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Anderzorg healthcare insurance terms and conditions 2021

Basis | Budget | Jong | Extra | Tand

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Contact en service

We are more than happy to assist if you have any questions or need to pass on information.

Our website

You will find all the information about your insurance by visiting our website anderzorg.nl. You can, for example, calculate your premium, claim online, find care providers and view and compare all reimbursements from A to Z

Contact

You can reach us by telephone, chat and Whatsapp, post or via social media. You can also pass on information or a change in your policy, wherever and whenever you want, via Mijn Anderzorg: anderzorg.nl/mijnanderzorg.

Calling Anderzorg

The most important telephone numbers are given below. Visit anderzorg.nl/contact for information on current opening times.

Telephone numbers

Customer service: 088 222 44 22
Anderzorg Emergency Centre: +31 317 455 555 Can be reached 24 hours a day
Anderzorg Transport Service Line: +31 317 492 051

Postal address

Anderzorg
PO Box 1177
7500 BD Enschede

Complaints

Do you have a complaint about Anderzorg? Information regarding complaints and disputes can be found on anderzorg.nl/klantenservice. Or see Article A17 of the General terms and conditions.

Anderzorg-app

The Anderzorg App for iPhone and Android devices has many convenient features. The app contains detailed information about your insurance and offers the possibility to submit your claims online. Should you get stuck, you can also use the app to contact us. Your Anderzorg care card is also visible in your app. That is convenient whenever you visit a care provider! Download the Anderzorg app from the App Store or Play Store now!

Your Basic Insurance Anderzorg Basis

Below you will find a description of the care for which you are covered.

The Dutch text is binding should any disputes arise from the interpretation of the text.

Your Basic Health Insurance

The government defines the insured package of the Basic Insurance. The Dutch Healthcare Insurance Act, together with the Healthcare Insurance Decree and the Healthcare Insurance Regulations, is the foundation of these terms and conditions. We have described your coverage as clearly as possible in these insurance terms and conditions. In these terms and conditions, we sometimes refer to the Anderzorg Insurance Regulations. These Regulations are an integral part of the terms and conditions. In the unlikely event that something in these insurance terms and conditions should not concur with the Dutch Healthcare Insurance Act what has been defined in this Act will apply to you. If any other legal scheme can lead to the same care being paid, you will not be entitled to this care based on this Basic Insurance.

You can download the Anderzorg Insurance Regulations on anderzorg.nl/reglement (only available in Dutch). You can also call our Customer Service Center at 088 222 44 22 and ask for this document. More information on the Dutch Healthcare Insurance Act, Decree or Regulations is available on wetten.overheid.nl.

Contracted

You have chosen to take out the Anderzorg Basis. This is an insurance that is intended for everybody who lives in or outside of the Netherlands and who has to take out healthcare insurance. Anderzorg Basis is a contracted care policy. Contracted (or in-kind) means that you are entitled to the care itself (the opposite to contracted is restitution: restitution means that you are not entitled to the care itself but to be reimbursed for the costs of the care and to receive brokerage services for this care). All care for which you are insured is described on the following pages.

Going to a contracted care provider

In-kind benefits means that you are entitled to the care itself. Anderzorg, therefore, concludes contracts with care providers with regard to quality, price, accessibility and access times. Anderzorg has made arrangements that the bill of the care provider is sent directly to Anderzorg. You can check which type of care provider can deliver the care in the Articles below. A care provider is, for example, a hospital, medical specialist, speech therapist, physiotherapist, etc.

Going to a non-contracted care provider

If you decide to use a care provider who has not concluded a contract with Anderzorg, the costs will be reimbursed up to a maximum amount. Anderzorg reimburses 65% of the bill of the care provider up to a maximum of 65% of the amount that Anderzorg has contracted for this treatment on average. More information about this can be found on our website anderzorg.nl/vergoedingen. You can also call Anderzorg

Customer Service on 088 222 44 22. Any personal contributions that are owed and, subsequently, mandatory and voluntary excesses will be deducted from the amount to be reimbursed. If you would prefer a care provider without a care agreement, but the lower reimbursement (65%) is preventing you from making this decision, you can indicate to us why this lower reimbursement is preventing you from making this decision and request that a higher percentage be reimbursed as yet. We will handle your request and will inform you within 4 weeks whether we are able to offer you a higher reimbursement (at most 75% of the bill of the care provider, up to a maximum of 75% of the amount that Anderzorg has contracted for this treatment on average). Thereafter, any personal contributions to be paid and the mandatory and voluntary excess will be deducted from the amount to be reimbursed.



Note

Ask your care provider about his treatment rate and the treatment code in advance. The treatment code can be used to determine the maximum reimbursement. Please take into account unexpected circumstances, such as complications, follow-up treatments, a different treatment code or postponement of treatment. A different treatment code or postponement of treatment may affect the amount of the reimbursement. Complications or follow-up treatments may result in the non-contracted care provider charging additional costs. The amount you have to pay yourself may be higher if this is the case.

The Anderzorg Zorgvinder (Anderzorg Care Finder)

Anderzorg has made agreements with care providers close to your home about the quality, speed, service and price of the care provided. You can find out which care providers have a contract with Anderzorg by visiting 'The Anderzorg Zorgvinder' (The Anderzorg Care Finder) on anderzorg.nl/zorgvinder. Should you not have access to the Internet, you can also call Customer Service on 088 222 44 22. If you have questions about the care, please call the Anderzorg Care Advisor on 088 222 44 22.



Note

Care provided by a care provider that does not meet the criteria as specified in the insurance terms and conditions will not be eligible at all for reimbursement.

Contracted volume (revenue ceiling)

If Anderzorg has a contract with a care provider, an agreement may have been made about the maximum volume (revenue ceiling). This may mean that the care provider no longer needs to accept you for treatment if his or her revenue ceiling has (nearly) been reached. The care provider or Anderzorg will help you find another care provider who can treat you when this is the case. If agreements have been made with a care provider about the volume (revenue ceilings), this will be indicated in the ZorgVinder (Care Finder). If you are already being treated when the care provider reaches his or her revenue ceiling, you will not be affected. You can complete the treatment with your care provider.

Content and scope of care

The content and scope of the care in these insurance terms and conditions are determined by what care providers ‘tend to offer’, the state-of-the-art and best practices. Many care types have not been described in detail in law. These care types have been indicated as care as a certain professional group tends to offer. This is how the care type is indicated. Whether a treatment falls under a covered care type, is in part determined by the state-of-the-art and best practices.

The aforementioned means that you are covered for the care that the involved professional group counts amongst the accepted range of medical examination and treatment methods. Other types of care are described in detail such as medication and medical aids. It also applies to this that these care types only belong to the covered care insofar as they meet the state-of-the-art and best practices. There is no ‘state of the art’ with regard to certain types of care, for example, in relation to non-emergency patient transport services. A slightly different rule applies in these cases: you are insured for the assistance that applies within the involved professional area as responsible and adequate care and services.

Indication and efficiency

You will, of course only be examined or treated if this is required. There must be an indication to qualify for care. As the law prescribes, you must really be in need of this care. Which care is required for your case will be objectively determined. This care must, moreover, be effective. Care that is unnecessary or costs too much unnecessarily when compared to other types of care that is on an equal footing in view of the indication and your care need, will not be covered by the insurance.

Reasonable term and distance

You are entitled to care within a reasonable term and within a reasonable distance from your home address. What is deemed to be reasonable will depend on the type and urgency of the care. You are, in any case, entitled to care within the term that is deemed to be acceptable as a maximum in medical terms.

Excess

You will have to pay a mandatory excess of € 385 per calendar year when you are 18 or older. You can also pay a voluntary excess of € 100, € 200, € 300, € 400 or € 500 per calendar year in addition to your voluntary excess. Should you decide to accept a voluntary excess, you will receive a discount on the basis of the premium calculation. Per month with an excess of € 100 this discount amounts to € 4, with an excess of € 200 this discount amounts to € 7, with an excess of € 300 this discount amounts to € 11, with an excess of € 400 this discount amounts to € 16 and with an excess of € 500 this discount amounts to € 24.

Note

Some forms of treatment are claimed with a treatment code, this is referred to formally as: a DBC care product (diagnosis treatment combination), such as the care you receive in a hospital. A DBC care product comprises all activities and procedures carried out by the hospital and the medical specialist for the purpose of diagnosis and treatment. The hospital claims a single amount for a DBC care product. In the event a DBC care product is provided in 2 consecutive years, the costs of the DBC care product count towards the excess of the year in which the DBC care product commenced (opening date). This means that if a DBC care product is opened in 2021and closed in 2022, the costs of the DBC care product count towards the excess for the year 2021. If a new, follow-up DBC care product is opened after a DBC care product has been closed, you will have to pay excess again for this new DBC care product.

No Excess

The excess – mandatory and voluntary – does not apply to:

- maternity and obstetric care (the excess does apply to the costs of laboratory tests, medication and (ambulance) transport). Care received during and after child-birth is regarded as obstetric care, regardless of the outcome of the pregnancy (for instance a miscarriage), no mandatory excess applies to these costs and neither to treatment costs for health problems which occur within 6 weeks after child-birth and which are related to the pregnancy,
- medical aids that are issued on loan (the excess does apply to the consumables of the medical aid),
- the costs of registering with a general practitioner (GP) or an institution providing GP care,
- General practitioner care, multidisciplinary care which includes general practitioner care, stop smoking programmes and combined lifestyle interventions. Laboratory and functional examinations requested by the general practitioner are covered by the excess if these examinations are carried out elsewhere and are charged separately. The excess also applies to Medical Care for Specific Patient Groups,
- chronic medical assessment Solely prescription medication use if you visit a pharmacy or general practitioner,
- nursing and (home) care,
- donors, they do not have to pay a compulsory excess for care directly related to organ donation,
- transport of the donor in relation to transplants that are listed in the “Transplant” article at the 8th and 9th hyphen under “Which care”,
- follow-up check-ups of the donor with regard to transplantation after the period specified in the Transplantation the article at the 7th hyphen under “Which care” has elapsed,
- Medication and nicotine-replacing substances as part of a stop smoking programme, if you purchase them from a contracted care provider.

If you pay a personal contribution or payment, this will not be part of your excess. If the insurance does not start or end on 1 January of a year, the excess will be applied proportionally. First, the mandatory excess is applied and thereafter the voluntary excess. If Anderzorg pays your healthcare bill to the care provider

directly, you or the policyholder (at the discretion of Anderzorg) must reimburse Anderzorg the excess and possibly the personal contribution (should this apply). You or the policyholder will receive a bill from Anderzorg in this case. The excess or personal contribution will also apply if you visit a contracted care provider.

Examples

1. You will be 18 on 20 November. The excess will then apply as from 1 December. The excess related to a 31/365 part applies for that year.
2. You will have to pay an excess of € 385. You are treated in hospital but will not receive a bill. Anderzorg will pay the costs directly to the hospital. You will, next, receive a bill from Anderzorg for € 385.
3. You are admitted to hospital on 20.12.2021 and are discharged on 10.01.2022. The excess will now be applied once in 2021.

Order of personal payments

Different types of personal payments may apply to the reimbursement of a bill. The order in which they are applied is:

1. any non-insured part is deducted from a bill,
2. any part that is not reimbursed because the care provider does not have a contract with Anderzorg,
3. any personal contribution,
4. the still outstanding part of a mandatory excess,
5. The still outstanding part of any voluntarily selected excess.

Other

Forensic care as referred to in Section 2 of the Forensic Care Interim Decree and youth mental healthcare as referred to in Section 10.2, first paragraph, of the Dutch Youth Care Act as referred to in Section 1.1 of the Dutch Youth Care Act is not insured in your Basic Insurance. We have made agreements with municipalities for integral care provision (Section 14a of the Dutch Healthcare Insurance Act). Insofar as they may be important for the insurance terms and conditions, they have been processed in these insurance terms and conditions in accordance with Section 14a, paragraph 1.

Abroad

The rules of these insurance terms and conditions, EC Regulation 883/2004 and bilateral agreements apply to care abroad.

Which care?

The terms and conditions as specified below for the different care types in the insurance terms and conditions apply to care abroad. You are entitled to care provided by a foreign care provider contracted by Anderzorg. If care is provided by a non-contracted care provider, you will be reimbursed for the costs of care that you would receive in the Netherlands from a non-contracted care provider. If you are residing or staying in another EU/EEA country or Treaty Country and not the Netherlands, you can choose from:

- right to care in accordance with the statutory scheme of that country,

- right to care from a care provider contracted by Anderzorg, or
- reimbursement of costs for care from a non-contracted care provider that you would be reimbursed if you would receive care from a non-contracted care provider in the Netherlands.

This choice will also be available to you if you reside in another EU/EEA country or Treaty Country and are staying in the Netherlands or another EU/EEA country or Treaty Country temporarily. If you reside or are staying in a country that is not an EU/EEA country or Treaty Country, you will be entitled to the reimbursement of the costs of care that you would be given in the Netherlands by a non-contracted care provider.

Permission

For hospital care abroad, that is to say medical care with admission in an institution of at least one night in another country than the country where you reside, you will require prior permission from Anderzorg. Call the Anderzorg Care Advisor on 088 222 44 22 for more information. Prior permission is not required when care is needed while you are abroad and the care involved cannot be deferred in all reasonableness until you return to the Netherlands.

Emergency Centre

If you are abroad and you require care there, you can call the Emergency Centre on +31 317 455 555. You will also find this telephone number on your Anderzorg Care Card. The Emergency Centre can be reached day and night. Call in the Emergency Centre direct to assist with regard to emergency care.

Additional information

You can find additional information about care abroad on anderzorg.nl/buitenland.

Audiological assistance

Audiological assistance is a type of medical specialist care. Audiological assistance is preventing, tracing, examining and treating different types of hearing disorders.

Which care?

You are entitled to :

- hearing disorder investigation,
- advice about hearing aids to be purchased,
- information provision about the use of the aids,
- psychosocial care when you are having problems with regard to the affected hearing,
- assistance when making a diagnosis with regard to speech and language disorders with regard to a child.

Which care provider?

You can visit an audiological centre for audiological assistance.

Anderzorg has contracts with audiological centres. You can select a centre from this list of centres. You will find an overview of care providers who have concluded a contract with Anderzorg on our website anderzorg.nl/zorgvinder by entering the “audiological assistance” search term. You can also call Customer

Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral

You are only entitled to audiological assistance when you have a written referral from your general practitioner or medical specialist (paediatrician or throat, nose and ear specialist).

Additional information

Would you like more information about hearing aids? Hearing aids are part of Medical aids. More information can be found in the Insurance Rules and Regulations and the Health Insurance Regulations. These rates can be found by visiting anderzorg.nl.

Dietetics

Dietetics is information provision about nutrition and eating habits with a medical objective. A dietician is the appointed expert that discovers, studies and, if required, adjusts eating patterns. The dietician can boost physical health by recommending a specific eating pattern (diet).

Which care?

You are entitled to a maximum of 3 treatment hours for dietetics per calendar year with a medical objective about eating and eating habits. A treatment hour consists of the planned time that you are consulting the dietician and the average time that is required for the work related to the consultation (for example, finding information, setting down a dietary recommendation on paper or providing a report to the doctor).

Which care provider?

You can visit a dietician who is earmarked as “Quality Registered” in the Paramedic Quality Register with regard to this care. You can find this register on kwaliteitsregisterparamedici.nl.

Anderzorg has contracted dieticians. You can select from these care providers. You will find an overview of dieticians on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral

No referral is required when you visit a contracted dietician who is immediately available for consultation. For this purpose can see whether a dietician can be accessed immediately in the Paramedic Quality Register.

In the following cases, a prior written referral from your general practitioner, medical specialist or youth healthcare doctor is always required, or from your company doctor when the complaints are related to your work:

- when you visit a contracted dietician who is not immediately available for consultation,
- when you visit a non-contracted dietician,
- when you visit a dietician who works at a hospital, care home or rehabilitation centre,
- when you want dietetics outside of the dietician’s practice, except for treatment at home.

Dietary preparations

A dietary preparation or prescription diet is a food type with another composition and another form than normal food. An example is drip-feeding.

Welke zorg

You are entitled to polymer, oligomer, monomer and modular dietary preparations. You will only be entitled to dietary preparations when you cannot manage on an adjusted normal diet and/or other special diet products and if you:

- suffer from a metabolic disorder,
- suffer from a food allergy,
- suffer from a resorption disorder,
- suffer from a illness-related malnutrition determined through a validated screening instrument or are at risk of suffering from this, or
- are dependent on dietary preparations in accordance to the guidelines that have been accepted by the relevant professional groups in the Netherlands.

Which care provider?

For dietary preparations, you can visit a dispensing chemist's, a general practitioner with dispensing facilities or a supplier of dietary preparations.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The "To a non-contracted care provider" article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Treatment advice

You require treatment advice from a general practitioner, a medical specialist or a dietician.

Maximum period

You are entitled to dietary preparations for at most a month for each prescription.

Permission

If you use a contracted care provider, you should hand over a medical certificate completed by your general practitioner, medical specialist or dietician together with the prescription. If the indication conditions have been met, you will immediately be given the dietary preparations. If you use a care provider who has not concluded a contract with Anderzorg you will require prior permission from Anderzorg. You can in this case use a Anderzorg request form for pharmaceutical care. With the form you must enclose a written well-founded explanation from the doctor who is treating you. You can find the request form by visiting anderzorg.nl.

Note

Prior permission for infant formulae in case of cow's milk allergy:

- without carrying out a provocation test,
- when the child is aged two years or older,
- in excess of 1000 ml per day.

Note

- Should you purchase a dietetic preparation over the counter such as at the supermarket or a chemist, you will not be reimbursed for the incurred costs.
- The medical certificate will be assessed by the care provider. If you would rather the care provider does not do this, the medical certificate can be assessed by Anderzorg.

Primary care institution

It may be the case in specific situations that you have to deal with care requirements where your GP does not believe that it is medically responsible any more to stay at home, but where you do not have to be admitted to hospital. Your general practitioner can then determine in consultation with you that you be admitted in what is referred to as a primary care institution.

Which care?

You are entitled to stay during the 24 hours that are required medically in relation to medical care as general practitioners usually offer. You are also entitled to the related required nursing, care and paramedical care. Your admittance is insured for an uninterrupted period of 1,095 days. An interruption of a maximum of 30 days is not considered to be an interruption but does not count for the calculation of the 1,095 days. An interruption due to weekend or holiday leave does, however, count.

Which care provider?

Primary care institution takes place at an institution that is accredited under the Care Institutions (Accreditation) Act (WTZi) as an institution for nursing and care or is accredited as an institution for nursing, care and treatment.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg by using the “staying in a primary care institution” search string. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Indication and permission

You are only entitled to staying in a primary care institution if you have a prior written indication from your general practitioner, medical specialist (who can delegate this to a transfer nurse), geriatric specialist, doctor for the mentally challenged or social worker. If the stay is for a period that is longer than 6 months, you will require prior permission from Anderzorg. Your treating physician (GP, geriatric specialist or doctor for the mentally challenged) can request this permission on your behalf.

Genetic testing

Genetic testing is a form of medical specialist care (also see that Article). Genetic testing is carried out to determine whether a complaint or a congenital defect is hereditary.

Which care?

You are entitled to :

- central diagnostics, coordination and registration of supplied blood and bone marrow preparations,
- the examination into and of inherited defects by means of genealogical tests, chromosome tests, biochemical diagnostics, ultrasound and DNA tests,
- hereditary advice and the psychosocial supervision related to this care,
- testing of other people should this be necessary to provide advice. Advice can also be provided to the other people.

Which care provider?

You can visit a centre for genetic testing for this type of testing. This is an institution holding a permit pursuant to the Dutch Special Medical Procedures Act [Wet op de bijzondere medische verrichtingen (Wbmv)] for the application of clinical genetic research and advice on matters concerning hereditary diseases.

Anderzorg has contracts in place with centres for genetic testing. You can select a centre from this list of centres. You can find an overview of care providers who have concluded a contract with Anderzorg by visiting anderzorg.nl/zorgvinder and searching based on the “Genetic testing” search term. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non- contracted care provider.

Referral

You are only entitled to genetic testing when you have a written referral from your general practitioner or medical specialist issued in advance.

Occupational therapy

Occupational therapy helps people who experience problems in carrying out daily activities due to physical, mental, sensory or emotional complaints. The occupational therapist (also known as an ergotherapist) provides practical solutions in the environment of the client so that daily activities are again possible. The occupational therapist can also provide advice about the use of aids and offer support with regard to the request/application procedure.

Which care?

You are entitled to at most 10 treatment hours of occupational therapy per calendar year when the objective is stimulating and restoring your ability to care for yourself and your ability to live independently.

Which care provider?

You can visit an occupational therapist who has the entry of “Quality Registered” in the Paramedic Quality Register. You can find this register on kwaliteitsregisterparamedici.nl.

Anderzorg has contracts in place with occupational therapists. You can select from these occupational therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted

care provider" article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non- contracted care provider.

Referral

You do not need a referral if you visit a contracted occupational therapist who is available immediately. You can find out whether an occupational therapist is available immediately in the Paramedic Quality Register.

In the following cases, a prior written referral from your general practitioner, medical specialist or youth healthcare doctor is always required, or from your company doctor when the complaints are related to your work:

- when you visit a contracted occupational therapist who is not immediately available for consultation,
- when you visit a non-contracted occupational therapist,
- when you visit an occupational therapist who works at a hospital, care home or rehabilitation centre.

Physiotherapy, exercise therapy, pelvic physiotherapy

Physiotherapy

The physiotherapist stabilises, reduces or restores a functional disorder or the results of this by applying physiotherapy, advice and/or supervision. The physiotherapist will try to improve the function of the posture and locomotory apparatus as well as other issues. Normal posture and movement will again be possible or you will learn how best to cope with your restrictions.

Which care?

You are entitled to physiotherapy. What you are exactly entitled to, will depend on whether you are older or younger than 18. Working on the improvement or retention of your physical condition in the form of medical fitness (or a comparable activity such as physiotherapy fitness, Slender You and group swimming) and extracorporeal shockwave therapy are not classed as being physiotherapy. You are not entitled to those treatments. More information can be found on anderzorg.nl.

18 years old or older

You are entitled to physiotherapy as from the 21st treatment when a complaint is involved that has been specified on the list defined by the Minister of the Dutch Ministry of Health, Welfare and Sport. You are entitled to physiotherapy for a maximum period in relation to a few conditions. You can find out whether this is the case from the list that the Minister of Public Health, Welfare and Sport has established. This is the list included in Annex 1 with Section 2.6 of the Decree on health insurance. You can find this list by visiting anderzorg.nl. You can also contact Customer Service on 088 222 44 22.

> **Note**
> You are not entitled to the first 20 treatments for each disorder based on your Basic Insurance. A number of treatments is included in the additional Anderzorg insurances. Check your additional insurance for more information.

Younger than 18

You are entitled to physiotherapy in the same cases as people who are 18 or older, but also from the first treatment. If you have a complaint that cannot be found on the list that the minister of Public Health,

Welfare and Sport has established, you are entitled to 9 treatments at most for the each complaint per calendar year. If the first 9 treatments are not sufficient, you are entitled to another 9 treatments at most per year.

Which care provider?
You can visit a general physiotherapist for most complaints. For some specific complaints, you are best visiting a therapist who specialises in the treatment of these complaints. Examples of this include the following:

- the manual therapist: specialised in complaints in which the spinal column and limbs play a part,
- the child physiotherapist: specialised in complaints in which the motor development and learning of the child play a crucial role,
- the geriatric physiotherapist: specialised in complaints in vulnerable older people and clients/ patients with a high (biological) age who have to deal with complex health issues,
- the pelvic physiotherapist: specialised in complaints in which the pelvic region and hips play a crucial role,
- the oedema therapist: specialised in complaints in which lymphoedema plays a crucial role.

We recommend asking your physiotherapist whether he or she specialises in the treatment of your complaints.

Note
You can only visit a general physiotherapist, child physiotherapist, manual therapist, oedema physiotherapist, geriatric physiotherapist or a pelvic physiotherapist who is registered in the Centraal Kwaliteitsregister Fysiotherapie (CKR; Central Quality Register) or in the Keurmerk Fysiotherapie (Physiotherapy Quality Mark) register. You can also visit a skin therapist who is registered as “Quality Registered” in the Paramedic Quality Register for oedema therapy and scar therapy. For questions regarding specialized physiotherapy you can contact the Anderzorg Care Advisor on 088 222 44 22 .

By visiting anderzorg.nl/zorgvinder you will find an overview of care providers who have concluded contracts with Anderzorg. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral
In the following cases a prior written referral from your general practitioner, medical specialist, youth healthcare doctor or dentist or from your company doctor when the complaints are related to your work is required:

- if it involves a condition that is specified in the aforementioned list (Annex 1, Article 2.6 of the Healthcare Insurance Decree). Your medical specialist must have made the diagnosis,
- when you are younger than 18: when you go to a non-contracted therapist for the first nine treatments or go to a contracted therapist who is not immediately available for consultation.

Note

It is possible that Anderzorg may make more inquiries about the purpose and need for the treatment at the physiotherapist. For example, when you receive more than 50 treatment sessions per year. Anderzorg and the professional group of physiotherapists believe that effective care provision is important. This ensures we can offer the correct treatment and we can keep costs as low as possible for you.

Exercise therapy

Exercise therapy is aimed at improving posture and the way in which people with physical complaints move. The idea behind the therapy is that posture and movement are unconsciously modified based on the complaints and that these complaints continue due to this. The therapy consists of exercises to correct posture and movement.

Which care?

You are entitled to exercise therapy. What you are exactly entitled to, will depend on whether you are older or younger than 18. Working on the improvement or retention of your physical condition in the form of medical fitness or a comparable activity such as Slender You and group swimming is not classed as exercise therapy. You are not entitled to those treatments. More information can be found on anderzorg.nl.

18 years old or older

You are entitled to exercise therapy as from the 21st treatment when a complaint is involved that has been specified on the list defined by the Minister of the Dutch Ministry of Health, Welfare and Sport. You are entitled to exercise therapy for a maximum period in relation to a few conditions. You find out whether this is the case from the list that the Minister of Public Health, Welfare and Sport has established. The list is included in Annex 1 of Article 2.6 of the Dutch Health Insurance Decree. You can find this list by visiting anderzorg.nl. You can also contact Customer Service on 088 222 44 22.

Note

You are not entitled to the first 20 treatments. A number of treatments is included in the additional Anderzorg insurances. Check your additional insurance for more information.

Younger than 18

You are entitled to exercise therapy in the same cases as people who are 18 or older, but also from the first treatment. If you have a complaint that cannot be found on the list, you are entitled to 9 treatments at most for each complaint per year. If the first 9 treatments are not sufficient, you are entitled to another 9 treatments at most per year.

Which care provider?

You can visit an exercise therapist or a child exercise therapist who is registered as a “Quality registered” practitioner in the Paramedic Quality Register. Anderzorg has contracted exercise therapists. You can select an exercise therapist from this list. You will find an overview of care providers who concluded a contract with Anderzorg on anderzorg.nl/zorgvinder. Call the Anderzorg Care Advisor on 088 222 44 22 for more information about exercise therapy. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non- contracted care provider.

Referral
In the following cases a prior written referral from your general practitioner or medical specialist or from your company doctor when the complaints are related to your work is required:

- if it involves a condition that is specified in the aforementioned list (Annex 1, Article 2.6 of the Healthcare Insurance Decree). Your medical specialist must have made the diagnosis,
- when you are younger than 18: when you go to a non-contracted therapist for the first nine treatments or go to a contracted therapist who is not immediately available for consultation,
- for treatment outside of the therapist's practice, except for treatment at home.

Pelvic physiotherapy with regard to urine incontinency

The pelvic physiotherapist will help you recognise and train all relevant muscles around the pelvic area. The pelvic floor is a sling of muscles at the bottom of the pelvis that supports the stomach organs, opens and closes the pelvic exit and contributes towards pelvic stability. The pelvic floor muscles work closely together with the stomach and back muscles and play an important role with regard to our daily movement and in preventing back and pelvic pain.

Which care?
You are entitled to 9 pelvic physiotherapy treatments at most in relation to urine incontinency when you are 18 or older. This applies to the full insurance duration. Working on the improvement or retention of your physical condition in the form of medical fitness (or a comparable activity such as physiotherapy fitness, Slender You and group swimming) and extracorporeal shockwave therapy are not classed as being pelvic physiotherapy. You are not entitled to those treatments. More information can be found on anderzorg.nl.

Which care provider?
You can visit a pelvic physiotherapist who is registered with the Centraal Kwaliteitsregister Fysiotherapie (CKF; Central Physiotherapy Quality Register) or is registered in the Kwaliteitskeurmerk Fysiotherapie (the Physiotherapy Quality Mark).

Anderzorg has contracted therapists. You can select from these therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The "To a non-contracted care provider" article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Referral
You are only entitled to pelvic physiotherapy when you have a written referral from your general practitioner, medical specialist or obstetrician.

Note
Not all treatments are reimbursed. Treatments that are not regarded as physiotherapy will not be reimbursed. Examples include: Working on the improvement or retention of your physical condition in the form of medical fitness (or a comparable activity such as physiotherapy fitness, Slender You and group swimming) and extracorporeal shockwave therapy are not classed as being physiotherapy. You are not entitled to those treatments. More information can be found on anderzorg.nl. This list is not a full overview.

Intermittent claudication

Intermittent claudication is related to symptomatic peripheral arterial disease, a type of disability when walking. The arteries in your legs carry too little oxygen for the muscles that you use when walking within this context. This is because these arteries have narrowed. Narrowing occurs because of arteriosclerosis (Intermittent claudication condition).

Which care?

If you are 18 or older, you will be entitled for at most 12 months to at most 37 exercise therapy sessions under supervision of a physiotherapist or exercise therapist if you suffer from intermittent claudication. Intermittent claudication is deemed to mean the following: peripheral arterial disease in stage 2 Fontaine.

Which care provider?

You can visit a physiotherapist or exercise therapist who is a member of ClaudicatioNet.

Anderzorg has contracted therapists. You can select from these therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Referral

You are only entitled to being treated for intermittent claudication when you have a prior written referral from your general practitioner or medical specialist.

Arthrosis of the hip or knee joint

Arthrosis is wear of a joint. The cartilage becomes thinner and is damaged.

Which care?

If you are 18 or older, you will be entitled for at most 12 months to at most 12 exercise therapy sessions under supervision of a physiotherapist or exercise therapist if you suffer from arthrosis of the hip or knee joint.

Which care provider?

You can visit a physiotherapist or exercise therapist. Anderzorg has contracted therapists. You can select from these therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call our Customer Service desk on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Chronic obstructive pulmonary disease (COPD)

COPD is a pulmonary disease that has damaged your lungs. Breathing is more difficult and you have less energy. The abbreviation COPD stands for Chronic Obstructive Pulmonary Disease. Exacerbation applies in case the illness becomes more active after having shown no or little activity for a prolonged period of time.

Which care

If you are aged 18 or over you are entitled to exercise therapy under the supervision of a physiotherapist or exercise therapist in case of stage II or higher of the GOLD Classification for spirometry. This must be established by a doctor. You are entitled to at most:

a. in case of class A of the GOLD Classification for symptoms and risk of exacerbation: 5 treatments during a period of at most 12 months,
b. in case of class B1 of the GOLD Classification for symptoms and risk of exacerbation:
    1. 27 treatments during at most 12 months after the start of treatment, and
    2. 3 treatments per 12 months in the subsequent years;
c. in case of class B2, C or D of the GOLD Classification for symptoms and risk of exacerbation:
    1. 70 treatments during at most 12 months after the start of treatment, and
    2. 52 treatments per 12 months in the subsequent years.

Number of treatments per period	Class A	Class B1	Class B2, C	Class D
The maximum number of treatments during the 1st 12 months (the 1st year of treatment)	5	27	70	70
The maximum number of treatments per 12 months for the maintenance phase (the years after the 1st year of treatment)	0	3	52	52

Which care provider?
You can visit a physiotherapist or exercise therapist.

Anderzorg has contracted therapists. You can select from these therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call our Customer Service desk on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Mental healthcare

Mental Healthcare provides diagnostics and treatment for people with psychological disorders. The objective is to restore or improve mental health and to improve the quality of life. Mental Healthcare is subdivided into psychological care provided by the general practitioner, general basic mental healthcare (GBGGZ) and specialist mental healthcare. Specialist mental healthcare (SGGZ), in turn, is subdivided into outpatient specialist mental healthcare (without admission) and clinical specialist mental healthcare (with admission). Youth mental healthcare as referred to in Section 10.2, first paragraph, of the Dutch Youth Care Act as referred to in Section 1.1 of the Dutch Youth Care Act is not insured.

General basic mental healthcare (GBGGZ)

Which care?
You are entitled to general basic mental care if you have a recognised psychological DSM (Diagnostic and Statistical Manual or Mental Disorders) mental disorder. Treatment takes place based on a Short, Medium, Intensive or Chronic care product. A care product lasts a maximum of 365 days. The care product is determined through a treatment plan that the care provider and you draw up together. The scope of the care is limited by what clinical psychologist and psychiatrists usually offer.

Note

- Not every treatment of a mental disorder or mental healthcare treatment is covered by the Basic insurance. Ask your care provider before you start the treatment or ask the Anderzorg Care Advisor on 088 222 44 22 .
- You are not entitled to treatment of adaptive disorders and to assistance with regard to psychological complaints that are related to work and relational issues.
- If you submit a bill to Anderzorg, it must contain all data that is required in accordance with legislation and regulations. You can find it by visiting anderzorg.nl. Anderzorg can ask for additional information from you to establish the legitimacy of the claim.

Which care provider?
You can visit an independent:

- healthcare psychologist,
- psychotherapist,
- clinical psychologist,
- clinical neuropsychologist.

You can go to a mental healthcare institution where one of the following practitioners is a managing practitioner:

- healthcare psychologist,
- clinical psychologist,
- clinical neuropsychologist,
- psychotherapist,
- nursing specialist mental healthcare,
- if dementia is the main diagnosis: the geriatric healthcare specialist or clinical geriatrician,
- if the main diagnosis is addiction and/or gambling: the doctor who specialises in addiction.

Other practitioners involved in your treatment at that institution must formally act under the responsibility and supervision of this managing practitioner. The managing practitioner is the practitioner who is ultimately responsible for the entire treatment process. He is also the primary contactperson for everyone involved, including yourself and those close to you.

Quality charter
Every care provider must have a quality charter that is registered with the Zorginstituut Nederland (Dutch National Health Care Institute) as from 1 January 2017. This quality charter will specify what the healthcare provider has arranged for you about quality and justification. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Anderzorg has contracted care providers. You can select from these care providers. All care providers contracted by Anderzorg will have a quality charter. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

If you go to a non-contracted care provider, check whether this care provider has a quality charter prior to

the treatment. You can contact the Anderzorg Care Advisor on 088 222 44 22 for this. You can also contact the relevant care provider, visit the website of the care provider or visit zorginzicht.nl. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Referral
You are only entitled to general basic mental healthcare if you have a prior written referral from your general practitioner, medical specialist, emergency care physician (first aid), your community health doctor or your managing practitioner issued in advance. This means that the referral letter must be dated before the date of your first visit to the general basic mental health care provider. The referral letter must specify the DSM (Diagnostic and Statistical Manual of Mental Disorders) mental disorder your referrer thinks you suffer from.

Specialist mental healthcare without hospitalisation

You will receive care on a specialist level with regard to specialist mental healthcare. Outpatient specialist mental healthcare means that you visit the care provider regularly for your treatment but that you stay at home where you also sleep. Most psychological disorders can be treated as an outpatient.

Which care?
You are entitled to diagnostics and treatment of complex and/or multiple mental disorders where a multidisciplinary approach is often required. The scope of specialist mental healthcare (SGGZ) is limited by what clinical psychologists and psychiatrists usually offer.

Note

- Not every treatment of a mental disorder or mental healthcare treatment is covered by the Basic Insurance. Ask your care provider or ask our Anderzorg Care Advisor (Care Advice) for information on 088 222 44 22 before your treatment starts.
- You are not entitled to treatment of adaptive disorders and to assistance with regard to mental complaints that are related to work and relational issues.
- If you submit a bill to Anderzorg, it must contain all data that is required in accordance with legislation and regulations. You can find it by visiting anderzorg.nl. Anderzorg can ask for additional information from you to establish the legitimacy of the claim.
- Addiction healthcare is often expensive and is not really guaranteed in all cases and certainly when addiction healthcare takes place abroad. Therefore, ensure you are correctly informed in advance if you want to be treated for addiction. You can contact the Anderzorg Care Advisor on 088 222 44 22 for this.

Which care provider?
For specialist mental healthcare without admission you can go to an independently established:

- psychotherapist,
- clinical psychologist,
- clinical neuropsychologist,
- psychiatrist.

You can go to a mental healthcare institution or the outpatients' department of a psychiatric department of a hospital where one of the following practitioners is a managing practitioner:

- psychiatrist,
- clinical psychologist,
- clinical neuropsychologist,
- psychotherapist,
- healthcare psychologist,
- nursing specialist mental healthcare,
- geriatric healthcare provider specialist,
- clinical geriatrician,
- doctor who specialises in addiction.

Other practitioners involved in your treatment at that institution must formally act under the responsibility and supervision of this managing practitioner. A psychiatrist or clinical psychologist is always a part of the multidisciplinary team that treats you. The managing practitioner is the practitioner who is ultimately responsible for the entire treatment process. He is also the primary contactperson for everyone involved, including yourself and those close to you.

Quality charter

Every care provider must have a quality charter that is registered with the Zorginstituut Nederland (Dutch National Health Care Institute) as from 1 January 2017. This quality charter will specify what the healthcare provider has arranged for you about quality and justification. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Anderzorg has contracted care providers. You can select from these care providers. All care providers contracted by Anderzorg will have a quality charter. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The "To a non-contracted care provider" article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

If you go to a non-contracted care provider, check whether this care provider has a quality charter prior to the treatment. You can contact the Anderzorg Care Advisor on 088 222 44 22 for this. You can also contact the relevant care provider, visit the website of the care provider or visit zorginzicht.nl. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Referral

You are only entitled to specialist mental healthcare without admission if you have a prior written referral from your general practitioner, medical specialist your community health doctor or your managing practitioner issued in advance. This referral letter must be dated before the date of your visit to the SGGZ, must at least specify the (Diagnostic and Statistical Manual of Mental Disorders) mental disorder your referrer thinks you suffer from and the reason for the referral. If emergency care is required for which no referral was reasonably possible, you do not require a written referral.

Note

- If you decide not to go to your appointment and you have not cancelled it in time, you must pay the relevant costs yourself.
- If you do not wish the diagnosis code to be specified on the bill but want to claim the costs, a doctor's declaration is required in advance or with the first bill at the latest. You must sign a doctor's declaration together with your practitioner and send it to Anderzorg. This doctor's declaration pro forma can be found by visiting anderzorg.nl/vergoedingen.

Specialist mental healthcare with hospitalisation

Some mental issues are of such a serious nature that outpatient treatment is not sufficient. Admission at a psychiatric clinic or the psychiatric ward of a general hospital is then the best solution. This means that you will be given your treatment in the clinic or hospital and this also means that you will be living and sleeping in the clinic or the hospital for the duration of the treatment. The decision may also be taken to admit the patient in the case of a crisis situation.

Which care?

You are entitled to :

- admission and remaining during twenty-four hours in a psychiatric hospital or in a psychiatric department of a hospital during 1,095 days at most. An interruption of a maximum of 30 days is not considered to be an interruption but does not count for the calculation of the 1,095 days. Interruptions due to weekend and holidays do, however, count for the calculation of the 1,095 days,
- the paramedical care and medication, medical aids and dressing material, nursing and care related to the treatment during the period of admission.

Note

- Addiction healthcare is often expensive and is not really guaranteed in all cases and certainly when addiction healthcare takes place abroad. Therefore, ensure you are correctly informed in advance if you want to be treated for addiction. You can contact the Anderzorg Care Advisor on 088 222 44 22 for this.
- Not every treatment of a mental disorder or mental healthcare treatment is covered by the Basic insurance. Ask your care provider before you are admitted for treatment or ask the Anderzorg Care Advisor on 088 222 44 22 .
- You are not entitled to treatment of adaptive disorders and to assistance with regard to psychological complaints that are related to work and relational issues.

Which care provider?

You can go to a mental healthcare institution or the psychiatric department of a hospital where one of the following practitioners is a managing practitioner:

- psychiatrist,
- clinical psychologist.

Other practitioners involved in your treatment at that institution must formally act under the responsibility

and supervision of this managing practitioner. It can be agreed in consultation with the psychiatrist or clinical psychologist that the managing practitioner whom you had when your received specialised mental healthcare without being admitted will also be your managing practitioner when you are admitted. The managing practitioner is the practitioner who is ultimately responsible for the entire treatment process. He is also the primary contactperson for everyone involved, including yourself and those close to you.

Quality charter
Every care provider must have a quality charter that is registered with the Zorginstituut Nederland (Dutch National Health Care Institute) as from 1 January 2017. This quality charter will specify what the healthcare provider has arranged for you about quality and justification. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Anderzorg has contracted care providers. You can select from these care providers. All care providers contracted by Anderzorg will have a quality charter. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

If you go to a non-contracted care provider, check whether this care provider has a quality charter prior to the treatment. You can contact the Anderzorg Care Advisor on 088 222 44 22 for this. You can also contact the relevant care provider, visit the website of the care provider or visit zorginzicht.nl. If the healthcare provider whom you visit does not have a quality charter, the given care will not be eligible for reimbursement.

Referral
You are only entitled to specialised mental health care without admission when you have a written referral from your general practitioner, medical specialist, your community health doctor or your managing practitioner issued in advance. This referral letter must be dated before the date of your visit to the SGGZ, must specifically refer to the SGGZ and must at least specify the (Diagnostic and Statistical Manual of Mental Disorders) mental disorder your referrer thinks you suffer from and the reason for the referral. If emergency care is required for which no referral was reasonably possible, you do not require a written referral.

Permission
- If you decide to have treatment with admission at a care provider who has not entered into a contract with Anderzorg, the incurred costs will not be fully reimbursed. You also require prior permission from Anderzorg. Contact the Anderzorg Care Advisor on 088 222 44 22 to apply for this permission.
- If you want to continue staying after a period of 365 days or after the period for which consent has already been granted has elapsed, You must request permission from Anderzorg two months before the period of 365 days or the period for which permission has been granted elapses at the latest through your current managing practitioner. The application form can be found on anderzorg.nl.

Note

If you do not wish the diagnosis code to be specified on the bill but want to claim the costs, a doctor's declaration is required in advance or with the first bill at the latest. You must sign a doctor's declaration together with your practitioner and send it to Anderzorg. This doctor's declaration pro forma can be found by visiting anderzorg.nl/vergoedingen. The bill must contain all information that is required by legislation and regulations (with the exception, therefore, of the diagnosis code). Visit Anderzorg.nl for information on these requirements.

Medication

A medication (or drug) is a substance that has a specific, desired effect on the body. Medication is available in all different forms such as in tablet, injection liquid, suppository or plaster form. There are thousands of medications available on the market. Producers require a marketing authorisation in order to launch a medication on to the market. This authorisation is only granted if the (branded or non-branded) medication meets strict quality criteria.

Which care?

Registered medication

With the exception of the excluded products referred to under the header 'Preference policy', you are entitled to all medication that the Minister of the Dutch Ministry of Health, Welfare and Sport has included in the insurance package. Which medication has been included can be found in Annex 1 of the Healthcare Insurance Rules and Regulations. You can consult the Health Insurance Regulations and annexes by visiting overheid.nl. If you want to find out whether a specific medication is on the list, you can also contact our Customer Service on 088 222 44 22.

Non-registered medication

You are entitled to medication that is prepared in the dispensing chemist's itself. You are also entitled to medication that your doctor orders for you for use if this medication is prepared by a manufacturer in the Netherlands as referred to in Article 1, paragraph 1, mm of the Dutch Medicines Act. If an order of medication is involved that is not available on the Dutch market but is available in another country, this is only allowed if you are suffering from an illness that does not occur more than 1 time in every 150,000 residents in the Netherlands. In all cases this must involve a rational pharmacotherapy. That is to say, the treatment is taking place with a medication form that is suitable for the patient regarding which the effectiveness and efficacy has been demonstrated based on scientific literature and which also is the most economical for the healthcare insurance.

Advice and support

The advice and the support by the person who has made the medication available are included in this care.

Note

Restrictions apply with regard to: preference policy, indication, location where administered and maximum period.

Preference policy

All medication has an active ingredient. You are entitled to all active ingredients that are present in the medication listed in annex 1 of the Health Insurance Regulations. Often, different medications with the same active ingredient are available on the market. You will only be entitled to some medicines with the same active substance and the same form of administration to those medicines that are indicated by Anderzorg. These are the preferred medications. The Insurance Rules and Regulations list and on anderzorg.nl/preferentiebeleid for which active ingredients preferred medication has been indicated and which medication this involves. It may be the case in exceptional cases that treatment with a preferred medication is not medically safe. In such cases you are entitled to receive a different medication from Annex 1 of the Health Insurance Regulations. You can consult the Health Insurance Regulations and the annexes by visiting overheid.nl.

Note

You are only entitled to a spécialité (branded medication) if it is determined that you cannot be treated with generic (white label) medication other than the preferred medicine. You are not obliged to try more than 2 generic medicines.

Preferred medication

If treatment with a preferred medication is not justifiable medically and, therefore, you wish to use another, non-preferred medication, you require prior permission from Anderzorg. If you visit a dispensing chemist's with which Anderzorg has a contract in place, the pharmacist will immediately give you the medication when you submit a prescription signed by a doctor on which the doctor has written "Medisch noodzakelijk" (Medically Required) or "MN" (MR). The same applies when you submit a declaration completed by your Municipal Health Service, dentist, medical expert, obstetrician or a Municipal Health Service doctor together with the prescription. If you visit a dispensing chemist's with which Anderzorg has not concluded a contract in place, use the Pharmaceutical Care Request Form to ask permission from Anderzorg. Enclose the motivated explanation of your doctor with this form.

If medication is involved that you are using for the very first time, you will also be entitled to the medication for the first 15 days without Anderzorg' permission. You must, however, submit your request for permission at Anderzorg within those 15 days. If you do not submit the request on time or if the use of the preferred medication is justifiable at Anderzorg' discretion, you will no longer be entitled to be reimbursed for the non-preferred medication after the 15th day has elapsed.

Indication

You will only be entitled to reimbursement of the costs of certain medication when you have an indication that is described in the legal regulations. You can find information about these medications and indications in Annex 2 related to the Health Insurance Regulations. You can consult the Health Insurance Regulations and annexes by visiting overheid.nl. Other conditions also apply to some medicines that are specified in Annex 2. These conditions are specified in the Insurance Rules and Regulations. You can find the Insurance Rules and Regulations on anderzorg.nl or you can request them from Anderzorg Customer Service on 088 222 44 22.

Location where administered

Some drugs may only be administered and/or given in a hospital when the relevant medication needs to be

taken except when Anderzorg has given permission for the drugs to be administered or given elsewhere. These drugs are listed in table 2 of the Insurance Rules and Regulations. The drugs that are listed in table 3 of the Insurance Rules and Regulations may only be administered and/or given in a hospital when required. Administration or giving outside the hospital is not insured. The Insurance Rules and Regulations also define what is understood by a hospital.

Minimum and maximum supply period for medicines

The doctor's prescription and the prescribed quantity of medicine is guiding for the quantity of medicine supplied by your pharmacy, unless this exceeds the abovementioned quantities. Another reason may be that the shelf life of a medicine means that you are only supplied with part of the medicine. The pharmacist will always discuss this with you.

- In case of a newly prescribed medicine, you will be supplied with medicine for 15 days. Or you will receive the smallest medicine package. You will receive the smallest package of the preferred medicine if it concerns a medicine to which the preference policy applies.
- Contraceptive pills are subject to a delivery term of 3 months for a newly prescribed medicine. A term of 6 or 12 months, to be decided by the insured person in consultation with the pharmacist or the pharmacist's assistant, also applies.
- Medicines that are more expensive than €1,000 per month are supplied for a period of at most 1 month after they have been issued. HIV medication may be supplied for a period of at most 3 months after an adjustment period of 3 months.
- At least 3 months and at most 6 months for all medicines you have to take for a prolonged period of time (for chronic use). At least 3 months and at most 12 months for generic medicines and medicines included in Anderzorg' preference policy (for chronic use).
- 1 month for sleeping pills and sedatives.
- A period of 15 days applies in principle in case of medicine use during intensive care at home (pharmaceutical care during the palliative and terminal phase). A custom arrangement may also be concluded in consultation between the insured person, the doctor or general practitioner, district nurse and the pharmacist.
- At least 1 month for all other cases.

Personal contribution

You may have to pay a personal contribution. All medicines that you are entitled can be found in Annex 1 of the Health Insurance Regulations. This Annex has a section A and a section B. All medicines for which a reimbursement limit has been set can be found in section A. If you use medication that costs more than the reimbursement limit, you need to pay the part that is higher than the limit. This also applies when the medication that you use is prepared from a medication that costs more than the reimbursement limit. If the medication can be found in section B, there is no reimbursement limit.

Exclusions

You are not entitled to medication:

- in the cases specified in the Health Insurance Regulations,
- in the case of there being a risk of becoming ill when travelling,
- for tests as referred to in Article 40, third paragraph, b, of the Dutch Medicines Act,
- that are equivalent or virtually equivalent to any non-designated, registered medicine, unless the medicine is included in Appendix 3, part A, of the Healthcare Insurance Regulations,

- which are included in Appendix 3, part B, of the Healthcare Insurance Regulations,
- as referred to in Article 40, third paragraph, e, of the Dutch Medicines Act.

Which care provider?

You can visit a dispensing chemist's or a general practitioner with dispensing facilities for medication.

Anderzorg has contracts in place with pharmacists and GPs who have a pharmacy. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The "To a non-contracted care provider" article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Prescription

You require a prescription from a general practitioner, dentist, medical specialist, obstetrician, company doctor or Municipal Health Service doctor. Or from a geriatric specialist if you are staying in a first-line care facility (ELV).

Permission

For some medication you will require prior permission from Anderzorg. The specific medication that is involved has been specified in the Insurance Rules and Regulations in table 1. Your doctor can complete a doctor's declaration related to this medication. There are special forms for this. They can be found by visiting znformulieren.nl. If you visit a dispensing chemist's with which Anderzorg has a contract with this doctor's declaration, the chemist will assess whether you are entitled to this medication. You do not have to first ask Anderzorg' permission. If you decide to use a dispensing chemist's for the medication with which Anderzorg has not concluded a contract in place, you must ask prior permission from Anderzorg.

GP care

The general practitioner is the first point of contact if you have questions or problems regarding your health and illness. General medical care (as provided by, for example, a general practitioner) is freely accessible and person focused. You can be assisted in the evening, night and at weekends from a GP out-of-hours surgery.

Which care?

You are entitled to :

- general medical care except the flu jab,
- laboratory tests, representational diagnostics and function tests requested by a general practitioner,
- medical specialist care that borders on to the general practitioner medicine domain regarding which Anderzorg and the general practitioner have made agreements,
- care for mental disorders. The general practitioner arranges for the initial support in case of mental disorders and assesses whether he/she can treat you himself/herself or if you should be referred to the general basic mental healthcare (GBGGZ) of the specialist mental healthcare (SGGZ),
- chain care that is paid by applying the policy rule that has been defined based on the Dutch Healthcare (Market Regulation) Act for GP Care and multidisciplinary care. Visit anderzorg.nl/zorgvinder to find out with which general practioners Anderzorg has made these
- agreements. Chain care is a care programme especially developed for people who suffer from type 2 diabetes, COPD (Chronic Obstructive Pulmonary Disease) and VRM (Vascular Risk Management) in

which multiple care providers participate to better harmonise the care. Visit anderzorg.nl for more information.
- a combined lifestyle intervention (GLI) that has been assessed as proven effective by the National Institute for Public Health and Environmental Protection (RIVM) and has been included in the list that can be found at Loketgezondleven.nl, if you have a moderate or strongly increased weight- related health risk (in ac cordance with the obesity care standard: BMI of 25 or higher with an increased risk of a chronic affliction or BMI higher than 30). This must have been established by a general practitioner or medical specialist. You can find the obesity care standard at zorginzicht.nl.
- Medical Care for Specific Patient Groups (GZSP) provided by a Geriatric Specialist or a Doctor for the Mentally Handicapped.

Which care provider?

You should consult a general practitioner for general medical care. General practitioner care can also be provided by a care provider who works under the responsibility of a GP such as, for example, a doctor's assistant, nurse practitioner, somebody who supports the practice or a care provider with whom Anderzorg has made agreements about the general practitioner care. You can visit the GP out-of hours surgery or the general practitioner who is on call in the evenings, nights or during the weekend for GP care related to critical emergency issues. Ask your GP about which GP is on duty or to which GP station you can go. You will also find information on verenigingh uisartsenposten.nl.

For laboratory, representational diagnostics and function tests requested by a general practitioner you can go to a first-line diagnostics centre, a production group practice, a hospital or an independent treatment centre.

To have an IUD placed (to prevent pregnancy) you can also visit a obstetrician.

For the purpose of the Combined Lifestyle Intervention (GLI), you can apply to:

- a lifestyle coach who is registered in the BLCN register. BLCN stands for Beroepsvereniging Leefstijl Coaches Nederland (Professional Association of Lifestyle Coaches in the Netherlands).
- a paramedic (dietician, physiotherapist or exercise therapist) with the indication of lifestyle coach in the relevant register (the Central Quality Register or the Paramedic Quality Register),
- a partnership (such as a dietician and a physiotherapist) trained in the performance of the CLI designated as proven effective by RIVM.

If you have any questions concerning the GLI, please call the Anderzorg Care Advisor at 088 222 44 22 .

You can visit a podiatrist for preventive foot care outside the care pathway for diabetes mellitus.

If you require GZSP you can visit a Geriatric Specialist or a Doctor for the Mentally Handicapped.

Foot care referral with regard to diabetes mellitus

You are only entitled to foot care when you have a written referral from your general practitioner or medical specialist issued in advance.

Note

If you visit a pedicure directly for preventive foot care in relation to diabetes, you will not be reimbursed for the incurred costs. The costs of a pedicure will only be reimbursed as part of the care pathway or if the podiatrist refers you to the pedicure.

Referral combined lifestyle intervention (GLI)

You are only entitled to combined lifestyle intervention if you have obtained a written referral from your general practitioner, occupational physician or medical specialist in advance.

Referral Medical Care for Specific Patient Groups

You are only entitled to Medical Care for Specific Patient Groups if you have obtained a written referral from your general practitioner or medical specialist in advance.

Note

- The mandatory excess applies.
- After 6 months of care a request must be made for an extension of care in the event of:
  - Care in a group of vulnerable patients
  - Care in a group of physically disabled people / people with acquired brain damage

Anderzorg has contracted care providers. You can select one of these care providers. You can find an overview of care providers with whom Anderzorg has concluded a contract for the relevant care by entering the search term General Practitioner Care, GZSP or First-line Diagnostics via anderzorg.nl/zorgvinder. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Medical aids

A medical aid is, for example, a hearing aid or a leg prosthesis but also incontinence, dressing and diabetes test material.

Which care?

You are entitled to functional aids that the Dutch Minister of Health, Welfare and Sport has included in the insurance package. Which aids these are can be found in the Health Insurance Regulations. Some groups of medical aids are described specifically in the Health Insurance Regulations while others are described based on their function. In the last case, this means that you are entitled to a medical aid that fits in with a described function restriction. Anderzorg has included an overview of medical aids in its Insurance Rules and Regulations that fall under the Health Insurance Regulations. Anderzorg has also set further conditions in the Insurance Rules and Regulations with regard to obtaining these medical aids.

Example of a medical aid described based on its function

“External medical aids to be used when checking and regulating disorders in the blood sugar level”. Diabetes testing material, for example.

Do you require a medical aid that belongs to function-based aids but this medical aid is not included in the Insurance Rules and Regulations? In this case, submit a request with Anderzorg. Anderzorg will assess your request. The assessment criteria are also included in the Health Insurance Regulations that you must meet to be entitled to the medical aid. You can find the Health Insurance Regulations and the Insurance Rules and Regulations by visiting anderzorg.nl. If you want to know whether a specific medical aid is on the list, you can also contact our Customer Service on 088 222 44 22.

Personal contribution

A (percentage) statutory personal contribution or a maximum reimbursement applies to certain medical aids. You can find out from the Health Insurance Regulations whether this is the case and how much the personal contribution or maximum reimbursement will be. You pay the personal contribution to the supplier. The statutory personal contributions and maximum reimbursements can also be found in the Insurance Rules and Regulations.

Which care provider?

You can approach a supplier of medical aids in order to receive these. Anderzorg has contracts in place with suppliers for the different medical aids. You can select suppliers from this list of contracted suppliers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22.

If you decide to visit a care provider who does not have a contract with Anderzorg, the costs will be reimbursed up to a maximum amount per treatment. Consult the Insurance Rules and Regulations to find out what is paid/reimbursed. If you use a supplier who has not concluded a contract with Anderzorg for a medical aid, this supplier must sometimes meet specific quality and expertise criteria. You can find out what they are in the Insurance Rules and Regulations where they are specified for each medical aid.

Permission

Whether permission from Anderzorg is required is specified in the Insurance Rules and Regulations for each medical aid. This may involve the first issue but also replacements, corrections or repairs to the medical aid. You do not require permission from Anderzorg for most medical aids that are supplied by a contracted supplier. The supplier will assess your application. If the supplier is unsure whether Anderzorg will issue or reimburse the medical aid, the supplier will pass on the application to Anderzorg for permission.

Note

- If you wish to use a supplier who has not concluded a contract with Anderzorg, you require prior permission. Please specify on the request for permission that you wish to use a care provider who does not have a contract with Anderzorg.
- If you wish to receive a second medical aid that is exactly the same as the initial medical aid you will always require prior permission from Anderzorg.
- The Insurance Rules and Regulations explains the other terms and conditions that you must meet with regard to each medical aid, for example, including an explanation from a doctor.
- Your nursing specialist must complete a special form for the reimbursement of most dressing materials. Dressing materials will only be reimbursed in relation to a serious condition where long-term treatment is required. The special request form for dressing materials can be found by visiting znformulieren.nl/hulpmiddelen. You can also find more information in the Insurance Rules and Regulations.
- If Anderzorg has only contracted one supplier for a specific medical aid, Anderzorg can send the permission directly to this supplier as a copy. This also applies when the supply cannot wait because there is medical urgency.

Use of the medical aid

If you expressly damage the medical aid or if it is damaged because the medical aid has not been cared for properly due to you, you will not be entitled to a replacement, correction or repair of the medical aid before the use duration as specified in the Insurance Rules and Regulations has elapsed. If you have the medical aid on loan and you have expressly damaged it or if it is damaged because the medical aid has not been cared for properly by you, Anderzorg is entitled to recover the costs from you.

Note

- You are not entitled to compensation for the costs due to normal use of medical aids unless it has been determined in the Health Insurance Regulations that this is compensated. An example of normal use is the replacement of batteries.
- If use terms or use quantities are specified in the Insurance Regulations, they are provided to give a normal average. We can deviate from these use terms or use quantities in individual cases.
- If you are entitled to a medical aid, this is deemed to mean that you are entitled to the issue (reimbursement), replacement, correction or repair of a medical aid.
- For information on costs of home dialysis see: Non-clinical dialysis.
- For information on medical aids for the personal measuring of coagulation times see: Thrombosis service.

In-vitro fertilisation (IVF)

IVF and ICSI are fertility treatments. In vitro fertilisation (IVF) means ‘in glass fertilisation’ and is also referred to as test tube fertilisation. ICSI stands for intracytoplasmic sperm injection. Fertilisation of the female egg cell by a male sperm cell takes place artificially within the context of these treatments. IVF treatment has its own place within the context of stepped

care. The choice of treatment takes ac count of the effectiveness, the intensity of this treatment for couples, the risks and the costs.

Which care?

Your age will determine what you are entitled to exactly. Ask your care provider to inform you well before you start the treatment or ask the Anderzorg Care Advisor on 088 222 44 22 .

Younger than 38

You are entitled to the 1st, 2nd and 3rd IVF attempt per pregnancy to be realised. You are only entitled to the reimbursement of costs of the 1st and 2nd IVF attempt per pregnancy to be realised when a maximum of 1 embryo is placed back in the uterus. With the 3rd attempt a maximum of 2 embryos may be placed back in the uterus.

Age of 38 up to the age of 42

You are entitled to the 1st, 2nd and 3rd IVF attempt per pregnancy to be realised. With each attempt a maximum of 2 embryos may be placed back in the uterus per attempt.

Note

- You are not entitled to IVF if you are 43 or older. You are entitled to IVF insofar as it concerns an IVF attempt that already started before you have reached the age of 43.
- ICSI treatment (intracytoplasmic sperm injection) and egg cell donation treatment are considered to be the same as IVF.
- The treatment of the donor of the cell and the donation of the cell are not covered by the insurance. Neither are the non-medical costs of sperm donation, including the cost of the sperm itself and of its transfer.
- IVF/ICSI treatments which have already been reimbursed by another health insurer are also seen as part of the total number of treatments.
- IVF/ICSI treatment with assisted hatching is not an insured service. Assisted hatching is a part of the total ICSI treatment. The professional group in the Netherlands does not carry this out. Assisted hatching is not a treatment in accordance with the state-of-the-art and practice. The entire ICSI treatment with assisted hatching is not reimbursed.

Which care provider?

You can visit an IVF centre for IVF treatment that has the authorisations that are required by law for this purpose.

Anderzorg has contracted IVF centres. You can select a centre from this list of centres. You can find an overview of centres that have concluded a contract with Anderzorg by visiting anderzorg.nl/zorgvinder and searching based on the “IVF” search term. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral and permission

You will only be entitled to IVF if you have a prior written referral from your medical specialist and you require permission from Anderzorg before receiving IVF treatment. If you wish to use a care provider who has not concluded a contract with Anderzorg, please call our Anderzorg Care Advisor before the treatment

starts on 088 222 44 22 .

Additional information

A full IVF attempt consists of the following 4 phases:

1. you are given hormones that stimulate the maturation of egg cells in your body,
2. next, the follicular puncture takes place (fertilised egg cells are harvested),
3. the egg cells are fertilised and embryos are incubated in a laboratory,
4. finally, 1 or 2 embryos are implanted in the uterus once or multiple times.

An attempt will only be deemed an attempt when a successful follicular puncture has taken place. Only an attempt that has ended between the moment that a follicular puncture was successful and the moment that a continued pregnancy is involved counts with regard to the number of attempts. A continued pregnancy is a pregnancy of at least 10 weeks as from the moment of the follicular puncture. A continued pregnancy is a pregnancy of at least 9 weeks and 3 days as from the implant when cryopreserved (frozen) embryos are transferred. The transfer of all embryos obtained during the attempt (either interim cryopreserved or not) is a part of the attempt with which the embryos are obtained. A pregnancy of at least 12 weeks after the first day of the last menstruation that has occurred without medical intervention is also deemed to be a continued pregnancy.

Examples to determine the number of insured attempts

- A follicular puncture is performed during your third attempt. After 4 weeks, it fails and the attempt is interrupted. The next attempt will not be reimbursed.
- A follicular puncture is performed during your third attempt. After 4 weeks, it fails and the attempt is interrupted. Because there is still another preserved embryo, this will be transferred. This is still part of the same (third) attempt.
- A follicular puncture is performed during your third attempt. After 15 weeks, it fails and the attempt is interrupted. You now again are entitled to 3 attempts.
- You have been reimbursed for 3 attempts but without a positive result. After some time you are pregnant without medical intervention. This pregnancy lasts 12 weeks. You now again are entitled to 3 attempts.

Other fertility enhancing treatments

Which care?

Medical specialist care as referred to in that article includes the following with regard to other fertilisation-stimulating treatments: gynaecology treatments that stimulate fertility (for example ovulation induction (OI) and intrauterine insemination (IUI).

Note

Women who are 43 or older are not entitled to this care.

Which care provider?

You can visit a gynaecologist or urologist for this care.

Anderzorg has contracted these care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have entered into a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Referral
You are only entitled to fertilisation-stimulating treatments when you have a prior written referral from your general practitioner or medical specialist.

Note
There are a number of clinics that work in partnerships with hospitals in Germany and Belgium for IVF/ICSI treatments. Please note that you are not entitled to reimbursement of costs when the treatment abroad does not meet the conditions included in this and the previous article. Ask your care provider to inform you well before you start the treatment or ask the Anderzorg Care Advisor on 088 222 44 22 .

Maternity care

The maternity care provider assists the obstetrician/midwife or doctor during childbirth and makes arrangements with regard to issues such as linen in the first hours after having given birth. Next, the maternity care provider usually assists during a week in taking care of the mother and baby. The maternity care provider will provide information and checks the mother and baby during the first days after the birth.

Which care?
You are entitled to maternity care for up to 10 days at most as from the date on which you gave birth.

Protocol
The number of hours of maternity care is determined based on the National Recommended Protocol for Maternity Care (Landelijk Indicatieprotocol Kraamzorg). You can find the protocol on anderzorg.nl.

E-Health
You can use Babybalance. This is e-health in the form of videos about the care for your new-born baby. Babybalance can only by purchased in combination with maternity care at your home. The use of Babybalance is considered to form part of the maternity care hours within the National Recommended Protocol for Maternity Care. Babybalance costs 4 hours of maternity care; no personal contribution applies.

Personal contribution
A statutory personal contribution of € 4.60 per hour applies to maternity care at home. If you are having your baby in a hospital or a birth centre without a medical indication, you will pay a statutory personal contribution of € 37 per day that you are admitted (€ 18,50 for the mother and € 18,50 for the baby). If the hospital charges an amount that is higher than € 262 per day (€ 131 for the mother and € 131 for the baby), you must, in addition to the € 37, also pay the amount that is higher than € 262 per day.

Which care provider?

Maternity care is granted by a qualified maternity care provider that is related to a maternity care institution.

Anderzorg has contracts with maternity care providers. You can select providers from the list of maternity care providers. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Registration

Call the Anderzorg Care Advisor on 088 222 44 22 for advice on maternity care. You can then apply for the maternity pack too. You can also do this through anderzorg.nl/zelf-regelen/kraamzorg-en-kraampakket.

Speech therapy

A speech therapist provides assistance with regard to breathing, voice, speech, language and hearing disorders. This assistance can consist of treating the disorder but also doing a test, providing advice and information and supervision of the family (carer) of the patient.

Which care?

You are entitled to speech therapy if:

- this has a medical objective, and
- it can be expected that the treatment will lead to the recovery or improvement of speech or the power of speech.

Note

You are not entitled to speech therapy with regard to:

- dyslexia,
- treatments with an educational objective,
- language development disorders related to speaking a dialect or another language,
- treatment related to the execution of your professional duties, for example, with regard to singers,
- speaking in public.

Which care provider?

You can visit a general speech therapist for most complaints. Some speech therapist have an entry for specific complaints. Examples of this include the following:

- stutter/stammering therapy: treatment for stuttering of which the seriousness is such that smooth speech is clearly impeded,
- aphasia therapy: treatment for a language and speech impediment as a result of brain injury,
- preverbal speech therapy: the treatment of eating and drinking problems and/or swallowing disorders with regard to young children,
- Hänen Programme for the Elderly: step-by-step support for parents in a practical manner when improving the communication with and stimulating speech development of their child when there are language problems. The Hänen Programme for the Elderly is not the right form of assistance for all

language problems. That is why extensive speech therapy examination and an interview in advance are always required,
- integral stuttering care group treatment.

We recommend asking your speech therapist whether he or she specialises in the treatment of your complaints.

You can consult a speech therapist for this care who is registered in the Paramedic Quality Register. You can find this register on kwaliteitsregisterparamedici.nl. The speech therapists who have a specific entry can be found in the relevant subregister of the NVLF (Nederlandse Vereneging voor Logopedie en Foniatrie). They can be found on nvlf.nl.

Anderzorg has contracts in place with speech therapists. You can select a speech therapist from the list of speech therapists. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) lists what will be reimbursed if you visit a non-contracted care provider.

Referral
No referral is required when you visit a contracted speech therapist who is immediately available for consultation. You can find out whether a speech therapist is immediately available in the Paramedic Quality Register.

In the following cases a prior written referral from your general practitioner, dentist or medical specialist is always required:

- when you visit a contracted occupational therapist who is not immediately available for consultation,
- when you visit a non-contracted speech therapist,
- when you visit a dietician who works at a hospital, care home or rehabilitation centre,
- when you want speech therapy outside of the speech therapist’s practice, except for treatment at home.

Permission
You are only entitled to speech therapy at a school or day nursery with prior written permission from Anderzorg. Your speech therapist can apply for this permission from Anderzorg on your behalf.

Specialist medical care
A medical specialist is a doctor who has specialised after completing his or her basic training and is registered as a medical specialist. There are approximately 30 different specialisations in the Netherlands. Most medical specialisations are linked to a hospital.

Which care?
You are entitled to :

- being examined and diagnosed,
- treatment,
- materials used by the medical specialist such as medication, dressing material or medical aids;
- laboratory tests,

- mechanical breathing and the related medical specialist care, medication, overnight stays, nursing and care in or under the responsibility of a breathing centre
- an allowance towards the electricity costs in case of mechanical respiration at home.

Note

You are not entitled to treatments when it concerns:

- correction of paralysed or drooping upper eyelids except if:
  a. the paralysis or slackening is the result of a congenital defect, or
  b. the paralysis or slackening is the result of a chronic defect present during the birth, or
  c. the paralysis or slackening leads to a severe visual impairment.
- liposuction (suction-assisted fat removal from under the skin) of the abdomen,
- placing, replacing and removing through an operation of an artificial breast except when one or both breasts have been fully or partially amputated or with regard to agenesia or aplasia of the breast in women and the situation that can be compared to this when transsexuality has been determined,
- removal of a breast prosthesis through an operation without this being required medically,
- treatment to stop snoring using uvulopalatoplasty,
- sterilisation,
- reversing a sterilisation,
- circumcision (unless this is required medically),
- treatment of plagiocephaly and brachycephaly (flat head syndrome) without craniosynostosis with a cranial remoulding helmet,
- 4th and next IVF treatment per pregnancy to be achieved.

Note

Some forms of (medical specialist) care are described separately in these insurance terms and conditions. Refer to the relevant Article for details. They are:

- the care types described in the Article “Provisional admission”,
- audiological assistance,
- genetic testing,
- part of medical mental healthcare,
- in-vitro fertilisation (IVF) and other fertilisation stimulating treatments,
- non-clinical haemodialysis in a dialysis centre,
- oncology assistance for children,
- overnight stay in relation to medical specialist care,
- plastic or reconstructive surgery,
- medical specialist rehabilitation,
- transplantation,
- thrombosis service.

Which care provider?

You can visit a hospital and consult the medical specialist who is linked to this hospital or you can consult a medical specialist who has his or her own practice for medical specialist care. You can also visit an independent treatment centre (in Dutch: ZBC) that offers care by a medical specialist.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Note

- Independent treatment centres do not offer all forms of medical specialist care.
- Medical specialist care that is given by an institution that has not been accredited based on the Dutch Care Institutions (Accreditation) Act (WTZi) will not be reimbursed.
- Medical specialist care insofar as it concerns treatment with a medication that is listed in table 2 or 3 of the Insurance Rules and Regulations will only be reimbursed when the treatment takes place in or by a hospital.

Note

Emergency care in the Netherlands will always be fully reimbursed in accordance to the rates that apply in the Netherlands for this.

Referral

You are only entitled to medical specialist care when you have a prior written referral from your GP, medical specialist, nurse specialist, physicians assistant obstetrician, specialist geriatric care provider (nursing home doctor), a doctor who works in youth health care or a doctor for the mentally challenged.

- For specialist eye care, an optometrist or orthoptist can also make a referral.
- For specialist hearing care, a triage-audiologist can make a referral to a throat-nose-ear specialist.
- The Municipal Health Service (GGD) doctor may also refer to the medical specialist if it concerns tuberculosis.
- If the complaints are related to your work, the company doctor may also make a referral.
- For the insertion of dental implants, you need a referral from a dentist in advance. Referral to an ophthalmologist, paediatrician or orthopaedic doctor may also take place by a youth doctor/doctor who works in youth healthcare.

You do not need a written referral for emergencies.

Permission

You require prior permission for a number of treatments:

1. Limitative list of medical specialist healthcare

You can find these treatments listed in the Limitative List of Medical Specialist Healthcare (in Dutch:

Limitatieve Lijst Medische Specialistische Zorg) of the Association of Dutch Health Insurers (ZN). Which treatments does this refer to?

- **Ophthalmology** refraction surgery (eye laser treatment or lens implants that ensure the patient is less dependent on spectacles or contact lenses), developed ptosis and upper eyelid corrections.
- **Throat, nose and ear surgery** auricle corrections and treatment of nose shape defects.
- **Surgery** gynaecomastia ("man boobs"), mamma hypertrophy (abnormal size of breasts) and stomach wall corrections.
- **Dermatology** benign tumours, pigmentation disorders, vascular dermatitis (birthmarks).
- **Gynaecology** vulva and virginal defects.
- **Plastic surgery** various treatments.
- **Breast prostheses.**

Note
The list may change during the year. Visit zn.nl to obtain the most recent version.

2. Others
You are only entitled to these treatments when you have obtained permission from Anderzorg in advance:

- clinical pulmonary rehabilitation,
- care given by Stichting Merem Behandelcentra (Dutch Asthma Centre Davos) or Stichting MC Astmacentrum (SMCA) in Switzerland.

Advice
We recommend that you request permission for the treatment should you have any doubts. Your medical specialist must inform you that you must pay the care expenses if you do not have prior permission.

The entitlement to plastic surgery treatment types is arranged in the plastic and/or reconstructive surgery policy article. If you are looking for a medical specialist with a special area of expertise or for highly complex care, call the Anderzorg Care Advisor on 088 222 44 22 for more information.

Non-clinical dialysis

Non-clinical dialysis includes haemodialysis and peritoneal dialysis. Haemodialysis is a therapy that replaces the kidney function where use is made of filters; the so-called artificial kidneys. Specially formulated dialysis fluid is introduced in the abdomen to purify the blood with regard to peritoneal dialysis. This is why this is sometimes referred to as a renal replacement therapy. Dialysis can be provided in a dialysis centre, an independent treatment center or in a hospital, but home dialysis is also possible.

Which care?
You are entitled to haemodialysis and peritoneal dialysis, the related medical specialist care, examinations, treatment, nursing, medication and psychosocial supervision. Psychosocial supervision is also provided to people who assist in carrying out dialysis at home. You will also be entitled to the following with regard to

home dialysis:

- reimbursement of the costs related to the training of the people that carry out the home dialysis or who help with regard to this,
- loan of dialysis equipment and accessories,
- regular control and maintenance of the dialysis equipment (including replacements),
- chemicals and liquids that are required for the dialysis,
- reimbursement of the costs for adjustments that must be carried out in your home in all reasonableness and the costs for removing these adjustments and there is no other statutory arrangement that will (partially) reimburse you for the costs for these adjustments and their removal,
- reimbursement of the costs that are directly related to home dialysis and are not refunded based on another scheme,
- the required expert assistance by the dialysis centre with regard to the dialysis,
- any other consumables that are required in all reasonableness for home dialysis.

The Insurance Regulations includes further conditions for the reimbursement of costs related to home modifications that are reasonably required in relation to home dialysis and the reimbursement of costs that are related directly to home dialysis.

Which care provider?

You can visit a dialysis centre, an independent treatment center or a hospital for this care.

Anderzorg has contracted various care providers you can choose from. You can find an overview of care providers who have concluded a contract with Anderzorg by visiting anderzorg.nl/zorgvinder and searching based on the “dialyse” (dialysis) search term. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral

You are only entitled to non-clinical dialysis when you have a prior written referral from your general practitioner or medical specialist.

> **Note**
> The reimbursement of costs of any adaptations to your home and reasonable costs directly related to home dialysis fall under medical aid care. Refer to the Insurance Rules and Regulations for more information.

Oncology assistance for children

Investigation into the spread of the disease and the further typing of the tumour is required for effective treatment as well as having the correct diagnosis. The SKION has a central laboratory for children with blood and lymph node cancer (hematologic malignancies) where blood, bone marrow and cerebrospinal fluid of all Dutch children with these diseases are investigated.

Which care?

You are entitled to register and be examined and compared with the material present to ensure you have

the best possible treatment plan.

Which care provider?
The care is provided by the Stichting Kinderoncologie Nederland (SKION).

Referral
You are only entitled to oncology assistance for children if you have a prior written referral from a general practitioner or a medical specialist.

Plastic surgery or reconstructive surgery
Plastic surgery is a surgical specialisation in which the focus is on the modification of your appearance from a functional (and sometimes aesthetic) perspective, for example, the restoration of congenital or suffered mutilation. Plastic surgery has been included in a very limited fashion in the Basic Insurance.

Which care?
You are entitled to the treatment of a plastic surgical nature when it involves the correction of the following:

- defects or abnormalities in your appearance that are coupled with demonstrable physical functional disorders,
- mutilation due to illness, an accident or medical activity,
- paralysed or drooping upper eyelids if:
  a. The paralysis or slackening is the result of a congenital defect, or
  b. The paralysis or slackening is the result of a chronic defect present during the birth, or
  c. The paralysis or slackening leads to a severe visual impairment,
- the next congenital malformation: cleft lip, jaw and palate, malformation of the facial bony area, benign tumours of blood vessels, lymph vessels or connective tissue, birth marks or malformations of urinary passage and genital organs,
- appearance of the primary sexual characteristics with regard to a determined transsexuality.

Note

You are not entitled to treatment of a plastic surgical nature if the following is involved:

- correction of paralysed or drooping upper eyelids except if:
  a. the paralysis or slackening is the result of a congenital defect, or
  b. the paralysis or slackening is the result of a chronic defect present during the birth, or
  c. the paralysis or slackening leads to a severe visual impairment,
- liposuction (suction-assisted fat removal from under the skin) of the abdomen,
- placing, replacing and removing through an operation of an artificial breast except when one or both breasts have been fully or partially amputated or with regard to agenesia or aplasia of the breast in women and the situation that can be compared to this when transsexuality has been determined,
- removal of a breast prosthesis through an operation without this being required medically,
- treatment to stop snoring using uvulopalatoplasty,
- sterilisation,
- reversing a sterilisation,
- circumcision unless this is required medically,
- treatment of plagiocephaly and brachycephaly (flat head syndrome) without craniosynostosis with a cranial remoulding helmet.

Which care provider?

You can visit a hospital and a medical specialist that is linked to this hospital for plastic surgery. You can also visit an independent treatment centre (in Dutch ZBC) if a medical specialist is linked to this centre.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non- contracted care provider.

Referral

You are only entitled to plastic surgery when you have a prior written referral from your general practitioner, medical specialist or specialist geriatric care provider (nursing home doctor).

Permission

For reimbursement of treatments on the ‘Limitatieve Lijst Medisch Specialistische Zorg’ of ‘Zorgverzekeraars Nederland’ (ZN) you require permission from Anderzorg prior to the treatment. If we give you permission, it is valid for 1 year, starting on the date on which you received our written permission. If the permission is valid for a shorter or longer period of time, we will mention this explicitly when giving the permission.

Rehabilitation

Rehabilitation (medical specialist)

Rehabilitation is a form of medical specialist care under the responsibility of a rehabilitation doctor. Medical specialist rehabilitation focuses on the recovery of people with a temporary or

chronic disorder as a result of an accident, medical intervention or serious illness. If full recovery is not being expected in the short term, the rehabilitation doctor will try to help you to prevent permanent limitations by using the assistance of care providers from different disciplines. If this does not have the desired effect either, the rehabilitation doctor and his or her team will work with you to manage your limitation as best as possible within your life and environment and society in general.

Which care?
You are entitled to medical specialist rehabilitation if this care is the most effective for your case to prevent, reduce or overcome a handicap/disability. You will be able to attain or keep a certain degree of independence that is considered to be possible in all reasonableness that takes your disability into account after rehabilitation. This must refer to a disability that is due to one of the following:

- disorders or limitations related to your mobility capacity, or
- a complaint of the central nervous system that leads to limitations in the communication, cognition (the processes related to, for example, learning, observing, remembering and thinking) or behaviour.

Note
You are entitled to medical specialist rehabilitation as part-time or outpatients' treatment. You will only be admitted (to an institution) for rehabilitation if better results can be expected quickly when compared to part-time or outpatients' treatment rehabilitation.

Which care provider?
You will be treated by a multidisciplinary team of experts led by a medical specialist or a rehabilitation doctor. This team must be linked to a rehabilitation institution or hospital.

You can find an overview of care providers who have concluded a contract with Anderzorg by visiting anderzorg.nl/zorgvinder and searching based on the "revalidatie" (rehabilitation) search term. You can also call Customer Service on 088 222 44 22. The "To a non-contracted care provider" article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral
You are only entitled to medical specialistic rehabilitation when you have a prior written referral from your GP, medical specialist, mental health doctor, geriatric specialist (nursing home doctor) or company doctor when the complaints are linked to your work.

Permission
Will you be visiting a care provider who does not have a contract with Anderzorg for rehabilitation care? You are only entitled to medical specialist rehabilitation if you have prior consent from Anderzorg. Please enclose a well- founded explanation and a treatment plan from the care provider with your request.

Note
Reintegration in the workplace is not part of the care that is insured.

Geriatric rehabilitation

Geriatric rehabilitation focuses on vulnerable elderly people who have received medical specialist treatment in a hospital, for example, because of a stroke or a bone fracture. These

people require rehabilitation treatment that combines multiple types of care such as nursing, physiotherapy, occupational therapy, speech therapy, psychotherapy, dietary advice and care provided by a social and geriatric healthcare provider specialist. The above is all offered under the responsibility of a geriatric healthcare provider specialist. The care is adjusted to the individual recovery options and the training pace of elderly people and takes into account other existing conditions and disorders. The aim is to assist these elderly patients to return to their homes.

Which care?
You are entitled to geriatric rehabilitation in relation to vulnerability, complex multimorbidity and reduced learning capacity and trainability. Geriatric rehabilitation is integral and multidisciplinary rehabilitation care and must focus on the reduction of functional restrictions in such a way that to return to the home is made possible.

You are entitled to geriatric rehabilitation if you are hospitalised at the start of the geriatric rehabilitation and

- the geriatric rehabilitation fits in within a week with hospitalisation in relation to medical specialist care. It applies within this context that you are only entitled to geriatric rehabilitation if you had been admitted to a nursing home before being admitted. Being admitted to a nursing home means staying in an institution as referred to in Section 3.1.1 of the Dutch Long-term Care Act (Wet Langdurige Zorg; Wlz), or
- the geriatric rehabilitation is required because of an acute disorder for which you received medical specialist assistance before and, because of this disorder, the following is involved:
  - acute mobility disorders, or
  - a reduction in your possibilities to look after yourself.
- Geriatric rehabilitation may not take longer than 6 months.

Which care provider?
You can go to an institution that provides geriatric rehabilitation care in accordance with the Geriatric Rehabilitation Treatment Frameworks for geriatric rehabilitation. The Geriatric Rehabilitation Treatment Frameworks have been drawn up by the Dutch Association of Elderly Care Physicians and Social Geriatricians, Verenso. The institution has been authorised as an institution for specialist care (independent treatment centre, hospital or rehabilitation centre) or has been authorised as an institution for providing treatment and sleeping arrangements (nursing home) based on the Dutch Care Institutions (Accreditation) Act (WTZi).

Anderzorg has contracted care providers. You can select from these care providers. You can find an overview of care providers who have concluded a contract with Anderzorg by visiting anderzorg.nl/zorgvinder and searching based on the “Geriatrische revalidatie” (Geriatric rehabilitation) search term. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral
You are only entitled to geriatric rehabilitation if you have a prior written referral from a medical specialist of the hospital where you were admitted and the indication for geriatric rehabilitation has been determined under the supervision of a geriatric specialist.

The indication for geriatric rehabilitation should always be made under the responsibility of a geriatric specialist, clinical geriatrician or a geriatric internist.

Permission
Will you be visiting a care provider who does not have a contract with Anderzorg for geriatric rehabilitation? You are only entitled to geriatric rehabilitation if you have prior consent from Anderzorg. Please enclose a well-founded explanation and a treatment plan from the care provider with your request.

Second opinion

A second opinion is requesting an assessment of a diagnosis or proposed treatment provided by a doctor from a second, independent doctor who works in the same specialisation field as the first consulted doctor.

Which care?

You will be entitled to a second opinion when:

- the second opinion refers to medical care as already discussed with the first person providing treatment, and
- you will be returning to the original person providing treatment with the second opinion; this person is responsible for your treatment.

Which care provider?

You can visit a GP, medical specialist, midwife, physiotherapist, clinical psychologist, mental healthcare institution or an (out-patients' department of a) psychiatric department of a hospital.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The "To a non-contracted care provider" article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral

You are fully entitled to a second opinion when you have a prior written referral from the person who is treating you.

Quitting smoking

A programme to quit smoking consists of a combination of interventions to change behaviour (in a group or individually) sometimes with the support of medication. The behaviour-based support forms the basis with regard to this integral programme. This means that a form of recognised behaviour- based support is always deployed that may be supplemented with medication that has been proven to be effective but that medication can never be deployed without behaviour-based support.

Which care?

You are entitled to a programme to quit smoking once per calendar year:

- that focuses on changing behaviour, and
- that has the goal of quitting smoking,

- that may be in combination with medication.

Which care provider?

For behaviour support when quitting smoking you can visit a care provider contracted by Anderzorg. You can also visit your general practitioner for behaviour-based support. For nicotine products and medication you can go to a supplier of nicotine products and medication contracted by Anderzorg. The medication must have been prescribed through the medication application form used when quitting smoking or with a prescription of the general practitioner.

You will find an overview of care providers who have concluded a contract with Anderzorg for behaviour support and the supply of nicotine products and medication on anderzorg.nl/zorgvinder when you enter the search term “Stoppen met roken” (Quitting smoking). You can also call Anderzorg Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Note

1. You are only entitled to nicotine products and medication when they are part of a quitting programme; separate reimbursement for nicotine products and medication (therefore, that are not part of the quitting programme) will not take place.
2. When you select a care provider for behaviour-based support who has not concluded a contract with Anderzorg, you must send the specified bill to Anderzorg. When this care provider is not registered in the “Kwaliteitsregister stoppen met roken” (Quitting Smoking Quality Register) or when the provided care does not meet the Dutch Institute for Healthcare Improvement (CBO) guideline “Behandeling bij tabaksverslaving” (Treatment for tobacco addiction) or the Care Module “Quitting Smoking”, you will not be reimbursed.
3. If you select a supplier for nicotine products and medication who has not concluded a contract with Anderzorg for the supply of nicotine products and medication, you must send a copy of the application form for the medication or a copy of the prescription of the general practitioner together with the bill.

Note

The excess applies to the quitting smoking programme even when the general practitioner provides the behaviour-based support.

Dentistry

Special dentistry

Special dentistry work is meant for people for whom regular dentistry work is not sufficient with regard to a special complaint. Examples are a cleft palate or a very severe overbite.

Which care?

You are entitled to special dentistry work that is essential if you:

- have a serious development disorder, growth disorder or an acquired defect of the tooth/jaw buccal

system. This also includes implant insertion when you have a severely atrophied toothless jaw and inserting the fixed part of the suprastructure. You should be able to attach removable dentures to these,
- have a non-dental physical or mental complaint,
- must have a non-dental medical treatment and this treatment will have demonstrably insufficient results without the special dentistry work.

Note

- You are only entitled to special dentistry work if this is necessary to retain or acquire a dental function that is similar to the dental function that you would have had without the complaint.
- You are only entitled to orthodontic assistance if a severe development disorder, growth disorder or an acquired defect of the tooth/jaw buccal system is involved where a co-diagnosis or co-treatment from other disciplines than dental is required. You are only entitled to orthodontic healthcare if it is provided by an orthodontist.

Personal contribution

- You must pay a personal contribution for special dentistry when care is involved that is not directly linked with your indication for special dentistry. The personal contribution will then be the amount that you would have had to pay if you had not had an indication for special dentistry work.
- If the special dentistry work concerns a full set of dentures that must be placed (a full prosthetic facility) in your case, you will pay a personal contribution of 25% of the total cost of the dentures. A personal contribution of 10% applies for the bottom jaw and 8% for the top jaw for dentures on implants. You can also find more information in the Insurance Rules and Regulations. Consult the scheme on anderzorg.nl or request this information from Anderzorg Customer Service on 088 222 44 22.

Which care provider?

You can visit a dentist, a Centre for Special Dentistry Work, a dental surgeon or an orthodontist. You can visit an orthodontist for the orthodontic part of the treatment.

Referral

- You are only entitled to special dentistry work by a orthodontist when you have a prior written referral from your dentist of dental surgeon. The dental surgeon must be linked to a hospital.
- You are only entitled to special dental work by a orthodontist when you have a prior written referral from your dentist of dental surgeon.

Permission

You require prior permission from Anderzorg for special dentistry work. Please enclose a written well-founded explanation and a treatment plan from the care provider with your request.

Dentistry

You are entitled to dentistry. What you are exactly entitled to, will depend on whether you are older or younger than 18.

Which care?

Up and including 17 years of age
You are entitled to :

- 1 regular preventive dental examination per year unless you require this type of examination several times per year,
- incidental dental consultation,
- tartar removal,
- 2 fluoride applications per year unless you require such an application more times during a year from the time permanent teeth emerge,
- sealing,
- parodontic treatment (gum treatment),
- anaesthesia,
- endodontic treatment (root canal treatment),
- restoration of teeth elements using plastic material (fillings),
- assistance related to jaw problems or grinding,
- removable prosthetic provisions (dentures and frame dentures),
- teeth replacement assistance with non-plastic material and inserting implants:
  - treatment if it is for the replacement of one or more missing permanent incisors or canines that have not come through, or
  - this tooth (teeth) missing being the direct result of an accident,
- surgical dental treatment except inserting implants,
- X-rays except X-rays for orthodontic treatment.

Up and including 22 years of age
You are entitled to dental replacement treatment with non-plastic materials and inserting implants if they are replacing one or more permanently missing incisors or laniaries that were not initially present, or because the absence of that tooth or those teeth is the direct consequence of an accident. You are only entitled to this care if the need has been established before you became 18.

Note
Should you visit the dentist outside normal surgery hours, you will only be entitled to dentistry work if the visit cannot be postponed to another day.

From 18 years of age
You are entitled to :

- surgical dentistry work by a dental surgeon and the X-rays related to this except for parodontal surgery, inserting implants and uncomplicated extractions,
- removable full dentures for the top or bottom jaw that may or may not be placed on dental implants.

Personal contribution
Are you 18 years old or older? You pay a personal contribution of 25% of the total costs of full dentures. You pay a personal contribution of 10% of the total costs of full dentures on implants and related mesostructure for the bottom jaw and 8% of the total costs of full dentures on implants and related mesostructure for the top jaw. The excess for repairs and filling (rebasing) of a detachable full prosthetic facility is 10% of the costs of this repair or filling. You can also find more information in the Insurance Rules

and Regulations. Consult the scheme on anderzorg.nl or request this information from Anderzorg Customer Service on 088 222 44 22.

Which care provider?
You can visit a dentist, oral surgeon or dental prosthesis specialist. If you are younger than 18, you can also visit an independent oral hygienist. For implants related to the placing of full dental prosthesis in the top jaw you can visit a care provider contracted for this purpose or to a dentist/implantologist that is recognised by the Nederlandse Vereniging voor Orale Implantologie (NVOI; Dutch Association for Oral Implantology). You can find out who they are by visiting nvoi.nl/erkende-implantologen.

For full dentures and implants, Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what you will be reimbursed if you visit a non-contracted care provider.

Note (for people who are both younger and older than 18)
Will you visit an oral surgeon in an Independent Treatment Centre who does not have a contract with MAnderzorg? The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral
You are only entitled to a treatment by a dental surgeon, if you have a prior written referral from a dentist or a general practitioner.

Permission
You will require prior permission from Anderzorg:

- for tooth replacement assistance using non-plastic materials and implant insertion,
- for periodontal assistance, treatment under anaesthesia, osteotomy and inserting an implant by a dental surgeon,
- for an X-ray of all your teeth at once (Orthopantomogram), when you are not yet 18 years old,
- if a dentist or a dental prosthesis specialist makes full and removable dentures for the top and bottom jaw and the total costs (including the technology costs) are more than € 700 per jaw,
- for positioning dentures on implants and the related mesostructures made by a care provider not contracted for this,
- for the repair and rebasing of a dental prosthesis on implants by a care provider not contracted for this purpose,
- if the full and removable dentures for the top and/or bottom jaw that you now have are replaced within 6 years after delivery. This does not apply to immediate dentures,
- if you must be treated where you are staying (for example, at home or at an institution).

Please enclose a written well-founded explanation and a treatment plan from the care provider with your request.

Transplantation

Transplantation is a form of medical specialist care. Transplantation is the replacement of an organ or tissue that no longer functions or only functions poorly of a patient by the organ of a donor. Organs/ tissues that can be transplanted are, for example, the heart, skin, lungs, kidneys, the pancreas, the liver, bones and bone marrow. Sections of organs can also be transplanted.

Which care?

You are entitled to a transplant of tissues or organs if the transplant takes place:

- in a member state of the European Union,
- in a state/nation/country within the European Economic Area, or
- in the state/nation/country where the donor lives when the donor is your spouse, registered partner or a blood relative in the first, second or third degree.

You are also entitled to be reimbursed for the costs related to:

- specialist medical care in relation to the selection of the donor,
- specialist medical care in relation to the operational removal of the transplant material with regard to the selected donor,
- the examination, preservation, removal and transport of the post mortem transplant material in connection with the intended transplant,
- care for the donor with regard to admission to an institution for selection and removal of the transplant material during at most 13 weeks and/or half a year in case of a liver transplant after the date of discharge from the institution. This care for the donor includes the care to which you are entitled based on this Basic Insurance,
- transport of the donor within the Netherlands with regard to the selection, admission and discharge from the hospital in connection with the care as described in the preceding item of this list,
- the costs of the lowest class of public transport within the Netherlands or, if this is required medically, transport by car within the Netherlands is reimbursed,
- transport to and from the Netherlands of a liver, kidney or bone marrow donor who lives outside the Netherlands.

Other costs incurred due to the transplant and the donor living abroad are also reimbursed except the costs linked to staying in the Netherlands and lost income.

> **Note**
> The costs for the transport under hyphens 8 and 9 in relation to “Which Care” are to be paid by the healthcare insurer of the donor. If the donor has not taken out healthcare insurance, the costs will be paid from your Basic Insurance.

Which care provider?

For a transplant, you can visit a medical specialist in a hospital that is licensed to perform transplants.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You

can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non- contracted care provider.

Referral

You are only entitled to a transplant when you have a prior written referral from your general practitioner or medical specialist.

Thrombosis service

Thrombosis is a clot in a blood vessel or artery. This can occur in, for example, the leg vessels, coronary arteries, capillaries of the lung and brain vessels. The intensive care department for thrombotic patients is responsible for setting up, checking and supervising out-patients who use specific oral anticoagulants.

Which care?

You are entitled to :

- the regular drawing of blood samples,
- laboratory tests if this is required for determining the coagulation time of blood,
- the use of equipment and accessories with which you can measure the coagulation time of your blood,
- training to learn how to use the abovementioned equipment and supervision when taking measurements,
- advice about the application of medication that influences coagulation.

The Insurance Regulations includes further conditions for the reimbursement of costs related to blood coagulation self-measurement equipment.

Which care provider?

You can visit an intensive care department for thrombotic patients.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral

You will only be entitled to care offered by an intensive care department for thrombotic patients if you have a prior written referral from your general practitioner or medical specialist.

Hospitalisation

Patients can be admitted for examination, intervention or observation after consulting a medical specialist. If a patient must be admitted for several days, the patient is deemed to have been ‘clinically’ admitted. The stay in a hospital or institution may be long term. In this case, 1,095 days will be covered by the Basic Insurance. Dutch Long-term Care Act (in Dutch: Wet langdurige zorg (Wlz)) insures any admissions that occur after the first 1,095 days. If you have questions about the care, please call the Anderzorg Care Advisor on 088 222 44 22 .

Which care?

You are entitled to stay during the 24 hours that are required medically in relation to obstetrician care, oral surgeon dentistry care of a specialist nature, medical specialist care and geriatric rehabilitation. You are also entitled to the related required nursing, care, paramedical care and medication. You are also entitled to the related required nursing, care, paramedical care and medication. You admittance is insured for an uninterrupted period of 1,095 days. An interruption of a maximum of 30 days is not considered to be an interruption but does not count for the calculation of the 1,095 days. An interruption due to weekend or holiday leave does, however, count.

> **Note**
> Admittance with regard to mental healthcare is not described here. You can find this information under “Mental healthcare”. Primary care institution is not described here, but in the “Primary care institution” article.

Anderzorg has contracted institutions. You can select one of these institutions. You can find an overview of care providers who have concluded a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non- contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Permission

You are only entitled to rehabilitation if you have prior permission from Anderzorg with regard to:

- admission,
- clinical pulmonary rehabilitation,
- care given by Stichting MC Astmacentrum (SMCA; MC Asthma Centre Foundation) in Switzerland.

Obstetric care

Most obstetric care given to pregnant women is provided by midwifes. They will supervise and check women during their pregnancies and when the baby is delivered.

Which care?

You are entitled to obstetric care and prenatal screening.

The prenatal screening consists of:

- counselling (providing information and advice),
- if you have a medical indication: a combination test, a non-invasive prenatal test (NIPT) and an invasive diagnosis (chorionic villus sampling and fertility test). You must, in any case, have a medical indication:
  - for a non-invasive prenatal test (NIPT) if a combination test shows that there is a considerable probability that the foetus has a chromosome abnormality such as Down’s syndrome,
  - for an invasive diagnosis (chorionic villus sampling and fertility test) if a combination test shows that there is a considerable probability that the foetus has a chromosome abnormality such as Down’s syndrome,
- structural echoscopic examination in the second trimester (the 20-week echo).

Which care provider?

For obstetric care you can visit a general practitioner who is registered in the Obstetrician Register of the College voor huisartsen met bijzondere bekwaamheden (CHBB; Board of General Practitioners with Special Competences) or an obstetrician. If there is a medical requirement, obstetric care is given in a hospital under the supervision of a medical specialist. See the article about medical specialist care. For laboratory. representational diagnostics and function tests requested by a general practitioner or obstetrician you can go to a first-line diagnostics centre, a production group practice, a hospital or an independent treatment centre.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call Customer Service on 088 222 44 22. The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non- contracted care provider.

Note

The structural echoscopic examination and the combination test may only be performed by a care provider who has been granted a permit based on the Dutch Population Screening Act or has a cooperation agreement with a Regional Centre that has been granted a permit based on the Dutch Population Screening Act permit. WBO is Dutch for Wet op het bevolkingsonderzoek (Population Screening Act). No WBO permit is required with a medical indication for the examination.

Obstetric care personal contribution

A statutory personal contribution of € 4.50 per hour applies to maternity care at home. If you deliver your baby in a hospital or a birth centre without a medical indication, you must pay a statutory personal contribution of € 36 per admittance day (€ 18 for the mother and € 18 for the baby). If the hospital charges an amount that is higher than € 255 per day (€ 127,5 for the mother and € 127,5 for the baby) you must, in addition to the € 36, also pay the amount that is higher than € 255 per day.

Transport by ambulance

There are 2 types of ambulance transport: emergency transport (usually reported by dialling 112) and booked transport. The ambulance care is provided by nurses and drivers who have been especially trained for this (paramedic staff).

Which care?

You are entitled to :

- transport to a care provider or institution to receive care. This care must be insured in full or partially by the Basic Insurance,
- transport to an institution where you will be staying and will be fully or partially paid through the Wlz (Long-term Care Act),
- transport from a Wlz (Long-term Care Act) institution to a care provider or institution for examination or treatment that will be fully or partially paid through the Wlz (Long-term Care Act),
- transport from a Wlz (Long-term Care Act) institution to a care provider or institution for measuring, fitting and repairing prostheses that are fully or partially covered through the Wlz (Long-term Care Act),

- transport to your home or, if you cannot receive the required care there, to another private address if you came from one of the care providers or institutions referred to above,
- if you are younger than 18, transport to a person from whom or an institution where you will receive mental healthcare regarding which the costs will be fully or partially be at the expense of the mayor and aldermen by virtue of the Dutch Youth Care Act.

You are entitled to transport with another means of transport than an ambulance (for example, a helicopter) when ambulance transport is not possible.

Which care provider?

Ambulance transport is provided by a permit holder designated by the Ministry of VWS.

Referral

You are only entitled to plastic surgery when you have a prior written referral from your general practitioner, medical specialist or specialist geriatric care provider (nursing home doctor). You are only entitled to transport by helicopter when you have a prior written referral from the Ambulance Central Control Room (Meldkamer Ambulance Zorg) or a centre for neonatal and child surgery intensive care unit. You do not require a referral for emergency transport.

Indication

The transport must have been indexed by the doctor in charge of treatment.



Note

- The right to ambulance transport is limited to a distance of no more than 200 kilometres for a single journey.
- If Anderzorg gives you permission to visit a specific person or institution, the limitation of 200 kilometres does not apply.
- You are not entitled to ambulance transport with regard to care during a 4-hour day period in a Wlz (Long-term Care Act) institution.

Nursing and care

Nursing and care focuses on physical healthcare, social self-sufficiency, metal well-being and your own living environment.

Which care?

You are entitled to nursing and care. Nursing and care mean the following: care as offered by nurses that

a. is related to the need of GP care, medical specialist care or a high risk of this,
b. is not linked with admittance and,
c. does not involve maternity care.

You are also entitled to specialized pediatric daycare and care at a pediatric care facility if you are less than 18 years old and need care because of complex somatic issues or a physical disability where

- continuous supervision is required, or
- there must be care 24 hours a day in the vicinity and this care is linked to one or more specific nursing

action.

Note

You are not entitled to nursing and care when you have been indicated based on the Dutch Long-term Care (for Chronic Conditions) Act or if the personal care is a part of the Dutch Social Support Act (WMO).

Person-linked budget

A person-linked budget (PLB) is an amount that you can use to purchase nursing and care services yourself. If you are entitled to nursing and care, you may also possible apply for the reimbursement of this care in the form of a person-linked budget. The Insurance Regulations provide information when you are eligible for this, what your responsibilities are with regard to this and how the PLB is paid. You can find the Insurance Regulations on our website. You can also request these regulations from Anderzorg Customer Service on 088 222 44 22.

Which care provider?

You can hire a nurse or carer with training level of 3 or higher who is employed by an institution that has been accredited for nursing and caring (home care institution) based on the Dutch Care Institutions (Accreditation) Act (in Dutch: Wet toelating zorginstellingen; WTZi) or that has been accredited for admission or as a nursing home or an institution for disabled care that provides outpatient care. You can also hire a nurse or caregiver with training level 3 or higher who is has a KIWA-certification for the self-employed in the healthcare business.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Indication and care plan

You are only entitled to nursing and care when you have an indication. This indication must meet the standards for indexing and organising of nursing and care in your own environment as established by the professional association of community nurses, Verpleegkundigen & Verzorgenden Nederland (V&VN). To be eligible for reimbursement you must have a nursing indication with a care plan that describes the care that you need with regard to its nature, scope and duration including the set goals. This care plan must be drawn up by a HBO-community nurse (education level 5) and must be signed by you and the care provider.

Medical specialist nursing at home (MSVT)

If you need nursing and care at the instructions and under the responsibility of a medical specialist, the medical specialist must have issued a medical specialist nursing in the home situation execution request to the care provider that must contain the following:

- scope of the nursing required,
- frequency of the nursing,
- duration of the nursing (start and end dates).

Permission
The costs incurred are not fully reimbursed if you opt for treatment by a care provider that has not concluded a contract with Anderzorg. You also require Anderzorg' prior approval. You can contact the Anderzorg Care Advisor at 088 222 44 22 in order to request this approval.

Advice
Do you have any questions about nursing and care? Call the 088 222 44 22 on 088 222 44 22 for more information on the options.

Conditional admission
Some forms of care have been included in the Basic Insurance conditionally. This concerns care regarding which there are doubts about the effectiveness or regarding which the effectiveness has not or has not fully been proven yet. It may concern new treatment methods but also care that is already included in the Basic Insurance but regarding which there are doubts or doubts have arisen.

You will find the care options that are permitted conditionally in the Insurance Terms and Conditions and on anderzorg.nl.

Sensory care for the disabled
Sensory care for the disabled is a treatment for people with a sensory impairment. A sensory impairment is a visual, hearing or communication impairment as a result of a language development disorder or a combination of these impairments. Multiple specialists are involved in the treatment (multidisciplinary care).

This care consists of:

- diagnostic research,
- interventions that focus on learning to deal with the disability physically, and
- interventions that remove the impairments or that compensate and, therefore, increase self-sufficiency.

In addition to the treatment of the person who has the sensory impairment, it also concerns (indirect) system-focused co-treatment of parents or carers, children and adults around the person with the sensory impairment who will learn skills in the interest of the person with the sensory impairment.

Support with being able to perform socially and the complex, log-term and life-wide support to adults who are deaf and blind and adults who are pre-lingual deaf does not fall under sensory care for the disabled.

Which care?
You are entitled to multidisciplinary care (care where different specialists are involved). You need this care because you have a:

- visual impairment (you are blind or visually impaired,
- hearing impairment (you are deaf or hearing impaired), or
- communication impairment (serious difficulties with speech/language) as a result of a language development disorder and you are younger than 23.

The care focuses on learning to cope, removing or compensating with/for the impairment to ensure that you can perform as independently as possible.

Which care provider?

You can visit an institution that has been accredited in accordance with the Dutch Care Institutions Accreditation Act for giving sensory care to the disabled and which mainly focuses on providing out-patient treatment for the sensory impaired.

Anderzorg has contracted care providers. You can select from these care providers. You will find an overview of care providers on anderzorg.nl/zorgvinder who have concluded a contract with Anderzorg. You can also call the Anderzorg Care Advisor on 088 222 44 22 . The “To a non-contracted care provider” article at the start of this section (Basic Insurance) specifies what will be reimbursed when you visit a non-contracted care provider.

Referral and indication

You are only entitled to sensory care for the disabled if you have a referral in advance. If it concerns the treatment of a visual impairment, you need a referral from a medical specialist who has established rehabilitation and a referral based on the evidence-based NOG (Nederlands Oogheelkundig Gezelschap; Dutch Ophthalmic Society) guideline Visual Disorders that a visual impairment is involved.

If it concerns the treatment of an auditive and/or communication impairment, you need a referral from a clinical physicist-audiologist from the audiology centre or a doctor who has established based on the applicable FENAC (Federatie van Nederlandse Audiologische Centra; Federation of Dutch Hearing Centres) guidelines that an auditive and/or communication impairment is or are involved.

Permission

You will require prior permission from Anderzorg for sensory care for the disabled from a care provider who does not have a contract with Anderzorg. Please enclose a written well-founded explanation and a treatment plan from the care provider with your request.

Non-emergency patient transport

You can make an appeal on this insurance for the transport or the costs of this transport with regard to certain indications. There are 3 types of non-emergency patient transport services. You can be conveyed using your own transport, public transport or using a different means of transport, for example, a boat.

Which care?

You are entitled to public transport of the lowest class or the reimbursement of the costs of using a vehicle. When a private car is used, you are entitled to be reimbursed € 0.32 per kilometre. You are entitled to transport using a different means of transport, when you cannot be conveyed by public transport or by using your own transport. If supervision is required or when a child younger than 16 is involved who needs to be supervised, the costs of public transport and personal transport or transport using a different means of transport of the attendant/ carer will also be paid/reimbursed. In special cases, Anderzorg will allow the reimbursement of the costs of public transport and personal transport or the transport using a different means of transport for 2 attendants/carers.

You are entitled to transport if:

- it involves the transport from and to persons, institutions and the private addresses as referred to in the Article about ambulance transport, and
- you must receive kidney dialysis, or if you have to attend consultations, examinations or check-ups that are necessary as part of the treatment, or
- you must receive oncology treatment with chemotherapy, immunotherapy or radiotherapy, or if you have to attend consultations, examinations or check-ups that are necessary as part of the treatment, or
- your mobility is solely dependent on a wheelchair, or
- your mobility is dependent on supervision due to your visual impairment, or
- you depend for a prolonged period of time on transport for the treatment of a long-term illness or complaint and the check-ups, examinations and consultations, which are necessary as part of that treatment and refusing said transport or the reimbursement of the costs will be highly unfair to you, or
- you are younger than 18 and need care because of complex somatic issues or because of a physical disability that means that there is a need for permanent supervision or round the clock care in the vicinity and this care is linked to one or more specific nursing actions, or
- you depend on geriatric rehabilitation.
- you need transport to and from day treatment for specific patient groups (people with a chronic progressive degenerative disorder, acquired brain injury or with a mental disability) (Medical care for specific patient groups, GZSP).

Overnight stay

If you are entitled to reimbursement of travel expenses and you require such transport on three or more consecutive days, you may opt for reimbursement of the costs of overnight stay. The reimbursement of the costs of overnight stay is at most €75 per night and partially replaces the reimbursement of the travel expenses.

Note

- The transport or reimbursement of costs entitlement is limited to a distance of no more than 200 kilometres for a single journey.
- If Anderzorg gives you permission to go to a specific person or institution, the 200 km restriction does not apply.
- If you are entitled to transport or reimbursement of costs, you may also obtain reimbursement of the costs of transport incurred by a possible assistant if you require assistance. Children below the age of 16 are always entitled to reimbursement of the travel expenses of assistants. Anderzorg may reimburse the costs of 2 assistants in special cases.
- If you use your own transport, the reimbursement will be calculated based on the fastest possible normal route in accordance with the ANWB route planner.
- The transport related to care during a 4-hour period in a Wlz (Long-term Care Act) institution will not be paid/reimbursed.

Personal contribution

You pay a personal contribution of € 108 per calendar year. The personal contribution does not apply to the reimbursement of overnight stay.

You do not pay a personal contribution for transport:

- if you are admitted to an institution at the expense of the health insurer or under the Long-Term Care Act and must be transported to a different institution where you will be admitted because you require specialist examination or specialist treatment that cannot be provided in the first institution;
- if you are admitted to an institution at the expense of the health insurer or under the Long-Term Care Act and must be transported to a different institution or person for specialist examination or specialist treatment at the expense of the health insurer. This applies only if that treatment could not be provided at the first institution. This applies to outward and return journey.
- if you are admitted to an institution at the expense of the health insurer or under the Long-Term Care Act and must be transported to a different institution or person because you require specialist dental treatment that cannot be provided in the first institution.

Which care provider?

The transport will be provided by a transport company or a private person (for example, a member of your family or an acquaintance). Anderzorg has contracts in place with transport companies. When permission is granted, the transport companies that can be used will be specified. If you decide to use a transport company that has not concluded a contract with Anderzorg, you will receive a maximum of € 0.85 per kilometre. You will receive € 0.32 per kilometre when the transport is provided by a private person.

Permission

You must request prior permission from Anderzorg. Call the Transport Service Line on +31 317 492 051 or send the request form “non-emergency patient transport”. The request form can be downloaded by visiting anderzorg.nl. Anderzorg will determine whether you will be given permission and for which type of transport (public transport, personal transport or transport with a different vehicle) you will be given permission.

Note

Other costs such as parking or ferry costs will not be reimbursed.

Your Additional Insurance

Anderzorg offers different additional insurances. Below we list all the care types that are included in the additional insurances. Every care type includes a table. We specify in this table for each additional insurance whether the care is covered and/or what any possible reimbursement will be. Your healthcare policy will specify which additional insurance you have.

The Dutch text is binding should any disputes arise from the interpretation of the text.

Basic Insurance or additional insurance?

Your additional insurance is a supplement to your Basic Insurance. The additional insurance is not a replacement of the Basic Insurance. That which is insured through the Basic Insurance is not reimbursed through your additional insurance. This also applies to your excess and personal contribution of the Basic Insurance unless it is included in the additional insurance as an additional reimbursement.

Contracted or approved care providers

Anderzorg makes agreements with care providers. Hospitals, doctors and physiotherapists are, for example, care providers. These agreements are related to the payment of bills but also to the quality of the provided care. Anderzorg can also approve care providers. This approval will depend on, for example, good training. Some types of care are not insured except when you visit a contracted care provider or an approved care provider. If this is the case, this type of care will be specified. You can find contracted and approved care providers by visiting anderzorg.nl/zorgvinder.

How does the Zorgvinder (Care Finder) work?

- select the type of care you want in the Care Finder, for example, physiotherapy,
- if required, refine the selection (for example, manual therapy),
- enter your postcode or town and specify the distance in which to search,
- next you will see the care providers that have been contracted or recognised by Anderzorg.
- Should you not have access to the Internet, you can also call Customer Service on 088 222 44 22. If you have questions about health care, please call the Anderzorg Care Advisor on 088 222 44 22.

How will you be reimbursed?

Anderzorg has a contract with many care providers. This care provider can submit the bill directly to Anderzorg. You will not have to do anything. You can, however, always check all bills in Mijn Anderzorg. Have you received a bill from a care provider? You can claim your bill online through anderzorg.nl/mijnanderzorg. You can also use the free Anderzorg claiming app. This makes submitting your bills very easy, fast and secure.

Note

Only the costs for care supplied in the Netherlands by a care provider or supplier established in the Netherlands will be reimbursed. The exception to the above is emergency care abroad (see the Article Abroad).

Indication and efficiency

You will only be examined or treated if this is required. There must be a medical indication to qualify for the reimbursement of care. Which care is required for your case will be objectively determined. This care must also be effective (must have a purpose). Care that is unnecessary or costs too much unnecessarily when compared to other types of care that is on an equal footing in view of the indication and your care need, will not be covered by the insurance.

Acne treatment

Acne is a skin defect. A skin therapist or beautician will determine which form of treatment is the best and will clean the skin. The treatment will ensure that the acne is kept at bay or removes scars by means of a peeling treatment. The skin therapist or beautician will also provide advice about the daily care of your skin.

You will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Budget	Jong	Extra
€ 0	€ 200	€ 0

You are entitled to be reimbursed when the treatment is provided by a skin therapist (or someone who works under his responsibility, such as a beautician), who has been recognised by Anderzorg. A list of recognised skin therapists can be found at anderzorg.nl/zorgvinder.

Alternative care

Alternative treatment methods (complementary treatment methods) are different ones to the standard (regular) treatments. They are often a supplement to standard treatments but can also be independent from these. Alternative treatment methods include the following: homoeopathy, anthroposophy, acupuncture, acupressure, psychological assistance, natural therapies, care for posture and exercise. Alternative medication refers to homeopathic and anthroposophic medicines. It is recommended that your general practitioner or medical specialist be informed if you use alternative treatment methods.

You will be reimbursed for treatments, homeopathic and anthroposophic medicines up to a maximum amount. The reimbursements for treatments (€ 40 per treatment day) and medicines (100%) are added together until the specified maximum amount is reached. This maximum amount is per calendar year:

Budget	Jong	Extra
€ 0	€ 0	€ 200

You will be reimbursed if:

- the (individual) treatment is provided by a practitioner who is affiliated to a professional association approved by Anderzorg as a certified member. You can find out which professional associations are approved by visiting anderzorg.nl/zorgvinder,
- the homeopathic medicine is registered in accordance with the Dutch Medicines Act,
- it is a WALA or Weleda anthroposophic medicine,
- a doctor prescribes the medicine, and
- a dispensing chemist's or a general practitioner with dispensing facilities provides the medicine.

Spectacles and contact lenses

Spectacles or contact lenses are a medical aid for daily use that is used on or in front of eyes and compensates for a deviation of the eye or eyes that ensures that the user can focus better.

You will be reimbursed for spectacles (glasses on prescription including the frame) and (night time) contact lenses up to a maximum amount from an optician contracted by Anderzorg. The reimbursements for spectacles and contact lenses are added together up to the specified maximum amount has been reached. This maximum amount is as follows for 2 calendar years:

Budget	Jong	Extra
€ 0	€ 75	€ 75

Note

Reimbursement of spectacles and contact lenses

You can only obtain your spectacles or contact lenses from Pearle or Eye Wish Opticiens. If you purchase spectacles from another optician, you will not be reimbursed for these.

For more information and examples, please see anderzorg.nl/brillen.

SamenGezond: additional discount on spectacles

Additional discount on spectacles

On top of the regular reimbursement for spectacles Pearle and Eye Wish Opticiens offer you an additional discount when you purchase prescription spectacles with them.

Hand in your SamenGezond discount voucher at the register and receive the following additional discounts:

- € 25 additional discount, when you purchase spectacles for € 100 until € 250, or
- € 50 additional discount, when you purchase spectacles for € 250 until € 500, or
- € 75 additional discount, when you purchase spectacles for € 500 or more.

You can hand in one voucher per purchase. The voucher can be used in combination with other special offers from Pearle or Eye Wish Opticiens. Are you not a member of SamenGezond yet? You can enroll for free on samengezond.nl.

The discount voucher can also be used by customers of Anderzorg with no coverage for spectacles. For more information, the complete terms and conditions of this offer and examples, see anderzorg.nl/brillen.

Abroad

When staying abroad, you may require immediate medical care or medication. You will receive service and support from the Anderzorg Emergency Centre with regard to emergency care during a stay abroad. The Emergency Centre will, for example, take responsibility for the contact with the treating doctors and repatriation and will act as a guarantor. Additional information can be found by visiting anderzorg.nl/buitenland.

Prevention when travelling abroad

Tropical infections occur in specific countries for which you can be inoculated or take medication.

You will be reimbursed for consultations, injections, medication and (repeat) prescriptions in connection with a trip abroad. You will receive a reimbursement up to a maximum amount. The reimbursements for consultations, inoculations, medicines and (repeat) prescriptions are added together up to the specified maximum amount is reached. This maximum amount applies per calendar year:

Budget	Jong	Extra
€ 0	€ 100	€ 0

You are entitled to be reimbursed when:

- the consultation must take place at a doctor recognised by Anderzorg,
- the medication is prescribed or the injection is administrated by a doctor recognised by Anderzorg. You can find out who the doctors are by visiting anderzorg.nl/zorgvinder,
- the medication is supplied by a pharmacy or a dispensing GP.

Emergency dentistry work abroad

Dentistry work is classed as requiring emergency treatment if there are pain complaints as is the case with regard to the inflammation of a nerve or gums that means that the dentistry work cannot be deferred until you return to the Netherlands and it had not been foreseen that this dentistry work would be required.

Dentistry work will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Budget	Jong	Extra
€ 250	€ 250	€ 250

You will only be reimbursed the costs if:

- pain complaints are involved that means that dentistry work is required quickly and cannot be deferred until you return to the Netherlands,
- it could not have been foreseen that this dentistry work would be needed. A filling, implant or crown are examples of treatments that are provided.

Emergency care and medication abroad

Care is an emergency when a situation is involved in which medical assistance is needed as soon as possible that makes returning to the Netherlands no longer an option. It had not been foreseen that this medical assistance would be required.

You will receive a supplement to the reimbursement that you receive based on the Basic Insurance.

The supplement is the difference between the reimbursement that you receive from the Basic Insurance and the charged costs.

Budget	Jong	Extra
Yes	Yes	Yes

You will only be reimbursed the costs if:

- a situation is involved in which care and/or medicines are required as soon as possible that mean that returning to the Netherlands is no longer an option,
- it could not have been foreseen that this care and/or medicines would be needed,
- the situation was reported immediately to Anderzorg' Emergency Centre when admitted to an institution,
- you are not staying abroad for more than 1 year,
- you have a prescription from a general practitioner or medical specialist in the case of medicines and the effective ingredient in the medicine is part of a medicine that is reimbursed in the Netherlands based on the Basic Insurance, and
- the costs would have been reimbursed if they had been incurred in the Netherlands.

Example

You break a leg in the United States. You are given a bill for an amount of € 3,000 for the treatment. This would have cost € 2,000 in the Netherlands. You will receive this amount based on the Basic Insurance. The additional insurance will then reimburse the remaining € 1,000.

Emergency Centre +31 317 455 555

Rescue costs are costs incurred with regard to tracking, rescue and salvage. If you want to be reimbursed for rescue costs, take out travel insurance. For more information visit anderzorg.nl/reisverzekering.

Transport when ill, after an accident and after death

You may become sick or suffer an accident when abroad and that you need to return to the Netherlands for further treatment.

You will be reimbursed for transport from the location abroad to an institution in the Netherlands.

Budget	Jong	Extra
Yes	Yes	Yes

You will be entitled to this reimbursement when the medical need has been determined by Anderzorg' Emergency Centre and they also make the arrangements for travel.

Note

- If a travel companion wishes to travel with the person who is to be repatriated, Anderzorg will pay/reimburse these costs when the Anderzorg Emergency Centre deems that supervision by this travel companion is necessary.
- The travel costs of the mortal remains of the insured are paid/reimbursed from the place where death occurred to the Netherlands.
- Do you also want to be reimbursed for transport costs when there is no medical necessity? For example, when you break your arm on holiday (skiing) and you want to return to the Netherlands. Take out travel insurance for this. More information about travel insurance can be found on anderzorg.nl/reisverzekering.

Camouflage therapy and camouflage aids

Camouflage therapy will teach people with a serious facial or neck skin defect how best to camouflage the skin defect using camouflage aids. Camouflage therapy will teach people with a serious facial or neck skin defect how best to camouflage the skin defect using camouflage aids.

You will be reimbursed for camouflage therapy and camouflage aids up to a maximum amount. The

reimbursements for camouflage therapy and aids are added together up to the specified maximum amount has been reached. This maximum amount is per calendar year:

Budget	Jong	Extra
€ 0	€ 200	€ 200

You are entitled to this reimbursement if the treatment is provided by a skin therapist (or someone who works under his responsibility, such as a beautician), who has been recognised by Anderzorg. A list of recognised skin therapists can be found at anderzorg.nl/zorgvinder.

Dietetics

Dietetics is information provision about nutrition and eating habits with a medical objective. A dietician is the expert who discovers, studies and, if required, advices about making adjustments to eating patterns. The dietician can boost physical health by recommending a specific eating pattern (diet).

Dietetics is partly insured in the Basic Insurance. The additional insurance offers an extra reimbursement. You will be reimbursed for dietetics for a maximum number of treatment hours per calendar year:

Budget	Jong	Extra
0	0	2

You are entitled to be reimbursed when the dietician has a contract with Anderzorg. You can find the contracted supplier on anderzorg.nl/zorgvinder.

Note

If you decide to visit a dietician who does not have a contract with Anderzorg the dietician must be registered as a “Quality Registered” practitioner in the Kwaliteitsregister Paramedici (Paramedic Quality Register) and the costs will be reimbursed up to a maximum amount per treatment. Anderzorg wil reimburse 75% of the invoice of the care provider, with a maximum of 75% of the amount at which Anderzorg has contracted the treatment on average.

Epilation

Abnormal hair growth in the face and neck can be removed. Epilation through electrical power, laser, flashing light or equipment of a similar nature makes growth after epilation of the hair practically impossible.

You will be reimbursed for 80% of the costs of epilation if abnormal hair growth in the face and neck up to a maximum amount. This maximum applies for the full duration of the insurance.

Budget	Jong	Extra
€ 0	€ 500	€ 500

You are entitled to this reimbursement if the treatment is provided by a skin therapist (or someone who works under his responsibility, such as a beautician), who has been recognised by Anderzorg. A list of recognised skin therapists can be found at anderzorg.nl/zorgvinder.

Physiotherapy and exercise therapy

People with disorders related to the posture and locomotory apparatus are given support through exercises or different therapies and are assisted to improve their movement capacity and to reduce pain. When you have complaints related to your posture and locomotory apparatus, you can visit a physiotherapist or exercise therapist. This therapist will try to improve the function of your posture and locomotory apparatus by applying different techniques and exercise. A normal posture and movement will again be possible or you will be taught how to cope with your limitations in the best possible manner.

You will be reimbursed for physiotherapy treatments and exercise therapy up to a maximum number of treatment sessions. This maximum number of treatments per calendar year is:

Budget	Jong	Extra
9	9	9

You are entitled to be reimbursed when your therapist has a contract with Anderzorg. Visit anderzorg.nl/zorgvinder to find out who these therapists are.

Note

- You can visit a general physiotherapist for most complaints. For some specific complaints, you are best visiting a therapist who specialises in the treatment of these complaints. Examples of this include the following complaints:
  - in which the spinal column and limbs play a part (manual therapist),
  - in which the motor development and learning of the child play a crucial role (child therapist/ child exercise therapist),
  - vulnerable older people and clients/patients with a high (biological) age who have to deal with complex health issues (geriatric physiotherapy),
  - in which the pelvic region and hips play a crucial role (pelvic physiotherapist),
  - in relation to stress and complaints such as pain and tiredness for which there is no immediate physical cause can be found (psychosomatic physiotherapist and exercise therapist),
  - in which (lymph)oedema clays a crucial role (oedema therapist).
    We recommend asking your physiotherapist whether he or she specialises in the treatment of your complaints.
- You can only visit a general physiotherapist, child physiotherapist, manual therapist, oedema therapist, geriatric physiotherapist or a pelvic therapist who is registered in the Centraal Kwaliteitsregister Fysiotherapie (CKR; Central Quality Register) or in the Keurmerk Fysiotherapie (Physiotherapy Quality Mark) register. You can also visit a skin therapist who is registered as “Quality Registered” in the Paramedic Quality Register for oedema therapy and scar therapy.
- Will you be visiting a therapist who does not have a contract with Anderzorg? You will then have the costs reimbursed up to a maximum amount. Anderzorg reimburses 75% of the bill of the care provider up to a maximum of 75% of the amount that Anderzorg has contracted for this treatment on average.
- Manual therapy will be reimbursed for each indication up to a maximum of 9 treatments per calendar year. These treatments are part of the specified maximum per calendar year.
- A screening is deemed to be 1 treatment. If an intake and check-up take place at the same time, the first visit will be deemed to be 1 treatment. If the screening, intake and check-up do not take place on the same day, this will be deemed 2 treatments.
- You will not be reimbursed for treatments that are not deemed to be physiotherapy or exercise therapy such as physiotherapy fitness, shockwave therapy and swimming in a heated pool. Ask your therapist, visit anderzorg.nl/fysiotherapie for even more examples or call our Customer Service if you have any doubts.

FysioZelfCheck (app)

FysioZelfCheck is an app developed by and of physiotherapists. FysioZelfCheck offers exercises, information and suggestions in an easily accessible way with which people can actively work on solving their complaints themselves. The app is for people with mild musculoskeletal complaints, such as sore shoulders, low back pain or complaints during/after exercise.

You get full access to FysioZelfCheck

Budget	Jong	Extra
yes	yes	yes

About FysioZelfCheck

Common, mild musculoskeletal complaints often diminish or disappear within a few weeks with rest and simple exercises. FysioZelfCheck can help in these situations. Users of FysioZelfCheck start by completing a questionnaire. These are questionnaires that meet the current guidelines of the profession. On this basis, the user is presented with information, suggestions and a series of exercises. With various instruction videos and vlogs from, mostly specialist physiotherapists, the user can get started with the exercises. If the questionnaire shows that additional care is required, a recommendation will be made to make an appointment with a (specialist) physiotherapist or GP.

Child care when hospitalized

If you are hospitalized and you have children, it is not always possible to arrange child care yourself. You can have your children looked after temporarily at a day-care centre (day nursery or crèche) or after school child care facility or by a child-minder.

You will be reimbursed € 20 per day as a contribution towards the costs of child care from the 11th day that you have been hospitalized. The reimbursement applies for up to a maximum of 3 months per calendar year.

Budget	Jong	Extra
No	No	Yes

You are entitled to be reimbursed when 1 or more children within your family are younger than 12 years.

Bed-wetting alarm

When someone who is 7 years old or older frequently wets his or her bed without a physical reason being involved, we refer to this as bed-wetting (or enuresis). A bed-wetting alarm is a device that will react at the very first sign of unwanted urine loss through an alarm tone.

You will be given a bed-wetting alarm once for the whole insurance period.

Budget	Jong	Extra
No	No	Yes

You are entitled to be reimbursed when the supplier has a contract with Anderzorg. You can find the supplier by visiting anderzorg.nl/zorgvinder.

Soft brace or splint

A soft brace is a medical aid to stabilize a joint (for example, a knee). A brace or splint is covered by the Basic Insurance in certain cases.

You will be reimbursed for the purchasing costs of a soft brace or splint up to a maximum amount per calendar year:

Budget	Jong	Extra
€ 0	€ 50	€ 50

Sports medical advice

Sports medical advice is given to people who (wish to) participate in sports, have an injury or complaints whilst exercising and who wish to know which sporting activity is best for them. Specialized institutions offer various research packages to ensure that sound advice can be provided regarding this. The packages are adjusted based on sporting intensity and age and may, for example, consist of a heart film, lung functional tests, an extensive examination of the posture and locomotory system and an exercise test (endurance).

Sports Medical Advice is deemed to mean the following:

- basic physical medical exam,
- basic physical medical exam with ECG,
- basic physical medical exam with ECG and exercise ECG,
- elaborate physical medical exam (also called professional sports medical exam),
- physical medical supervision (training advice and individual training schedule),
- physical examination (mandatory according to the sports federation).

Sports medical advice will be reimbursed up to a maximum amount per calendar year:

Budget	Jong	Extra
€ 0	€ 250	€ 200

You will be entitled to this reimbursement when the advice is provided by a sports doctor (or someone who falls under his or her responsibility) who works at an institution approved by Anderzorg. You can find out which they are by visiting anderzorg.nl/zorgvinder.

Note

You will not be reimbursed for Sporting Medical Advice that is required for a course, performing a profession or top sports.

Dental expenses after an accident

An accident can lead to high dental expenses. An accident is a sudden, unexpected act of violence that comes from outside in relation to the insured person that has led to direct physical injury that can be established medically. Events regarding which you can foresee in advance that damage to the dentures will occur do not fall under this definition. Examples of this are opening a bottle with your teeth, biting on something that is hard such as nuts, not using dental protection with regard to relevant sports and damage to teeth as a result of an

illness.

If you are 17 or younger, dental expenses after an accident are insured in the Basic Insurance. The dental insurance covers dental expenses after an accident if you are 18 or older. You will receive a reimbursement for dental expenses after an accident up to a maximum amount of € 10,000 for each accident in the following packages:

Budget	Jong	Extra	Tand
Yes	Yes	Yes	Yes

Dental expenses are fully reimbursed up to at most € 10,000 for each accident provided that:

- you were 18 or older when the accident occurred, and
- the accident took place in the Netherlands, and
- the treatment is given by a dentist or orthodontist in the Netherlands,
- the dental expenses are not covered by the Basic Insurance, and
- you have an additional insurance that covers dental expenses after an accident when the accident and treatment took place.

Any expenses related to the excess and personal contribution (Basic Insurance) will not be reimbursed.

Exclusions

You are not entitled to a payment in case of dental damage that is due to:

- deliberate intent and/or willful recklessness,
- when you were under the influence of alcohol or drugs,
- because of eating food,
- because of being active in a sport as a (sub)profession,
- because of already existing shortcomings of the denture (before the accident),
- because of being involved in a fight that cannot be classed as self-defence,
- when you have not taken the usual protective measures when pursuing a sport.

Permission

You need a statement of approval from Anderzorg before you start treatment. Your dentist or orthodontist can apply for this from us by drawing up a treatment plan and sending it to Anderzorg. If required, Anderzorg may request photos to make an assessment. You must also complete a statement with information about the accident. You can find the statement on anderzorg.nl/tandongeval.

Assessment

We will assess whether the treatment is eligible for reimbursement based on the treatment plan of your dentist or orthodontist and your statement. We will then determine whether an accident has been involved that caused the damage, whether the exclusions are applicable and whether you meet the other conditions. We will also assess whether the proposed treatment will be effective. Care that is unnecessary or costs too much unnecessarily when compared to other types of care that is on an equal footing in view of the indication and your care need, will not be covered by the insurance.

If you meet all specified conditions, you will receive a statement of approval for the treatment At most, the amount of the treatment plan of your dentist or orthodontist will be reimbursed. Are third parties involved?

Report this to Anderzorg. We will then recover the losses.

Bill because of an accident

Your dentist or orthodontist will claim the expenses for which consent has been granted for the accident cover directly from Anderzorg. You will not receive a bill for this. If you do receive a bill, contact your dentist or orthodontist.

Foot care

Foot care means treatment and aids that are related to your feet.

Orthopaedic arch supports

An orthopaedic arch support is a loose insole for a shoe. Orthopaedic arch supports can have a relieving or supporting function or a correcting function. The foot and walking posture will be improved.

Pedicure care

A pedicure (chiropodist) looks after feet, toes and nails related to complaints. Pedicure care is insured in the Basic Insurance in specific cases.

Chiropody

The chiropodist treats feet function disorders and feet complaints. This can be achieved by applying corrective or protective techniques such as shoe and sole corrections, podiatric supports and providing advice about feet complaints.

Podiatry

The podiatrist treats all occurring complaints with regard to feet, toes and nails and complaints elsewhere in your body that may be influenced by feet, toe and nail corrections.

You will be reimbursed for orthopaedic support soles, repair of orthopaedic arch supports, pedicure, chiropody and podiatry up to a maximum amount. The treatments and medical aids are added together until the maximum amount is reached. This maximum amount is per calendar year:

Budget	Jong	Extra
€ 0	€ 150	€ 150

You are entitled to be reimbursed when the supplier or care provider has been approved by Anderzorg. You can find out who they are by visiting anderzorg.nl/zorgvinder.

Note

Pedicure care is only reimbursed in case of foot problems with an increased risk of wounds and/or infections. Would you like to know which foot problems this concerns? If so, please visit anderzorg.nl/zorgvinder.

Contraceptives

Contraceptives are products that are used to prevent pregnancy. These products and any insertion are insured through the Basic Health Insurance for insured persons up to the age of

21. This also applies to insured persons from the age of 21 if there is a medical indication.

The costs of the following contraceptives are reimbursed: the pill, hormone-holding vaginal ring, injection contraception, implant contraception, copper coil, diaphragm and hormone-holding coil. You will be reimbursed for the costs of each service.

Budget	Jong	Extra
No	Yes	Yes

You are entitled to be reimbursed when:

- you are 21 or older,
- the contraceptive is being prescribed by a GP or medical specialist, and
- the contraceptive is being supplied by a pharmacy or a dispensing GP.

Note

- You can visit your general practitioner or a medical specialist (when there is a medical indication) for inserting a contraceptive (for example, a coil). The costs related to this will be reimbursed based on the Basic Health Insurance.
- The costs for general practitioner care are not deemed to fall under your excess. If the coil is inserted by a medical specialist, this will be deemed to be part of the excess.
- We recommend requesting an estimate from your care provider in advance with regard to inserting a contraceptive. This will ensure that you can determine which part of the costs is covered under your Basic insurance, which part under your additional insurance and which part of the costs might be paid by yourself.

Your dental insurance Anderzorg Tand, Anderzorg Jong en Anderzorg Budget (2020)

You can choose from different dental insurances at Anderzorg. Your healthcare policy sheet will specify which dental insurance you have chosen. Below you will find what is insured in the dental insurance.

The Dutch text is binding should any disputes arise from the interpretation of the text.

Basic and dental insurance

What is insured in the Basic Insurance can be found in the “Your Basic Insurance” section under the Dentistry article. What is insured in your additional dental insurance or dental cover can be found in the reimbursement table on anderzorg.nl/klantenservice/downloads. That which is insured through the Basic Insurance will not be reimbursed by your dental insurance. This also applies to your excess and personal contribution that are determined in the Basic Insurance unless it is included in the dental insurance as a reimbursement. Full dentures are partially insured in the Basic Insurance. Dental care is mostly insured in the Basic Healthcare Insurance for younger people up to the age of 17 except orthodontics, crowns and bridges.

Which care provider?

You can visit any dentist, orthodontist, independent oral hygienist or dental prosthesis specialist who is established in the Netherlands or border regions. The border area is up to 15 kilometres from the Dutch border. You can also visit a dental surgeon for a crown or bridge implant.

Code system

Care providers claim using codes. These codes represent specific services. For example: C11 – regular check-up. The services, codes and rates have been legally determined by the Dutch Healthcare Authority (NZa). You can find them by visiting nza.nl.

Legislation and regulations

You will only be reimbursed if legislation and regulations are observed. The care provider must meet the rules that are included in a (rate) ruling by the Dutch Healthcare Authority (NZa). You can find this (rate) ruling by visiting on nza.nl. If your care provider submits bills contrary to legislation and regulations, you will not be reimbursed for the incurred costs. This can, for example, be the case when your care provider carries out treatment for which the care provider is not certified or authorized.

Anderzorg Tand, Anderzorg Jong en Anderzorg Budget reimbursements

Anderzorg Tand reimbursement

Treatments will be reimbursed up to the specified maximum amount with Anderzorg Tand. Anderzorg Tand has a separate reimbursement for orthodontics for those who are older than 18. More information can be found in the Orthodontics article. The following treatments will be reimbursed:

Treatment	Reimbursement
Regular check-up (C11 and C13)	100%
Consultations (other C codes)	80%
Anaesthesia (A and B codes)	80%
Root canal treatments (E codes)	80%
Jaw treatments (G codes)	80%
Surgical treatments (H codes)	80%
Implants (J codes)	80%
Preventive dental care (M codes)	80%
Prosthetic provisions (P codes)	80%
Crowns, bridges and inlays (R codes)	80%
Gum treatments (T codes)	80%
Fillings (V codes)	80%
X-rays (X codes)	80%

The maximum amount is € 500 per calendar year.

Note

The following are not reimbursed: external bleaching (E97), the jaw overview photo (X21) below the age of 18, general anaesthesia (A20), anti-snoring devices (G71, G72 and G73).

Waiting times for crowns, bridges and implants in Anderzorg Tand

A waiting time of 1 year applies to crowns, bridges and implants in Anderzorg Tand. This means that you will pay a premium during the waiting time, but will not yet be reimbursed for the crowns, bridges and implants. The waiting time will apply when you switch to Anderzorg Tand and starts on the effective date of Anderzorg Tand. For more information about waiting times visit anderzorg.nl/wachttijd.

Orthodontics (braces) Anderzorg Tand

If you are 18 or older, your braces will be reimbursed up to 80% up to a maximum amount of € 500 for the full insurance duration. Have you already been reimbursed for a brace when younger than 18? This reimbursement will be subtracted from the maximum amount for a

brace when older than 18.

Waiting time for orthodontics

A waiting time of one year applies to orthodontics. This means that you will pay a premium during the waiting time, but will not yet be reimbursed for the orthodontics. The waiting time will apply if you switch to Anderzorg Tand. The waiting time will start on the insurance's Anderzorg Tand effective date. If you are insured with Anderzorg Tand in 2020, there will not be a waiting time in 2021 for you in Anderzorg Tand. For more information about waiting times visit anderzorg.nl/wachttijd.

Anderzorg Jong reimbursements

The following will be reimbursed:

Treatment	Reimbursement
Regular check-up (C11 and C13)	100%
Consultations (other C codes)	80%
Anaesthesia (A codes)	80%
Anaesthesia (B codes)	-
Root canal treatments (E codes)	80%
Jaw treatments (G codes)	-
Surgical treatments (H codes)	80%
Implants (J codes)	-
Preventive dental care (M codes)	80%
Prosthetic provisions (P codes)	-
Crowns, bridges and inlays (R codes)	-
Gum treatments (T codes)	-
Fillings (V codes)	80%
X-rays (X codes)	80%

Up to the maximum amount of € 150 per calendar year.

Note

The following are not reimbursed: external bleaching (E97), the jaw overview photo fX211 below the age of 18, general anaesthesia (A201), anti-snoring devices (G71, G72 and G73).

Anderzorg Budget reimbursements

You will be reimbursed up to 75% of the costs of dental treatments and the related material and technology costs in accordance with the Anderzorg Budget dental care service table up to a maximum of € 250 per calendar year.

You can find the service table on anderzorg.nl/klantenservice/downloads.

Technique and material costs

Technique and material costs may be charged with regard to a few treatments such as crowns and dentures. Calculated technique and material costs will be reimbursed for the same percentage as the percentage that is specified at the treatment. For example, when a one-surface inlay is made, you will be reimbursed 80% from Anderzorg Tand for the fees and 80% for the calculated technique and material costs.

How to claim for your bill

If your dental care provider gives you a bill for dental care, you can claim online by visiting anderzorg.nl/mijnanderzorg. Visit anderzorg.nl/declareren for more information about claiming bills. Some care providers claim directly from Anderzorg. You will, in this case, receive a bill from your care provider for the costs that you must pay.

General terms and conditions

Below you will find the general terms and conditions. You will find the rules that apply to your Basic Insurance, additional insurance and dental insurance in the general terms and conditions (1). For example, about cancelling your insurance, premium payment and how you can submit a complaint. You will also find (additional) terms and conditions that do not apply to the Basic Insurance but do apply to the additional and dental insurances in the general terms and conditions (2).

The Dutch text is binding should any disputes arise from the interpretation of the text.

general terms and conditions (1)

Who is Anderzorg?

Anderzorg is the one that carries the risk of your insurance. Anderzorg refers to the following: Anderzorg N.V. when it involves the Basic Insurance and Menzis N.V. when it involves the additional insurance or the dental insurance. Coöperatie Menzis U.A. is the only shareholder of Anderzorg N.V. and Menzis N.V. By taking out the insurance you will become a member of Coöperatie Menzis U.A. as a Anderzorg insured party. This Cooperation focuses on promoting the interests of its members. Coöperatie Menzis U.A., Anderzorg N.V. and Menzis N.V. are non-profit organisations.

A1 General

- The government determines the insured package for the Basic Insurance. The Dutch Healthcare Insurance Act and the related regulations prescribe what you need to be insured for. Every healthcare insurer must strictly adhere to the law. We have specified as clearly as possible for what you are insured in these insurance terms and conditions. In the unlikely event that something in these insurance terms and conditions should not concur with the legal rules and regulations, what has been defined in the legal rules and regulations will apply to you.
- The insurance contract consists of: your healthcare policy, these general terms and conditions insofar as the insurance described therein applies to you, and the Insurance Regulations.
- If below the word ‘insurance’ has been used, we are referring to the Basic Insurance, the additional insurance and/or the dental insurance.
- The policyholder is the person who has taken out the insurance with Anderzorg. The insured is the person who incurs (may incur) medical costs. Often, the policyholder and the insured are the same person. When we use ‘you’, Anderzorg means you as the insured. If a provision only applies to the policyholder, this will be specified. Articles A10 through to A13 only apply to the policyholder.

A2 Working area

Anderzorg Basis is a Basic Insurance that is meant for everybody who lives in or outside the Netherlands and who must take out a Basic Insurance.

A3 Insurance period

The insurance will become effective on the date that is shown on your healthcare policy. Your insurance will run up to 1 January of the next calendar year. The insurance will be tacitly extended by a year on 1 January for as long as the insurance is not cancelled.

Note

The “duration of the insurance” is not the same as a “calendar year”. The insurance term may consist of many calendar years.

A4 Retroactive effect

- If your Basic Insurance with Anderzorg was taken out within 4 months after you were obliged to insure yourself, this Basic Insurance cover will have a retroactive effect up to the day on which you were obliged to take out insurance.
- If your Basic Insurance with Anderzorg was taken out within a month after you terminated another Basic healthcare insurance, this Basic Insurance will have a retroactive effect up to the day on which your previous healthcare insurance terminated.

A5 Changing the insurance

If you are the policyholder, you can change your insurance as from 1 January of any year. You can change your voluntary excess or select another additional insurance or dental insurance. Anderzorg must have received your request no later than on 31 December. You can implement these changes online at Mijn Anderzorg (MyAnderzorg). You can also call Customer Service on 088 222 44 22, send an email or complete a change form.

A6 Cancelling the insurance

Only the policyholder can cancel an insurance policy through a letter.

- If your email address is on record at Anderzorg, you can also cancel by email.
- Please clearly specify which insurance you exactly wish to cancel: your Basic Insurance, your additional insurance or your dental insurance. Also please clearly specify to which insured the cancellation applies.

A7 When can I cancel?

If you are the policyholder, you can:

- always cancel as from 1 January. Anderzorg must have received the cancellation no later than on 31 December. Insurers have developed a transfer service. This entails that if you take out healthcare insurance by 31 December at the latest for the following calendar year, the new insurer will cancel the Anderzorg healthcare insurance and, if you specify this, the additional insurance and dental insurance on your behalf,
- cancel the insurance of an insured during the interim period if the insured has taken out a Basic Insurance somewhere else. The cancellation will become effective on the day on which the insured is covered by virtue of another Basic Insurance. The cancellation must have been received prior to this day by Anderzorg. If the cancellation is received later, the cancelation will start on the first day of the 2nd calendar month after the day on which cancellation took place,
- cancel in the interim period if you have a group insurance with your employer and you wish to participate in the group insurance of a new employer. Anderzorg must have received your cancellation within 30 days after your new employment has started. The cancellation will apply as from the day on which you are insured by virtue of another Basisverzekering (Basic Insurance) healthcare insurance. The condition that applies is, however, that the cancellation must have been received prior to this day

by Anderzorg. If the cancellation is received later, the cancelation will start on the first day of the 2nd calendar month after the day on which cancellation took place,
- also cancel your insurance if Anderzorg changes the terms and conditions and the new terms and conditions are disadvantageous not to your advantage. Anderzorg must have received your cancellation at least one month after you have been informed about the change. The cancellation will become effective as from the day on which the change applies. You cannot cancel the insurance if Anderzorg is required to change the terms and conditions by law.
- not cancel the Basic Insurance if you have not paid the premium and have been sent a reminder for this unless Anderzorg has suspended cover of this insurance or has confirmed the cancellation within 2 weeks, cancel the Basic insurance within the first 12 months after the CAK has registered you for an insurance with Anderzorg. If you can prove that you were already insured with another healthcare insurer during the period mentioned in article 9d, section 1 of the Health Insurance Act, you can declare the Basic Insurance with Anderzorg null and void. You have to do this within 2 weeks after the CAK has notified you that they have registerd you with Anderzorg.



Note

- You cannot cancel the Basisverzekering (Basic Insurance) when you have not paid the premium and have been sent a reminder for this unless Anderzorg has suspended cover or has confirmed the cancellation within 2 weeks.
- A policyholder cannot cancel a healthcare insurance as referred to in the first paragraph of Article 9d of the Dutch Healthcare Insurance Act during the first 12 months during which it is valid if required in derogation to Article 7 of the Dutch Healthcare Insurance Act unless the fourth paragraph of this Article applies (Article 9d.7 of the Dutch Healthcare Insurance Act).

Examples

1. Your daughter leaves home and wishes to insure herself. You can now cancel the insurance for your daughter as the policyholder as from the date on which she has taken out her own insurance.
2. Due to a divorce, you and your ex partner wish to have your own cover. You can now cancel the insurance of the insured (ex partner) as the policyholder. You can cancel as from the day on which he or she has taken out his or her own insurance.
3. You are individually insured. You start employment on 1 May at a new employer. You wish to participate in the group insurance of your new employer. This is not possible as from 1 May but you can as from next 1 January.

A8 Is Anderzorg allowed to terminate the insurance?

Anderzorg can terminate the insurance if:

- the premium has not been paid; see Article A13,
- you have not given Anderzorg the full facts or you have provided incorrect information; see Article A24,
- you have not behaved appropriately with regard to Anderzorg or its staff,
- Anderzorg takes the insurance off the market and no longer offers it as an option. If the CAK has taken out an insurance policy with Anderzorg on your behalf, Anderzorg can declare this policy null and void if

it later emerges that the person who the CAK insured did not have an obligation to insure himself or herself at that moment in time.

A9 When will the Basic Insurance end automatically?

Your Basic Insurance will terminate automatically on the day after:

- your obligation to insure terminates,
- you die,
- Anderzorg changes the working area and you live outside this area,
- Anderzorg may not offer any Basic Insurances anymore.

Your Basic Insurance will end by operation of law on the 1st day of the 2nd month that follows on the day on which you start to live outside the working region of Anderzorg because of your move. If Anderzorg changes the working area or is no longer permitted to offer Basic Insurances, MAnderzorg will inform you about this no later than 2 months before your Basic Insurance terminates.

A10 Cooling off period

If you have taken out insurance with Anderzorg, you can cancel the insurance up to 14 days after receiving your healthcare policy. You do not have to specify a reason when cancelling within this period. This means that you do not have to pay premiums or costs. You will not be reimbursed for costs either. You can cancel the insurance using the same method as specified in Article A6.

A11 Obligation to inform Anderzorg

- You are obliged to inform Anderzorg in writing and within 30 days about:
  - a change of address,
  - a demise,
  - a change of bank account number,
  - an entrance into active military service,
  - the start and end of a prison sentence,
  - you not longer being eligible to participate in group insurance,
  - you not longer being obliged to have a Basic Health insurance.
- You are also obliged to let us know who is your new healthcare insurer if you have cancelled your insurance with Anderzorg. Should Anderzorg come to the conclusion based on the data that you have provided that your Basic Insurance will be terminating or has been terminated, Anderzorg will immediately inform you about this.
- You are obliged to provide Anderzorg with the information they request from you, as far as you are able to provide this information. For example, about the reason for hospitalisation, for fraud being investigated or for checking. Should you not cooperate, your entitlement to receive care or to be reimbursed for costs may no longer apply.
- You are obliged to inform Anderzorg if a third party can be held liable for health care costs reimbursed by Anderzorg, for example, after a traffic accident or a medical mistake. You can then contact Customer Service at 088 222 44 22 or the Redress department at 050 523 43 77. You can also provide this information online on www.anderzorg.nl/zelf-regelen/schade-melden. Anderzorg can advise you and recover the loss with the liable party. You are not allowed to come to an arrangement yourself with the liable third party or his or her insurer should this not be to the advantage of Anderzorg.

A12 Premium, payment method and payment of the excess

A12.1 Premium

- The basis of the premium calculation for the Basic Insurance amounts to € 110 per calendar month as from 1 January 2021. The premium to be paid is the basis of the premium calculation from which any premium discount that may apply has been deducted. You can receive a premium discount due to participating in group insurance and by choosing a voluntary excess. The premium you have to pay is specified on your healthcare policy.
- Up til the age of 18, you do not have to pay a premium for the Basic Insurance. You do need to pay a premium for the Basic Insurance from the first day of the calendar month that follows the calendar month in which you reach the age of 18.
- Anderzorg must have received your premium before the period to which the premium relates has started.
- You may not settle the premium with a payment that you are expecting from Anderzorg.
- If you make a payment without stating the Anderzorg payment reference, Anderzorg will determine for which payment this applies and should be written off.
- If you do not pay through direct debit or a giro collection form email, you will receive a giro collection form from Anderzorg. € 2 will be charged for this.
- If you have agreed on a payment arrangement with Anderzorg, Anderzorg may charge costs.

A12.2 Payment method

If you authorise Anderzorg to collect the insurance premium through a direct debit authorisation, this autorisation also applies to all other amounts that you must pay Anderzorg. For example, payments for excess and personal contributions. You will be informed about direct debits of excess payments or personal contributions ahead of time. This will happen at least 5 days before the direct debit takes place. The healthcare policy is the announcement for taking the premium through direct debit from your account for the whole of the calendar year.

A12.3 Payment of the excess and personal contribution

- Anderzorg will charge you for the excess and personal contribution for yourself and all others whom you have insured.
- If you do not pay the excess and personal contribution through direct debit or a giro collection form email, you will receive a giro collection form from Anderzorg. € 2 will be charged for this.

A13 What will happen if I do not pay the premium?

A13.1 Basic Insurance and additional insurance

1. Anderzorg will send you a reminder. If you pay the premium within 14 days after receiving this reminder, your cover will not be affected.
2. Should you not pay within 14 days after this reminder, this will have the following consequences:
    - Anderzorg can suspend the cover of all insurances. You will no longer receive reimbursements from the start of the period to which the premium not being paid is related,
    - you will continue to be liable to pay the premium,
    - payment discounts will no longer apply,
    - you must pay for the collection costs due to the additional work that Anderzorg has had to do such as sending a payment slip and reminders and the work of the bailiff,
    - You must pay statutory interest based on the full claim.
3. If Anderzorg has received the premium, collection costs and the legal interest, the cover offered by the insurance will again be effective the day after your payment has been received. Costs that have been incurred during the suspension will not be paid/ reimbursed. This is also the case should Anderzorg

have granted permission for a treatment or provision.
4. If you do not pay the premium even after having received a reminder, Anderzorg will terminate the insurance of all insured parties.
5. Anderzorg may transfer sending reminders and collecting payments to a collection partner. Should the payment have been transferred to a collection partner, Anderzorg may also transfer new outstanding payments without you receiving a reminder.

A13.2 Basic Insurance

Should you not pay the premium even when sent a reminder, Anderzorg can report your Basic Insurance to the Centraal Administratiekantoor (CAK; Central Accounting Office) based on the Dutch Healthcare Insurance Act for deduction at source. An administrative premium of at least 110% and at most 130% of the average market premium will be imposed. This premium shall be deducted from, for example, your salary or benefits. You can read when we report you to the CAK. The rules related to this can be found in articles 18a up to and including 18g of the Dutch Healthcare Insurance Act. Which rules apply when the CAK starts to collect the administrative premium are also described in these articles.

What happens when you have not paid a premium for 2 months

1. Once it has been determined that you have not paid a premium for 2 months, Anderzorg can offer you a payment arrangement. This payment arrangement entails the following:
   a. that you authorise Anderzorg to collect through direct debit,
   b. that you have made agreements with Anderzorg to pay your payment arrears in terms,
   c. that Anderzorg will not terminate the Basic Insurance or that it will not suspend or defer the cover of the Basic Insurance as long as the payment arrangement is in place. This will not apply if you withdraw the direct debit specified in (a) or when you do not comply with the made agreements about payments.
2. Have you insured someone else? And have you not paid the premium for the Basic Insurance of this insured for 2 months? The payment arrangement will then also entail that we will offer to terminate this insurance. This will only apply if:
   a. the insured has taken out Basic Insurance for himself or herself on the date that the payment arrangement comes into force, and
   b. if the insured stays with Anderzorg, he or she has issued an authorisation as referred to in a of 1.
3. In the letter in which Anderzorg offers you a payment arrangement it is specified that you have 4 weeks to accept the arrangement. We will also explain in the letter what will happen if you do not pay the premium for 6 months. We will also tell you that you can receive debt assistance, how you can obtain this assistance and which debt assistance is available in the letter.
4. If you have (also) insured someone else, this person will receive the same letter about the payment arrangement as you have received.

What happens when you have not paid a premium for 4 months

5. If you have not paid premiums for 4 months, we will inform you and your co-insured that Anderzorg is planning to report you to the CAK when you have not paid premiums for 6 months or more. If Anderzorg reports you to the CAK, this will mean that the CAK will collect the administrative premium.

   a. Anderzorg will not report you (as yet) if you let Anderzorg know in time that you do not believe you owe Anderzorg any amounts. Or if you let Anderzorg know in time that you believe that the sum of the debt is incorrect. You will have done this in time if you send Anderzorg a letter no later than 4 weeks after you have been informed about the situation by us. Anderzorg will, next, investigate

whether it has calculated your debt correctly. If Anderzorg believes it has calculated your debt correctly, Anderzorg will inform you about this. If you disagree with the opinion of Anderzorg, you can submit this to the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ; Health Insurance Complaints and Disputes Board) or to a civil court. If you do this within 4 weeks after you received the letter from Anderzorg, Anderzorg will not report you to CAK until the Stichting Klachten en Geschillen Zorgverzekeringen or the civil court has decided whether Anderzorg has calculated the level of your debt correctly.

b. You can also ask Anderzorg whether it is prepared to make a payment arrangement. You can read what a payment arrangement entails in the sections above under 1 and 2. If Anderzorg agrees to a payment arrangement with you, Anderzorg will not report you to the CAK as long as you pay the new premiums on time.

What happens when you have not paid a premium for 6 months

6. If Anderzorg has established you have not paid premiums for a period of 6 months, Anderzorg will report you to the CAK. Anderzorg will pass on your personal details and of the people whom you have insured to the CAK. Anderzorg will only pass on those personal details to the CAK and that they required to charge for the administrative premium. You and the person whom you have insured will also be informed by Anderzorg about this.
7. Any selected voluntary excess will no longer apply nor the related premium discount.

A14 Is Anderzorg allowed to change the terms and conditions and the premium?

Anderzorg is entitled to change the terms and conditions, the premium and discounts at any given time. If Anderzorg changes the basis of the premium of the Basic Insurance, this change will not come into effect until 7 weeks have elapsed after the day on which you were informed about the change.

A15 Group insurance

A16 Submitting a bill

Anderzorg often pays care providers directly. Sometimes, however, you may receive a bill. You can submit a bill online:

- you can do this on Mijn Anderzorg, or by using our claims-app,
- a scanned bill will be regarded as an original,
- Anderzorg may ask you to send in the original bill,
- you must keep the original bill for 3 years.

You can submit a bill by standard mail:

- the original bill must be sent and not a copy, duplicate or reminder,
- bills will not be returned.

Note

Act when you receive a bill. Do not save your bills for later. The best option is to submit a bill immediately.

A bill must meet the following requirements:

- You have to submit a bill within 3 years of receiving it from your care provider. The billing date is regarded as the receival date.
- The bill must specify details to such an extent that we can determine your entitlement to be reimbursed.
- Anderzorg may ask you to send a translation of the bill if a bill is not drawn up in the Dutch, English or German language. The translation must be carried out by a sworn translator. You will have to pay for the translation yourself.

The following applies to all insurances (Basic Insurances, additional insurances and dental insurances):

- Anderzorg is entitled to settle every payment to every insured specified on the insurance policy based on any insurance with any Anderzorg amount owed from every insurance with regard to every insured specified on the insurance policy.
- If you submit a bill without specifying on which account number the reimbursement must be paid, Anderzorg will pay the reimbursement to the account number of the policyholder that is known to Anderzorg.
- A bill in a foreign currency will be converted by Anderzorg into euros. The exchange rate used by Anderzorg will be the one that is used by the Dutch banks on the date that the bill was issued.
- If Anderzorg makes a reimbursement directly to the care provider, this will mean that you will not be reimbursed directly.
- Reimbursement of the care provided by a non-contracted provider is only paid into a bank ac count registered in the name of the insured person or, in the absence thereof, a bank
- ac count registered in the name of the policyholder. The policyholder or the insured person cannot designate a different bank ac count into which payment should be made.
- The transferability of the rights of claim that arise on the part of the insured person and/ or policyholder from an insurance contract concluded with Anderzorg is excluded. This is a stipulation as referred to in Article 3:84 paragraph 2 of the Dutch Civil Code.

A17 Complaints and disputes

If you are unsatisfied about the services Anderzorg provides, please let Anderzorg know at your earliest convenience. How should you deal with this situation and to whom should you be submitting it?

How should you deal with this?

- You complete the online complaints form on anderzorg.nl/klachtafhandeling where you can specify why and about what you are dissatisfied. If you need assistance in completing this form, please call the Anderzorg Customer Service on 088 222 44 22.
- You can send this form to the Klachtenmanagement (Complaints Management) department.
- Anderzorg will carefully study your complaint and ensure you receive a reply.
- If you do not agree with the reply given by Anderzorg or if you have not received a reply within 30

days, you can submit your issue to the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ)
- You can find information about the SKGZ on skgz.nl. You can also approach the SKGZ through the European platform for online dispute resolution. You can find information about this platform on ec.europa.eu/odr.
- The SKGZ will first submit your issue to the Ombudsman Zorgverzekeringen (Healthcare Insurance Ombudsman). The ombudsman will try to solve your issue through mediation. If mediation does not lead to a satisfactory result or if it fails, you can submit your issue to the Geschillencommissie Zorgverzekeringen of the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ).
- Processing by the Geschillencommissie Zorgverzekeringen will cost € 37. The Geschillencommissie Zorgverzekeringen processing will end with a binding recommendation. Anderzorg and you must comply with this recommendation.
- You can also submit your issue to one of the following bodies:
  - If forms are involved: the Nederlandse Zorgautoriteit (NZa; Dutch Healthcare Authority),
  - A civil court.

Note

Also refer to Section A13.2 for complaints about premium arrears.

To whom should I submit this?

If you do not exactly know to whom you should be sending your complaint/objection, the Klachtenmanagement department can provide assistance.

- Anderzorg Klachtenmanagement department, PO Box 75000, 7500 KC Enschede
- Stichting Klachten en Geschillen Zorgverzekeringen, PO Box 291, 3700 AG Zeist
- Dutch Healthcare Authority, Attn. the Information Line/the Reporting Point, PO Box 3017, 3502 GA Utrecht

A19 Acts of war

You are not entitled to care or a reimbursement for costs if they are a result of an armed conflict, revolts, civil war, national riots, insurrection and/or mutiny. These 6 specified forms of damage as well as the definitions of this can be found in the text that has been filed under number 136/1981 by the Verbond van Verzekeraars (Dutch Association of Insurers) in the Netherlands on 2 November 1981 with the registry of the district court in The Hague.

A20 Terrorism

If you need care due to an act of terrorism, the following applies regarding the Basic Insurance:

If the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V.(NHT) expects the total loss that will be claimed due to such acts in any calendar year from non-life, life or funeral services (benefits in kind for funerals) insurers to which the Dutch Financial Supervision Act applies, will be higher than the maximum amount reinsured by this company per calendar year, you will only be entitled to care or the reimbursement thereof up to a percentage of the costs or value of the care or other services to be determined by the NHT which is equal for all insurances. It is possible that after a terrorist act an additional amount is provided to Anderzorg based on Article 33 of the Dutch Care Insurance Act or Article 3.16 of the Healthcare Insurance Decree. If this is the case, you will be entitled to the provisions with regard to which the scope is established in the scheme as referred to in Article 33 of the Dutch Care Insurance Act or

Article 3.16 of the Healthcare Insurance Decree as well as the provisions as referred to in the first sentence of this article.

A21 cancelled

A22 Liability

Anderzorg cannot be held liable for damages that you suffer as the result of any action or omission of a care provider whose care you have used. Any liability on Anderzorg' part for damages as a result of Anderzorg' own shortcomings is limited to the amount of the costs that would have been charged to Anderzorg should the insurance have been executed correctly.

A23 No reimbursement for missed appointments

You are not entitled to the reimbursement of costs that you are charged if you have missed an appointment with your care provider.

A24 Combating fraud

If you or the policyholder deliberately mislead Anderzorg, you are no longer entitled to reimbursement. Anderzorg will then also have the right to terminate all your insurances. The amounts that Anderzorg may already have paid either to yourself or directly to the care provideras a direct result of the deception, must be paid back. You must also pay Anderzorg for the incurred investigation costs. Anderzorg will report you and your data will be registered. This will be done in the registers in accordance with the Insurance and Criminality Protocol (Protocol Verzekeraars en Criminaliteit) of the Dutch Association of Insurers.

A25 Code of conduct with regard to personal data

- You have entrusted us with your personal data such as your name, address and date of birth. Anderzorg will deal with your data carefully. Your personal data will be used for taking out and executing your insurance. Anderzorg also uses your personal data for executing legal obligations and statistical analyses. Anderzorg also uses your personal data to inform you about products and services that may be of interest to you. Should you wish to examine your data or if you do not wish to receive information about our products and services, please let us know in writing. More information is provided on the website.
- The Code of Conduct for Dutch Healthcare Insurers applies to processing personal data. Anderzorg keeps to the rules of the Code of Conduct. Material control, processing medical data and fraud investigation are performed as defined in the Code of Conduct.
- Other parties are also involved and not just Anderzorg when executing your insurance such as care providers or a factoring agency (debt collecting agency) that collects outstanding amounts. It is sometimes necessary that Anderzorg provides these people with your personal data and that they provide your personal data to us to ensure your insurance is correctly executed. It is assumed that you have given your permission to this.
- If you claim online for a bill, Anderzorg shall be entitled to check with the care provider to verify that this care provider has sent the bill to you. It is assumed that you have given your permission to this.
- Anderzorg will include your personal public service number (BSN) in its administration. Your care providers, other care service providers and Anderzorg use your personal public service number in all forms of communication.

A26 Miscellaneous

- The date on which you were treated, medication has been prepared or an aid delivered is the determining factor for the reimbursement and the excess. The date on which the bill has been issued or

paid is unimportant with regard to this.
If the treatment is funded through a Diagnosis Treatment Combination (DBC), the opening date of the DBC-care product is the determining factor for reimbursement. For a DBC-care product which was opened in 2021 and closed in 2022 you will therefore be reimbursed according to 2021 terms and conditions.

- You grant Anderzorg the authorisation to reclaim amounts that have been paid but to which you were not entitled.
- If you visit or call Anderzorg and Anderzorg makes a verbal promise, you can ask Anderzorg to confirm this promise in writing. A verbal promise that is not confirmed in writing will be deemed not to have been made.
- Dutch law applies to the insurance.

general terms and conditions (2)

The general terms and conditions (2) only apply to the additional insurance and the dental insurance. The Dutch text is binding should any disputes arise from the interpretation of the text.

A27 Cancellation

If you are the policy holder and you cancel the Basic Insurance, you can have your Anderzorg additional insurance and dental insurance continued or cancelled as from the same date.

A28 Is Anderzorg allowed to terminate the insurance?

Anderzorg can cancel the additional and dental insurance when:

- you take up residence in another country than the Netherlands, or
- you are staying for more than 12 months in another country than the Netherlands, or
- Anderzorg takes the relevant additional or dental insurance off the market and no longer offers it as an option.

A29 Change

If you are a policyholder and you change your additional or dental insurances successively for another Anderzorg additional or dental insurance, this will not interrupt the insurance period. Not even when this change is because you or other insured listed on the healthcare policy sheet will be participating in a group insurance or the participation in such insurance ends. Nor after suspension of cover due to non- payment. An existing term for reimbursement will then not restart. The insurance period will, however, be interrupted if you end the additional and dental insurances and you do not successively take out a Anderzorg additional or dental insurance.

A30 Premium

- Menzis N.V. has authorised Anderzorg N.V. to collect the premium for the additional insurances and dental insurances and possibly also other payments (such as personal contributions) on its behalf. Even when a bailiff is called in or legal proceedings are started.
- Anderzorg can charge a personal contribution from the policyholder or the insured who is involved.
- For the additional insurance of someone who is not yet 18 years old, no premium has to be paid. For a dentist insurance of someone who is not yet 10 years old, no premium has to be paid. This only applies if there is another person on the same policy who does pay premium for this insurance (or a more extensive one). People who have a Anderzorg Jong insurance have to pay premium, regardless of their age.

A31 For your child

Anderzorg will accept you without medical selection for the additional insurances and dental insurances. Additional insurance with more extensive cover than for one of the insured specified on the healthcare policy who is 18 or older cannot be requested for children younger than 18. An adult premium will then be charged for the child.

A32/A33 Concurrence

The additional insurance and dental insurance do not offer cover for costs for losses that are already being reimbursed based on another insurance that may or may not be of a later date or an Act, a treaty, an agreement or some other provision.

The additional insurance and dental insurance do not offer cover for costs for losses that would already have been reimbursed based on another insurance that may or may not be of a later date or an Act, a treaty, an agreement or some other provision if you had not taken out the additional insurance or dental insurance.

If you rely on the additional or dental insurance while you could rely on another insurance or provision, for example, travel insurance, you must inform Anderzorg about this other insurance or provision.

A34 Terrorism

When terrorist acts are involved, the following will apply to the additional insurance and dental insurance. You are not entitled to care or reimbursement of costs if these are the result of terrorism, malicious infection or preventive measures to avert the danger of terrorism or malicious infection. This will be different if these costs are reinsured with the Dutch Terrorism Risk Reinsurance Company. The Clauses Sheet Terrorism Cover is a part of the insurance and can be consulted through anderzorg.nl or terrorismeverzekerd.nl and will be sent to you upon request.

A35 Nuclear reactions

Care or the reimbursement of the costs related to care as a result of a nuclear reaction is not covered by the additional and dental insurances. A nuclear reaction is deemed any nuclear reaction where energy is released such as nuclear fusion, nuclear fission and artificial or natural radioactivity.

A36 Application rejection

Anderzorg may reject the application to conclude an additional or dental insurance if (this is not an exhaustive list):

- you still need to pay premiums for another insurance with Anderzorg,
- you have committed (insurance) fraud.