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Insurance terms and conditions Menzis Basis Vrij Collectief 2024

Basic insurance, additional and dental insurances and practical information. Applicable as from 1 January 2024.

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Contact and service

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

Our website

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

Contact

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

Calling Menzis

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 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

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

Menzis Zorgvinder

The Menzis Zorgvinder (Menzis Care Finder) helps you to find care providers close to your home. You can easily find out which care providers have a contract with Menzis. Visit menzis.nl/zorgvinder for more information.

Menzis Care Advisor

Do you have a question regarding your healthcare? Or do you need advice about informal care or legislation? Please contact our Care Advisor at 088 222 40 40 (on workdays from 8.30 until 19.00).

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

You can download the Menzis Insurance Regulations on menzis.nl/reglement (only available in Dutch). More information on the Dutch Healthcare Insurance Act, Decree or Regulations is available on wetten.overheid.nl.

Reimbursement

You have chosen to take out the basic insurance Menzis Basis Vrij. This is an insurance that is intended for everybody who lives in or outside of the Netherlands and who has to take out healthcare insurance. 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 has contracts with many care providers. Hospitals, doctors, medical specialists and physiotherapists are, for example, care providers. You can choose the care provider who is either a contracted or a non-contracted one.

ⓘ Note

- Healthcare providers are obliged to register under the 'Wet toetreding zorgaanbieders' (Wtza) or to have a permit to provide healthcare. An exception applies to some healthcare providers. You can only go to a healthcare provider that demonstrably meets the requirements of the Wtza.
- 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

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. You can also call Customer Service on 088 222 40 40. If you have questions about the care, please ask for the Care Advisor.

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.

Care must be provided in accordance with the applicable Dutch quality standards.

Indication and efficiency

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

Reasonable term and distance

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

Excess

You will have to pay a mandatory excess of € 385per 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 € 15.

ⓘ Note

Some forms of treatment are claimed with a treatment code, this is referred to formally as: a DBC care product (diagnosis treatment combination), such as the care you receive in a hospital. A DBC care product comprises all activities and procedures carried out by the hospital and the medical specialist for the purpose of diagnosis and treatment. The hospital claims a single amount for a DBC care product. In the event a DBC care product is provided in 2 consecutive years, the costs of the DBC care product count towards the excess of the year in which the DBC care product commenced (opening date). This means that if a DBC care product is opened in 2024and closed in 2025, the costs of the DBC care product count towards the excess for the year 2024. If a new, follow-up DBC care product is opened after a DBC care product has been closed, you will have to pay excess again for this new DBC care product.

No Excess

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

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

If you pay a personal contribution or payment, this will not be part of your excess. If the insurance does not start or end on 1 January of a year, the excess will be applied proportionally. First, the mandatory excess is

applied and thereafter the voluntary excess. If Menzis pays your healthcare bill to the care provider 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 20.12.2024 and are discharged on 10.01.2025. The excess will now be applied once in 2024.

Order of personal payments

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

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

Other

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

Abroad

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

Which care?

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

- right to care in accordance with the statutory scheme of that country,
- right to care from a care provider contracted by Menzis, or
- reimbursement of costs for care from a non-contracted care provider that you would be reimbursed if you

would receive care from a non-contracted care provider in the Netherlands.

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

Permission

For hospital care abroad, that is to say medical care with admission in an institution of at least one night in another country than the country where you reside, you will require prior permission from Menzis. You can contact us 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 direct 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 the reimbursement of costs of :

- 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). A referral is valid for a maximum of one year.

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

Which care provider?

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

Referral

No referral is required when you visit a dietician.

Dietary preparations

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

Welke zorg

You are entitled to 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 at most a month for each

prescription.

Permission

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

Note

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

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

Note

- Should you purchase a dietetic preparation over the counter such as at the supermarket or a chemist, you will not be reimbursed for the incurred costs.
- The medical certificate will be assessed by the care provider. If you would rather the care provider does not do this, the medical certificate can be assessed by 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 the reimbursement of costs of stay during the 24 hours that are required medically in relation to medical care as general practitioners usually offer. You are also entitled to the related required nursing, care and paramedical care. Your admittance is insured for an uninterrupted period of 1,095 days. An interruption of a maximum of 30 days is not considered to be an interruption but does not count for the calculation of the 1,095 days. An interruption due to weekend or holiday leave does, however, count.

Which care provider?

Primary care institution takes place at an institution for nursing and care where the medical care is under responsibility of the general practitioner, geriatric specialist or doctor for mentally disorder.

Indication and permission

You are only entitled to the reimbursement of costs of staying in a primary care institution if you have a prior written indication from your general practitioner, medical specialist (who can delegate this to a transfer

nurse), geriatric specialist, doctor for the mentally challenged or social worker. If the stay is for a period that is longer than 6 months, you will require prior permission from Menzis. Your treating physician (GP, geriatric specialist or doctor for the mentally challenged) can request this permission on your behalf.

Genetic testing

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

Which care?

You are entitled to the reimbursement of costs of :

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

Which care provider?

You can visit a centre for genetic testing for this type of testing. This is an institution holding a permit pursuant to the Dutch Special Medical Procedures Act for the application of clinical genetic research and advice on matters concerning hereditary diseases.

Referral

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

Occupational therapy

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

Which care?

You are entitled to 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

You do not need a referral if you visit a occupational therapist

Physiotherapy, exercise therapy, pelvic physiotherapy

Physiotherapy

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

Which care?

You are entitled to 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 are not classed as being 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. You can find this list by visiting menzis.nl. You can also contact our Customer Service.

> **Note**
> You are not entitled to the reimbursement of costs of the first 20 treatments for each disorder based on your Basic Insurance. 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 physiotherapy in the same cases as people who are 18 or older, but also from the first treatment. If you have a complaint that cannot be found on the list that the minister of Public Health, Welfare and Sport has established, you are entitled to the reimbursement of costs of 9 treatments at most for the each complaint per calendar year. If the first 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.

> **Note**
> You can only visit a general physiotherapist, child physiotherapist, manual therapist, oedema physiotherapist, geriatric physiotherapist or a pelvic physiotherapist who is registered in the Centraal Kwaliteitsregister Fysiotherapie (CKR; Central Quality Register) or in the Keurmerk Fysiotherapie (Physiotherapy Quality Mark) register. You can also visit a skin therapist who is registered as "Quality Registered" in the Paramedic Quality Register for oedema therapy and scar therapy. For questions regarding specialized physiotherapy you can contact our Customer Service.

Referral
You do not need a referral if you visit a physiotherapist. You do need proof of diagnosis. The proof of the diagnosis must contain at least the name of the patient and the person who made the diagnosis. The diagnosis must be specific enough to determine whether it concerns a condition that is listed in the Healthcare Insurance Decree and/or Appendix 1 Article 2.6 of the Healthcare Insurance Decree.

> **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 find out whether this is the case from the list that the Minister of Public Health, Welfare and Sport has established. The list is included in Annex 1 of Article 2.6 of the Dutch Health Insurance Decree. You can find this list by visiting menzis.nl. You can also contact Customer Service.

ⓘ Note

You are not entitled to the reimbursement of costs of the first 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 first 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 first 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 an exercise therapist or a child exercise therapist who is registered as a "Quality registered" practitioner in the Paramedic Quality Register. You can contact our Customer Service for more information about exercise therapy.

Referral

You do not need a referral if you visit a physiotherapist. You do need proof of diagnosis. The proof of the diagnosis must contain at least the name of the patient and the person who made the diagnosis. The diagnosis must be specific enough to determine whether it concerns a condition that is listed in the Healthcare Insurance Decree and/or Appendix 1 Article 2.6 of the Healthcare Insurance Decree.

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 one-off entitled to the reimbursement of costs of 9 pelvic physiotherapy treatments at most in relation to urine incontinency when you are 18 or older. 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 registered in the Kwaliteitskeurmerk Fysiotherapie (the Physiotherapy Quality Mark).

Referral

You do not need a referral if you visit a pelvic physiotherapist.

You do need proof of urinary incontinance diagnosis from your attending physician. The proof of the diagnosis must contain at least the name of the patient and the person who made the diagnosis.

Note

Not all treatments are reimbursed. Treatments that are not regarded as physiotherapy will not be reimbursed. Examples include: Working on the improvement or retention of your physical condition in the form of medical fitness (or a comparable activity such as physiotherapy fitness, Slender You and group swimming) and extracorporeal shockwave therapy are not classed as being physiotherapy. You are not entitled to those treatments. More information can be found on 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 for the reimbursement of costs of at most 12 months to at most 37 exercise therapy sessions under supervision of a physiotherapist or exercise therapist if you suffer from intermittent claudication. Intermittent claudication is deemed to mean the following: peripheral arterial disease in stage 2 Fontaine.

Which care provider?

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

Referral

You do not need a referral if you visit a physiotherapist or exercisetherapist who is a member of Chronisch ZorgNet.

You do need proof of the diagnosis Intermittent claudication from your attending physician. The proof of the diagnosis must contain at least the name of the patient and the person who made the diagnosis.

Fall-preventative movement intervention

Fall-preventative movement intervention is aimed at reduction of all risks. You may receive the advice to start attending a movement programme based on a fall risk analysis carried out by the general practitioner. This is referred to as fall-preventative movement intervention.

Which care?

If you are aged 18 or over you are entitled to a fall-preventative movement intervention. What you are entitled to exactly depends on your fall risks and the underlying or additional somatic or psychological problems.

You are entitled to a fall-preventative movement intervention once per calendar year.

Which care provider?

You can go a physical therapist or exercise therapist who is specialised in the Otago exercise at home programme.

Referral

You will only be entitled to a fall-preventative movement intervention if you received a written referral from

the general practitioner in advance.

Arthrosis of the hip or knee joint

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

Which care?

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

Which care provider?

You can visit a physiotherapist or exercise therapist who is registered as a "Quality registered" practitioner in the Paramedic Quality Register.

Chronic obstructive pulmonary disease (COPD)

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

Which care

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

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

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

Which care provider?

You can visit a physiotherapist or exercise therapist.

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 (see the article general practitioner care for more

information), mental healthcare without hospitalisation and mental healthcare with hospitalisation. 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.

Specialist mental healthcare without admission

Mental healthcare without admission 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 without admission.

Which care?

You are entitled to a diagnosis and treatment for recognised mental DSM disorders. DSM stands for Diagnostic and Statistical Manual of Mental Disorders. The scope of care within mental healthcare without admission is limited by what clinical psychologists and psychiatrists tend to 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 Care Advisor (Care Advice) for information on 088 222 40 40 before your treatment starts.
- You are not entitled to the reimbursement of 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 40 40 for this.

Which care provider?

You can see an independent care provider or visit a mental healthcare institution. The care provider must have a quality charter that meets the requirements of the Quality Charter and act accordingly. This quality charter must be registered with the National Health Care Institute. In addition, for directive treatment, the 'Temporary implementation of directive treatment' field arrangement applies. A directive practitioner bears final responsibility for the total treatment. In addition, he is the central point of contact for all parties involved, and for you as a patient and your loved ones.

If you go to a care provider, check whether this care provider has a registered quality charter prior to the treatment. You can contact our Customer Service. You can also contact the relevant care provider, visit the website of the care provider or visit zorginzicht.nl. If the healthcare provider whom you visit does not have a registered quality charter, the given care will not be eligible for reimbursement.

Referral

You are only entitled to mental healthcare without admission if you have a prior written referral from the general practitioner, company doctor, medical specialist, emergency room doctor, street doctor, society and health doctor or your directive practitioner. This referral letter must comply with the 'Mental healthcare referral agreements' established by the Ministry of Health, Welfare and Sport.

Note

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

Specialist mental healthcare with admission

Some mental issues are of such a serious nature that treatment without admission is not sufficient. Admission at a psychiatric clinic or the psychiatric ward of a general hospital is then the best solution. This means that you will be given your treatment in the clinic or hospital and this also means that you will be living and sleeping in the clinic or the hospital for the duration of the treatment. The decision may also be taken to admit the patient in the case of a crisis situation.

Which care?

You are entitled to the reimbursement of costs of :

- diagnosis and treatment of complex and/or multiple recognized DSM mental disorders where a multidisciplinary approach is often required. DSM stands for Diagnostic and Statistical Manual of Mental Disorders. The scope of care within mental healthcare without admission is limited by what clinical psychologists and psychiatrists tend to offer.
- 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. If your admission is interrupted for less than 31 days, the days that the interruption lasts do not count towards the 1,095 days. Counting continues after the interruption.
- the paramedical care and medication, medical aids and dressing material, nursing and care related to the treatment during the period of admission.

Note

- Addiction healthcare is often expensive and is not really guaranteed in all cases and certainly when addiction healthcare takes place abroad. Therefore, ensure you are correctly informed in advance if you want to be treated for addiction. You can contact the Menzis Care Advisor on 088 222 40 40 for this.
- Not every treatment of a mental disorder or mental healthcare treatment is covered by the Basic insurance. Ask your care provider before you are admitted for treatment or ask the Menzis Care Advisor on 088 222 40 40.
- You are not entitled to the reimbursement of costs of treatment of adaptive disorders and to assistance with regard to psychological complaints that are related to work and relational issues.

Which care provider?

You can visit a mental healthcare institution. The care provider must have a quality charter that meets the requirements of the Quality Charter and act accordingly. This quality charter must be registered with the

National Health Care Institute. In addition, for directive treatment, the 'Temporary implementation of directive treatment' field arrangement applies. A directive practitioner bears final responsibility for the total treatment. In addition, he is the central point of contact for all parties involved, and for you as a patient and your loved ones.

If you go to a care provider, check whether this care provider has a registered quality charter prior to the treatment. You can contact our Customer Service. You can also contact the relevant care provider, visit the website of the care provider or visit zorginzicht.nl. If the healthcare provider whom you visit does not have a registered quality charter, the given care will not be eligible for reimbursement.

Referral
You are only entitled to the reimbursement of costs of mental healthcare without admission if you have a prior written referral from the general practitioner, company doctor, medical specialist, emergency room doctor, street doctor, society and health doctor or your directive practitioner.

No referral is needed in the case of acute care. However, an immediate referral is required for any treatment that takes place after the acute situation has passed.

The referral contains a clear request for help that can be answered by the mental healthcare centre, must refer specifically to the mental healthcare centre and must at least state what the mental (DSM) disorder suspected by the referrer is and the reason for the referral. The referral must comply with the 'Mental healthcare referral agreements' established by the Ministry of Health, Welfare and Sport. Among other things, this means your treatment must start within 9 months of the referral being issued. If there are more than 9 months in between, ask for a new 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 40 40 to apply for this permission.
- If you want to continue staying after a period of 365 days or after the period for which consent has already been granted has elapsed, You must request permission from Menzis two months before the period of 365 days or the period for which permission has been granted elapses at the latest through your current managing practitioner. The application form can be found on menzis.nl.
- If you would like to use the esketamine, including Spravato, you will need Menzis's prior, written approval. You can contact Customer Service in order to request this approval.

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 annexes by visiting overheid.nl. If you want to find out whether a specific medication is on the list, you can also contact our Customer Service.

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

Advice and support

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

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

Preference policy

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

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 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 you will no longer be entitled to be reimbursed for the non-preferred medication after the 15th day has elapsed.

Indication

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

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.

Minimum and maximum supply period for medicines

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

- In case of a newly prescribed medicine, you will be supplied with medicine for 15 days. Or you will receive the smallest medicine package. You will receive the smallest package of the preferred medicine if it concerns a medicine to which the preference policy applies.
- Contraceptive pills are subject to a delivery term of 3 months for a newly prescribed medicine. A term of 6 or 12 months, to be decided by the insured person in consultation with the pharmacist or the pharmacist's assistant, also applies.
- Medicines that are more expensive than €1,500 per month are supplied for a period of at most 1 month after they have been issued. HIV medication may be supplied for a period of at most 3 months after an

adjustment period of 3 months.
- At least 3 months for medicines that treat a chronic disease and at most 6 months if it concerns medicine indicated as preferred by Menzis, unless you are demonstrably not permitted to have a medicine in your possession for that long for medical reasons.
- 1 month for sleeping pills and sedatives.
- A period of 15 days applies in principle in case of medicine use during intensive care at home (pharmaceutical care during the palliative and terminal phase). A custom arrangement may also be concluded in consultation between the insured person, the doctor or general practitioner, district nurse and the pharmacist.
- At least 1 month for all other cases.

Personal contribution

You may have to pay a personal contribution. All medicines that you are entitled to be reimbursed for 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 equivalent or almost equivalent to any non-designated, registered medicine, unless it concerns a pharmacy preparation of a medicine included in Appendix 3, part A, of the Healthcare Insurance Regulations, or it concerns a pharmacy preparation of a medicine in respect of which the Minister has not yet made a decision regarding inclusion in the insured package, as apparent from appendices 1 and 3 of the Healthcare Insurance Regulations,
- which are included in Appendix 3, part B, of the Healthcare Insurance Regulations,
- as referred to in Article 40, third paragraph, e, of the Dutch Medicines Act.

Which care provider?

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

Prescription

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

Permission

For some medication you will require prior permission from 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 a contract with this doctor's

declaration, the chemist will assess whether you are entitled to the reimbursement of costs of this 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 ask prior 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 the reimbursement of costs of :

- general medical care except the flu jab,
- laboratory tests, representational diagnostics and function tests requested by a general practitioner,
- medical specialist care that borders on to the general practitioner medicine domain regarding which 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 mental healthcare without admission or mental healthcare with admission,
- chain care that is paid by applying the policy rule that has been defined based on the Dutch Healthcare (Market Regulation) Act for GP Care and multidisciplinary care. Visit menzis.nl/zorgvinder to find out with which general practioners Menzis has made these agreements. Chain care is a care programme especially developed for people who suffer from type 2 diabetes, COPD (Chronic Obstructive Pulmonary Disease) and VRM (Vascular Risk Management) in which multiple care providers participate to better harmonise the care. Visit menzis.nl for more information.
- a combined lifestyle intervention (GLI) that has been assessed as proven effective by the National Institute for Public Health and Environmental Protection (RIVM) and has been included in the list that can be found at Loketgezondleven.nl, if you have a moderate or strongly increased weight- related health risk (in ac cordance with the obesity care standard: BMI of 25 or higher with an increased risk of a chronic affliction or BMI higher than 30). This must have been established by a general practitioner or medical specialist. You can find the obesity care standard at zorginzicht.nl.
- care and support for children with overweight or suffering from obesity below the age of 18. This care consists of a broad analysis, supervision, coordination and a combined lifestyle intervention (GLI) for children. It must involve a moderate or strongly increased weight-related health risk (in accordance with the obesity care standard: BMI of 25 or higher with an increased risk of a chronic affliction or BMI higher than 30). You are only entitled to supervision and coordination if the treatment plan offers a GLI for children. The GLI for children is offered in the shape of a programme and implemented in accordance with the experiments in Arnhem (GO) or Limburg (Your Coach Next Door) or Amsterdam (Healthy Weight Approach). Supervision and coordination may last at most 3.5 years. The GLI for children may last for at most 24 consecutive months.
- Medical Care for Specific Patient Groups (GZSP) provided by a Geriatric Specialist or a Doctor for the Mentally Handicapped.

- preventive foot care: if you have diabetes and an increased risk of foot ulcer (deep inflammation of the foot), or if you have an increased risk of a foot ulcer due to other medical conditions or medical treatment.
- fall risk analysis: an analysis of the causes of a possible fall you made or the determination of high risks of falling. You may then receive the advice to start attending a movement programme. This is referred to as

fall-preventative movement intervention. Please refer to the information in the article entitled 'Physiotherapy, exercise therapy and pelvic physiotherapy'.

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. Ask your GP about which GP is on duty or to which GP station you can go. You will also find information on verenigingh uisartsenposten.nl.

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

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

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

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

Care and support for children with overweight or suffering from obesity below the age of 18:

- a youth care nurse trained as a central care provider for a broad analysis, supervision and coordination.
- for the purpose of a GLI for children you go to a lifestyle coach who is registered in the BLCN who has attended training as children's lifestyle coach and who cooperates with the municipality for dealing with overweight and obesity.

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

You can visit a podiatrist for preventive foot care outside the care pathway. The podiatrist can engage a pedicurist for preventive foot care. The pedicurist works under the responsibility of the podiatrist.

Note

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

Referral

- Foot care: You are only entitled to the reimbursement of costs of foot care when you have a written referral from your general practitioner or medical specialist issued in advance.
- Combined lifestyle intervention: You are only entitled to the reimbursement of costs of combined lifestyle

intervention if you have obtained a written referral from your general practitioner, occupational physician or medical specialist in advance.
- Care and support for children with overweight or suffering from obesity below the age of 18: you are only entitled to a broad analysis, supervision and coordination by a central care provider and a GLI for children if you have obtained a written referral from your general practitioner, paediatrician or a doctor working in youth healthcare.
- Medical Care for Specific Patient Groups: You are only entitled tothe reimbursement of costs of Medical Care for Specific Patient Groups if you have obtained a written referral from your general practitioner or medical specialist in advance.

Permission
For care in a group for frail elderly people from the Medical Care for Specific Patient Groups (GZSP), you require prior permission from Menzis from the 100th treatment onwards.

Note
- The mandatory excess applies for Medical Care for Specific Patient Groups.

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 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 its 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". Diabetes testing material, for example.

Do you require a medical aid that belongs to function-based aids but this medical aid is not included in the Insurance Rules and Regulations? In this case, submit a request with 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 Health Insurance Regulations and the Insurance Rules and Regulations by visiting menzis.nl. If you want to know whether a specific medical aid is on the list, you can also contact our Customer Service.

Personal contribution
A (percentage) statutory personal contribution or a maximum reimbursement applies to certain medical aids.

You can find out from the Health Insurance Regulations whether this is the case and how much the personal contribution or maximum reimbursement will be. You pay the personal contribution to the supplier. The statutory personal contributions and maximum reimbursements can also be found in the Insurance Rules and Regulations.

Which care provider?

You can approach a supplier of medical aids in order to receive these. They are listed for each medical aid in the Insurance Rules and Regulations. You can also contact our Customer Service.

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. You do not require permission from Menzis for most medical aids that are supplied by a contracted supplier. 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

- If you wish to use a supplier who has not concluded a contract with Menzis, you require prior permission. Please specify on the request for permission that you wish to use a care provider who does not have a contract with Menzis.
- 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.
- The Insurance Rules and Regulations explains the other terms and conditions that you must meet with regard to each medical aid, for example, including an explanation from a doctor.
- Your nursing specialist must complete a special form for the reimbursement of most dressing materials. Dressing materials will only be reimbursed in relation to a serious condition where long-term treatment is required. The special request form for dressing materials can be found by visiting znformulieren.nl/hulpmiddelen. You can also find more information in the Insurance Rules and Regulations.
- If 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 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 compensation for the costs due to normal use of medical aids unless it has been determined in the Health Insurance Regulations that this is compensated. An example of normal use is the replacement of batteries.

- If use terms or use quantities are specified in the Insurance Regulations, they are provided to give a normal average. We can deviate from these use terms or use quantities in individual cases.
- If you are entitled to a medical aid, this is deemed to mean that you are entitled to the issue (reimbursement), replacement, correction or repair of a medical aid.
- For information on costs of home dialysis see: Non-clinical dialysis.
- For information on medical aids for the personal measuring of coagulation times see: Thrombosis service.

In-vitro fertilisation (IVF)

IVF and ICSI are fertility treatments. In vitro fertilisation (IVF) means 'in glass fertilisation' and is also referred to as test tube fertilisation. ICSI stands for intracytoplasmic sperm injection. Fertilisation of the female egg cell by a male sperm cell takes place artificially within the context of these treatments. IVF treatment has its own place within the context of stepped care. The choice of treatment takes ac count of the effectiveness, the intensity of this treatment for couples, the risks and the costs.

Which care?

Your age will determine what you are entitled to exactly. Ask your care provider to inform you well before you start the treatment or ask the Care Advisor by contacting our Customer Service.

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 are not entitled to the reimbursement of costs of IVF 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. Neither are the non-medical costs of sperm donation, including the cost of the sperm itself and of its transfer.
- IVF/ICSI treatments which have already been reimbursed by another health insurer are also seen as part of the total number of treatments.
- IVF/ICSI treatment with assisted hatching is not an insured service. Assisted hatching is a part of the total lCSl treatment. The professional group in the Netherlands does not carry this out. Assisted hatching is not a treatment in accordance with the state-of-the-art and practice. The entire ICSI treatment with assisted hatching is not reimbursed.

Which care provider?

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

Referral and permission

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, 1 or 2 embryos are implanted in the uterus once or multiple times.

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

Examples to determine the number of insured attempts

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

ⓘ Note

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

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 6 weeks 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.

E-Health

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

Personal contribution

A statutory personal contribution of € 5.10 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 € 40 per day that you are admitted (€ 20 for the mother and € 20 for the baby). If the hospital charges an amount that is higher than € 286 per day (€ 143 for the mother and € 143 for the baby), you must, in addition to the € 40, also pay the amount that is higher than € 286 per day.

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

Registration
Please contact Customer Service for advice on maternity care. You can then apply for the maternity pack too. You can also do this through menzis.nl/zorgadvies/aanvraagformulier-gratis-medisch-kraampakket.

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

Which care?
You are entitled to the reimbursement of costs of speech therapy if:

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

> **Note**
> You are not entitled to the reimbursement of costs of speech therapy with regard to:
>
> - dyslexia,
> - treatments with an educational objective,
> - language development disorders related to speaking a dialect or another language,
> - treatment related to the execution of your professional duties, for example, with regard to singers,
> - speaking in public.

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

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

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

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

Referral

No referral is required when you visit a speech therapist.

Permission

You are only entitled to the reimbursement of costs of speech therapy at a school or 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 the reimbursement of costs of :

- being examined and diagnosed,
- treatment,
- materials used by the medical specialist such as medication, dressing material or medical aids;
- laboratory tests,
- mechanical breathing and the related medical specialist care, medication, overnight stays, nursing and care in or under the responsibility of a breathing centre;
- an allowance towards the electricity costs in case of mechanical respiration at home.

ⓘ Note

You are not entitled to the reimbursement of costs of treatments when it concerns:

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

- treatment of plagiocephaly and brachycephaly (flat head syndrome) without craniosynostosis with a cranial remoulding helmet,
- 4th and next IVF treatment per pregnancy to be achieved.

Note

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

- the care types described in the Article “Provisional admission”,
- audiological assistance,
- genetic testing,
- part of medical mental healthcare,
- in-vitro fertilisation (IVF) and other fertilisation stimulating treatments,
- non-clinical dialysis (dialysis without admission),
- oncology assistance for children,
- overnight stay in relation to medical specialist care,
- plastic or reconstructive surgery,
- medical specialist rehabilitation,
- transplantation,
- thrombosis service.

Which care provider?

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

Note

- Independent treatment centres do not offer all forms of medical specialist care.
- 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, clinical physicist, nurse specialist, physicians assistant obstetrician, specialist geriatric care provider (nursing home doctor), a doctor who works in youth health care or a doctor

for the mentally challenged.

- An optometrist or orthoptist can make a referral for specialist eye care.
- A triage-audiologist can make a referral to an ear-nose-throat specialist (ENT specialist) for specialist hearing care,
- A triage audiologist may refer to the clinical physicist-audiologist,
- The Municipal Health Service (GGD) doctor may refer to the medical specialist if it concerns tuberculosis.
- The occupational physician can make a referral if the complaints are related to your work,
- The dentist or orthodontist may refer to the dental surgeon when it comes to placing dental implants,
- A youth doctor may refer to an ophthalmologist, pediatrician or orthopedist,
- An obstetrician may refer in case of pregnancy or childbirth. An obstetrician may also refer to a paediatrician within the first 10 days after childbirth and to an ENT specialist if the string of the tongue must be cleaved,
- The RIVM (National Institute for Public Health and the Environment) may refer to a specialist paediatrician in the event of an abnormal result of a heel prick,
- The CBT dentist can refer to the neurologist, anesthetist as a pain relief specialist and ENT specialist.

You do not need a written referral for emergencies.

A referral is valid for a maximum of 1 year

Permission

You require prior permission for a number of treatments:

1. Limitative list of medical specialist healthcare

You can find these treatments listed in the Limitative List of Medical Specialist Healthcare (in Dutch: Limitatieve Lijst Medische Specialistische Zorg) of the Association of Dutch Health Insurers (ZN). Which treatments does this refer to?

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

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

2. Others

You are only entitled to these treatments when you have obtained permission from Menzis in advance:

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

Advice

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

The entitlement to plastic surgery treatment types is arranged in the plastic and/or reconstructive surgery policy article. If you are looking for a medical specialist with a special area of expertise or for highly complex care, contact our Care Advisor by contacting our Customer Service for more information.

Non-clinical dialysis

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

Which care?

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

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

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

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

Referral
You are only entitled to the reimbursement of costs of non-clinical dialysis when you have a prior written referral from your general practitioner or medical specialist. A referral is valid for a maximum of 1 year

Note

- Dialysis at home is reimbursed exclusively on the basis of medical specialist care.
- The reimbursement of adjustments to the home and reasonable costs directly related to dialysis at home are covered by nursing articles care. Please refer to the information in the Insurance 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 register and be examined and compared with the material present to ensure you have the best possible treatment plan.

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

Referral
You are only entitled to 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,
- mutilation due to illness, an accident or medical activity,
- paralysed or drooping upper eyelids if:
  a. The paralysis or slackening is the result of a congenital defect, or
  b. The paralysis or slackening is the result of a chronic defect present during the birth, or

c. The paralysis or slackening leads to a severe visual impairment,
- the next congenital malformation: cleft lip, jaw and palate, malformation of the facial bony area, benign tumours of blood vessels, lymph vessels or connective tissue, birth marks or malformations of urinary passage and genital organs,
- appearance of the primary sexual characteristics with regard to a determined transsexuality.

Note

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

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

Which care provider?

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

Referral

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).

Permission

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

Rehabilitation

Rehabilitation (medical specialist)

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

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

Which care?
You are entitled to the reimbursement of costs of 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 outpatients' treatment. You will only be admitted (to an institution) for rehabilitation if better results can be expected quickly when compared to part-time or outpatients' treatment rehabilitation.

Which care provider?
You will be treated by a interdisciplinary team of experts led by 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 medical specialistic rehabilitation when you have a prior written referral from your GP, medical specialist, mental health doctor, geriatric specialist (nursing home doctor) or company doctor when the complaints are linked to your work. A referral is valid for a maximum of 1 year

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 medical specialist 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.

Interdisciplinary care in case of complex, chronic lung diseases

Interdisciplinary care in case of complex, chronic lung diseases is a form of interdisciplinary medical specialist care under the responsibility of a lung specialist. Care in connection with complex, chronic lung diseases is aimed at the functioning of the entire body of people with a complex, chronic lung disease.

Which care?
You are entitled to the reimbursement of costs of interdisciplinary care in case of complex lung diseases if

your health condition is so serious as a result of your serious chronic lung disease that an interdisciplinary approach is required. A treatment plan is formulated for the functioning of the entire body. The treatment plan focuses on the improvement of the physical performance, reduction of complaints and the limitations and the improvement of the quality of life.

Note
You are entitled to the reimbursement of costs of Interdisciplinary care in case of complex, chronic lung diseases as part-time treatment or as day treatment. You are only admitted for Interdisciplinary care in case of complex, chronic lung diseases if it is expected that this will yield better results more quickly than as part-time treatment or as day treatment.

Which care provider?
You are treated by an interdisciplinary team of experts under leadership of a lung specialist. This team must be affiliated with a rehabilitation institution or a hospital.

Referral
You are only entitled to the reimbursement of costs of interdisciplinary care in case of complex chronic lung diseases if you received a written referral from the lung specialist in advance. A referral is valid for at most one year.

Permission
Will you be visiting a care provider who does not have a contract with Menzis for interdisciplinary care in case of complex chronic lung diseases? You are only entitled to the reimbursement of costs of this care if this has been approved by Menzis in advance. Please enclose a well- founded explanation and a treatment plan from the care provider with your request.

Geriatric rehabilitation

Geriatric rehabilitation focuses on vulnerable elderly people who have received medical specialist treatment in a hospital, for example, because of a stroke or a bone fracture. These people require rehabilitation treatment that combines multiple types of care such as nursing, physiotherapy, occupational therapy, speech therapy, psychotherapy, dietary advice and care provided by a social and geriatric healthcare provider specialist. The above is all offered under the responsibility of a geriatric healthcare provider specialist. The care is adjusted to the individual recovery options and the training pace of elderly people and takes into account other existing conditions and disorders. The aim is to assist these elderly patients to return to their homes.

Which care?
You are entitled to 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 the 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 fits in within a week with hospitalisation in relation to medical specialist care. It applies within this context that you are only entitled to geriatric rehabilitation if you had been admitted to a nursing home before being admitted. Being admitted to a nursing home means staying in an institution as referred to in Section 3.1.1 of the Dutch Long-term Care Act (Wet Langdurige Zorg; Wlz), or

- the geriatric rehabilitation is required because of an acute disorder for which you received medical specialist assistance before and, because of this disorder, the following is involved:
  - acute mobility disorders, or
  - a reduction in your possibilities to look after yourself.
- Geriatric rehabilitation may not take longer than 6 months.

Which care provider?
You can go to an institution that provides geriatric rehabilitation care in accordance with the Geriatric Rehabilitation Treatment Frameworks for geriatric rehabilitation. The Geriatric Rehabilitation Treatment Frameworks have been drawn up by the Dutch Association of Elderly Care Physicians and Social Geriatricians, Verenso.

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.

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

Permission
Will you be visiting a care provider who does not have a contract with 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 will be entitled to a the reimbursement of costs of second opinion when:

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

Which care provider?

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

Referral

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

Quitting smoking

A programme to quit smoking consists of a combination of interventions to change behaviour (in a group or

individually) sometimes with the support of medication. The behaviour-based support forms the basis with regard to this integral programme. This means that a form of recognised behaviour- based support is always deployed that may be supplemented with medication that has been proven to be effective but that medication can never be deployed without behaviour-based support.

Which care?

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

ⓘ Note

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

Dentistry

Special dentistry

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

Which care?

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

Note

- You are only entitled to the reimbursement of costs of special dentistry work if this is necessary to retain or acquire a dental function that is similar to the dental function that you would have had without the complaint.
- You are only entitled to 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 of orthodontic healthcare if it is provided by an orthodontist.

Personal contribution

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

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

Permission

You require prior permission from 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. What you are exactly entitled to, will depend on whether you are older or younger than 18.

Which care?

Up and including 17 years of age

You are entitled to the reimbursement of costs of :

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

Up and including 22 years of age

You are entitled to the reimbursement of 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 the reimbursement of 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 the reimbursement of costs of :

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

Personal contribution

Are you 18 years old or older? You pay a personal contribution of 25% of the total costs of full dentures. You pay a personal contribution of 10% of the total costs of full dentures on implants and related mesostructure for the bottom jaw and 8% of the total costs of full dentures on implants and related mesostructure for the top

jaw. The excess for repairs and filling (rebasing) of a detachable full prosthetic facility is 10% of the costs of this repair or filling. You can also find more information in the Insurance Rules and Regulations. Consult the scheme on menzis.nl or request this information from Customer Service.

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

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

Permission
You will require prior permission from 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,
- for an X-ray of all your teeth at once (Orthopantomogram), when you are not yet 18 years old,
- if a dentist or a dental prosthesis specialist makes full and removable dentures for the top and bottom jaw and the total costs (including the technology costs) are more than € 750 per jaw,
- for positioning dentures on implants and the related mesostructures made by a care provider not contracted for this,
- for the repair and rebasing of a dental prosthesis on implants by a care provider not contracted for this purpose,
- if the full and removable dentures for the top and/or bottom jaw that you now have are replaced within 6 years after delivery. This does not apply to immediate dentures,
- if you must be treated where you are staying (for example, at home or at an institution).

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

Transplantation

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

Which care?

You are entitled to 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 based on this Basic Insurance,
- transport of the donor within the Netherlands with regard to the selection, admission and discharge from the hospital in connection with the care as described in the preceding item of this list,
- the costs of the lowest class of public transport within the Netherlands or, if this is required medically, transport by car within the Netherlands is reimbursed,
- transport to and from the Netherlands of a liver, kidney or bone marrow donor who lives outside the Netherlands.

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

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

Which care provider?

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

Referral

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

Thrombosis service

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

Which care?

You are entitled to the reimbursement of costs of :

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

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

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

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

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.

The reimbursement for hospitalisation other than the hospital after CAR-T cell therapy is a maximum of € 77.50 per day.

Permission
You are only entitled to the reimbursement of costs of rehabilitation if you have prior permission 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),
- structural echoscopic examination in the second trimester (the 20-week echo).
- a non-invasive prenatal test (NIPT). You are only entitled to this test if you have a medical indication,
- Invasive diagnostics (chorionic villus sampling and amniotic fluid testing). You are only entitled to this diagnostics if you have a medical indication.

Which care provider?

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

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

Obstetric care personal contribution

A statutory personal contribution of € 5.10 per hour applies to maternity care at home. If you deliver your baby in a hospital or a birth centre without a medical indication, you must pay a statutory personal contribution of € 40 per admittance day (€ 20 for the mother and € 20 for the baby). If the hospital charges an amount that is higher than € 286 per day (€ 143 for the mother and € 143 for the baby) you must, in addition to the € 40, also pay the amount that is higher than € 286 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 the reimbursement of costs of :

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

Nursing and care focuses on physical healthcare, 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.

You are also entitled to the reimbursement of costs of specialized pediatric daycare and care at a pediatric care facility if you are less than 18 years old and need care because of complex somatic issues or a physical disability where continuous supervision is required, or there must be care 24 hours a day in the vicinity and this care is linked to one or more specific nursing action.

Note

Supervision is not an insured care. An exception to this is when your treating doctor has determined that the palliative terminal phase has arrived. If it is medically necessary for nursing supervision to be present, this supervision may be eligible for reimbursement. Even in the palliative terminal phase, attendance resulting from the lack of a family care network is not insured 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 with a care plan that describes the care that you need with regard to its nature, scope and duration including the set goals. This indication and care plan must be drawn up by a HBO-community nurse or nurse specialist and must be signed by you and the care provider. When determining the indication, the Child Care Indication Process Guideline (HIK) must also be observed in addition to the standards for indicating and organising nursing and care in the own environment.

ⓘ Note

You are not entitled to the reimbursement of costs of nursing and care if these forms of care can be financed for you on the basis of the Long-Term Care Act (Wlz) or the Social Support Act (Wmo). If there are indications that your care can be financed on the basis of one of these acts, Menzis may ask you to invoke these acts by requesting a decision on the care required from the Care Needs Assessment Centre (CIZ) or the municipality of your place of residence. You are no longer entitled to nursing and care if you do not cooperate in this or if the CIZ or your municipality actually decides that you have the right to rely on the Wlz or the Wmo.

Person-linked budget (PGB)

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

Menzis Customer Service.

Which care provider?

You can go to a (homecare) institution for nursing and care with a higher professional education (HBO) (paediatric) nurse or a nursing specialist who is permanently employed. The HBO (paediatric) nurse or nursing specialist determines the care required and remains involved in the performance and evaluation of the care plan. The care is provided by a HBO/senior secondary vocational education (MBO) nurse, nursing specialist or care worker level 3 or higher.

You can also go to an independently working HBO (pediatric) nurse or nursing specialist for determinating the indication and care (zzp'er). The care can also be provided by an MBO nurse or a carer with education level 3 or higher who is in possession of the KIWA quality mark for self-employed persons in care or the HKZ-NEN quality mark for self-employed persons (zzp'er) in 'Zorg & Welzijn'. This is only allowed if this healthcare provider works together with the HBO (pediatric) nurse or the nurse specialist who has determined the indication. The care provider who has determined the indication remains involved in the implementation and evaluation of the care plan

Permission

The costs incurred are not fully reimbursed if you opt for treatment by a care provider that has not concluded a contract with Menzis. You also require Menzis' prior approval. You can ask our Care Advisor by contacting Customer Service in order to request this approval.

A permission is valid for a maximum of 365 days, unless expressly stated otherwise. A permission is no longer valid if applicable laws or regulations change.

Advice

Do you have any questions about nursing and care? Please contact our Care Advisor 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,
- hearing impairment (you are deaf or hearing impaired), or
- communication impairment (serious difficulties with speech/language) as a result of a language development disorder and you are younger than 23.

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

Which care provider?

You can visit an institution which mainly focuses on providing out- patient treatment for the sensory impaired.

Referral and indication

You are only entitled to the reimbursement of 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 the reimbursement of 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 € 0,38 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 if it involves the transport from and to persons, institutions and the private addresses as referred to in the Article about ambulance transport, and:

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

Overnight stay

If you are entitled to reimbursement of travel expenses and you require such transport on three or more consecutive days, you may opt for reimbursement of the costs of overnight stay. The reimbursement of the costs of overnight stay is at most € 89 per night and partially replaces the reimbursement of the travel expenses.

Note

- The transport or reimbursement of costs entitlement is limited to a distance of no more than 200 kilometres for a single journey.
- If Menzis gives you permission to go to a specific person or institution, the 200 km restriction does not apply.
- If you are entitled to transport or reimbursement of costs, you may also obtain reimbursement of the costs of transport incurred by a possible assistant if you require assistance. Children below the age of 16 are always entitled to reimbursement of the travel expenses of assistants. Menzis may reimburse the costs of 2 assistants in special cases.

- If you use your own transport, the reimbursement will be calculated based on the fastest possible normal route in accordance with the ANWB route planner.
- The transport related to care during a 4-hour period in a Wlz (Long-term Care Act) institution will

not be paid/reimbursed.

Personal contribution

You pay a personal contribution of € 118 per calendar year. The personal contribution does not apply to the reimbursement of overnight stay.

You do not pay a personal contribution for transport:

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

Which care provider?

The transport will be provided by a transport company or a private person (for example, a member of your family or an acquaintance). If you decide to use a transport company that has not concluded a contract with Menzis, you will receive a maximum of € 0,90 per kilometre. You will receive € 0,38 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.
- If you have questions about health care, please contact our Customer Service.

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 Mijn 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.

Alternative care

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

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 350	€ 550	€ 750

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.

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
€ 50	€ 100	€ 100	€ 150

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

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
Yes	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.

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 (night time) 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	€ 75	€ 175	€ 275

Example

For instance, you are entitled to € 75 per 2 calendar years and you purchase spectacles for € 150 in 2024. The maximum amount of € 75 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 2025. You will again be reimbursed as from 2026.

Note

The bill for the spectacles or contact lenses must specify the prescription of the spectacle lenses or contact lenses.

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. You will receive a reimbursement up to a maximum amount. The reimbursements for consultations, inoculations, medicines and (repeat) prescriptions are added together up to the specified maximum amount is reached. This maximum amount applies per calendar year:

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 must take 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 out who the doctors are by visiting 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 there are pain complaints as is the case with regard to the inflammation of a nerve or gums that means that the dentistry work cannot be deferred until you return to the Netherlands and it had not been foreseen that this dentistry work would be required.

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

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

You will only be reimbursed the costs if:

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

Emergency care and medication abroad

Care is an emergency when a situation is involved in which medical assistance and/or medicines 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 and/or medicines 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:

- in case of urgent care (this is assessed by the Menzis medical advisor and/or the Emergency Centre medical advisor),
- 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 more information 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.

Non-urgent specialized medical (hospital) care in Belgium and Germany

You are entitled to reimbursement from the Basic Insurance for non-urgent specialized medical (hospital) care in Belgium and Germany. Because Menzis does not have contracts with foreign hospitals, you will receive a reimbursement of 75% of the hospital bill with a maximum of 75% of the average contracted amount. Your additional insurance offers coverage for the remaining 25%.

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

You will only be reimbursed if:

- the specialized medical care is covered by the Basic Insurance, and
- you receive the care in Belgium or Germany.

A list of reimbursements from the Basic Insurance for different kinds of specialized medical care can be found on menzis.nl/klantenservice (only available in Dutch).

Are you admitted to a hospital? Then the reimbursement is limited to the supplement of the coverage from the Basic Insurance up tot the amount for which Menzis has contracted the specific care in the Netherlands on average, for a maximum of 365 nursing days per case.

According to Menzis a case is: every uninterrupte need for medical treatment, which stems from the same illness or accident.

Note

The same conditions and exclusions with regard to the Basic Insurance which apply to specialized medical (hospital) care in the Netherlands, also apply to this type of care abroad. If, for instance, you need a referral in the Netherlands? Then you will also need one abroad. Please see the appropriate paragraph in the chapter on the Basic Insurance for more information.

You can send the bill of the foreign care provider to Menzis. If you have any questions regarding care abroad, please contact our Care Advise department at 088 222 40 40.

Example

You work in the Netherlands, but live in Belgium. You are admitted in a Belgian hospital with a groin rupture. After receiving treatment, you receive a bill of € 400 for this. You can send this bill to Menzis. In the list of reimbursements from the Basic Insurance on menzis.nl, you can see that you will receive a reimbursement of € 267.43 from the Basic Insurance for the treatment. This is 75% of the average amount for which Menzis has contracted this care in the Netherlands. From your additional insurance you will receive an additional reimbursement up to 100% of this amount (€ 89.14). Therefore you will receive a total reimbursement of (€ 267.43 + € 89.14 =) € 365.57.

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. An occupational therapist can also provide advice about the use of resources.

Occupational therapy is partly insured in the Basic Insurance. If it is an addition to the reimbursement from the Basic Insurance, you will be reimbursed for occupational therapy for a maximum number of hours per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
0	0	3	5

You are entitled to be reimbursed when the occupational therapist has a contract with Menzis. Visit menzis.nl/zorgvinder to find out who these therapists are.

Note

If you decide to visit an occupational therapist who does not have a contract with Menzis, you will be reimbursed the incurred costs up to a maximum amount for each treatment if the occupational therapist is registered as a Quality Registered practitioner in the Kwaliteitsregister Paramedici (Paramedic Quality Register). 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.

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.

Physiotherapy and exercise therapy

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	32

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 there is no immediate physical cause can be found (psychosomatic physiotherapist and exercise therapist),
  - in which (lymph)oedema clays a crucial role (oedema therapist).

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

- You can only visit a general physiotherapist, child physiotherapist, manual therapist, oedema therapist, geriatric physiotherapist or a pelvic therapist who is registered in the Centraal Kwaliteitsregister Fysiotherapie (CKR; Central Quality Register) or in the Keurmerk Fysiotherapie (Physiotherapy Quality Mark) register. You can also visit a skin therapist who is registered as “Quality Registered” in the Paramedic Quality Register for oedema therapy and scar therapy.
- Will you be visiting a therapist who does not have a contract with 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. In the event treatment takes place following intake and examination on the same day, such will count as 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 contact our Customer Service if you have any doubts.

FysioZelfCheck (app)

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

You get full access to FysioZelfCheck:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
yes	yes	yes	yes

Physiotherapy and exercisetherapy after an accident

You will receive compensation for care you need after an accident. An accident is a sudden, unexpected, external force on the body, directly resulting in medically detectable physical injury. Events in which it can be foreseen in advance that physical injury to the body may occur are not covered by this definition.

You will be reimbursed for physiotherapy or remedial therapy treatments following an accident. The maximum amount per accident is:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
16	16	16	16

You will be reimbursed for physiotherapy and/or remedial therapy following an accident, provided that:

- the accident took place in the Netherlands, and
- at the time of the accident and the treatment, you have an issurance which covers the costs following an accident.
- the care takes place as a direct result of an accident
- the treatment is not covered by the Basic Insurance

Please note: any costs of the excess and personal contributions (Basic health Insurance) will not be reimbursed unless stated otherwise.

Exclusions

You are not entitled to compensation if the complaint has arisen:

- by intent and/or deliberate recklessness,
- while you were under the influence of alcohol or drugs,
- participation by the insured in a brawl, other than in self-defence
- by pre-existing complaints (before the accident),
- as a result of overexertion of the body, e.g. due to a tennis elbow, mouse wrist, incorrect sitting posture or complaints due to failure to maintain or care for body parts
- when lifting or carrying persons or objects and the possible consequences thereof.
- are caused during sports and not by external violence, such as regular sports injuries such as muscle injuries, hamstring injuries, whiplash injuries, etc;
- if you have not taken the usual protective measures during sports
- by engaging in one of the following dangerous sports and activities: Skydiving, Kiting, Rafting, Abseiling, Delta and ultralight flying, Paragliding, Gliding, Hang-gliding, White water rafting, Deep sea diving, Caving, Ice hockey.
- by practising sport as a (secondary) profession,
- during your work or a company outing.

The following are examples of situations in which you are not entitled to reimbursement:

- After a day of digging in your father-in-law's garden, your lower back is troubling you.
- Join the tennis competition while you have had elbow problems for some time.
- You lift a shopping crate from the ground and you feel a shooting pain in the back.
- Tearing your ligament during a football match after a cutting manoeuvre.

For example, in one of the following situations you are entitled to reimbursement

- You tripped or fell off something; for example, a fall from the kitchen stairs when changing a lamp, causing your ankle to twist.
- Your opponent's hockey stick hits your wrist during a match.
- You are launched by your dog and fall on your hip.
- You are hit by a vehicle.

You will be entitled to this reimbursement if your therapist has a contract with Menzis. The relevant therapists can be found at The Menzis Zorgvinder.

Consent

You will need permission from Menzis before you can claim compensation. In doing so, you must fill in a statement with information about the accident. You can apply for permission at menzis.nl.

Physiotherapy and exercisetherapy for specific disorders and complaints

You are entitled to physiotherapy or exercisetherapy under the Basic health Insurance for a number of disorders or complaints, for example in the event of recovery from a broken leg or as part of the treatment of a muscle disease. It concerns diseases and complaints included on a list drawn up by the Minister of Health, Welfare and Sport. This is the list included in Appendix 1 to Article 2.6 of the Healthcare Insurance Decree.

This list can be found at menzis.nl

Under the Basic health Insurance, you are entitled to physiotherapy as from the 21st treatment, per disorder or complaint. The first 20 treatments for each initial diagnosis will not be reimbursed under the Basic health Insurance.

If you meet the conditions of the Basic health Insurance, the first 20 treatments will be reimbursed under the supplementary insurance.

This maximum number of treatments per 12 months is: 20 treatments after the first diagnosis, per disorder or complaint. This maximum number applies to combined physiotherapy and/or remedial therapy treatments.

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
yes	yes	yes	yes

You are entitled to this reimbursement if:

- your therapist has a contract with Menzis. The relevant therapists can be found at menzis.nl/zorgvinder and;
- it concerns conditions and complaints included on a list drawn up by the Minister of Health, Welfare and Sport. This is the list included in Appendix 1 to Article 2.6 of the Healthcare Insurance Decree. This list can be found at anderzorg.nl and;
- at the time of the diagnosis and treatment, you have a supplementary insurance with Menzis which covers physiotherapy in the event of specific disorders and complaints, and
- you are 18 years of age or older.

Excluded are disorders that are reimbursed as from the first treatment under the Basic health Insurance; osteoarthritis of the hip and knee joints, intermittent claudication, COPD and pelvic physiotherapy in the event of urinary incontinence.

Referral

You need proof of diagnosis. Proof of the diagnosis can be provided digitally or on paper clearly mentioning the names of the patient and the diagnostician. The diagnosis is specific enough to determine whether it concerns a disorder listed in Appendix 1 Article 2.6 of the Healthcare Insurance Decree.

Hearing aids

If you purchase hearing aids for the first time, or to replace the ones you are already using, you may be entitled to reimbursement from the Basis Insurance. You then have to pay a personal contribution of 25% of the purchase price.

The Additional insurance covers part of this personal contribution. You will be reimbursed for a maximum amount per hearing aid per year. The maximum amount is:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 150	€ 200

You are entitled to this reimbursement if you purchase your hearing aids from a supplier contracted by Menzis. You can find out who they are by visiting menzis.nl/zorgvinder.

Hospitium or 'Bijna-Thuis-Huis'

In a hospitium or 'Bijna-Thuis huis' care is provided to people who are terminally ill. They stay in the facility until they die. A hospitium or 'Bijna-Thuis huis' charges a personal contribution per treatment day for (amongst others) breakfast, lunch, dinner and clean bedding.

You will be reimbursed up to € 35 per day up to an overall maximum amount. The overall maximum amount is:

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

You are entitled to this reimbursement if the hospitium or 'Bijna-Thuis huis' is approved by Menzis. You can find out which institutions are approved by visiting menzis.nl/zorgvinder.

Skin care

Skin care includes acne treatments, camouflage therapy and epilation for serious skin defects on the face or neck.

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.

Camouflage therapy

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 acne treatment and camouflage therapy up to a maximum amount. The reimbursements for acne treatment and camouflage therapy 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	€ 500

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

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	€ 1.250

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

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.

Child care when hospitalized

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

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

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

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

Voluntary care

Voluntary care is deemed to mean that you take 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
€ 100	€ 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.

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
€ 350	€ 350	€ 350	€ 350

You are entitled to be reimbursed if Menzishas approved the voluntary care broker. You can find out who they are by visiting menzis.nl/zorgvinder.

Respite care service

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
a maximum amount of € 2.325 per calendar year	a maximum amount of € 2.325 per calendar year	a maximum amount of € 2.325 per calendar year	a maximum amount of € 2.325 per calendar year

You are entitled to reimbursement for substitute informal care when the care provider 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.

Prevention

With regard to prevention you are entitled to reimbursement for flu jabs, advice, training and courses which help you become more healthy, stay healthy or make you feel better.

Flu jab

The flu jab against the "normal" seasonal flu is funded by the National Programme for Flu Prevention, 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.

Menopause consult

A menopause consultant is an experienced nurse who has specialized in the menopause. During a consult you will receive information and advice on this subject and the menopause consultant will put together a treatment plan, with the help of the client, that fits into the client's personal situation.

First aid course and resuscitation/AED course

If you take a first aid or resuscitation/AED course, you will learn to administer the correct first aid when necessary. In this course you will learn what to do, but also what not to do.

General health course

A general health course focusses on improving lifestyle choices (such as 'nutrition and living healthy'), learning how to cope with a chronic illness (for instance 'diabetes') or looking after others (such as how to cope with a family member with dementia).

Lifestyle coaching

Lifestyle coaching focusses on improving lifestyle choices such as nutrition, exercise, sleep, quitting smoking, relaxation and sleep. A lifestylecoach focuses on what you need to make healthy choices in everyday life; choices that suit you and are sustainable.

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, for which you do not need a referral from your GP.

Fall prevention course

A fall prevention course is aimed at people who have difficulty moving or who are afraid to fall down. During this course, you will learn to prevent a fall. You will also be trained in keeping your balance and learned how to fall down safely when falling down is unavoidable.

Nutritional consultant

During a nutritional consult you will receive information about nutrition and eating healthily , without there being a direct medical reason for this.

Pregnancy course

In a pregnancy course, expectant mothers are prepared for child birth.

You will be reimbursed for all prevention items together up to a maximum amount. The cost of all flu jabs, advice, training and courses will be added up until the maximum amount is reached. This maximum amount is per calendar year:

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 100	€ 200	€ 300	€ 400

Regarding training and courses, you are only entitled to reimbursement of the training/course if you have completed the full training/course. You are only reimbursed for items regarding prevention, if the organisations giving the flu jab, advice, training or course are approved by Menzis. You can find out which organizations are approved 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

Soft brace or splint

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

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

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

Sports medical advice

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

Sports Medical Advice is deemed to mean the following:

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

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

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.

Verwijzing

U heeft een verwijzing nodig van de huisarts.

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.

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.

Foot care

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

Orthopaedic arch supports

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

Chiropody

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

Podiatry

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

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

Collectief Aanvullend 1	Collectief Aanvullend 2	Collectief Aanvullend 3	Collectief Aanvullend 4
€ 0	€ 100	€ 150	€ 200

You are entitled to be reimbursed when the supplier or care provider has been approved by Menzis. You can find out who they are by visiting 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

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

You can find what is insured in the "Your Basic Insurance" section in the Dentistry Article. What is insured in your additional dental insurance, can be read further along. 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 mostly insured in the Basic Healthcare Insurance for younger people up to the age of 17 except orthodontics, crowns and bridges.

Which care provider?

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

Code system

Care providers claim using codes. These codes represent specific services. For example: C002 – 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, 750 en 1000 reimbursements

Collectief Tand 250, 500, 750 and 1000 reimbursements

All treatments will be reimbursed up to the specified maximum amount with Collectief Tand 250, 500, 750 and 1000. If you are covered through Collectief Tand 750 of 1000, a separate reimbursement applies to orthodontics. More information can be found in the Orthodontics article. The following will be reimbursed:

Treatment	Reimbursement
Regular check-up (C001, C002 and C003)	100%
Consultations (other C codes)	75%

Treatment	Reimbursement
Anaesthesia (A and B codes)	75%
Root canal treatments (E codes)	75%
Jaw treatments (G codes)	75%
Surgical treatments (H codes)	75%
Implants (J codes)	75%
Preventive dental care (M codes)	75%
Prosthetic provisions (P codes)	75%
Crowns, bridges and inlays (R codes)	75%
Gum treatments (T codes)	75%
Fillings (V codes)	75%
X-rays (X codes)	75%

This maximum amount is per calendar year:

Collectief Tand 250	Collectief Tand 500	Collectief Tand 750	Collectief Tand 1000
€ 250	€ 500	€ 750	€ 1,000

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

Waiting times for crowns, bridges and implants in Collectief Tand 750 and 1000

A waiting time of 1 year applies to crowns, bridges and implants in Collectief Tand 750 and 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 when you switch to Collectief Tand 750 and 1000 and starts on the effective date of Collectief Tand 750 and 1000. For more information about waiting times visit menzis.nl/wachttijd.

Orthodontics (braces) Collectief Tand 750 and 1000

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 Tand 250	Collectief Tand 500	Collectief Tand 750	Collectief Tand 1000
€ 0	€ 0	€ 2,250 (up to 18 years of age) € 500 (from 18 years of age)	100% (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 Tand 750 or Collectief Tand 1000.

Dental expenses after an accident

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

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

Collectief Tand 250	Collectief Tand 500	Collectief Tand 750	Collectief Tand 1000
Yes	Yes	Yes	Yes

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

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

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

Dental expenses after an accident do not fall under the maximum amount of Collectief Tand 250, 500, 750 en 1000.

Exclusions

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

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

Permission

You need a statement of approval from Menzis before you start treatment. Your dentist or orthodontist can apply for this from us by drawing up a treatment plan and sending it to Menzis. If required, Menzis may request photos to make an assessment.

You must also complete a statement with information about the accident. You can find the statement on menzis.nl/tandongeval. The following applies in this connection:

- you have to request approval within 3 months after the accident,
- treatment must be completed within 1 year,
- unless it is necessary to postpone the (definitive) treatment.

Assessment

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

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

How to claim for your bill

If your dental care provider gives you a bill for dental care, you can claim online by visiting menzis.nl/mijnmenzis. Visit 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)

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.

A1 General

- The government determines the insured package for the Basic Insurance. The Dutch Healthcare Insurance Act and the related regulations prescribe what you need to be insured for. Every healthcare insurer must strictly adhere to the law. We have specified as clearly as possible for what you are insured in these insurance terms and conditions. In the unlikely event that something in these insurance terms and conditions should not concur with the legal rules and regulations, what has been defined in the legal rules and regulations will apply to you.
- The insurance contract consists of: your healthcare policy, these general terms and conditions insofar as the insurance described therein applies to you, and the Insurance Regulations.
- If below the word ‘insurance’ has been used, we are referring to the Basic Insurance, the additional insurance and/or the dental insurance.
- The policyholder is the person who has taken out the insurance with 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 is a Basic Insurance that is meant for everybody who lives in or outside the Netherlands and who must take out a Basic Insurance.

A3 Insurance period

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

Note

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

A4 What is the commencement date of the insurance?

- If your Basic Insurance with Menzis was taken out within 4 months after you were obliged to insure yourself, this Basic Insurance cover will have a retroactive effect up to the day on which you were obliged to take out insurance.
- If your Basic Insurance with Menzis was taken out within a month after you terminated another Basic healthcare insurance, this Basic Insurance will have a retroactive effect up to the day on which your previous healthcare insurance terminated.
- Your additional insurance and/or dental insurance commence at the same moment as your Basic Insurance.

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 Mijn Menzis (MyMenzis). You can also call Customer Service on 088 222 40 40, send an email or complete a change form.

A6 Cancelling the insurance

Only the policyholder can cancel an insurance policy. You can cancel your insurance through a letter, at Mijn Menzis or by chat on our website.

- 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. 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,
- cancel the insurance of an insured during the interim period if the insured has taken out a Basic Insurance somewhere else. The cancellation will become effective on the day on which the insured is covered by virtue of another Basic Insurance. The cancellation must have been received prior to this day by Menzis. If the cancellation is received later, the cancelation will start on the first day of the 2nd calendar month after the day on which cancellation took place,
- cancel in the interim period if you have a group insurance with your employer and you wish to participate in the group insurance of a new employer. 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 after 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. You cannot cancel the insurance if Menzis is required to change the terms and conditions by law.
- not cancel the Basic Insurance if you have not paid the premium and have been sent a reminder for this unless Menzis has suspended cover of this insurance or has confirmed the cancellation within 2 weeks, cancel the Basic insurance within the first 12 months after the CAK has registered you for an insurance with Menzis. If you can prove that you were already insured with another healthcare insurer during the period mentioned in article 9d, section 1 of the Health Insurance Act, you can declare the Basic Insurance with Menzis null and void. You have to do this within 2 weeks after the CAK has notified you that they have registerd you with Menzis.

ⓘ Note

- 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. If the CAK has taken out an insurance policy with Menzis on your behalf, Menzis can declare this policy null and void if it later emerges that the person who the CAK insured did not have an obligation to insure himself or herself at that moment in time.

A9 When will the Basic Insurance end automatically?

Your Basic Insurance will terminate automatically on the day after:

- your obligation to insure terminates,
- you die,
- 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, MMenzis will inform you about this no later than 2 months before your Basic Insurance terminates.

A10 Cooling off period

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

A11 Obligation to inform Menzis

- You are obliged to inform Menzis in writing and within 30 days about:
  - a change of address,
  - a demise,
  - a change of bank account number,
  - an entrance into active military service,
  - the start and end of a prison sentence,
  - you not longer being eligible to participate in group insurance,
  - you not longer being obliged to have a Basic Health insurance.
- You are also obliged to let us know who is your new healthcare insurer if you have cancelled your insurance with 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.
- You are obliged to provide Menzis with the information they request from you, as far as you are able to provide this information. For example, about the reason for hospitalisation, for fraud being investigated or for checking. Should you not cooperate, your entitlement to receive care or to be reimbursed for costs may no longer apply.
- You are obliged to inform Menzis if a third party can be held liable for health care costs reimbursed by Menzis, for example, after a traffic accident or industrial accident. You can then contact Customer Service at 088 222 40 40 or the Redress department at 050 523 43 77. You can also provide this information online on menzis.nl/klantenservice/schade-melden. Your entitlement to care or reimbursement of costs may lapse if you do not cooperate. Menzis recovers the care costs that were reimbursed and will be able to advise you on how you may recover your own damage from the liable party. Such as the excess you have paid. You are not allowed to come to an arrangement yourself with the liable third party or his or her insurer should this not be to the advantage of Menzis.

A12 Premium, payment method and payment of the excess

A12.1 Premium

- The basis of the premium calculation for the Basic Insurance amounts to € 161,75 per calendar month as from 1 January 2024. The premium to be paid is the basis of the premium calculation from which any premium discount that may apply has been deducted. You can receive a premium discount on your additional (dental) insurance due to participating in group insurance, if you pay your premium annually in advance (i.e. as a lump sum) and by choosing a voluntary excess. The premium you have to pay is specified on your healthcare policy.
- Up til the age of 18, you do not have to pay a premium for the Basic Insurance. You do need to pay a premium for the Basic Insurance from the first day of the calendar month that follows the calendar month in which you reach the age of 18.
- 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 from Menzis.
- 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. € 2 will be charged for this.
- If you have agreed on a payment arrangement with Menzis, Menzis may charge costs.

A12.2 Payment method

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

A12.3 Payment of the excess and personal contribution

- Menzis will charge you for the excess and personal contribution for yourself and all others whom you have insured.
- If you do not pay the excess and personal contribution through direct debit or a giro collection form email, you will receive a giro collection form from Menzis. € 2 will be charged for this.
- Do you pay your excess and personal contribution by direct debit? If so, we will debit amounts up to € 450 automatically. You receive a (digital) invoice for invoices exceeding €450.

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 from the day you received this demand for payment, your cover will not be affected.
2. Should you not pay within 14 days from the day you received this demand for payment, 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 in respect of the entire overdue amount.

3. If you have failed to pay the premium even after the demand for payment, Menzis will have the right to end the insurance of all insured persons.
4. 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.
5. If Menzis has received overdue amount, 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.

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 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. If Menzis changes the basis of the premium of the Basic Insurance, this change will not come into effect until 7 weeks have elapsed after the day on which you were informed about the change.

A15 Group insurance

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. 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. Or Menzis can terminate your additional (dental) insurance and transfer you to
an additional (dental) insurance that is most similar to your 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. Or Menzis can terminate your additional (dental) insurance and transfer you to
an additional (dental) insurance that is most similar to your group insurance.

A16 Submitting a bill

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

- you can do this on Mijn Menzis, or by using our claims-app,
- 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.

You can submit a bill by standard mail:

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

Note

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

A bill must meet the following requirements:

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

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

- 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 you submit a bill 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 not be reimbursed directly.
- Reimbursement of the care provided by a non-contracted provider is only paid into a bank ac count registered in the name of the insured person or, in the absence thereof, a bank
- ac count registered in the name of the policyholder. The policyholder or the insured person cannot designate a different bank ac count into which payment should be made.
- The transferability of the rights of claim that arise on the part of the insured person and/ or policyholder from an insurance contract concluded with Menzis is excluded. This is a stipulation as referred to in Article 3:84 paragraph 2 of the Dutch Civil Code.

A17 Complaints and disputes

If you are unsatisfied about the services 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.

- You can send this form to the Klachten (Complaints) 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 Klachten department can provide assistance.

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

A19 Acts of war

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

A20 Terrorism

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

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

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 cancelled

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 mislead Menzis, you are no longer entitled to reimbursement. Menzis will then also have the right to terminate all your insurances. The amounts that Menzis may already have paid either to yourself or directly to the care provideras a direct result of the deception, must be paid back. You must also pay Menzis for the incurred investigation costs. Menzis can report you and will registers your data. This will be done in the registers in accordance with the Incident warning system for financial institutions. (Incidentenwaarschuwingssysteem Financiële Instellingen) of the Dutch Association of Insurers.

A25 Protection of 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. You can find more information on what Menzis uses your personal data for can be found in the privacy statement at menzis.nl.
- We comply with legislation and regulations when using personal data. Such as 'Algemene verordening Gegevensbescherming' (AVG), the 'Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars' and the 'Protocol Incidentenwaarschuwingssysteem Financiële Instellingen'.
- 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 is funded through a Diagnosis Treatment Combination (DBC), the opening date of the

DBC-care product is the determining factor for reimbursement. For a DBC-care product which was opened in 2024 and closed in 2025 you will therefore be reimbursed according to 2024 terms and conditions.
- You grant Menzis the authorisation to reclaim amounts that have been paid but to which you were not entitled.
- 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.
- Applications, invoices or other correspondence with Menzis must be drawn in Dutch or English. For example, if you enter a bill in German, Menzis may ask you to send a translation of the bill. A sworn translator must translate the note. You pay for the translation yourself.
- Dutch law applies to the insurance.

General terms and conditions (2)

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

A27 Cancellation

If you are the policy holder and you cancel the Basic Insurance, you can have your 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, or
- if you no longer meet the conditions for participation in the group insurance or if the agreement between your employer or representative and Menzis has been terminated. In these situations, Menzis can transfer you to an additional (dental) insurance that most closely resembles your group insurance.

- we are unable to establish that you are subject to compulsory insurance pursuant to the Healthcare Insurance Act (reasonable doubt).

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.

- For the additional insurance of someone who is not yet 18 years old, no premium has to be paid. For a dentist insurance of someone who is not yet 10 years old, no premium has to be paid. This only applies if there is another person on the same policy who does pay premium for this insurance (or a more extensive one). People who have a JongerenVerzorgd insurance have to pay premium, regardless of their age.

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.