per night

32.2 Accommodation and/or transport costs for family members staying in a hospital or GGZ institution

Are you staying in a hospital or mental healthcare institution in the Netherlands, Belgium or Germany? Then we reimburse the following for your family members:

- Overnight accommodation in a Ronald McDonald guest house or another guest house in the vicinity of the hospital for your family members.
- Regardless of the mode of transport €0.30 per kilometre for transport by private car, public transport (lowest class) or taxi from the home address to and from the hospital, the GGZ institution or the guesthouse and the costs of transport between the guest house and the hospital or the mental healthcare institution. The number of reimbursable kilometres is based on the fastest route between the postcodes of your departure address and destination.

Personal payments transport

A personal contribution of €100 per calendar year applies for transport by public transport, taxi or private car. This means that you are responsible for the first €100 in costs for transport.

Conditions for reimbursement

- We only reimburse the costs for overnight stays in a guesthouse if you are staying in a hospital or mental healthcare institution located more than 50 kilometres from your home.
- What if you are staying in a hospital or mental healthcare institution in Belgium or Germany? Then we only reimburse the costs if your hospital stay was not arranged by our Healthcare Mediation team, as referred to in article 9.3 of 'Reimbursements covered by supplementary insurance policies'.
- Use the 'Vervoers- en/of overnachtingskosten' (Transport and/or Accommodation) claim form to submit your expenses. You can find the claim form on our website.
- You must be able to provide proof that you incurred the transport and/or accommodation expenses if we ask for it.
- Your family members must have AV Compact or AV Royaal supplementary insurance with us.

AV Compact
Accommodation expenses: a maximum of €35 per night. A maximum of €0.30 per kilometre, irrespective of the method of transport Transport and/or accommodation expenses: a maximum of €500 per calendar year for all family members combined
AV Royaal
Accommodation expenses: a maximum of €35 per night. A maximum of €0.30 per kilometre, irrespective of the method of transport Transport and/or accommodation expenses: a maximum of €500 per calendar year for all family members combined

Hospital, treatment and stay

Article 33 Mammaprint

We reimburse a mammaprint (diagnostic breast cancer test). In some cases a mammaprint enables the doctor providing treatment to make a more accurate diagnosis. This allows you and your treating physician to determine whether chemotherapy is the most suitable treatment for your situation.

Condition for reimbursement

The diagnostic test must be performed by the Agendia laboratory.

AV Compact
100%
AV Royaal
100%

Article 34 Ear repositioning (without medical indication)

We reimburse ear repositioning for cosmetic reasons for insured persons up to the age of 18.

Conditions for reimbursement

- The procedure must be performed by a medical specialist.
- You must be under the age of 18.

We only reimburse contracted care

The corrective procedure must be performed by a contracted care provider. What if you choose a non-contracted care provider? Then you will receive no reimbursement.

Do you want to know which care providers we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
100%

Article 35 Sterilisation

We reimburse sterilisation.

Conditions for reimbursement

The treatment must be performed at:

- The practice of a general practitioner qualified to perform the procedure if the insured person is male.
- A hospital or independent treatment centre (outpatient or day treatment).

We only reimburse contracted care

The treatment must be performed by a general practitioner qualified to perform the procedure or a medical specialist contracted for this purpose. What if you choose a general practitioner who is not qualified to provide this treatment or a non-contracted medical specialist? Then you will receive no reimbursement.
Do you want to know with which medical specialists we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

Please note! You are not required to pay an excess for the sterilisation itself. However, you are required to pay an excess for:

- The 1st consult if the operation will take place more than 90 days later.
- The post-check if it occurs more than 42 days after the operation.

What we do not reimburse

We do not reimburse reversal surgery.

AV Compact
No reimbursement
AV Royaal
100%

Article 36 Second Doctor Online

We reimburse the costs of Second Doctor Online. Second Doctor Online is a digital platform. Do you have doubts about a diagnosis and/or recommended treatment? Then you can seek advice from a (medical) specialist of your choice.

Condition for reimbursement

You must apply through ozf.nl/tweedeartsonline where you will also find more information. You are also welcome to contact us.

AV Compact
100%
AV Royaal
100%

Pregnancy/baby/child

Article 37 Maternity care related to adoption or medical screening required for adoption

Have you legally adopted one or more children during the period covered by your insurance and added the child(ren) to the OZF Zorgpolis? Then we reimburse the costs of:

- Maternity care related to adoption.
- Medical screening (preventive examinations).

Conditions for reimbursement

- In the case of maternity care related to adoption, the adopted child must be less than 12 months old at the time of adoption and must not already be part of your family.
- You can only opt for medical screening if you are adopting a child from abroad.
- The medical screening must be performed by a paediatrician.
- The medical screening must be a compulsory part of the adoption process.

We only reimburse contracted care

The maternity care related to adoption must be provided by a contracted maternity centre. What if you choose a non-contracted maternity centre? Then you will receive no reimbursement.
Do you want to know with which maternity centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

What we do not reimburse

We do not reimburse medical screening of an adopted child if the adoption process has already been completed.

AV Compact
Maternity care related to adoption: a maximum of 10 hours, or Medical screening required for adoption: a maximum of €300 per adopted child
AV Royaal
Maternity care related to adoption: a maximum of 10 hours, or Medical screening required for adoption: a maximum of €300 per adopted child

Article 38 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

The maternity package must be requested through ozf.nl/zwanger at least 2 months prior to the anticipated delivery date.

AV Compact
100%
AV Royaal
100%

Article 39 Maternity care

This article explains the situations in which we reimburse the statutory personal contribution payable by female insured persons for maternity care provided at home or in a birth or maternity centre (39.1). Reimbursement of extended maternity care (39.2) and postponed maternity care (39.3) is also listed below.

39.1 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 OZF Zorgpolis (see article 35 of 'OZF Zorgpolis Entitlements and Reimbursements')? In that case, we reimburse this statutory personal contribution for female insured persons.

AV Compact
A maximum of 24 hours per pregnancy
AV Royaal
100%

39.2 Extended maternity care

For female insured persons we reimburse extended maternity care for a maximum of 5 days if there is a medical necessity. Extended maternity care commences on the 11th day after the child was born.

Condition for reimbursement

A medical statement must confirm that there is a medical necessity.

We only reimburse contracted care

We only reimburse extended maternity care provided by a contracted maternity centre. What if you choose a non-contracted maternity centre? Then you will not receive a reimbursement.
Do you want to know with which maternity centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
A maximum of €200 per day for a maximum of 5 days

39.3 Postponed maternity care

For female insured persons we reimburse postponed maternity care if there is a medical necessity. Postponed maternity care is maternity care provided from the 11th day after the birth onwards.

Conditions for reimbursement

- The maternity centre must consider the postponed maternity care to be medically necessary.
- There was no provision of maternity care for the first 10 days after the child was born.

We only reimburse contracted care

We only reimburse postponed maternity care provided by a contracted maternity centre. What if you choose a non-contracted maternity centre? Then you will receive no reimbursement.
Do you want to know with which maternity centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
A maximum of €300

Article 40 Lactation care

For female insured persons who are having problems with breast-feeding, we reimburse advice and assistance provided by a lactation expert.

Conditions for reimbursement

The lactation expert:

- Must be a member of the Dutch Association of Lactation Experts (Nederlandse Vereniging van Lactatiekundigen (NVL)), or must meet the quality criteria established by the association.
- Must be employed by one of our contracted maternity centres. Do you want to know with which maternity centres we have a contract? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
No reimbursement
AV Royaal
A maximum of €115 per calendar year

Article 41 Outpatient childbirth without medical indication

Did you give birth in a hospital or birth centre as an outpatient under the supervision of an obstetrician, a midwife or a general practitioner without having a medical indication?
In that case, you are required to pay a statutory personal contribution under your basic insurance (see article 33.2 of 'OZF Zorgpolis Entitlements and Reimbursements'). We reimburse this statutory personal contribution for female insured persons.

AV Compact
100%
AV Royaal
100%

Article 42 TENS during delivery

For female insured persons we reimburse a TENS device used for pain relief during delivery. The delivery must be supervised by an obstetrician, a midwife or a general practitioner acting in this capacity.

Condition for reimbursement

You must be referred by a general practitioner, obstetrician, a midwife or a gynaecologist.

We only reimburse contracted care

We only provide reimbursement if the equipment is supplied by a contracted supplier. What if you choose a non-contracted supplier? Then you will receive no reimbursement.

Do you want to know which suppliers we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.

AV Compact
1 x for the duration of the supplementary insurance
AV Royaal
1 x for the duration of the supplementary insurance

Article 43 '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.

AV Compact
1 subscription for the duration of the supplementary insurance
AV Royaal
1 subscription for the duration of the supplementary insurance

Article 44 Antenatal classes

For female insured persons we reimburse:

- Antenatal courses during pregnancy that help prepare you for and/or guide you through the delivery process.
- Courses that promote physical recovery following delivery.

Conditions for reimbursement

- You must provide us with a confirmation of registration for the course and payment of the fees.
- The course, yoga or antenatal fitness classes must be given by:
  - A home nursing agency or maternity care institution.
  - 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).
  - An obstetric or midwifery practice or a health centre.

AV Compact
A maximum of €50 per pregnancy
AV Royaal
A maximum of €75 per pregnancy

Other questions

Article 45 Dietetic therapy and nutrition education

We reimburse dietetic therapy by a dietitian (article 45.1 and nutrition education by a weight management consultant or (sports) nutritionist (article 45.2).

45.1 Dietetic therapy by a dietitian

We reimburse dietetic therapy by a dietitian. Dietetic therapy involves the provision of information about, and advice on, nutrition and eating habits for medical reasons. This reimbursement applies in addition to the reimbursement of dietetic therapy under OZF Zorgpolis (see article 38 of 'OZF Zorgpolis Entitlements and Reimbursements').

Lower reimbursement for non-contracted care

Are you being treated by a non-contracted dietitian? In that case, we reimburse up to 75% of the average tariff we pay for this care (provided by contracted care providers).

Do you want to know which dietitians we have a contract with? In that case, use the Medical Provider Search Tool on ozf.nl/zorgzoeker or contact us.
A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen or obtained from us.

What we do not reimburse

We do not reimburse the costs of both dietetic therapy and nutrition education (see article 45.2) for the same diagnosis.

AV Compact
No reimbursement
AV Royaal
2 hours

45.2 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 there being a medical reason.

Conditions for reimbursement

- 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.
- 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 nutritionists can be found at sportzorg.nl/zoek-een-sportzorgprofessional.
- The (sports) nutritionist must be a member of the Nederlandse Vereniging van Diëtisten (NVD) (Dutch Association of Dietitians).

What we do not reimburse

We do not reimburse the costs of both dietetic therapy and nutrition education (see article 45.1) for the same diagnosis.

AV Compact
A maximum of €120 per calendar year
AV Royaal
A maximum of €120 per calendar year

Article 46 Hospice

We reimburse the costs of your stay at a hospice in the Netherlands. A hospice is a facility with a homelike atmosphere that provides end-of-life care for terminally ill people expected to die within a foreseeable period.

Conditions for reimbursement

- 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

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.

AV Compact
No reimbursement
AV Royaal
A maximum of €40 per night

Article 47 Patients association membership

We reimburse the costs of membership of a patients association.

Conditions for reimbursement

- The patients association must be affiliated with one of the following organisations:
  - Patiëntenfederatie Nederland (Netherlands Federation of Patient Associations).
  - Landelijk Platform Geestelijke Gezondheidszorg (LPGGz) (National Platform for Mental Health Care).
  - The Ieder(in) network for people with a disability or chronic illness.
- You must provide us with the original confirmation of payment.

AV Compact
No reimbursement
AV Royaal
A maximum of €25 per calendar year

Article 48 Support for informal caregivers and recipients

Informal care refers to the provision of unpaid, long-term care for a chronically ill or handicapped person in your immediate social circle. Are you an informal caregiver or do you receive informal care? Then to help cover the costs of necessary support services to ensure that you can keep providing or receiving informal care, we provide an allowance.

For you as an informal caregiver. Or for you as a recipient of informal care. What can you use the allowance for?

- Are you receiving informal care at home? Then you can use the allowance to pay for temporary replacement care while your main informal caregiver is away.
- For temporary professional support by taking over all kinds of regulatory tasks in the field of care, welfare, finance, etc. (informal care agent), up to a maximum amount of €250 per calendar year.
- for informal care instructions, informal care coaching and informal care courses, up to a maximum amount of €150 per calendar year.
- For receiving temporary domestic help up to a maximum amount of €450 per calendar year.

Conditions for reimbursement

- We must give you permission in advance. To request permission call the Personal Care Coach on (071) 364 0 280. You are also welcome to contact us. The Personal Care Coach will first see if they can provide the information and assistance you need and will then determine what kind of support you need and how much it will cost. The Personal Care Coach will then determine the amount of the allowance.
- Do the informal caregiver and the person receiving informal care both have supplementary insurance that covers Support for informal caregivers and recipients? Then reimbursement of Support for informal caregivers and recipients is first provided under the informal caregiver's supplementary insurance, and then under the recipient's supplementary insurance. Are several informal caregivers providing informal care for the same person? In that case, an allowance will only be provided for 1 informal caregiver.
- Do you want to use the allowance to pay for replacement care? Then your main informal caregiver must be absent when the replacement of informal care is provided.

What we do not reimburse

- The costs of services provided for both the informal caregiver and the person receiving informal care. Costs can only be claimed once.
- If these costs (regardless if via PGB or not) are reimbursed under the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)), Jeugdwet (Jw) or Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
- The costs of informal care if less than 8 hours of informal care a week has been provided or received for less than 3 months.
- The costs of additional hours of informal care required as a result of a (temporary) deterioration in the recipient's health. In this case, you must apply for another care needs assessment.
- Costs of support for informal care when the person receiving informal care is permanently staying in a long-term care institution.

AV Compact
A maximum of €750 per person per calendar year for all care provided by your Personal Care Coach combined.
AV Royaal
A maximum of €1,000 per person per calendar year for all care provided by your Personal Care Coach combined.

Article 49 Therapeutic holiday camps

We reimburse therapeutic holiday camps for children (49.1) and the disabled (49.2). At these holiday camps children and the disabled learn to cope with their illness, condition or disability, by learning and practising with others in the same situation.

49.1 Therapeutic holiday camp for children

Does your child have a serious or chronic illness? In that case, we reimburse a stay at a therapeutic holiday camp organised by:

- Diabetes Jeugdvereniging Nederland (for children with diabetes).
- Stichting Kinderoncologische Vakantiekampen (for children being treated for cancer).
- Stichting De Ster (Sterkamp and Maankamp) (to increase self-confidence and self-esteem).
- Nederlandse Hartstichting (Jump) (for children with cardiovascular disease).
- Bas van de Goor Foundation (sports camps for diabetics).
- Stichting Heppie.

Conditions for reimbursement

- You must be under the age of 18.
- You must provide us with proof of payment.

AV Compact
No reimbursement
AV Royaal
A maximum of €150 per calendar year

49.2 Therapeutic holiday camp for the disabled

We reimburse insured persons who are physically or mentally disabled for the stay in a therapeutic holiday camp.

Condition for reimbursement

You must provide us with proof of payment, which clearly states that it concerns a therapeutic holiday camp.

AV Compact
No reimbursement
AV Royaal
A maximum of €150 per calendar year

Reimbursements covered by dental insurance policies

Tand Compact and Tand Royaal

These articles only apply if this cover is specified on your policy certificate. For Tand Royaal you have to undergo a medical assessment. For this insurance, as part of the application process, we ask you to complete and submit a dental health certificate. You can find this on our website via ozf.nl/downloads.

Oral health care and dentistry

Article 50 Regular dental care and oral hygiene for insured persons aged 18 or older

Are you 18 or older? In that case, we reimburse dental treatment by a dentist, oral hygienist, dental surgeon or clinical dental technician.

Do you visit a dentist? In that case, we reimburse anaesthesia (A codes), consultations (C codes), fillings (V codes), extractions (H codes), X-rays (X codes) and a second opinion: 100%.

We reimburse 75% of the costs of other treatments, including oral hygiene (M codes) and periodontal treatment (T codes).

Do you visit an oral hygienist? In that case, the oral hygienist can conduct consultations (C codes), provide oral hygiene treatments (M codes), place small fillings (V codes) and perform periodontal treatments (T codes). We provide full reimbursement for C codes and V codes. We reimburse M codes and V codes for 75%.

Are you being treated by a dental surgeon? In that case, we reimburse periodontal surgery for 75%.

Are you going to get a full set of removable dentures? Or a full set of removable implant-retained (click-tight) dentures? And do we reimburse the dentures under the OZF Zorgpolis (see article 11 of 'OZF Zorgpolis Entitlements and Reimbursements')? Then we reimburse the statutory personal contribution for 75% under Tand Royaal.

Please note! We only reimburse the costs of dental care if the maximum reimbursement provided by your chosen Supplementary Dental Insurance has not yet been reached. This maximum reimbursement is €250 under Tand Compact and €1,000 under Tand Royaal.

What we do not reimburse

We do not reimburse:

- Dental check-up reports.
- Dental statements.
- Missed appointments.
- Non-restorative caries treatment in the deciduous teeth (M05).
- A fluoride treatment (M40).
- External bleaching of teeth and molars.
- A mandibular repositioning device (MRD) (a device used to prevent snoring) or the related diagnostic and follow-up care.
- A gum shield.
- Crowns, bridges, inlays and implants (see article 51 on this page).
- Orthodontic treatment (see article 52 on page 72).
- Cosmetic treatments.
- Subscription fees.
- General anaesthetic and nitrous oxide.
- A complicated extraction (removal of a tooth or molar) by a dental surgeon (see article 10 of 'OZF Zorgpolis Entitlements and Reimbursements').

Tand Compact
Anaesthesia (A codes), consultations (C codes), fillings (V codes), extractions (H codes), X-rays (X codes) and a second opinion: 100% Other dental treatments: 75% A maximum total reimbursement is €250 per calendar year
Tand Royaal
Anaesthesia (A codes), consultations (C codes), fillings (V codes), extractions (H codes), X-rays (X codes) and a second opinion: 100% Other dental treatments: 75% Statutory personal contribution toward the costs of a full set of removable (implant-retained) dentures (false teeth): 75% A maximum total reimbursement is €1,000 per calendar year

Article 51 Dental care - crowns, bridges, inlays and implants

We reimburse crowns, bridges, inlays and implants including the dental technician costs.

Conditions for reimbursement

- The treatment must be performed by a dentist or dental surgeon.
- On completion, the dentist or dental surgeon must declare the cost of the treatment as a single amount. In other words, the cost of the treatment cannot be declared as separate amounts (over 2 calendar years). This condition for reimbursement does not apply to implants.

What we do not reimburse

We do not reimburse partially completed work (R90).

Tand Compact
No reimbursement
Tand Royaal
75% up to a maximum of €750 per calendar year

Article 52 Dental care - Orthodontics (braces) for insured persons up to the age of 18 years

We reimburse orthodontic treatment (braces) and the costs of a second opinion for insured persons up to the age of 18.

Conditions for reimbursement

- An orthodontist or dentist must perform the treatment or provide the second opinion.
- You must be under the age of 18.

What we do not reimburse

- Have you lost or damaged existing orthodontic appliances through your own fault or negligence? Then we do not reimburse repair or replacement.
- A gum shield.

Waiting period for orthodontic care.

There is a waiting period of 12 months for the reimbursement of orthodontic care costs. This means that you will be paying the insurance premium during the waiting period, but cannot yet receive reimbursement for orthodontic care. The waiting period applies if you take out Tand Royaal in 2019 and did not have Tand Royaal in 2018. Your waiting period also applies if you switch from one of the other Achmea health insurers.

Tand Compact
No reimbursement
Tand Royaal
75% up to a maximum of €2,000 for the duration of the supplementary insurance

Services

OZF health insurance services

Some of the services you can count on when you are insured with us are listed below.

General contact information
Do you wish to make use of our services or do you have questions? Please call our Customer Service Department on (074) 789 0 789. Lines are open from 08:00 to 17:00 on working days. Of course, there is also a lot of information on our website, ozf.nl.

Claiming your care expenses is fast and easy
Many care providers invoice us directly for the services they provide. We usually settle the invoice directly with your care provider. Have you received an invoice? In that case you can send it to us. You can do this in 2 ways:

- Online: ozf.nl/declareren.
- By post: Zorgverzekeraar OZF, Claims Service Department, Postbus 94, 7550 AB Hengelo - NL.

Do you want to notify us of a change?
We obtain our data from the Municipal Personal Records Database (Basisregistratie personen (BRP)). This means that you do not need to provide us with certain information, you simply have to notify the municipal authorities if you move home or in the event of death, for example. What changes are you required to notify us of? You need to notify us if, for example, you wish to change your insurance package or your voluntarily chosen excess. Or if your bank details change, if you are separating or getting divorced, or if you want to add your baby to your OZF insurance policy. You also need to let us know if your telephone number or email address changes.
You can notify us in the following ways:

- Call our Customer Service team on (074) 789 0 789.
- Use the contact form on ozf.nl/contact.
- Send an email to info@ozf.nl.
- Through ozf.nl/mijnozf (after logging in with your DigiD).

Questions about reimbursements or how to find a contracted care provider?
Do you want to know what we reimburse? Then please see www.ozf.nl/vergoedingen. A list of the reimbursement tariffs that apply to care provided by non-contracted care providers can be found at ozf.nl/vergoedingen. You can use the Medical Provider Search Tool on ozf.nl/zorgzoeker to find a contracted care provider. Naturally, you are also welcome to call our Customer Service team on (074) 789 0 789 about any of these matters.

Do you want to pay your mandatory excess in instalments?
This option has been available for several years. For 2019, the government has set the statutory mandatory excess for insured persons aged 18 or older at €385. The invoice for the excess often arrives unexpectedly and always at an inopportune moment. In 2019 we once again make it possible for you to avoid this unpleasant financial surprise. You can pay the mandatory excess for 2019 in 12 monthly instalments of €32.08. You can pay these instalments together with your premium. This makes particular sense if you expect your care expenses to exceed the mandatory excess in 2019. What if your care expenses are less than the mandatory excess in 2019? In that case we will refund any overpayment. We will settle your account as soon as we have processed the invoices for the calendar year 2019. We will do this by 1 July 2020 at the latest. For more information see ozf.nl/eigenrisico.
Please note! If you wish to apply for or cancel your insurance, you must do this by 31 December 2018.

We offer attractive discounts
You will find full up-to-date details of customer benefits in 2019 at ozf.nl/klantvoordelen. You are also welcome to contact us for this information.

Also be sure to check out ozf.nl/mijnozf
In the Mijn OZF ('My OZF') section of our website you can see your healthcare use and costs, the status of your excess, the premium you have to pay and your policy certificate(s). Are you a policy holder? Then you will also be able to view summaries of your claims. You can choose to receive your healthcare costs digitally or by mail. As the policy holder you can also change your payment details and the insurance cover for yourself and co-insured family members. As the policyholder you can also apply for a payment arrangement online. Because this information is privacy sensitive, you have to log in with your DigiD and a code sent to your mobile device as a text message. You can also use the DigiD app.

Seeking help from our emergency response centre Eurocross Assistance
What if you fall ill unexpectedly during a temporary stay abroad and need emergency assistance? In that case please contact our emergency response centre Eurocross Assistance. If you are admitted to hospital it is actually compulsory for you to contact Eurocross Assistance. The assistance coordinators at Eurocross Assistance are there to help you 24 hours a day on +31 71 364 1 282.

Eurocross Assistance provides the following services:

- The emergency response centre can be contacted for advice and assistance 24 hours a day, 365 days a year.
- The assistance coordinators at Eurocross Assistance are aware of the local healthcare services and the quality of hospitals worldwide.
- During your stay in hospital the medical team at Eurocross Assistance will maintain regular contact with the doctor who is treating you abroad.
- Eurocross Assistance will support you abroad until you recover.
- Do you have OZF Zorgpolis basic insurance and AV Compact or AV Royaal supplementary insurance? Then Eurocross Assistance will arrange medical repatriation if necessary.

Holiday Doctor
What do you do if you are on holiday with your family and one of your children has been experiencing stomach pain for a couple of days? Do you go to a local doctor? Or do you decide to wait a bit longer? In cases such as these, when you are unsure, the Holiday Doctor (Vakantiedokter) is there to help. If you need non-urgent medical assistance, you can call the Holiday Doctor for free advice from your holiday address on +31 71 364 1 802. You will be put through to an expert assistant who speaks Dutch. The Holiday Doctor can be contacted between 07:00 and 23:00 from Monday to Friday, and between 09:00 and 21:00 on weekends and public holidays.
Please note! The Holiday Doctor is not for emergency assistance. For emergency assistance you should call our emergency response centre Eurocross Assistance on +31 71 364 1 282 (24 hours a day).

ZORGVERZEKERAAR OZF

OZF.
Your health insurer.

We are a relatively small health insurer. Our team of 30 staff provide dedicated and caring assistance for our customers. We make personal attention and customer friendliness a priority. We are a non-profit organisation. As well as providing personal insurance, we also provide group health insurance for a large number of companies. We are based in Hengelo in the Netherlands and operate nationally.

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Call us
Customer Service (074) 789 0 789
Lines are open from 08:00 to 17:00 on working days.

Email us
info@ozf.nl

Write to us
Zorgverzekeraar OZF
Customer Service Department
Postbus 94
7550 AB Hengelo

Submit your claims
- Online:
  ozf.nl/declareren
- By post:
  Zorgverzekeraar OZF
  Claims Service Department
  Postbus 94
  7550 AB Hengelo - NL

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