Insurance terms and conditions Menzis Basis Vrij Collectief 2017

Basic insurance, additional and dental insurances and practical information. Applicable as from 1 Januari 2017.

Contact and service

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

You can reach us by telephone, email, post and at our shops and service points. You can also visit menzis.nl/contact.

Our website

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

By email

You can also send your questions by email.
You will find our contact form by visiting menzis.nl/contact.

Calling Menzis

You can also call us. The most important telephone numbers are given below. Visit menzis.nl/contact for information on current opening times.

Telephone numbers

Customer Service	088 222 40 40	
Menzis Care Advisor	088 222 42 42	
Menzis Emergency Centre	+31 317 455 555	Can be reached 24 hours a day
Menzis Transport Service Line	0317 492 051	

Postal address

Menzis
PO Box 75000
7500 KC Enschede

Addresses

Menzis Groningen, Winschoterdiep 70, 9723 AB Groningen
Menzis Enschede, De Ruyterlaan 25, 7511 JH Enschede
Menzis Wageningen, Lawickse Allee 130, 6709 DZ Wageningen

Complaints

Information regarding complaints and disputes can be found on the customer service page on our website. Or see Article A17 of the General terms and conditions.

The Menzis Zorgvinder

Menzis 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 Menzis by visiting “De Menzis Zorgvinder” (The Menzis Care Finder) on menzis.nl/zorgvinder. Do you not have access to the Internet? You can also call our Customer Service on 088 222 40 40. If you have questions about the care, please call the Menzis Care Advisor on 088 222 42 42.

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Your basic insurance Menzis Basis Vrij

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 and the related regulations prescribe what you need to be insured for. Every healthcare insurer must strictly adhere to the law. We have indicated as clearly as possible in these insurance terms and conditions what you are covered for. 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.
If a legal scheme can lead to the same care being paid, you will not be entitled to this care based on this Basic Insurance.

Reimbursement

You have chosen to take out the basic insurance Menzis Basis Vrij. This is an insurance that is indented for everybody who lives in or outside of the Netherlands and who has to take out healthcare insurance. Menzis Basis Vrij is a reimbursement healthcare insurance. Reimbursement 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. We reimburse the amount that is deemed suitable and reasonable in the Dutch market. All care for which you are insured is described on the following pages.

Freedom of choice

Menzis concludes contracts with care providers. Hospitals, doctors, medical specialists and physiotherapists are, for example, care providers. You choose the care provider who is either a contracted or a non-contracted one.

ⓘ 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.

The Menzis Zorgvinder (Care Finder)

Menzis 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 Menzis by visiting 'De Zorgvinder' (The Care Finder) on menzis.nl/zorgvinder. Should you not have access to the Internet, you can also call Menzis Customer Service on 088 222 40 40. If you have questions about the care, please call the Menzis Care Advisor on 088 222 42 42.

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 entitled to the reimbursement of costs of an examination or treatment that 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.

Insurance Rules and Regulations

Reference is made to the Insurance Rules and Regulations, the Healthcare Insurance Decree or the Health Insurance Regulations in the insurance terms and conditions. They are an integral part of these insurance terms and conditions. The Insurance Rules and Regulations can be downloaded from menzis.nl. You can also request these regulations from Menzis Customer Service on 088 222 40 40. You can also find the Healthcare Insurance Decree and the Health Insurance Regulations on overheid.nl.

Permission

You will require prior written permission from Menzis for certain types of care. When this is required, this will be specified including what you should do to be granted permission.

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 € 3, with an excess of € 200 this discount amounts to € 6, with an excess of € 300 this discount amounts to € 9, with an excess of € 400 this discount amounts to € 12 and with an excess of € 500 this discount amounts to € 20.

ⓘ Note

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),
- 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,
- GP care including care that is paid by applying the policy rule that has been defined based on the Dutch Healthcare (Market Regulation) Act for the performance payment related to multidisciplinary healthcare provision for chronic disorders (chain care). Laboratory and function examination requested by a general practitioner does fall under the excess if the examination is performed elsewhere and is charged separately,
- chronic medical assessment Solely prescription medication use if you visit a pharmacy or general practitioner,
- nursing and care,
- transport of the donor in relation to transplants that are listed in the "Transplant" article at the 8th and 9th items under "Which care",
- follow-up check-ups of the donor with regard to transplantation after the period specified in the "Transplant" article at the 7th item of the list under "Which care" has elapsed.

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 Menzis pays the care provider your care bill directly, you or the policyholder (at the discretion of Menzis) must reimburse Menzis the excess and possibly the personal contribution (should this apply). You or the policyholder will receive a bill from Menzis 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. Menzis will pay the costs directly to the hospital. You will, next, receive a bill from Menzis for € 385.
3. You are admitted to hospital on 20 December 2017 and are discharged on 10 January 2018. The excess will now be applied once in 2017.

Order of personal payments

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

1. any non-insured part is deducted from a bill,
2. any personal contribution,
3. the still outstanding part of a mandatory excess,
4. the still outstanding part of any voluntarily selected excess.

Others

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 83/2004 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 the reimbursement of costs of care by a foreign 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,
- entitlement to the reimbursement of costs of care up to the maximum applicable rate of the Dutch Healthcare (Market Regulation) Act if the care would have been provided in the Netherlands, or up to a an amount that is in line with the Dutch market.

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.

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 Menzis. Call the Menzis Care Advisor on 088 222 42 42 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 Menzis Care Card. The Emergency Centre can be reached day and night. Call in the Emergency Centre immediately to assist with regard to emergency care.

Additional information

You can find additional information about care abroad on menzis.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 be reimbursed for the following costs:

- 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.

Referral

You are only entitled to the reimbursement of costs of 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 menzis.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 the reimbursement of costs of at most 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.

Referral

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

- when you visit a 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.

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.

Which care?

You are entitled to the reimbursement of costs of polymer, oligomer, monomer and modular dietary preparations. You will only be entitled to the reimbursement of costs of 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.

Treatment advice

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

Maximum period

You are entitled to the reimbursement of costs of dietary preparations for one month at most 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 Menzis, you will require prior permission from Menzis. You can in this case use a Menzis request form for pharmaceutical care. You must enclose a written well-founded explanation from the doctor who is treating you with the form. You find the request form by visiting menzis.nl.

ⓘ 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 Menzis.

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 be reimbursed the costs of staying during the 24 hours that are required medically in relation to medical care as general practitioners usually offer.
You are also entitled to the reimbursement of costs of 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?

For staying in a primary care institution, you can go to an institution that has been authorised as an institution for treatment and staying (nursing home) or has been accredited for nursing and caring based on the Dutch Care Institutions (Accreditation) Act (WTZi) and the related regulations.

Indication and permission

You are only entitled to be reimbursed for the costs of staying in a primary care institution if you have a prior written indication from your GP. If the stay is for a period that is longer than 6 months, you will require prior permission from Menzis. Your general practitioner can request this permission on your behalf.

Transition right with regard to staying in a primary care institution

- Have you had an assessment by the Centrum indicatiestelling zorg (CIZ; Home care assessment centre) for staying in a primary care institution before 1 October 2016? You will then continue to be entitled to be reimbursed for the costs of staying in a primary care institution until this indication ends.
- If you have had an assessment by the Centrum indicatiestelling zorg (CIZ; Home care assessment centre) for staying in a primary care institution after 1 October 2016, the following applies:
  a. to the basic staying in a primary care institution (VV3) and intensive staying in a primary care institution (VV6) indications, it applies that you continue to be entitled to be reimbursed for the costs for the care for up to no more than 3 months after the effective date of the indication,
  b. to the staying in a primary care institution for palliative terminal care (VV10) indication, it applies that you continue to be entitled to be reimbursed for the costs of the care for up to no more than 3 years after the effective date of the indication,
- Entitlement to the transition right of staying in a primary care institution will end, in any case, when there is no longer a medical reason for the indicated care.
- You may continue to receive the care from the same care provider.

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 be reimbursed for the following costs:

- central diagnostics, coordination and registration of supplied blood and bone marrow preparations,
- the test into and of inherited disorders 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.

Referral

You are only entitled to the reimbursement of costs for genetic testing when you have a prior written referral from your general practitioner or medical specialist.

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 the reimbursement of costs of 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.

Referral

No referral is required when you visit a contracted occupational therapist who is immediately available for consultation. You can find out whether an occupational therapist is immediately available for consultation 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 accessible,
- 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 locomotor 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 the reimbursement of costs of 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 is not classed as physiotherapy. You are not entitled to those treatments. More information can be found on menzis.nl.

18 years old or older

You are entitled to the reimbursement of costs of 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 the reimbursement of costs of 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. This list can be found on menzis.nl. You can also call Menzis Customer Service on 088 222 40 40.

ⓘ Note

You are not entitled to the reimbursement of costs of the 1st 20 treatments for each disorder based on your Basic Insurance. A number of treatments are included in the additional Menzis insurances. Check your additional insurance for more information.

Younger than 18

You are entitled to the reimbursement of costs of physiotherapy in the same cases as people who are 18 or older, but also from the 1st treatment. If you have a complaint that cannot be found on the list that the Dutch Minister of Public Health, Welfare and Sport has established, you are entitled to the reimbursement of costs of 9 treatments at most for each complaint per calendar year. If the 1st 9 treatments are not sufficient, you are entitled to the reimbursement of costs of 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.

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.
You can also call the Menzis Care Advisor on 088 222 42 42 for questions about specialised physiotherapy.

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 1st 9 treatments or go to a contracted therapist who is not immediately available for consultation,
- for treatment outside of the therapist's practice.

ⓘ Note

It is possible that Menzis 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. Menzis 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 the reimbursement of costs of 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 menzis.nl.

18 years old or older

You are entitled to the reimbursement of costs of 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 the reimbursement of costs of exercise therapy 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. The list is included in Annex 1 of Article 2.6 of the Dutch Health Insurance Decree. This list can be found on menzis.nl. You can also call Menzis Customer Service on 088 222 40 40.

ⓘ Note

You are not entitled to the reimbursement of costs of the 1st 20 treatments. A number of treatments is included in the additional Menzis insurances. Check your additional insurance for more information.

Younger than 18

You are entitled to the reimbursement of costs of exercise therapy in the same cases as people who are 18 or older, but also from the 1st treatment. If you have a complaint that cannot be found on the list, you are entitled to the reimbursement of costs of 9 treatments at most for each complaint per year. If the 1st 9 treatments are not sufficient, you are entitled to the reimbursement of costs of another 9 treatments at most per year.

Which care provider?

You can visit a Cesar/Mensendieck exercise therapist or a child exercise therapist who is registered as a "Quality registered" practitioner in the Paramedic Quality Register. You can also call the Menzis Care Advisor on 088 222 42 42 for questions about specialised physiotherapy.

Referral

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

- 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 1st 9 treatments or go to a contracted therapist who is not immediately available for consultation,
- for treatment outside of the therapist's practice.

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 being reimbursed for the costs of 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 menzis.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 registerd in the Kwaliteitskeurmerk Fysiotherapie (the Physiotherapy Quality Mark Register).

Referral
You are only entitled the reimbursement of costs of 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 pelvic physiotherapy. You are not entitled to those treatments. More information can be found on menzis.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 to being reimbursed for the costs of at most 12 months of at most 37 exercise therapy sessions under supervision 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.

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

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) andspecialist 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 the reimbursement of costs of general basic mental care if you have a recognised DSM (Diagnostic and Statistical Manual of 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 Menzis Care Advisor on 088 222 42 42.
- You are not entitled to the reimbursement of costs of treatment of adaptive disorders or to assistance with mental complaints that are related to work and relational issues.
- If you submit a bill to Menzis, it must contain all data that is required in accordance with legislation and regulations. You can find it by visiting menzis.nl. Menzis 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,
- 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.

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. If you go to a provider, check whether this care provider has a quality charter prior to the treatment. You can contact the Menzis Care Advisor on 088 222 42 42 for this. You can also contact the relevant care provider or visit the website of the care provider.

Referral

You are only entitled to the reimbursement of costs of general basic mental healthcare if you have a prior written referral from your general practitioner or medical specialist for the general basic mental healthcare issued in advance. This means that the referral letter must be dated before the date of your first visit to the GBGGZ care provider. The referral letter must specify the DSM (Diagnostic and Statistical Manual of Mental Disorders) mental disorder your general practitioner or medical specialist thinks you suffer from.

Specialist mental healthcare without hospitalisation

You will receive care on a specialist level with regard to specialist mental healthcare. Out-patient 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 out-patient.

Which care?

You are entitled to the reimbursement of costs of 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 Menzis Zorgadvies (Care Advice) for information on 088 222 42 42 before your treatment starts.
- You are not entitled to being reimbursed for the costs of 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 Menzis, it must contain all data that is required in accordance with legislation and regulations. You can find it by visiting menzis.nl. Menzis 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 Menzis Care Advisor on 088 222 42 42 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,
- 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.

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.

If you go to a provider, check whether this care provider has a quality charter prior to the treatment. You can contact the Menzis Care Advisor on 088 222 42 42 for this. You can also contact the relevant care provider or visit the website of the care provider.

Referral
You are only entitled to the reimbursement of costs of specialist mental healthcare without admission if you have a prior written referral from your general practitioner or medical specialist 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 general practitioner or medical specialist 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 1st bill at the latest. You must sign a doctor's declaration together with your practitioner and send it to Menzis. This doctor's declaration pro forma can be found by visiting menzis.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 and this also means that you will be living and sleeping in the clinic or 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 be reimbursed for the following costs:

- 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

- 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 Menzis Care Advisor on 088 222 42 42.
- You are not entitled to the reimbursement of costs of treatment of adaptive disorders or to assistance with mental complaints that are related to work and relational issues.
- 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 Menzis Care Advisor on 088 222 42 42 for this.

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.

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.

If you go to a provider, check whether this care provider has a quality charter prior to the treatment. You can contact the Menzis Care Advisor on 088 222 42 42 for this. You can also contact the relevant care provider or visit the website of the care provider.

Referral

You are only entitled to the reimbursement of costs of specialised mental health care with admission when you have a written referral from your general practitioner or medical specialist 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 general practitioner or medical specialist 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 Menzis, the incurred costs will not be fully reimbursed. You also require prior permission from Menzis. Contact the Menzis Care Advisor on 088 222 42 42 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 consent from Menzis through your managing practitioner two months before the period of 365 days or the period for which consent has been granted elapses at the latest. The application form can be found on menzis.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 Menzis. This doctor's declaration pro forma can be found by visiting menzis.nl/vergoedingen. The bill must contain all information that is required by legislation and regulations (with the exception, therefore, of the diagnosis code). Visit menzis.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 the reimbursement of costs of 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 the annexes by visiting overheid.nl. If you want to find out whether a specific medication has been put on this list, you can also contact Menzis Customer Service on 088 222 40 40.

Non-registered medication

You are entitled to the reimbursement of costs of medication that is prepared in the dispensing chemist's itself. You are also entitled to the reimbursement of costs of 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, 1st paragraph, 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 the reimbursement of costs of 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 the reimbursement of costs of some medicines with the same active substance and the same form of administration with regard to medicines that are indicated by Menzis. These are the preferred medications. The Insurance Rules and Regulations list and information is provided on menzis.nl/preferentiebeleid about 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 the reimbursement of costs of 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.

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 Menzis. If you visit a dispensing chemist's with which Menzis 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 Menzis has not concluded a contract in place, use the Pharmaceutical Care Request Form to ask permission from Menzis. 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 reimbursement of costs of the medication for the first 15 days without Menzis' permission. You must, however, submit your request for permission at Menzis within those 15 days. If you do not submit the request on time or if the use of the preferred medication is justifiable at Menzis' 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 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 menzis.nl or you can request them from Menzis Customer Service on 088 222 40 40.

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 Menzis 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.

Maximum period
You are entitled to the reimbursement of costs of the medication for a specific period with regard to each prescription. This period is:
- 15 days if this medication has been prescribed to you for the first time,
- 15 days if an acute complaint must be treated with antibiotics or chemotherapeutic drugs,
- 3 months with regard to medication that treat a chronic disease and at least 3 months when it involves a generic delivered medication and at least 3 months up to no more than six months if it involves medication that is indicated as being preferred medication by Menzis unless you can prove medically that you cannot have a drug so long,
- 1 month with regard to sleeping pills or sedatives,
- a year for oral contraceptives (the pill). If you are prescribed oral contraceptives for the first time, the maximum period is three months,
- 1 month for medication that costs more than € 1,000 a month,
- 1 month in all other cases.

If you get liquid medication from your dispensing chemist's or general practitioner with dispensing facilities for the 1st time, this will be provided in the smallest packaging.

Personal contribution
You may have to pay a personal contribution. All medicines for which you are entitled to be reimbursed for the costs 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 the reimbursement of costs of 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 the same or nearly the same as any non-indicated registered medication,

- 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.

Prescription
You require a prescription from a general practitioner, dentist, medical specialist, obstetrician, company doctor or Municipal Health Service doctor.

Permission
For some medication you will require prior permission from Menzis. 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 Menzis has concluded a contract with this doctor's declaration, the chemist will assess whether you are entitled to the reimbursement of costs of the medication. You do not have to first ask Menzis' permission. If you decide to use a dispensing chemist's for the medication with which Menzis has not concluded a contract in place, you must first ask permission from Menzis.

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 be reimbursed for the following costs:
- general medical care except the flu vaccination,
- 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 Menzis 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 if Menzis has made agreements with your general practitioner about this. Visit menzis.nl/zorgvinder to find out with which GPs Menzis has made 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. The care is based on the care standard for type 2 diabetes, COPD and VRM. You can decide whether you wish to participate in chain care. More information about chain care? For more information visit menzis.nl.

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 Menzis 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. GPs work together at a GP station to provide emergency GP care. Ask your GP about which GP is on duty or to which GP station you can go. You can also find information by visiting 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.

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

Foot care referral with regard to diabetes mellitus

You are only entitled the reimbursement of costs of 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.

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 the reimbursement of costs of functional medical 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. Menzis has included an overview of medical aids in the Insurance Rules and Regulations that fall under the Health Insurance Regulations. Menzis 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". Diabetic testing materials, 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 Menzis. Menzis 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 Healthcare Insurance Regulations and Insurance Rules and Regulations if you visit menzis.nl. If you wish to find out whether a specific medical aid has been included in this list, you can contact Menzis Customer Service on 088 222 40 40.

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 go to any supplier who meets specific quality or expertise requirements. They are listed for each medical aid in the Insurance Rules and Regulations.

Permission
Whether permission from Menzis 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. The supplier will assess your application. If the supplier is unsure whether Menzis will issue or reimburse the medical aid, the supplier will pass on the application to Menzis for permission.

ⓘ Note
- The Insurance Rules and Regulations explains whether you need prior consent or the other terms and conditions that you must meet with regard to each medical aid, for example, including an explanation from a doctor.
- 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 Menzis.
- 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. You can also find more information in the Insurance Rules and Regulations.
- If Menzis has only contracted one supplier for a specific medical aid, Menzis 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 the reimbursement of costs of 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, Menzis is entitled to recover the costs from you.

ⓘ Note
- You are not entitled to the reimbursement of 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 Rules and 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)

In-vitro fertilisation (IVF) is a form of medical specialist care. IVF is also referred to as test-tube fertilisation. This is a reproduction technique where one or more egg cells are fertilised using sperm cells outside the body. One or two embryos are placed in the uterus. This may be repeated several times if this is necessary.

Which care?

Your age will determine the reimbursement of which costs you are entitled to exactly. Ask your care provider to inform you well before you start the treatment or ask the Menzis Care Advisor on 088 222 42 42.

Younger than 38

You are entitled to the reimbursement of costs of 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 reimbursement of costs of 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 will not be entitled to the reimbursement of costs of IVF or other fertility-related care if you are 43 or older. You are entitled to the reimbursement of costs of 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.
- 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 full linked ICSI treatment 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.

Referral

You will only be entitled to the reimbursement of costs of IVF if you have a prior written referral from your medical specialist.

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, one or two 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

1. A follicular puncture is performed during your 3rd attempt. After 4 weeks, it fails and the attempt is interrupted. The next attempt will not be reimbursed.
2. A follicular puncture is performed during your 3rd 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 (3rd) attempt.
3. 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 the reimbursement of costs of 3 attempts.
4. 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 the reimbursement of costs of 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 the reimbursement of costs of this care.

Which care provider?

You can visit a gynaecologist or urologist for this care.

Referral

You are only entitled to the reimbursement of costs for other fertilisation-stimulating treatments when you have a prior written referral from your general practitioner or medical specialist.

ⓘ Note

There is 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 Menzis Care Advisor on 088 222 42 42.

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 the reimbursement of costs of 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 menzis.nl.

Personal contribution

A statutory personal contribution of € 4.30 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 € 34 per day that you are admitted (€ 17 for the mother and € 17 for the baby). If the hospital charges an amount that is higher than € 242 per day (€ 121 for the mother and € 121 for the baby), you must, in addition to the € 34, also pay the amount that is higher than € 242 per day.

Which care provider?

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

Registration

Call the Menzis Care Advisor on 088 222 42 42 for advice on maternity care. You can then apply for the maternity pack too. You can also do this through menzis.nl/kraamzorg.

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 the reimbursement of costs of speech therapy when:

- 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 the reimbursement of costs for 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 regarding 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

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

Permission

You are only entitled to the reimbursement of the costs of speech therapy at a school or a day nursery with prior written permission from Menzis. Your speech therapist can apply for this permission from Menzis 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 be reimbursed for the following costs:

- 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.

ⓘ Note

You are not entitled to the reimbursement of costs of the treatments if the following are 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,
- treatments against snoring with uvular correction,
- 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. You can also visit an independent treatment centre (ZBC) that offers care by a medical specialist.

ⓘ 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 the reimbursement of costs of medical specialist care when you have a prior written referral from your GP, medical specialist, obstetrician, specialist geriatric care provider (nursing home doctor), a doctor who works in youth health care or a mental health doctor. If the complaints are related to your job, a company doctor may also refer you. You need a prior referral from a dentist for dental implants to be inserted by a dental surgeon. A youth healthcare doctor or a doctor working in youth healthcare may also refer someone to an ophthalmologist, paediatrician or orthopaedist. You do not need a written referral for urgent treatment.

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) by visiting znformulieren.nl. 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** see Advice below.
- **Breast prostheses.**

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

2. Others
You are only entitled to these treatments when you have obtained permission from Menzis in advance:
- clinical pulmonary rehabilitation,
- care given by Stichting MC Astmacentrum (SMCA; MC Asthma Centre Foundation) 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 Menzis Care Advisor on 88 222 42 42 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 but home dialysis is also possible.

Which care?
You are entitled to the reimbursement of costs of non-clinical haemodialysis and peritoneal dialysis, the related medical specialist care, tests, 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 reimbursement of the costs for the following with regard to home dialysis:
- 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,
- 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,
- 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 for this care.

Referral
You are only entitled to the reimbursement of costs for 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 are part of 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 the reimbursement of costs of registration, examination and comparison 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 the reimbursement of costs of 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 reimbursement of costs of 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,
- deformities that are the result of an illness, accident or a medical procedure or drooping upper eyelids if such as:
  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 the reimbursement of costs of the treatment of a plastic surgical nature when it involves the following:

- correction of paralysed or slack top eyelids 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 who is linked to this hospital for plastic surgery. You can also visit an independent treatment centre (ZBC) if a medical specialist is linked to this centre.

Referral and permission

You are only entitled to the reimbursement of costs of plastic surgery when you have a prior written referral from your general practitioner, medical specialist or specialist geriatric care provider (nursing home doctor). You also require prior permission from Menzis except for medically required circumcision.

Rehabilitation

Rehabilitation (medical specialist)

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 the reimbursement of costs for 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 the reimbursement of costs of medical specialist rehabilitation as part-time or out-patients treatment. You will only be admitted (to an institution) for medical specialist rehabilitation if better results can be expected quickly when compared to part-time or out-patients' 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.

Referral

You are only entitled to the reimbursement of costs of rehabilitation when you have a prior written referral from your general practitioner, 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 Menzis for rehabilitation care? You are only entitled to the reimbursement of costs of rehabilitation if you have prior consent from Menzis. 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, 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 the reimbursement of costs of 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 your home is made possible.

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

- the geriatric rehabilitation follows on within a week from an admission in relation to medical specialist care. It applies within this context that you are not entitled to geriatric rehabilitation if you had been admitted in a nursing home before this admission. An admission in a nursing home means staying in an as referred to in Section 3.1.1 of the Dutch Long-term Care Act (in Dutch: Wet Langdurige zorg (Wlz)), or
- you are admitted at the start of the geriatric rehabilitation because this is required due to 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 medical 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).

Referral

You are only entitled to the reimbursement of costs of 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.

Permission

Will you be visiting a care provider who does not have a contract with Menzis for geriatric rehabilitation? You are only entitled to the reimbursement of costs of geriatric rehabilitation if you have prior consent from Menzis. 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 are entitled to the reimbursement of costs of a second opinion when:

- the second opinion refers to medical care as already discussed with the 1st 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 general practitioner, medical specialist, obstetrician, physiotherapist, clinical psychologist, mental healthcare institution or an (out-patients' department of a) psychiatric department of a hospital.

Referral

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

Quit smoking

A programme to quit smoking is an intervention 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 the reimbursement of costs of 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-based support when quitting smoking you can visit a care provider for this type of care. You can also visit your general practitioner for behaviour-based support.

ⓘ Note

1. You are only entitled to the reimbursement of costs of nicotine products and medication when they are part of a quitting programme; separate reimbursement for nicotine products and medication (i.e. without a quitting programme) is not possible.
2. When you select a care provider for behaviour-based support who has not concluded a contract with Menzis, you must send the specified bill to Menzis. When this care provider is not registered in the "Kwaliteitsregister stoppen met roken" (Quit 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 "Quit Smoking", you will not be reimbursed.
3. When you choose a supplier of nicotine products and medication with whom Menzis has not concluded a contract, you must send a copy of the medication request form and the specified bill for these products to Menzis you must send a copy of the medication request form or a copy of the prescription of the general practitioner together with the specified bill for these products.

ⓘ Note

The excess applies to the quit 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 the reimbursement of costs of 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. You are also entitled to 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 the reimbursement of costs for special dentistry work if this is essential to retain or acquire a dental function that is similar to the dental function that you would have had if the complaint had not presented itself.
- You are only entitled to the reimbursement of costs of 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 the reimbursement of costs for orthodontic healthcare if it is provided by an orthodontist.

Personal contribution

- You pay a personal contribution for special dentistry work when it involves care that is not directly related to your indication for special dentistry work. 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 € 125 per jaw. A personal contribution of 10% applies for the bottom jaw and 8% for the top jaw for dentures on implants. You can also find this information in the Insurance Rules and Regulations. Consult the scheme on menzis.nl or request this information from our Customer Service on 088 222 40 40.

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 the reimbursement of costs of special dentistry work by an orthodontist when you have a prior written referral from your dentist or dental surgeon.
- You are only entitled to the reimbursement of costs of special dental work by a dental surgeon when you have a prior written referral from your dentist or general practitioner. The dental surgeon must be linked to a hospital.
- You are only entitled to the reimbursement of costs of special dental work provided by a Centrum voor Bijzondere Tandheelkunde (Centre for specialised dentistry) when you have a prior written referral from your general practitioner, dentist or dental surgeon.

Permission

You require prior permission from Menzis 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 the reimbursement of costs of dentistry. Which rebursement of the costs 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 be reimbursed for the following costs:

- 1 regular preventive dental check-up per year unless you require this type of check-up 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 1 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 being reimbursed for the costs of 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 being reimbursed for the costs of 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 the reimbursement of costs of dentistry work if the visit cannot be postponed to another day.

From 18 years of age
You are entitled to be reimbursed for the following costs:
- surgical dentistry work by a dental surgeon and the X-rays related to this except for parodontal surgery, inserting implants and uncomplicated extractions,
- semovable full dentures for the top or bottom jaw that may or may not be placed on dental implants.

Personal contribution
Are you older than 18? 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 for the bottom jaw and 8% of the total costs of full dentures on implants 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 this information in the Insurance Rules and Regulations. Consult the scheme on menzis.nl or request this information from our Customer Service on 088 222 40 40.

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 an oral surgeon 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.

Referral
You are only entitled to the reimbursement of costs of 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 Menzis:
- 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,
- 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,
- 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 the reimbursement of costs of 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 to the reimbursement of costs 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 items 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.

Referral

You are only entitled to be reimbursed for the costs related to transplantation 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 be reimbursed for the following costs:

- 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.

Referral

You are only entitled to the reimbursement of costs for care offered by an intensive care department for thrombotic patients when 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. The Dutch Long-term Care (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 Menzis Care Advisor on 088 222 42 42.

Which care?

You are entitled to the reimbursement of costs of stay during the 24 hours that are required medically in relation to obstetric care, oral surgeon dentistry care of a specialist nature, medical specialist care and geriatric rehabilitation. You are also entitled to the reimbursement of costs of the related required nursing, care, paramedical care and medication. 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 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 care 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.

Which care provider?
The stay must take place in an institution for medical specialist care (hospital or independent treatment centre) or a rehabilitation centre) or a nursing home.

Permission
You are only entitled to the reimbursement of costs of rehabilitation if you have prior consent from Menzis 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 the reimbursement of costs of 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,
  - a structural echoscopic examination in the 2nd 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 tests, 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 (ZBC).

ⓘ 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.

Personal contribution obstetric care

A statutory personal contribution of € 4.30 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 will pay a statutory personal contribution of € 34 per day that you are admitted (€ 17 for the mother and € 17 for the baby). If the hospital charges an amount that is higher than € 242 per day (€ 121 for the mother and € 121 for the baby), you must, in addition to the € 34, also pay the amount that is higher than € 242 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 be reimbursed for the following costs:

- 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 the reimbursement of costs of 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 the reimbursement of costs of transport by ambulance when you have a prior written referral from your general practitioner, medical specialist, specialist geriatric care provider (nursing home doctor) or a mental health doctor. You are only entitled to the reimbursement of costs of 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 the reimbursement of costs of ambulance transport is limited to a distance of no more than 200 kilometres for a single journey.
- If Menzis gives you permission to visit a specific person or institution, the limitation of 200 kilometres does not apply.
- You are not entitled to the reimbursement of costs of ambulance transport with regard to care during a 4-hour day period in a Wlz (Long-term Care Act) institution.

Nursing and care
(community nurse care and medical specialist nursing at home)

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

Which care?

You are entitled to the reimbursement of costs of 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.

Younger than 18

If you have not yet reached the age of 18, you are only entitled to the reimbursement of costs of care when care is involved due to complex somatic issues or a physical disability where

a. continuous supervision is required, or
b. there must be care 24 hours a day in the vicinity and this care is linked to one or more specific nursing action (for example, administering oxygen).

ⓘ Note

You are not entitled to the reimbursement of costs of 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 possibly 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 Menzis Customer Service on 088 222 40 40.

Which care provider?

You can hire a nurse or carer with a minimum training level of 3 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.

Indication and care plan

You are only entitled to the reimbursement of costs of 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 including a care plan that describes the indication and 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

If you select a care provider who does not have a contract with Menzis, Menzis must give permission in writing for this.

Advice

Do you have any questions about nursing and care? Call the Menzis Care Advisor on 088 222 42 42 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 menzis.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 the reimbursement of costs of multidisciplinary care (care where different specialists are involved). You need this care because you have:

- a visual impairment (you are blind or visually impaired),
- a hearing impairment (you are deaf or hearing impaired), or
- a 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 where an ophthalmologist or a clinical psychologist is the main person providing treatment when a visual impairment is involved or where a clinical psychologist is the main person providing treatment with regard to a hearing and/or communication impairment.

Referral and indication

You are only entitled to a reimbursement for the costs of 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 Menzis for sensory care for the disabled from a care provider who does not have a contract with Menzis. 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 a reimbursement of the costs of 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 € 0.28 per kilometre. You are entitled to the reimbursement of costs of 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, Menzis 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 the reimbursement of costs of transport when:

- 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 dialyses,
- you must receive oncology treatment using chemotherapy or radiotherapy,
- your mobility is solely dependent on a wheelchair, or
- your mobility is dependent on supervision due to your visual impairment, or
- you suffer from a long-term illness or complaint and you rely on transport for the treatment of this and not allowing the conveyance or the reimbursement of the costs would be unreasonable to a high extent,
- 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 and this care is linked to one or more specific nursing actions (for example, intensive child care).

ⓘ Note

- The transport or reimbursement of costs entitlement is limited to a distance of no more than 200 kilometres for a single journey.
- If Menzis gives you permission to go to a specific person or institution, the 200 km restriction does not apply.
- 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 € 100 per calendar year.

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). If you use a transport company which has not concluded a contract

with Menzis, you will receive € 0.85 per kilometre. You will receive € 0.28 per kilometre when the transport is provided by a private person.

Permission

You must request prior permission from Menzis. Call the Transport Service Line on 0317 492 051 or send the request form "non-emergency patient transport". The request form can be downloaded by visiting menzis.nl. Menzis 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

Menzis 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

Menzis 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. Menzis 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 menzis.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 Menzis.

Should you not have access to the Internet, you can also call Customer Service on 088 222 40 40. If you have questions about the care, please call the Menzis Care Advisor on 088 222 42 42.

How will you be reimbursed?

Menzis has a contract with many care providers. This care provider can submit the bill directly to Menzis. You will not have to do anything. You can, however, always check all bills in My Menzis. Have you received a bill from a care provider? You can claim your bill online through menzis.nl/mijnmenzis. You can also use the free Menzis 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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 200	€ 250	€ 300	€ 500

You are entitled to be reimbursed when:

- you have a referral from a general practitioner or medical specialist, and
- the treatment is provided by a skin therapist or by a beauty specialist approved by Menzis. You can find the list with skin therapists and approved beauticians on menzis.nl/zorgvinder.

General check-up

When a general check-up (Preventive Consultation) is carried out, your general practictioner will check for signs of cardio vascular disease, diabetes type 2 and kidney damage.

You will receive a reimbursement for the costs of a general check-up (Preventive Consultation) up to a maximum amount. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 0	€ 100	€ 150

You are entitled to this reimbursement if the general check-up is performed by a general practitioner.

Alternative treatment methods and medication

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 consultations, treatments, homeopathic and anthroposophic medicines from 80% up to a maximum amount. The reimbursements for consultations, treatments and medicines added together until the specified maximum amount is reached. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 550	€ 750	€ 950

You will be reimbursed if:

- the (individual) treatment is provided by a practitioner who is affiliated to a professional association approved by Menzis as a certified member. You can find out which professional associations are approved by visiting menzis.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.

Childbirth and maternity care

The medical care related to the delivery of a baby is partially covered by the Basic Insurance. In addition to the Basic Insurance, the additional insurance offers a reimbursement.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
No	Yes	Yes	Yes

Breastfeeding

You will be reimbursed for the costs related to support and aids (that are part of the support) up to a maximum amount of € 200. You are entitled to this reimbursement if the support given and the aids are prescribed by a lactation consultant who is approved by Menzis. You can find out who the lactation consultants are by visiting menzis.nl/zorgvinder.

Maternity care

You will be reimbursed for the statutory personal contribution for maternity care.

Maternity care after adoption

Maternity care after adoption will be reimbursed up to a maximum of 16 hours.

Maternity care after admission

Maternity care after admission of your baby will be reimbursed up to a maximum of 16 hours.

Multiple birth payment

You will receive an amount of € 250 for a multiple birth. You are entitled to receive this payment/ reimbursement if you insure the children with Menzis.

Delivery room

If there is no medical indication for delivery your baby in a hospital (when you stay shorter than 24 hours) you need to pay a personal contribution for use of the delivery room from the Basic Insurance.

You will be reimbursed for this statutory personal contribution for use of the delivery room in a hospital or an institution approved by Menzis. You can find out which hospitals or approved institutions they are by visiting menzis.nl/zorgvinder.

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 contact lenses up to a maximum amount. 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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 200	€ 300

ⓘ Note

- The bill for the spectacles or contact lenses must specify the prescription of the spectacle lenses or contact lenses.
- You can visit an optician that has been contracted by Menzis. You can find out which opticians they are by visiting menzis.nl/zorgvinder.

Example

You are entitled to € 100 per 2 calendar years and you purchase spectacles for € 150 in 2017. The maximum amount of € 100 per 2 calendar years will have, therefore, been reached. This means that you will not be entitled to a reimbursement any more up to and including 2018. You will again be reimbursed as from 2019.

Abroad

When staying abroad, you may require immediate medical care or medication. You will receive service and support from the Menzis 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 menzis.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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
Yes	Yes	Yes	Yes

You are entitled to be reimbursed when:
- the consultation takes place at a doctor recognised by Menzis,
- the medication is prescribed or the injection is administrated by a doctor recognised by Menzis. You can find the recognised doctors at menzis.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 someone is in such pain, for instance because of a nerve or gum inflammation that the dentristry work cannot be deferred until their 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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 250	€ 250	€ 250	€ 250

You will only be reimbursed the costs if:
- the 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. Placing a filling, implant or crown is usually a foreseable treatment.

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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
Yes	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 Menzis' 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 information on the travel insurance visit menzis.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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
Yes	Yes	Yes	Yes

You will be entitled to this reimbursement when the medical need has been determined by Menzis' 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, Menzis will pay/reimburse these costs when the Menzis 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 menzis.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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 200	€ 250	€ 300	no maximum amount

You are entitled to be reimbursed when the therapy and the aids are provided by a skin therapist or beautician approved by Menzis. You can find the list with skin therapists and approved beauticians on menzis.nl/zorgvinder.

Courses (first aid, reanimation/AED and health courses)

If you follow a first aid course or reanimation/AED course you will learn about the correct first aid that should be applied when something happens in your environment. When following the course, you will learn what to do but especially what you must most certainly not do. The course is given by a doctor and a First Aid or Reanimation/AED trainer. A health course focuses on improving lifestyle choices (such as "nutrition and living healthily"), learning how to cope with your illness (for example "how to cope as a diabetes patient") or looking after others (such as how to cope with a family member who is becoming senile).

You will be reimbursed for first aid, reanimation/AED and health courses up to a maximum amount. The reimbursements for these courses are added together up to the specified maximum amount has been reached. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 200	€ 200	€ 250	€ 350

You are entitled to a reimbursement of the healthcare course if the course has been fully completed and the course is given by an organization approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

ⓘ Note

Courses that are given in relation to pregnancy are not viewed to be health courses.

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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
0	2	2	4

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

Note

- If you decide to visit a dietician who does not have a contract with Menzis 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. Visit menzis.nl for more information about the maximum reimbursements.
- You need a referral from your GP or medical specialist for treatment outside the practice of a dietician.

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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 200	€ 300	€ 700	€ 1.500

You are entitled to be reimbursed when the treatment is provided by or under the responsibility of a Menzis approved dermatologist or beauty specialist. Visit menzis.nl/zorgvinder to find out who these dermatologists or beauty specialists are.

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:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
9	18	27	40

You are entitled to be reimbursed when your therapist has a contract with Menzis. Visit menzis.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 no immediate physical cause can be found (psychosomatic physiotherapist and exercise therapist),
- in which (lymph)oedema plays 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 Menzis? You will then have the costs reimbursed up to a maximum amount. Menzis reimburses 75% of the bill of the care provider up to a maximum of 75% of the amount that Menzis 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 menzis.nl/fysiotherapie for even more examples or call our Customer Service if you have any doubts.

Referral

- You will need a referral from your GP, medical specialist, company doctor, obstetrician or dentist for therapists who do not have a contract with Menzis.
- You need a referral from your GP or medical specialist for treatment outside the practice of a therapist.

Medication (GVS personal contribution)

Medication is paid/reimbursed based on the Basic Insurance but sometimes you need to pay a personal contribution. The level of the personal contribution is arranged in the GVS (Geneesmiddelenvergoedingensysteem; Dutch Medication Reimbursement System).

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 750	€ 750	€ 750	€ 750

Flu vaccination

The vaccination against the "normal" seasonal flu will be paid/reimbursed based on the Dutch Long-term Care Act (in Dutch: Wet langdurige zorg (Wlz)) but only if you belong to a specific risk group. If you do not belong to the risk group, you can receive a reimbursement from your additional insurance.
You will be reimbursed for the flu vaccination and its administration once per calendar year.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
No	No	Yes	Yes

You are entitled to be reimbursed when the vaccine is administered by a general practitioner who has a contract with Menzis. Visit menzis.nl/zorgvinder to find out who these general practioners are.

Devices and aids for general daily vital functions

General daily vital functions (GDVF) are the actions that people perform daily during normal life to ensure they can continue to live independently. This refers to actions such as getting into and out of bed, cooking, showering, getting dressed, etc. GDVF devices and aids increase self-reliance and ensure that people can live independently (for longer).
You will be reimbursed for every GDVF device and aid if it is not being reimbursed by another scheme or facility. This concerns devices and aids such as adjusted cutlery and services or devices that help people to get dressed and undressed. You will be reimbursed up to a maximum amount each calendar year. This amount is:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 0	€ 100	€ 100

if you can claim reimbursement under another scheme or facility, you will not be reimbursed based on this additional insurance. For example, if you are reimbursed by your municipality under the Dutch Social Support Act of by the Employee Insurance Agency under the Dutch Work and Income Act.

The following aids are not reimbursed:
- simple walking aids such as a rollator, crutches or walking frames,
- aids that are only meant for carrying out a hobby/leisure activity.

Crowns and bridges up to the age of 18

Dental care is insured to a large extent in the Basic Insurance for youths up to the age of 17 inclusive. In addition to this, you will be reimbursed for crowns and bridges.
Crowns and bridges will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 250	€ 500	no maximum amount

You are entitled to this reimbursement if the care is provided by a dentist.

ⓘ Note

A waiting time of 1 year applies to Collectief Aanvullend 4. This means that you will pay a premium during the waiting period, but will not yet be reimbursed for the crowns and bridges. The waiting time will start on the effective date of Collectief Aanvullend 4.

Voluntary care

Voluntary care is deemed to mean taking care of a family member or someone in your close environment for a long period, without being paid and intensively. People who provide voluntary care are referred to as informal or voluntary caregivers. You are a voluntary caregiver if you provide voluntary care for more than 8 hours a week and longer than 3 months.

Voluntary care courses

Caring for another may be very satisfying but it also demands plenty of time and energy. The chances of becoming stressed are extensive. A voluntary care course does not just focus on improving the care that is given to others but also on improving yourself (being aware of your own limitations).
You will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 150	€ 150

You are entitled to be reimbursed for a voluntary care course when the voluntary care course is organized by an organization approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

Caregiving arrangement

A voluntary caregiver arrangement offers the voluntary caregiver the option to relax and recharge his or her batteries a few days a year. This is made possible by staying in a pleasant environment where relaxing and meeting people in similar situations are given the highest priority on your own or together with the person whom you are caring for. Attention is also paid to training and development for which expert supervision will be available during an arrangement.
You will receive a contribution towards the costs of a voluntary caregiver arrangement of € 125 per day up to a maximum number of days. The maximum number of days is the following per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
0	6	6	6

You are entitled to be reimbursed when the Voluntary caregiver arrangement is organized by an organization approved by Menzis. You can find out which they are by visiting www.menzis.nl/zorgvinder.

ⓘ Note

If the person cared for is insured through Menzis and you choose an arrangement for you and the person you care for jointly, the days will be counted twice until the specified maximum number of days has been reached.

Voluntary care broker

The voluntary care broker offers professional support to voluntary caregivers by taking over arrangement tasks. The voluntary caregiver will have less to deal with in this way. The voluntary caregiver broker will create an overview of the voluntary caregiver's tasks in consultation with this voluntary caregiver. In addition to the care tasks, this also includes the arranging tasks and obligations with regard to work. Next, a decision will be taken regarding what needs to be arranged to combine all of these tasks and to also have time for social contact and relaxation. Examples of this can be arrangements in the area of living, care, wellbeing, income, legislation, regulations and insurances.

You will be reimbursed for the voluntary care broker up to a maximum amount. This maximum amount is as follows for 2 calendar years:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 350	€ 350	€ 350

You are entitled to be reimbursed if Menzis has given you permission in advance and the voluntary care broker has been approved by Menzis. You can find out who they are by visiting menzis.nl/zorgvinder.

How can you request permission?

Contact the Menzis Voluntary Care Service on 088 222 42 42.

Respite care service

Voluntary care may be quite difficult for you regardless of how motivated you are in providing this care. You will, therefore, have the option of finding a person to replace you when you need a holiday.

You will be reimbursed for at most 15 days for replacement voluntary care.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
No	Yes	Yes	Yes

You are entitled to be reimbursed when the replacement voluntary care is arranged by Stichting Mantelzorgvervanging Nederland's "Handen in Huis". Call "Handen in Huis" on 030 659 09 70.

Orthodontics

Orthodontics is a type of dentistry that aims to improve the position of crooked or abnormally arranged teeth.

Orthodontics will be reimbursed up to a maximum amount. This maximum amount is for the full insurance term.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 0	€ 2,250 (up to 18 years of age)	no maximum amount (up to 18 years of age) € 500 (from 18 years of age)

You will receive this reimbursement if the treatment is performed by an orthodontist or dentist.

ⓘ Note

A waiting time of 1 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 start on the effective date of Collectief Aanvullend 3 or Collectief Aanvullend 4.

Orthopaedic arch supports

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

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 200	no maximum amount

You are entitled to be reimbursed when the supplier has been contracted or approved by Menzis. You can find out who they are by visiting menzis.nl/zorgvinder.

Menopause consultant

A menopause consultant is an experienced nurse who has specialized in the menopause. The consultant provides information and advice and will put together a treatment plan together with the client that fits in with the client's personal situation.

You will be reimbursed up to a maximum amount. This amount applies to the whole of the insurance period.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 0	€ 200	€ 200

You are entitled to be reimbursed when the menopause consultant has been approved by Menzis. You can find out who they are by visiting menzis.nl/zorgvinder.

Patient associations

A patient association is an association that protects the interests of people with a specific complaint. Associations usually have the aim of providing information about the complaint and organizing themed meetings. Members can contact other fellow-sufferers and exchange information.

Course

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 50	€ 50	€ 100	€ 100

You are entitled to be reimbursed when:

- the course is organized by a patient association approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder,
- the course is aimed at improving the client's lifestyle habits or for taking care of others.

Membership

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 50	€ 50	€ 50	€ 50

You are entitled to be reimbursed when the patient association has been approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

Therapy

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 100	€ 100	€ 100	€ 100

You are entitled to be reimbursed when the therapy is organized by a patient association approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

ⓘ Note

- Sporting activities organized by the patient association will only be reimbursed when the activity takes place under the supervision of a doctor, physiotherapist, exercise therapist, occupational therapist or nurse with a specialization for the relevant patient group.
- Hydrotherapy and therapeutic swimming in groups for insured suffering from rheumatoid arthritis, fibromyalgia, Bechterew's disease or heart conditions are also reimbursed.

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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
No	Yes	Yes	Yes

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

Wigs and alternatives

Wigs are insured up to a maximum amount in the Basic Healthcare Insurance. The additional insurance offers a reimbursement as a supplement to this. Not all people who have an indication for a wig wish to have one. They would prefer another way to cover their head such as with a scarf, headscarves, bandanas, buffs and mutssja's.
You will be reimbursed for a wig or the alternative up to a maximum amount per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 300	€ 500

You are entitled to be reimbursed when you have a prescription for a wig from a GP or a medical specialist.

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,
- physical medical supervision (training advice and individual training schedule),
- physical examination (as mandated by a sports federation).

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 100	€ 150	€ 200	€ 250

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 Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

ⓘ Note

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

Sterilization (men)

Sterilization for men (vasectomy) is an intervention that will make you irreversibly infertile. A vasectomy in itself is not a particularly inconvenient or complex intervention. The intervention can easily be performed under local anaesthesia.

The costs related to sterilization are reimbursed up to a maximum amount of:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 300	€ 300	€ 300

You will be reimbursed when the sterilization is performed by a medical specialist or GP.

ⓘ Note

- Reversal operations will not be reimbursed.
- We recommend requesting an estimate from your care provider in advance with regard to a vasectomy. This will ensure that you can determine which part of the costs is covered under your additional insurance and which part of the cost must be paid by you.

Sterilization (women)

Fallopian tubes are tied with regard to sterilization in women. This ensures that sperm cells can no longer reach the egg cell and the egg cell can no longer displace itself to the uterus. This ensures that pregnancy cannot occur.

The costs related to sterilization are reimbursed up to a maximum amount of:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 1,200	€ 1,200	€ 1,200

You are entitled to be reimbursed when the sterilization is performed by a medical specialist.

Referral

You require a referral from a general practitioner.

ⓘ Note

- Reversal operations will not be reimbursed.

- We recommend requesting an estimate from your care provider in advance with regard to a sterilization. This will ensure that you can determine which part of the costs is covered under your additional insurance and which part of the cost might be paid by yourself.

Quit smoking course

The quit smoking programme is insured under the Basic Insurance. You can visit your GP for this. In addition to the Basic Insurance, the additional insurance offers a reimbursement for courses that help when trying to quit smoking.

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 0	€ 150	€ 250

You are entitled to be reimbursed if you have completed the full course and the course is provided by an organisation approved by Menzis. You can find out which they are by visiting menzis.nl/zorgvinder.

Stuttering therapy

Some people have difficulty in fluently speaking. They can in these cases benefit from stuttering therapy. Stuttering therapy is partially covered by the Basic Insurance. You can visit a specialized stuttering therapist. Stuttering therapy that has been developed by experienced experts is covered by the additional insurance.

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 200	€ 350	€ 500	€ 1,000

ⓘ Note

You are only entitled to stuttering therapy provided by a Menzis contracted supplier. You can find the supplier by visiting menzis.nl/zorgvinder.

Guest house or hospice accommodation expenses (visiting family member)

A guest house or hospice is a house outside the hospital where members of your family can temporarily stay if you are hospitalized. Examples of guest houses or hospices are the Ronald McDonald house, the Familiehuis Daniel den Hoed, the Prinses Margriethuis, the Kiwanishuis and the Gasthuis van het Antoni van Leeuwenhoek Ziekenhuis.

The accommodation expenses in a guest house or hospice for a visiting member of your family will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 300	€ 450	€ 450

You are entitled to be reimbursed when the guest house or hospice has been approved by Menzis. You can find the list with guest houses or hospices on menzis.nl/zorgvinder.

Guest house or hospice accommodation expenses (patient)

A guest house or hospice is a house outside the hospital where you can temporarily stay before or after being hospitalized. Examples of guest houses or hospices are the Ronald McDonald house, the Familiehuis Daniel den Hoed, the Prinses Margriethuis, the Kiwanishuis and the Gasthuis van het Antoni van Leeuwenhoek Ziekenhuis.

The accommodation expenses in a guest house or hospice will be reimbursed up to a maximum amount. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 350	€ 350	€ 350

You are entitled to be reimbursed when the guest house or hospice has been approved by Menzis. You can find the list with guest houses or hospices on menzis.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.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
Yes	Yes	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 Collectief Tand

You can choose from different dental insurances at Menzis. 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

Dentistry care covers all care that a dentist, oral hygienist and/or dental prosthesis specialist offers. That which is insured through the Basic Insurance is not reimbursed through your additional dental insurance. This also applies to your excess and the legal personal contributions that are determined in the Basic Insurance unless this is included in the dental insurance as a reimbursement. Full dentures are partially insured in the Basic Insurance. Dental care is insured to a large extent in the Basic Insurance (orthodontics and crown and bridge work are not insured in the Basic Insurance) for youths up to the age of 17 inclusive. A reimbursement is included for orthodontics for children up to the age of 18 in Collectief Aanvullend 3 and 4 and for adults as from the age of 18 in Collectief Aanvullend 4.

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.

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.

Collectief Tand 250, 500 and 1000 reimbursements

All treatments will be reimbursed up to the specified maximum amount with Collectief Tand 250, 500 and 1000. A reimbursement is included in Collectief Aanvullend 3 and 4 for orthodontics.
The following will be reimbursed:

- consultations (C codes) 100%
- anaesthesia (A and B codes) 100%
- root canal treatments (E codes) 100% (with the exception of E97 and E98 external bleaching)
- jaw treatments (G codes) 100%
- surgical treatments (H codes) 100%
- implants (J codes) 100%
- preventive dental care (M codes) 100%
- prosthetic provisions (P codes) 100%
- crowns, bridges and inlays (R codes) 100%
- gum treatments (T codes) 100%
- fillings (V codes) 100%
- X-rays (X codes) 100%

This maximum amount is per calendar year:

Collectief Tand 250	Collectief Tand 500	Collectief Tand 1000
€ 250	€ 500	€ 1,000

Braces (orthodontics)

A reimbursement is included in Collectief Aanvullend 3 and 4 for orthodontics.

Waiting time for crowns, bridges and implants in Collectief Tand 1000

A waiting time of 1 year applies to crowns, bridges and implants in Collectief Tand 1000. 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 if you switch to Collectief Tand 1000. The waiting time will start on the insurance's Collectief Tand 1000 effective date. For more information about waiting times visit menzis.nl/wachttijd.

How to claim for your bill

If your dental care provider gives you a bill for dental care, you can claim online by visiting www.menzis.nl/mijnmenzis. Visit www.menzis.nl/declareren for more information about claiming bills. Some care providers claim directly from Menzis. 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)

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 and the previous sections insofar as the insurance applies that is described therein.
- These general terms and conditions apply to your Basic Insurance and to your additional insurance and dental insurance.
- If below the word 'insurance' has been used, we are referring to the Basic Insurance, the additional insurance and the dental insurance.
- Your healthcare policy will show which insurances you have taken out.
- Your rights as the insured have been described in the sections above. The applicable sections and these general terms and conditions together form the insurance terms and conditions.
- The policyholder is the person who has taken out the insurance with Menzis. 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', Menzis 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

Menzis Basis Vrij 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 you as the policyholder do not cancel the insurance. You as the policyholder shall be informed about the extension each year.

ⓘ 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 you have taken out a Basic Insurance with Menzis within 4 months after you were obliged to insure, the Basic Insurance cover will have a retroactive effect up to the day on which you were obliged to take out insurance.
- If you have taken out a Basic Insurance with Menzis within a month after another healthcare insurance terminated as from 1 January or due to term and condition changes that were not to your advantage, the 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. Menzis must have received your request no later than on 31 December. You can implement these changes online at MijnMenzis (MyMenzis). You can also call Customer Service on 088 222 40 40 or send an email.

A6 Cancelling the insurance

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

- If your email address is on record at Menzis, 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. Menzis must have received the cancellation no later than on 31 December,
- 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 condition that applies is, however, that the cancellation must have been received prior to this day by Menzis. If the cancellation is received later, the cancelation will start on the first day of the 2nd calendar month that follows from 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. Menzis 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 Menzis. If the cancellation is received later, the cancelation will start on the first day of the 2nd calendar month that follows from the day on which cancellation took place,

- also cancel your insurance if Menzis changes the terms and conditions and the new terms and conditions are disadvantageous not to your advantage. Menzis 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. 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 Menzis healthcare insurance and, if you specify this, the additional insurance and dental insurance on your behalf.

If the insured is insured based on Article 9d, first paragraph of the Dutch Healthcare Insurance Act, the insured can declare the healthcare insurance null and void during a period of two weeks to start as of the date on which the CAK has notified him or her if the insured proves to the CAK and the healthcare insurer during the period referred to in Article 9d, first paragraph of the Healthcare Insurance Act to have already been insured with another healthcare insurer (Article 9d.5 of the Healthcare Insurance Act).

ⓘ Note

- You cannot cancel with retroactive effect. You cannot cancel the insurance if Menzis must change the terms and conditions by operation of law. You cannot cancel the Basisverzekering (Basic Insurance) when you have not paid the premium and have been sent a reminder for this unless Menzis 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 Menzis allowed to terminate the insurance?

Menzis can terminate the insurance if:

- the premium has not been paid; see Article A13,
- you have not given Menzis the full facts or you have provided incorrect information; see Article A24,
- you have not behaved appropriately with regard to Menzis or its staff,
- Menzis takes the insurance off the market and no longer offers it as an option.

In derogation to Article 931 Book 7 of the Dutch Civil Code, Menzis is authorised to declare null and void an insurance contract concluded with him or her due to a mistake should it emerge later that the person who the CAK insured with it did not have an obligation to insure himself or herself at that moment in time (Article 9d.6 of the Dutch Healthcare Insurance Act).

A9 When will the Basic Insurance end by operation of law?

Your Basic Insurance will terminate by operation of law on the day after:

- your obligation to insure terminates,
- you die,
- Menzis changes the working area and you live outside this area,
- Menzis 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 Menzis because of your move. If Menzis changes the working area or is no longer permitted to offer Basic Insurances, Menzis will inform you about this no later than 2 months before your Basic Insurance terminates.

A10 Cooling off period

You have taken out insurance with Menzis and you change your mind. You can then cancel the insurance up to 14 days at most after having received your healthcare policy. You do not have to specify a reason when cancelling within this period. When you have sent your request to cancel (dissolve) the contract within these 14 days to Menzis, the insurance will be cancelled (the contract will be dissolved). The insurance will be regarded as not having been taken out. 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 What will you inform Menzis about?

- You must inform Menzis in writing and within 30 days about a change of address, death, bank account number change, being in active military service, the start and end of a prison sentence, no longer complying with the terms and conditions to participate in group insurance, the obligation to insure no longer applying with regard to the Basic Insurance and who is your new healthcare insurer if you have cancelled your insurance with Menzis.
- You must cooperate if Menzis requires information. For example, 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 must inform Menzis if a third party can be held liable for the care that is reimbursed by Menzis, for example, after a traffic accident or a medical mistake. You can then contact Customer Service or the Redress department. Menzis can then recover the loss and, therefore, ensure that premiums are kept as low as possible. You may not come to some arrangement yourself with this liable third party or his or her insurer should this not be to the advantage of Menzis.

Should Menzis come to the conclusion based on the data that you have provided that your Basic Insurance will be terminating or has been terminated, Menzis will immediately inform you about this.

A12 Premium, payment method and payment of the excess

A12.1 Premium

- The basis of the premium calculation for the Basic Insurance amounts to € 122 per calendar month as from 1 January 2017. The premium to be paid is the applicable basis of the premium calculation from which any premium discount that may apply has been deducted due to participating in group insurance and the premium discount belonging to any chosen voluntary excess has been deducted. The premium to be paid will have been specified on the healthcare policy.

- You must pay a premium for the Basic Insurance if you are 18 or older. You do not need to pay a premium for the Basic Insurance up to the first day of the calendar month that follows the calendar month in which you reach the age of 18.
- Menzis 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.
- If you make a payment without stating the Menzis payment reference, Menzis 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 Menzis. € 1.50 will be charged for this.
- If you have a payment arrangement with Menzis, Menzis may charge costs.

A12.2 Payment method

If you authorise Menzis through a direct debit authorisation in relation to the payment of the premium, this direct debit instruction will also apply to all other amounts that you must pay Menzis including the excess and your personal contribution. If you pay through direct debit, you will continue to be responsible for timely and full payment. The latest term when you will be informed before an amount is taken through direct debit is 5 working days. 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

- Menzis can charge you the excess and personal contribution for yourself and all other insured 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 Menzis. € 1.50 will be charged for this.

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

A13.1 Basic Insurance and additional insurance

1. Menzis 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:
   - Menzis 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 Menzis 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 Menzis 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 Menzis have granted permission for a treatment or provision.
4. If you do not pay the premium even after having received a reminder, Menzis will terminate the insurance of all insured parties.
5. Menzis may transfer sending reminders and collecting payments to a collection partner. Should the payment have been transferred to a collection partner, Menzis 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, Menzis 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, Menzis can offer you a payment arrangement. This payment arrangement entails the following:
   a. that you authorise Menzis to collect through direct debit,
   b. that you have made agreements with Menzis to pay your payment arrears in terms,
   c. that Menzis 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 Menzis, he or she has issued an authorisation as referred to in a of 1.
3. In the letter in which Menzis 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 Menzis is planning to report you to the CAK when you have not paid premiums for 6 months or more. If Menzis reports you to the CAK, this will mean that the CAK will collect the administrative premium.
   a. Menzis will not report you (as yet) if you let Menzis know in time that you do not believe you owe Menzis any amounts. Or if you let Menzis know in time that you believe that the sum of the debt is incorrect. You will have done this in time if you send Menzis a letter no later than 4 weeks after you have been informed about the situation by us. Menzis will, next, investigate whether it has calculated your debt correctly. If Menzis believes it has calculated your debt correctly, Menzis will inform you about this. If you disagree with the opinion of Menzis, 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 Menzis, Menzis will not report you to CAK until the Stichting Klachten en Geschillen Zorgverzekeringen or the civil court has decided whether Menzis has calculated the level of your debt correctly.
   b. You can also ask Menzis 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 Menzis agrees to

have a payment arrangement with you, Menzis 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 Menzis has established you have not paid premiums for a period of 6 months, Menzis will report you to the CAK. Menzis will pass on your personal details and of the people whom you have insured to the CAK. Menzis 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 Menzis about this.
7. Any selected voluntary excess will no longer apply nor the related premium discount.

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

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

A15 Group insurance

Menzis is entitled to make agreements with your employer or representatives about group insurances. You can participate in a group insurance if you meet the terms and conditions. Your employer or representative is aware of these terms and conditions. The following applies to group insurance:

- the group discount with regard to the premium has been specified on your healthcare policy,
- amended group agreements may apply that have been concluded with your employer or representative with regard to an additional insurance or a dental insurance. They can provide information about these terms and conditions,
- the group agreements agreed between your employer or representative and Menzis may change as from a specific date. The changed group agreements will apply to you as from this date.

ⓘ Note

The premium discount and the different agreements will no longer apply to you from the moment that you no longer meet the terms and conditions for participation in the group insurance. The premium discount and the different group agreements will also no longer apply from the moment that the agreement between your employer or representative and Menzis has terminated. Your insurances will, however, continue to run without premium discounts and different group agreements.

A16 Submitting a bill

Menzis often pays care providers directly. Sometimes, however, you may receive a bill. Please pay attention to the following when submitting bills:
submitting a bill online:

- you can do this on MijnMenzis.nl,
- a scanned bill will be regarded as an original,
- Menzis may ask you to send in the original bill,
- you must keep the original bill for 3 years.

Submitting a bill by standard mail:
- the original bill must be sent and not a copy, duplicate or reminder,
- bills will not be returned.

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

ⓘ Note
- The bill must not be older than 3 years.
- The bill must specify details to such an extent that we can determine the entitlement to be reimbursed.
- If a bill does not comply with the above in this Article, you will not be reimbursed.
- The data on the bill must be correct and must have been completed truthfully.
- The following applies to all insurances (Basic Insurances, additional insurances and dental insurances). Menzis is entitled to settle every payment to every insured specified on the insurance policy based on any insurance with any Menzis amount owed from every insurance with regard to every insured specified on the insurance policy.
- If an insured person submits a bill himself or herself without specifying on which account number the reimbursement must be paid, Menzis will pay the reimbursement to the account number of the policyholder that is known to Menzis.
- A bill in a foreign currency will be converted by Menzis into euros. The exchange rate used by Menzis will be the one that is used by the Dutch banks on the date that the bill was issued.
- If Menzis makes a reimbursement directly to the care provider, this will mean that you will no longer be reimbursed.

A17 Complaints and disputes
If you are unsatisfied about the services Menzis provides, please let Menzis 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 menzis.nl/klachtafhandeling where you can specify why and about what you are dissatisfied. If you need assistance in completing this form, please call the Menzis Customer Service on 088 222 40 40.
- Send this letter to the Klachtenmanagement (Complaints Management) department.
- Menzis will carefully study your complaint and ensure you receive a reply.
- If you do not agree with the reply given by Menzis 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. Menzis 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.
- Menzis 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

A18 Who is Menzis

Menzis is the one that carries the risk of your insurance. Menzis refers to the following: Menzis Zorgverzekeraar 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 Menzis Zorgverzekeraar N.V. and Menzis N.V. By taking out the insurance you will become a member of Coöperatie Menzis U.A. as a Menzis insured party. This Cooperation focuses on promoting the interests of its members. Coöperatie Menzis U.A., Menzis Zorgverzekeraar N.V. and Menzis N.V. are non-profit organisations.

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

The following applies to the Basic Insurance when acts of terrorism occur that mean that you require care: 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 Menzis 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 e-Court

If an insured person or policyholder does not meet his or her payment obligations with regard to Menzis such as the obligation of paying premiums, excesses or personal contributions, a debt collection dispute shall apply between the insured person or policyholder and Menzis.
Menzis can decide to have a debt collection dispute resolved through arbitration by the Stichting E-Court (e-court.nl). If Menzis submits a dispute to e-Court, the insured person or policyholder will have the opportunity during a month to have the dispute resolved by the civil court and not e-Court. The proceedings at e-Court will run in accordance with the proceedings regulation that is published on e-court.nl/juridisch/reglement/.

Only collection disputes can be submitted to e-Court for resolution. Other types of disputes such as disputes about your entitlements based on the healthcare insurance agreement can only be resolved by the civil court or the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ).
Menzis will continue to be at all times authorised to submit collection disputes to the civil court for resolution. If Menzis does this, the civil court is always authorised to resolve those disputes. Only Menzis is authorised to submit disputes to e-Court for resolution. An insured person or policyholder can only submit disputes to the civil court or the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) regardless of their nature.

A22 Liability

Menzis 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 Menzis' part for damages as a result of Menzis' own shortcomings is limited to the amount of the costs that would have been charged to Menzis 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 misleads Menzis, your rights will no longer apply. You will not be reimbursed in this case and Menzis will terminate all your insurances. The amounts that Menzis may already have paid either to yourself or directly to the care provider, must be paid back. You must also pay Menzis for the incurred investigation costs. Menzis will report you and your data will be registered. This will be done in the registers in accordance with the 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. Menzis will deal with your data carefully. Your personal data will be used for taking out and executing your insurance. Menzis also uses your personal data for executing legal obligations

and statistical analyses. Menzis 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. Menzis 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 Menzis when executing your insurance such as care providers or a factoring agency (debt collecting agency) that collects outstanding amounts. It is sometimes necessary that Menzis 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, Menzis 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.
- Menzis will include your personal public service number (BSN) in its administration. Your care providers, other care service providers and Menzis 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 does not take place on one day but during a longer period, the date on which the treatment started is the determining factor. If the treatment is funded through a Diagnosis Treatment Combination (DBC), the effective date of the DBC is the determining factor for determining the calendar year in which the reimbursement is allocated. If the treatment is funded through a Diagnosis Treatment Combination (DBC), it may be the case that you need to pay an excess in multiple calendar years for your treatment.
- You grant Menzis a power of attorney to recover all payments that have been too high.
- If you visit or call Menzis and Menzis makes a verbal promise, you can ask Menzis 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)

General

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 Menzis additional insurance and dental insurance continued or cancelled as from the same date.

A28 Is Menzis allowed to terminate the insurance?

Menzis 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
- Menzis 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 Menzis 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 Menzis additional or dental insurance.

A30 Premium

- Menzis N.V. has authorised Menzis Zorgverzekeraar 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.
- Menzis can charge a personal contribution from the policyholder or the insured who is involved.
- If you are the policyholder and do not pay the premium even after receiving a reminder, Menzis can stop the additional insurance and dental insurance on the start date of the period to which the premium relates. You must pay a premium for the additional insurances if you are 18 or older and for the dental insurances when you are 10 or older. A premium must be paid for all ages with regard to the JongerenVerzorgd insurance. Menzis can charge a premium for the additional insurance of an insured younger than 18. This may be the case when an insured aged 18 or older is not specified on the healthcare policy who pays a premium for the same package or a package with a higher number.

A31 For your child

Menzis 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 Menzis 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 menzis.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

Menzis 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 Menzis,
- you have committed (insurance) fraud.

Insurance terms and conditions Menzis Basis Vrij Collectief 2017

Menzis Basis Vrij	Modelnummer Zvw 1.99.17
ExtraVerzorgd	Modelnummer AV 1.96.17
TandVerzorgd	Modelnummer AV 1.96.17

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Statutory name: Menzis Zorgverzekeraar N.V. Address: Lawickse Allee 130, 6709 DZ Wageningen. Business name: Menzis Zorgverzekeraar N.V., Chamber of C ommerce number 50544810. Nature of the services: indemnity insurances. AFM registration number: 12020806. Statutory name: Menzis N.V. Address: Lawickse Allee 130, 6709 DZ Wageningen. Business name: Menzis N.V. Chamber of Commerce number 50544101. Nature of the services: indemnity insurances. AFM registration number: 12020807.

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