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# Aon's Global Health Supplement 2015 Terms and conditions

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## Important notice emergency assistance organizations

In the case of hospital admission worldwide, excluding the United States of America, you must first contact:

Aon Alarm Centre
Tel: +31 (0)10 448 8255

In the event you need to visit a healthcare provider in the United States of America, you must first contact:

GMMI (24 hours/7 days)
Tel: 1 800 682 6065 (free within the U.S.)
Fax: +954 370 8130
www.gmmusa.com

Billing address:
GMMI
1300 Concordterrace, Suite 300
Sunrise, Florida 33323 USA

Please have the following information on hand when you call:

- Patient's name
- Employer's name
- Patient's policy number
- Patient's contact information
- Hospital contact information

Failing to contact the aforementioned emergency assistance organization can result in whole or partial refusal to cover the costs.

# Chapter 1 General terms and conditions of supplementary insurances

## Article 1 Description of terms

In these terms and conditions, the following terms are defined as follows:

**1.1 Supplementary insurance**
Aon's Global Health Supplement.

**1.2 Ambulance**
A vehicle intended to transport sick persons and accident victims

**1.3 Pharmacist**
A pharmacist is understood to include (internet) pharmacies, chain pharmacies, hospital pharmacies, outpatient pharmacies and dispensing physicians.

**1.4 Doctor**
A doctor recognized by the competent authorities.

**1.5 Company doctor**
A doctor recognized by the competent authorities who acts on behalf of the employer or the Occupational Health and Safety Service with which the employer is affiliated.

**1.6 Day care**
Foreseeable care provided in a hospital for less than 24 hours, required to undergo examination or treatment on the same day by a medical specialist or dental surgeon.

**1.7 Diagnosis Treatment Combination (DBC)**
A DBC describes by means of a DBC performance code assigned by the Netherlands Healthcare Authority (Nza) the concluded and validated procedure of medical specialist and specialist (second line) healthcare. This includes the care demand, the type of care, the diagnosis and the treatment. The DBC procedure starts at the moment you report with your demand for care and is concluded at the end of the treatment, or after 365 days.

**1.8 Evacuation and repatriation**
Evacuation involves transport to the nearest medical facility that is equipped to provide the necessary care. Repatriation is transport to one's home country.

**1.9 Pharmaceutical care**
Pharmaceutical care means:
- the dispensation of the medications and dietary preparations referred to in this insurance agreement, and/or
- advice and guidance provided by pharmacists for medical evaluation and responsible use, both taking into account the further regulations stipulated by us. The insurance agree ment is based on the Healthcare Insurance Act, the Healthcare Insurance Decree, and the accompanying Healthcare Insurance Regulations.

**1.12 Fraud**
Fraud is obtaining a reimbursement from us or an insurance agreement with us under false pretences or on improper grounds and/or using improper methods.

**1.13 Physical therapist**
A physical therapist recognized by the competent authorities.

**1.14 Guesthouse accommodation**
A facility that is part of a hospital complex and provides accommodation for children and their parents while the child undergoes outpatient treatment at that hospital.

**1.15 Authorized agent**
Aevitae, who is authorized by the health insurer as referred to in article 1, under o of the Financial Services Act for the purposes of providing healthcare insurance.

**1.16 Family**
One adult or two married or permanently cohabiting people and the unmarried children, stepchildren, foster children or adopted children up to the age of 30, for whom there is an entitlement to child allowance or benefit stemming from the Student Finance Act 2000/Study Costs Allowances Act or to the deduction of exceptional expenses pursuant to fiscal legislation.

**1.17 Emergency assistance organization**
An organization that is contracted by us and that is specialized in providing assistance in the event of hospital admission, etc.

**1.18 Aon Alarm Centre**
The emergency assistance organization appointed by Aon Hewitt which provides medical advice and assistance and takes care of repatriation and evacuation 24 hours per day, 7 days a week worldwide except for the United States of America.

**1.19 GMMI**
The assistance organization GMMI which provides medical advice and assistance and takes care of repatriation and evacuation 24 hours per day, 7 days a week in the United States of America.

**1.20 Primary insurance**
The Health insurance agreement based on the Healthcare Insurance Act, the Healthcare Insurance Decree, and the accompanying Healthcare Insurance Regulations, including the explanatory notes accompanying these.

**1.21 Skin therapist**
A skin therapist recognized as such by the competent authorities.

**1.22 GP (General Practitioner)**
A doctor who is recognized as GP by the competent authorities, or who functions as such in places where the term GP is not used.

**1.23 Dental surgeon**
A dental specialist recognized by the competent authorities.

**1.24 Calendar year**
The period that runs from 1 January through 31 December.

**1.25** **Maternity centre**
An institution that provides obstetric and/or maternity care and which is recognized by the competent authorities.

**1.26** **Maternity care**
The care provided by a certified maternity carer or a nurse working as such.

**1.27** **Speech therapist**
A speech therapist recognized by the competent authorities.

**1.28** **Manual therapist**
A physical therapist specialised as a manual therapist and recognized as such by the competent authorities.

**1.29** **Medical adviser**
The doctor who advises us on medical matters.

**1.30** **Medical specialist**
A doctor recognized by the competent authorities, who is not a dentist, and who has devoted himself to specialist treatment.

**1.31** **Medical necessity**
The need for nursing, examination or treatment according to generally accepted scientific medical reasons.

**1.32** **Dental hygienist**
A dental hygienist recognized as such by the competent authorities.

**1.33** **Oedema therapist**
An oedema therapist recognized as such by the competent authorities.

**1.34** **Remedial therapist (Cesar or Mensendieck)**
A remedial therapist (Cesar or Mensendieck) recognized as such by the competent authorities.

**1.35** **Accident**
The sudden impact of violence on the body of the insured, of external origin and outside his will, which causes medically demonstrable bodily injury.

**1.36** **Admission**
Admission to a (psychiatric) hospital, psychiatric ward of a hospital, rehabilitation facility or convalescent home while and as long as medical nursing, examination or treatment can exclusively be provided in a hospital, rehabilitation facility or convalescent home.

**1.37** **Orthodontist**
A dentist or dental orthopaedic specialist recognized by the competent authorities.

**1.38** **Podiatrist**
A podiatrist recognized by the competent authorities.

**1.39** **Policy schedule**
The health insurance policy (contract) which contains the supplementary insurance concluded between you (policyholder) and us.

**1.40** **Psychiatrist/ neurologist**
A psychiatrist/neurologist recognized by the competent authorities.

**1.41** **Psychologist**
A psychologist recognized by the competent authorities

**1.42** **Rebilitation**
Examination, advice and treatment of specialist medical, paramedical, behavioural and rehabilitative nature. This care is provided by a multidisciplinary team of experts led by a medical specialist, affiliated with a rehabilitation facility recognized by the authorities.

**1.43** **Location/ country or residence**
The country where the insured has established the centre of his activities.

**1.44** **Dentist**
A dentist recognized by the competent authorities.

**1.45** **Dental prosthetician**
A dental prosthetician recognized by the competent authorities.

**1.46** **Home country**
The insured's country of birth and/or the country where the insured has established the centre of his life interests and to which insured will return after the period of secondment/stay abroad.

**1.47** **Permission**
The written permission granted by us.

**1.48** **You/ your**
The insured persons. These persons are named on the certificate of health insurance.
You (policyholder) means the party who took out the insurance.

**1.49** **Midwife**
A midwife recognized by the competent authorities.

**1.50** **Insured**
Anyone designated as such on the policy, the policy schedule, or the application certificate.

**1.51** **Policyholder**
The party who entered into the insurance agreement with us.

**1.52** **We/ us**
The authorized agent as described in art. 1 (description of terms) point 14.

**1.53** **Individual Healthcare Professions Act (Wet BIG)**
Individual Healthcare Professions Act. This law describes the expertises and competencies of the healthcare providers. The accompanying registers contain the names of healthcare providers who satisfy the statutory requirements.

**1.54** **Independent treatment centre**
A facility for specialist medical care (MISZ) for examinations and treatment which has been accredited as such in accordance with regulations drawn up by, or pursuant to, the law.

**1.55** **Hospital**
An facility for specialist medical care (MISZ) for nursing, examining and treating sick people which has been accredited in accordance with regulations drawn up by, or pursuant to, the law.

**1.56** **Hospital care**
Admittance to hospital for more than 24 hours, when and as long as, on medical grounds, care, examination and treatment can only be provided in a hospital while constant treatment by a medical specialist or dental surgeon is necessary.

**1.57** **Healthcare provider**
The person or institution that provides the healthcare.

**1.58** **Health insurer**
The insurance company that is admitted as such and provides insurance in the sense of the Healthcare Insurance Act. For the provision of supplementary insurance, this is Achmea Zorgverzekeringen N.V. Achmea Zorgverzekeringen is registered with the AFM under number 12000647.

**1.59** **Wlz**
The Long Term Care Act (Wet langdurige zorg).

## Article 2 Basis of the insurance

**2.1** The completed and signed application form or the completed online application form on our website and written information submitted with it separately, together with the information provided by the insured in the event of an examination, form the basis of the insurance agreement and constitute a part thereof. The contract is set down on the policy schedule. This policy schedule is provided to the policyholder annually.

**2.2** In addition to the policy schedule a healthcare card is provided. When help is called in, the insured must show the policy schedule or healthcare card to the healthcare provider.

**2.3** You may declare the costs of care, excluding personal contributions (unless personal contributions are insured in accordance with this supplementary insurance), to us on the basis of this supplementary insurance, unless the care provider sends the declaration directly to us. The costs of care declared by a contracted healthcare provider or emergency assistance organization will be reimbursed by us directly to this healthcare provider or emergency assistance organization in line with the rate agreed with this contracted healthcare provider or emergency assistance organization and in accordance with the coverage of this insurance.

**2.4** The claim to care or reimbursement of the costs of healthcare as described in this supplementary insurance are determined partly by science and practice, and in the absence of such a criterion, by what applies in the relevant professional area as responsible and adequate care and services.

**2.5** You are only entitled to healthcare insofar you reasonably depend on it in terms of content and scope.

## Article 3 Application and registration

**3.1** Everyone who is entitled to our Choice Healthcare Plan can apply upon request for supplementary insurance. You register for the supplementary insurance by sending in a fully completed and signed application form or you may register by filling in the online application form on our website (only possible if the application takes place at the same time as the application for the Choice Healthcare Plan).

**3.2** We can refuse a request for registration for supplementary insurance if:
a You still owe premium(s) for insurance purchased from us in the past.
b You have committed fraud as described in the Choice Healthcare Plan.
c The applicant's health condition gives reason to do so.

**3.3** It is not possible to purchase supplementary insurance for children under the age of 18 that is more extensive than the supplementary insurance of (one of) the parents insured with us.

## Article 4 Commencement date, duration and end of your supplementary insurance

**4.1** COMMENCEMENT DATE AND DURATION OF THE SUPPLEMENTARY INSURANCE
**4.1.1** The insurance starts on the date reported on the policy schedule as the commencement date.
**4.1.2** You can add supplementary insurance to an insurance policy already in effect with us. In principle, addition of supplementary insurance can only take place as of 1 January and after we have agreed to this in writing. Medical evaluation may take place.

**4.1.3** **Birth**
Children born to insured's during the duration of this insurance are included in the supplementary insurance without medical restrictions as long as they are reported to us within 30
days after their birth.

**4.2** END OF YOUR SUPPLEMENTARY INSURANCE
**4.2.1** You can terminate the supplementary insurance by ensuring that we receive the cancellation (in writing or by e-mail) by 31 December at the latest. The supplementary insurance will end as of the following 1 January. Cancellation is irrevocable once submitted and effected.
**4.2.2** In the event of definitive return to the Netherlands in connection with termination of the secondment, you have the possibility of converting the supplementary insurance within 60 days into a Dutch supplementary insurance in accordance with our rates and terms and conditions that apply at that moment. The conversion or cancellation of the supplementary insurance does not take place with retroactive effect.

**4.2.3** You are entitled to cancel the supplementary insurance early, with effect from the day of termination of the old employment contract in connection with entering into a new employment contract, if the reason for the cancellation concerns a changeover from one employment-related collective insurance to another employment-related collective insurance. You can cancel the old insurance up to 30 days after the new employment contract has taken effect. The cancellation does not take place with retroactive effect and takes effect on the first of the month.

**4.2.4** The supplementary insurance is terminated at a time specified by us if the amounts owed are not paid by the due date stipulated by the second written reminder. We will terminate your
supplementary insurance as well as that of the other insured(s) included in the supplementary insurance with immediate effect:

a If you do not promptly satisfy a request for information (in writing, if so desired), if this information is necessary for proper performance of the supplementary insurance;
b If it later emerges that the application form has been inaccurately or incompletely filled in, or circumstances which could have been important to us have not been reported;
c In the event of demonstrated fraud.

**4.2.5** This supplementary insurance is automatically non-selectively converted into an equivalent insurance if the insured is no longer entitled to the primary insurance due to a change in circumstances. The non-selective conversation can only take place as of the end date of the primary insurance and if the following points are satisfied:

a The application must take place within 30 days after the termination of the entitlement to the primary insurance.
b You will be seconded by an organization/employer recognized by us.
c You will not permanently reside abroad.
d The insured must not be older than 67 years of age.
e The primary insurance to be terminated must also have been concluded with us.

## Article 5 Obligations of the insured

You or the insured are required to:

**5.1**

a Worldwide with the exception of the United States of America: except in the case of force majeure, to always contact the Emergency assistance organization or have this organization contacted prior to hospital admission abroad or admission to a psychiatric facility outside the Netherlands. - United States of America: except in the case of force majeure, to always contact t he Emergency assistance organization or have this organization contacted prior to visiting a healthcare provider.
b Ask the treating doctor or medical specialist to report the reason for admission to the doctor of the Emergency assistance organization or our medical adviser, if the medical adviser so requests
c Lend cooperation to us, our medical adviser or those who are charged with control activities in obtaining all the desired information, taking into account privacy regulations.
d Be helpful towards us in seeking recourse on a liable third party.

**5.2** As applicable, to submit the original invoices to us within twelve months after the expiration of the calendar year in which treatment took place. The determining factor in this is the date of treatment and/or the date on which care was provided and not the date on which the invoice was issued. If the invoice relates to a DBC that commenced before the end date of the supplementary insurance, the costs related to this are regarded as having been incurred in the period during which the supplementary insurance applied. In the event you submit invoices to us later than 12 months after the expiration of the calendar year, we reserve the right to grant a lower reimbursement than that to which you would have been entitled according to the reimbursement. On the basis of article 942 of book of the Netherlands Civil Code, invoices that are submitted to us later than 3 years after the treatment date and/or the date of care provision are not processed.

**5.3** The original invoices must be itemised in such a manner that it can be ascertained what reimbursement we are required to pay. They must bear the date of treatment, the names and dates of birth of the patients, nature of the treatment and the name of the referring doctor (if applicable). We reserve the right to require proof of payment. The reimbursement to which you are entitled is in principle paid out to the policyholder, into the account number which we have on record. The reimbursement will be paid out in euros subject to the transfer price on the treatment date, unless fairness dictates otherwise.

**5.4** You have an obligation to limit damage. We and the Emergency assistance organizations have the right to propose cost-saving alternatives. You are required to lend your cooperation to this within the bounds of reasonableness and fairness.

**5.5** If our interests are damaged by the failure to satisfy the aforementioned obligations, you have no entitlement to care and/or we are not obliged to reimburse any costs.

**5.6** ELECTRONIC INVOICES AND OTHER DIRECT PAYMENTS
The personal contribution or deductible owed by you and advanced by us and/or uninsured costs owed by you and advanced by us are set off against the next declaration(s), or must be repaid to us at our first written request.

**5.7** You are required to inform us within a month of all incidents that could be significant for proper performance of the supplementary insurance, such as termination of the requirement to have insurance, a move of house, divorce, birth, death, etc. Notifications to sent to you at your last known address are deemed to have reached you.

## Article 6 Unlawful registration

**6.1** If an insurance agreement is concluded for you on grounds of the Healthcare Insurance Act and this insurance serves as supplement to that insurance and it emerges later that you were not required to have insurance, this insurance agreement expires with retroactive effect from the moment at which there was no (longer a) requirement to have insurance.

**6.2** We will set off the premium that you paid from the day that the insurance requirement no longer existed against the healthcare enjoyed by you since that point at our expense and either pay out to or charge you the balance, whichever applies. We assume a 30-day month in this respect.

## Article 7 Premium

**7.1** HEIGHT OF THE PREMIUM
**7.1.1** The height of the premium depends on your age. When the premium increases as you move into the next age bracket, the premium will change as of the first of the month following the month in which the advancement to the next bracket takes place.
**7.1.2** No premium is owed by you until the first day of the calendar month following on the calendar month in which you have reached the age of 18.

**7.2** PAYING THE PREMIUM
**7.2.1** You (the policyholder) are required to pay the premium. You are required to pay the premium in advance. We always use the premium payments received first to pay the oldest outstanding premium claim.
**7.2.2** You are not permitted to set off the premium owed against any claim on us for care needs or reimbursement of the costs of care.
**7.2.3** If the health insurance is terminated early, premium that has already been paid is refunded on a prorated basis. We base our calculation for this on a 30-day month. We are allowed to deduct an administrative fee from the premium to be refunded.

**7.3** LATE PAYMENT
**7.3.1** If you do not pay the premium on time, your entitlement to reimbursements under this supplementary insurance lapses with effect from the due date for payment of the premium. You are only entitled to reimbursement of your medical expenses again once the premium arrears has been satisfied in full. We are only required to reimburse expenses incurred after the premium arrears has been satisfied in full and which were not foreseeable.
**7.3.2** Your obligation to pay the overdue premium remains.
**7.3.3** If you do not pay your premium on time, we add administrative costs and interest to the amount o wed by you.
**7.3.4** If we take action to collect the premium, the costs incurred to collect these amounts, including judicial and extra judicial collection costs shall be borne by you.
**7.3.5** We reserve the right to terminate the insurance after the payment term specified in the second reminder (notice of default) has expired. If we terminate the insurance you receive written confirmation of this. The obligation to pay remains.

## Article 8 Automatic debit

Payment of premium, statutory personal contributions, statutory personal payments, personal payments and any other amounts take place preferably by automatic debit. If a payment method other than automatic debit is chosen, we can charge administration costs.

## Article 9 Change to premium and/ or terms and conditions

**9.1** We have the right to change the terms and conditions and/or the premium of the supplementary insurances in the lump or with respect to a group. Such a change will be implemented on a date further to be determined by us.

**9.2** When we increase the premium or limit the reimbursements included in the insurance terms and conditions, these changes also apply when you were already insured.

**9.3** If you (policyholder) do not agree with the increase to premium or limitation of the terms and conditions, you must notify us of this in writing within 30 days. In such a case we terminate your insurance on the day on which the change takes effect.

**9.4** You may not refuse the change if:
a The premium increase and/or limitations to reimbursements are the result of statutory regulations.
b The premium is increased because you have entered the next age bracket or because you have moved to another region.

## Article 10 Claims and reimbursements

**10.1** CLAIMS
For each healthcare claim, the amount of reimbursement to which you are entitled and/or the personal contribution that you owe is described.

**10.2** REIMBURSEMENTS
**10.2.1** You are entitled to reimbursement of incurred costs on the basis of the supplementary insurance, insofar as these costs are incurred during the period in which this supplementary insurance is in effect. The determining factor in this is the treatment date and/or the date of supply and not the invoice date. If a treatment is declared in the form of a DBC tariff, the moment of start of treatment is decisive.

**10.3** EXCLUSIONS

**10.3.1** You have no claim to, and we do not reimburse any costs caused by or arising from armed conflict, civil war, insurgency, domestic unrest, riots or mutiny, as stipulated in article 3:38 of the Financial Supervision Act (Wft).

**10.3.2** Reimbursement of medical expenses incurred as a consequence of terrorism is restricted to the benefit as described in the clauses schedule for terrorism coverage from the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringmaatschappij voor Terrorismeschaden N.V.). This clauses schedule and the related Protocol constitute part of this policy. The applicable Claims Settlement Protocol and the Terrorism coverage clauses sheet can be consulted at www.terrorismeverzekerd.nl.

**10.3.3** We do not reimburse costs related to missed appointments

**10.3.4** We do not reimburse the costs related to treatment administered by you at the expense of your I nsurance. For treatment by your partner, family member and/or relative once or twice removed ( insured) we must give our consent beforehand if you intend to claim reimbursement from us.

**10.4** CONCURRENCE

You can only claim from us reimbursements stemming from the supplementary insurance that are not or only partly extended via a statutory regulation and that fall under the coverage of the supplementary insurance. The supplementary insurance will not provide any reimbursement of:

A costs that are set off with the deductible of the Choice Healthcare Plan, unless the mandatory or voluntary deductible is reimbursed by the supplementary insurance.

B statutory personal contributions and amounts in excess of the statutory maximum reimbursement, unless the supplementary insurance explicitly includes coverage for this.

## Article 11 Liability of health insurance company

If a healthcare provider does or fails to do something and as a result you suffer damage, we are not liable for this, not even if the healthcare or assistance from that healthcare provider serves as part of the supplementary insurance.

## Article 12 Liability of third parties

**12.1** If a third party is liable for costs resulting from the illness, accident or injury of an insured, we must provide free of charge all information that is necessary to take recourse on the responsible party. The right of recourse is based on statutory regulations. This does not apply for liability that stems from statutory insurance, a public law healthcare insurance, or an agreement between you and another person (or legal entity).

**12.2** If you are affected by an illness, accident or injury in which a third party as referred to in the first paragraph was involved, this must be reported as quickly as possible to us and a police report must be filed.

**12.3** You may not accept any settlement that disadvantages out rights. You may only accept a settlement with a third party, or the person acting on this third party's behalf, if you have our written permission to do so.

## Article 13 Disputes

**13.1** Dutch law applies to this agreement.

**13.2** If you do not agree with a decision made by us or you are dissatisfied with the service provided by us, you can submit your complaint to the Central Complaints Office within six months after you have been notified of the decision or provided with the service. You may submit your complaint by letter, e-mail, telephone, internet or by fax.

**13.3** After receipt, the complaint is included in our complaints registration system and you will receive confirmation of this. Within three weeks at the latest you will receive a substantive response. If more time is needed to handle the complaint, the handler or the Central Complaints Office will notify you of this.

**13.4** If you do not agree with how the complaint has been handled, you may ask us to reconsider. The request for reconsideration may be submitted to the Central Complaints Office by letter, e-mail, telephone, internet or fax. You will receive a confirmation of this and a substantive response no later than within three weeks. If more time is needed to reconsider the com plaint, the handler or the Central Complaints Office will notify you of this.

**13.5** In contravention to the above paragraph or if you are not satisfied with the reconsideration, you may put the dispute before the Healthcare Insurance Complaints and Disputes Commission (Stichting Klachten en Geschillen Zorgverzekeringen), P.O. box 291, 3700 AG Zeist (www.skgz.nl).

**13.6** The Healthcare Insurance Complaints and Disputes Commission may not handle your complaint if the case has already been brought to court or if a court decision has already been made with regard to it. You are always free to go to the civil court, even after the Disputes Commission has issued binding advice.

**13.7** Regardless of the provisions in the other paragraphs of this article, consumers, healthcare providers and health insurers always have the right to submit a complaint to the Netherlands Healthcare Authority regarding forms used us. Such a complaint concerns forms that the complainant feels are superfluous or overly complicated. A pronouncement from the Netherlands Healthcare Authority provides the healthcare provider, health insurer and consumer with binding advice. For more information about how you can submit a complaint to us, how we subsequently handle complaints and the procedure at the Healthcare Insurance Complaints and Disputes Commission, we refer you to the brochure 'Klachtenbehandeling bij zorgverzekeringen' [Complaints handling with respect to healthcare insurance]. You can request this brochure from us.

## Article 14 Personal Information

**14.1** Upon the application for insurance or financial service we ask for personal information. This information is used within our organization for the entering into and performance of contracts, in order to inform you about relevant products and/or services, to guarantee the security and integrity of the financial sector, for statistical analysis, client management and to satisfy statutory requirements. The ethical guidelines for "Processing of Personal Data by Financial Institutions" apply to the use of the personal data. For health insurers the "Ethical Guidelines for the Processing of Personal Data by Health Insurers" also apply.

**14.2** If you (the policyholder) do not wish to receive information on products and/or services, you can notify us of this in writing.

**14.3** As part of a responsible acceptance policy, we may consult data at the Stichting CIS (central information system for insurance companies operating in the Netherlands foundation) in Zeist.In this context participants of the Stichting CIS may also exchange information with each other. The purpose of this is to manage risks and counter fraud. The privacy regulation of the Stichting CIS applies. More information can be found at www.stichtingcis.nl.

**14.4** From the moment the supplementary insurance starts, we may request information from third parties (healthcare providers, suppliers, etc.) and provide such parties with information insofar as this is necessary to be able to honour the obligations stemming from the supplementary insurance. Information is understood in this context to be your address and policy information. If urgent reasons make it necessary to refuse healthcare providers or suppliers access to the address information, you can inform us of this in writing.

## Article 15 Fraud

**15.1** Fraud is the securing of a claim and/or reimbursement from us under false pretences or on spurious grounds or by spurious means.

**15.2** Every right to claim and/or reimbursement based on this supplementary insurance lapses if the policyholder and/or an insured and/or another stakeholder in the claim and/or reimbursement gives a false representation of the situation, has submitted forged or misleading documents, or has given an inaccurate report related to a submitted claim or has remained silent on facts that could be important to us in assessing a submitted claim. In such a case any right to claim and/or reimbursement with regard to the entire claim lapses, also for those for which no inaccurate report has been made and/or with respect to which no inaccurate representation of the situation has been given.

**15.3** MATERIAL CHECK AND FRAUD
We investigate the lawfulness (was the performance from the healthcare provider actually supplied) and effectiveness (is the performance delivered the most appropriate performance given the insured's health situation) of declarations submitted in accordance with what is stipulated in this respect in the Choice Healthcare Plan by or pursuant to the Healthcare Insurance Act.

**15.4** Fraud may also prompt us to:
a File a police report.
b Terminate the insurance contract(s).
c Enter the incident in the detection systems used by insurers.
d Reclaim reimbursement(s) paid out and (investigation) costs incurred.

# Chapter 2 Supplementary insurance: Aon's Global Health Supplement

## Article 1 Introductory provision

The right to reimbursement of the insured claims on grounds of the supplementary insurance mentioned above only exist if this supplementary insurance is indicated on the policy schedule and primary insurance is also in effect for you. If and insofar as the policyholder or insured can make a claim to reimbursement of the insured costs or provision of benefits pursuant to the primary insurance, the claim based on the primary insurance has priority over the claim based on the supplementary insurance.
The reimbursement is determined as follows:

First of all the reimbursement is determined on the basis of the primary insurance. After that further reimbursement for the remaining part is granted according to the reimbursement regulations applicable and reported in the terms and conditions of this supplementary insurance. The costs that remain at your expense on grounds of the primary insurance, due to the application of a deductible or a (personal) contribution owed, are not reimbursed on the basis of this supplementary insurance, unless otherwise reported.

## Article 2 Coverage

### A Coverage area

The insurance offers worldwide coverage.

### B Scope of the coverage

**2.1** COVERAGE IN THE NETHERLANDS

When there is a medical need for the treatments listed below in article 2 B, point 3 (Supplementary reimbursements), we reimburse the costs, subject to the stipulated maximums, to a maximum of the (maximum) tariff in effect at the moment of healthcare provision on the basis of the Healthcare (Market Regulation) Act (WMG - Wet Marktordening Gezondheidszorg). If and insofar no (maximum) tariff is specified on the basis of the WMG, reimbursement of the costs takes place to the maximum of the applicable market rate in the Netherlands.

**2.2** COVERAGE OUTSIDE THE NETHERLANDS

a As a supplement to the primary insurance, this supplementary insurance provides full reimbursement of medically necessary healthcare due to illness, disorder or accident, subject to the provisions under B below. Only the part of the claim amount that exceeds the reimbursement of medically necessary healthcare from the primary insurance and the care reported in article 2B under 3 (Supplementary reimbursements) and C (Special provision forms of care) of this supplementary insurance are eligible for reimbursement.

b Medically necessary care in the United States of America and Canada. The reimbursement of the costs of medically necessary care in the United States of America and Canada is limited to any reimbursement on the basis of the primary insurance and the care reported in article 2B under 3 (Supplementary reimbursements) and C (Special provision for types of care) of this supplementary insurance, unless:
- there is an accident or unforeseen case of illness during holiday or business travel in one of the countries mentioned;
- there is an evacuation to one of the mentioned countries in connection with medical treatment that is not medically possible in the country of residence and which cannot be postponed and for which there are no medical alternatives at hand;
- one of the mentioned countries is your country of residence or home country and a premium applicable for these countries has been charged. Only that part of the claim amount that exceeds the reimbursement of medically necessary care from the primary insurance and the care reported in article 2 B under 3 (Supplementary reimbursements) and C (Special provision forms of care) of this supplementary insurance are eligible for reimbursement.

c Assistance in the event of hospital admission outside the Netherlands. If treatment is medically necessary, and the costs of this treatment are covered by the primary and/or supplementary insurance, the selection of a hospital will take place according to the criterion of internationally accepted quality of medical care. The Emergency assistance organization has the authority to determine whether a hospital satisfies this quality requirement. The medical adviser of the Emergency assistance organization will assess the situation objectively and subsequently select the right hospital or facility. You have a claim to reimbursement of the costs of admission in a standard hospital room equipped for the admission of more than two persons.
The Emergency assistance organization will organise the admission to hospital and where necessary, negotiate the costs of that hospital, the costs of the treating physicians and all additional costs. In emergency situations the Emergency assistance organization will actively ensure the provision of adequate medical treatment and monitor the progress of treatment.

**2.3** SUPPLEMENTARY REIMBURSEMENTS

For the cumulative costs of care listed in articles 2.3.6, 2.3.7.1., 2.3.11, 2.3.27, 2.3.29, 2.3.30, 2.3.33, 2.3.34, 2.3.35, 2.3.43, 2.3.47 en 2.3.48, a maximum reimbursement of EUR 500 per insured per calendar year applies, subject to a maximum that may apply per article. The insured may claim reimbursement of the costs of:

### 2.3.1 Adoption maternity care or medical screening for adoption

After one or more children, adopted legally during the duration of the supplementary insurance, have been registered with us in the Choice Healthcare Plan, we reimburse the costs of:

- adoption maternity care by a maternity centre or
- medical screening (preventive examination) of an adoptive child coming from abroad.

**Conditions**

- For maternity care the adopted child must be younger than 12 months at the time of adoption and may not already be a member of the family.
- The medical screening must be carried out by a pediatrician.
- The medical screening must be a required component of the adoption process.

**Exclusion**

We do not reimburse the costs of medical screening of the adoptive child if the adoption has already been completed.

**Reimbursement**

Adoption maternity care: maximum of 3 days, 3 hours per day or medical screening for adoption:
maximum EUR 300 per adoptive child.

### 2.3.2 Alternative therapies, treatments and medications

### 2.3.2.1 Alternative therapies, treatments and medications

We reimburse the costs of consulting the following alternative healers or therapists:

- Doctors
  Doctor-acupuncturist, homeopathic doctor, doctor of natural medicine, anthroposophist doctor, doctor of enzyme therapy, Sickesz doctor, manual doctor or Moerman doctor. In the context of this article doctor is also understood to mean osteopath

**Reimbursement**

Total maximum of EUR 75 per day is reimbursed for the costs of consulting the aforementioned doctors (as long as the consultation is considered one customary to the profession).

- Non-doctors
  Acupuncturist, physiotherapist-acupuncturist, traditional homeopath, manual therapist, chiropractor, haptotherapist or natural medicine therapist.

**Reimbursement**

For these healthcare providers collectively we reimburse a maximum of EUR 40 per day (as long as the consultation is considered one customary to the profession).

**Cumulative maximum reimbursement**

Of the total costs of the alternative healers or therapists listed above under A and B, a maximum of 20 consultations are reimbursed per calendar year.

**Conditions**

- For a medical therapist only the costs of a natural medicine consultation are eligible for reimbursement.
- The healers or therapists listed under B must be members of a nationally recognized professional association established for their discipline. If we so request, you must provide us with written proof of this membership.
- The consultation must take place in the context of medical treatment. We deem whether this is the case.
- The consultation is given on an individual basis.

**Exclusions**

- We do not reimburse the costs of treatments, examinations or courses with a social character or focused on wellness and/or prevention.
- We do not reimburse the costs of courses of treatment and travel.
- We do not reimburse the costs if the alternative healer or therapist is also the GP.
- We do not reimburse the costs related to alternative psychotherapy.

### 2.3.2.2 Alternative medicines

We reimburse the costs of homeopathic and anthroposophist medicines.

**Conditions**

The homeopathic and anthroposophist medicines must be prescribed by a GP or doctor.
The homeopathic and anthroposophist medicines must be provided by a pharmacy.

### 2.3.3 Contraceptives for insured persons 21 years and older

We reimburse female insured's the costs of hormonal contraceptives and IUDs.

**Conditions**

- The contraceptive must be prescribed by a GP or medical specialist.
- A prescription from the GP or medical specialist is only required the first time the contraceptive pill is supplied.
- The contraceptive must be supplied by a pharmacist.

**Reimbursement**

100%

### 2.3.4 Personal contribution to delivery, obstetric care, personal contribution

**2.3.4.1** We reimburse female insured's the costs of the statutory personal contribution charged on the basis of the Choice Healthcare Plan for an outpatient delivery without medical indication supervised by a midwife or GP.

Reimbursement
100% of the statutory personal contribution

#### 2.3.4.2 Delivery in a birth centre

We reimburse female insured's the costs of the statutory personal contribution charged on the basis of the Choice Healthcare Plan for delivery in a birth centre supervised by a midwife or GP.

Reimbursement
100% of the statutory personal contribution

### 2.3.5 Monitoring equipment for prevention of crib death

#### 2.3.5.1 Monitor

We reimburse the costs of renting a monitor for a maximum of 12 months.

Conditions
- You must be referred by a paediatrician.
- We must give permission in advance for the rental of a monitor.

#### 2.3.5.2 Sensormat

We reimburse the full purchase costs of the Sensormat from Nanny Care.

Conditions
- You must have been referred by a physician.
- You can contact Nanny Care directly for this.

### 2.3.6 Exercise in heated water

We reimburse insured's with rheumatism the costs of remedial therapy in heated water in a swimming pool.

Conditions
- You must submit a one-off medical indication from the GP or medical specialist to us which indicates that remedial therapy in heated water is necessary in connection with rheumatism.
- The remedial therapy must take place in a group supervised by a physiotherapist or remedial therapist.

Reimbursement
100%, subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.7 Glasses, contact lenses or laser eye surgery

#### 2.3.7.1 Glasses and contact lenses

We reimburse the costs of prescription glasses and contact lenses with a minimum strength of at least plus or minus 4 dioptre.

Condition
The glasses or contact lenses must be supplied by an optician or optical company.

Reimbursement
Subject to the total maximum cost reimbursement per insured per calendar year.
A Glasses or contact lenses for long term use: one pair of glasses or contact lenses with a maximum of EUR 250 per pair per 3 calendar years, or
B Contact lenses specially designed for short-term use: such as daily, weekly, monthly, halfyearly and yearly lenses, with a maximum of EUR 65 per calendar year.
Discount scheme at Collectief van Zelfstandige Opticiens (CVZO), Eye Wish or Specsavers In addition to above reimbursement on production of their health care card all insured's can take advantage of a discount scheme at Pearle Opticians-Netherlands, Eye Wish or Specsavers.
To obtain a summary of this discount scheme contact us or the optician.

#### 2.3.7.2 Laser eye surgery

Condition
The ophthalmologist who performs the laser eye surgery must be registered as a refractive surgeon the Dutch Ophthalmology Society (NOG) or fulfil the relevant quality requirements of the NOG.

Reimbursement
Maximum EUR 45.per insured per three calendar years.
Laser eye surgery at Visionclinics

Reimbursement
Maximum EUR 350 per person per three calendar years

### 2.3.8 Circumcision

We reimburse the costs of circumcision of a male on religious grounds.

**Condition**

The procedure must take place at a healthcare provider, in an independent treatment centre or at a circumcision clinic.

**Reimbursement**

100%

### 2.3.9 Pharmaceutical care

#### 2.3.9.1 Personal contribution (GVS upper limit price)

We reimburse the personal contribution (GVS upper limit price) that the insured must pay for pharmaceutical care on grounds of the Choice Healthcare Plan. We also reimburse the costs of prescripted medicine abroad, who are registered in the country of residence and not in the GVS up to 100%.

#### 2.3.9.2 Supplementary reimbursement

For pharmaceutical care provided abroad by a pharmacy that has not been contracted by the Company and which is reimbursed under the Choice Healthcare Plan up to 80%, supplementary reimbursement up to 100% takes place.

### 2.3.10 Physical therapy, remedial therapy and exercise programs

#### 2.3.10.1 Physical therapy and remedial therapy

We reimburse the costs of treatment by a physical therapist and/or by a remedial therapist after referral from a GP, company doctor or medical specialist. Manual lymph drainage in connection with serious lymph oedema may also be performed by a skin therapist. For insureds who are entitled to physical therapy or remedial therapy under the Choice Healthcare Plan, the reimbursement serves to supplement the reimbursement from that policy.

**Exclusions**

We do not reimburse the costs of individual or group treatment that is only aimed at promoting fitness by means of training. We do not reimburse the costs of individual treatment if you are eligible or exercise programs as described in article 10.2.

**Reimbursement**

We reimburse the costs up to a maximum of € 2,000 per person per calendar year by a physiotherapist or by a remedial therapist. The scope of the care provided is limited to that which physiotherapists and remedial therapists attempt to offer as care.

#### 2.3.10.2 Exercise programs

We reimburse the costs of exercise programs led by a physical therapist and/or remedial therapist. The reimbursement applies for insured's suffering from obesity (BMI >30), people in rehabilitation with previous heart failure, patients with type-2 diabetes and patients with COPD in stages Gold 1 and 2 with a lung value of FEV1/VC>60%.

**Condition**

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

**Reimbursement**

Maximum EUR 350 per insured per calendar year.

### 2.3.11 Guesthouse accommodation

We reimburse stay in guesthouse accommodation operated by the treating hospital in the event of outpatient treatment of the insured.

**Reimbursement**

Maximum EUR 35 per day, subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.12 TENS unit for labour/ birth

We reimburse the costs of renting a TENS unit for pain management during delivery by a midwife or GP acting as midwife.

**Conditions**

- The request for the equipment must be submitted to the health aid supplier by the midwife or GP acting as midwife.
- The equipment must be dispensed by a health aid supplier and is temporarily made available to the insured.

**Reimbursement**

100%

### 2.3.13 Mental health care

#### 2.3.13.1 Personal contribution to first line psychological care

We reimburse the statutory personal contribution that you owe in the event of reimbursement of first line psychological care based on the Choice Healthcare Plan.

**Reimbursement**

Maximum EUR 100 per insured per calendar year

### 2.3.13.2 Supplementary first line psychological care

As a supplement to the reimbursement under the Choice Healthcare Plan we reimburse the costs of extra sessions of first line psychological care.

**Condition**

- It must be acute, short-term help.
- You must be referred by a GP or medical specialist.

**Reimbursement**

Maximum 6 sessions per insured per calendar year.
A maximum of EUR 2,000 per insured per calendar year is reimbursed for the total costs listed under 13.1 and 13.2.

### 2.3.14 Recovery and Balance

We reimburse the costs of participation in the Recovery and Balance Program for ex-cancer patients offered by institutions under license from the Stichting Herstel en Balans.

**Condition**

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

**Reimbursement**

Maximum EUR 1,000 per insured per calendar year. The personal contribution amounts to EUR 100 if the training takes place elsewhere.

### 2.3.15 Sanatorium

We reimburse the costs of admission to a sanatorium recognized by us for somatic healthcare.

**Condition**

We must have provided written permission in advance.

**Exclusion**

We do not reimburse the costs of treatment in the context of psychosomatic healthcare.

**Reimbursement**

Maximum EUR 50 per day with a maximum of 28 days per calendar year.

### 2.3.16 Skincare

We reimburse the costs of:

- Acne treatment by a beautician or skin therapist, including the costs of the substances used for this.
- Camouflage therapy by a beautician or skin therapist, including the costs of the substances used for this.
- Electric hair removal treatments by a beautician or skin therapist.
- Laser hair removal by a skin therapist for women who suffer from seriously disfiguring facial hair.

**Conditions**

- You must be referred by a GP or medical specialist.
- We must have reached agreement in advance with the treating beautician on the rate to be charged.
- Laser hair removal must be performed by a skin therapist.

**Reimbursement**

Maximum EUR 600 per insured per calendar year.

### 2.3.17 Help supplies (personal contribution)

We reimburse the costs of those help supplies that are eligible for reimbursement on grounds of the (Avero) Achmea Help Supplies Regulation and insofar as these are costs that exceed the statutory maximum reimbursement as described in the (Avero) Achmea Help Supplies Regulation, or are specified as personal contribution.

**Explanation of conditions of reimbursement**

The help supplies to be reimbursed must be necessary for the insured, effective and not unnecessarily costly or unnecessarily complicated, all of which is subject to our evaluation.

### 2.3.17.1 Personal contribution hearing aids

Supplementary to the statutory maximum reimbursement for a hearing aid based on the Choice Healthcare Plan you are entitled to an extra reimbursement .

**Condition**

You must be entitled to reimbursement on the basis of the Choice Healthcare Plan.

**Reimbursement**

Maximum EUR 250.-- per insured per calendar year.

#### 2.3.17.2 Personal contribution wig

Supplementary to the statutory maximum reimbursement for a wig based on the Choice Healthcare Plan you are entitled to an extra reimbursement.

Condition

You must be entitled to reimbursement on the basis of the Choice Healthcare Plan.

Reimbursement

Maximum EUR 100 per insured per calendar year

#### 2.3.17.3 Head covering

We reimburse the costs of a head covering in the event of (temporary) hair loss due to chemotherapy

Condition

You must submit to us a one-off doctor's certificate from a GP or medical specialist which shows that you have suffered hair loss due to chemotherapy.

Reimbursement

Maximum EUR 75 per insured per calendar year.

#### 2.3.17.4 Personal contribution other help supplies

Supplementary to the statutory maximum reimbursements or as reimbursement of the statutory personal contribution towards help supplies under the (Avero) Achmea Help Supplies Regulation you are entitled to an extra reimbursement.

Conditions

- You must be entitled to reimbursement on the basis of the Choice Healthcare Plan.
- We must have provided permission in advance.

Exclusion

We do not reimburse the costs of the statutory personal contribution owed for orthopaedic shoes and allergy-free shoes.

Reimbursement

Maximum EUR 250 per insured per calendar year

### 2.3.18 In vitro fertilisation (IVF)

We reimburse the costs of IVF (in vitro fertilisation treatments) as described in the primary insurance in the article 'claims under the Choice Healthcare Plan', including the reimbursement from the primary insurance, to a maximum of EUR 7,000 per pregnancy.

### 2.3.19 Maternity package

We reimburse the costs of a medical maternity package for the female insured, to a maximum of EUR 50.

### 2.3.20 Maternity care

#### 2.3.20.1 Personal contribution maternity care

We reimburse female insured's the costs of the statutory personal contribution owed for maternity care charged on the basis of the Choice Healthcare Plan (home or birth centre).

#### 2.3.20.2 Postponed maternity care

We reimburse postponed maternity care to a maximum of 15 hours for female insureds provided by a maternity centre or a maternity nurse who is an independent contractor.

Condition

The maternity centre must deem the postponed maternity care medically necessary.

### 2.3.21 Lactation consultant care

We reimburse female insured's with breast feeding problems the costs of assistance and advice from a lactation consultant.

Condition

The lactation consultant must be affiliated with a nationally recognized professional association established for their discipline or be in the employ of a maternity centre.

Reimbursement

75% to a maximum of EUR 115 per insured per calendar year.

### 2.3.22 Lifestyle training

We reimburse a maximum of one lifestyle training course per calendar year. The following basic training courses are eligible for reimbursement:

- training for heart patients;
- training for whiplash patients;
- training for people suffering burn out;
- stress reduction training.

Condition
There must be a referral from a GP, company doctor, medical specialist or speech therapist.

Reimbursement
Maximum EUR 200 per insured per calendar year.

### 2.3.23 Walking aids

We reimburse the following walking aids: elbow crutches, walking frames with 3 or 4 feet and walkers.

Condition
The supplier determines whether the walking aid becomes your property or whether you are given the aid on loan. If you are given the aid on loan a small deposit will be payable.

Exclusions
- We do not reimburse the costs related to the delivery of an aid to your home.
- We do not reimburse the costs related to normal usage such as for example caps on crutches.

Reimbursement
Maximum EUR 250 per insured per calendar year.

### 2.3.24 Home carers (replacement)

We reimburse insured's who are disabled or chronically ill and who receive home care the costs of replacement care when home care is absent.

Condition
You must obtain our permission in advance.

Reimbursement
Maximum 21 days per insured per calendar year to a maximum EUR 1,000 per calendar year.

### 2.3.25 Melatonin

We reimburse the costs of the medication melatonin for sleeping problems resulting from DSPS, ADHD and PDD-NOS.

Conditions
- We must have given permission in advance.
- For problems associated with DSPS the melatonin must be prescribed by a doctor affiliated with a sleep disorder centre.
- For problems associated with ADHD or PDD-NOS the melatonin must be prescribed by a (pediatric) psychiatrist, pediatrician or (pediatric) neurologist.
  The melatonin must be dispensed by a pharmacy.

Reimbursement
100% of the costs to a maximum of EUR 150 per insured per calendar year.

### 2.3.26 Treatment for obesity

We reimburse the costs of participation in the part-time day treatment program for obese patients at an Obesity clinic. The program is focused on behavioral change by means of nonsurgical, multidisciplinary treatment.

Conditions
- There must be a case of grade 3 obesity. This is the case if the Body Mass Index (BMI) is equal to or greater than 40.
- You must complete the full program.
- We must have granted permission in advance.

Reimbursement
A maximum of EUR 1,000 for the entire duration of the supplementary insurance.

### 2.3.27 Orthodontics

#### 2.3.27.1 Orthodontics up to 18 years of age

We reimburse insured's up to the age of 18 the costs of orthodontic treatment (relining) administered by an orthodontist or a dentist.

Exclusion
We do not reimburse the costs of repairs or replacements in the event of loss of or damage to orthodontist equipment through fault or negligence.

Reimbursement
Maximum EUR 2000 per insured during the entire duration of this supplementary insurance.

### 2.3.27.2 Orthodontics 18 years and above

We reimburse insured's aged 18 and above the costs of orthodontic treatment (relining) administered by an orthodontist or a dentist.

**Exclusion**
We do not reimburse the costs of repairs or replacements in the event of loss of or damage to orthodontist equipment through fault or negligence.

**Condition**
Prior to the commencement of the treatment you must submit to our medical adviser a treatment plan drawn up by the attending orthodontist or the attending dentist together with cephalometric images. Treatment in respect of which there is no or insignificant treatment need in line with the score guidelines in the 'Index for Orthodontic Treatment Need' (IOTN). A score of 1 or 2 is not eligible for reimbursement. The orthodontist or attending dentist can provide information on this.

**Reimbursement**
70% subject to a maximum of EUR 1000 per insured during the entire duration of this supplementary insurance.

### 2.3.28 Orthopedic medicine

We reimburse the costs of consulting an orthopedic practitioner. The consultations consist of the diagnostics and treatment of disorders of the movement apparatus whereby no use is made of surgery.

**Conditions**
- There must be a referral from a GP.
- The orthopedic practitioner must be affiliated with a nationally recognized professional
association for his/her field.

**Reimbursement**
100% subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.29 Menopause consultant

We reimburse the consultation tariff for a menopause consultant.

**Condition**
The menopause consultant must be affiliated with a nationally recognized professional association established for their discipline.

**Reimbursement**
75% of the consultation tariff to a maximum of EUR 115 per insured per calendar year.

### 2.3.30 Patient associations

We reimburse membership to a maximum of EUR 25 per membership subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.31 Chiropodist

We reimburse the costs of foot care by a chiropodist to insured's with rheumatism or diabetes.

**Conditions**
- The chiropodist must be certified to treat diabetes and rheumatism patients.
- You must submit once to us a medical indication from the GP, medical specialist or diabetes nurse which indicates that foot care is necessary in connection with diabetes or rheumatism.

**Reimbursement**
100% subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.32 Adhesive strips for affixing prosthetic breasts

We reimburse the costs of adhesive strips used to affix breast prostheses worn externally after mastectomy.

**Reimbursement**
100%

### 2.3.33 Plastic surgery/ Cosmetic surgery

### 2.3.33.1 Plastic surgery (with medical indication)

We reimburse the costs of surgical correction of eye lids if there is demonstrable impairment of physical functioning.

**Reimbursement**
100%

### 2.3.33.2 Plastic surgery (without medical indication)

We reimburse the costs of ear correction surgery if the reason for such correction stems from personal desire, need or circumstance.

**Reimbursement**
100%

### 2.3.34 Bedwetting alarm

We reimburse the cost of purchasing or renting a bedwetting alarm. We also reimburse the related pants.

**Reimbursement**

100% subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.35 Podotherapy, podo-kinesiology, and podo-orthesiology

We reimburse the costs of treatment by a podiatrist or podologist. In addition to the consultation, the treatment is also deemed to include the costs of measuring, manufacturing and delivering podiatric or podologic soles and orthetics.

**Conditions**

- The costs of a podologist are only reimbursed if you have been referred by a doctor.
- The treating podologist must be affiliated with a nationally recognized professional association for his/her field.

**Exclusion**

We do not reimburse the costs of shoes or adjustments to shoes.

**Reimbursement**

100% subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.36 Preventive courses

We contribute to the costs of the following preventative courses:

- weight loss
- heart problems
- 'Alcohol free lifestyle' training
- first aid for child accidents or the online court First Aid for children from Eerste Hulp in Huis
- baby massage
- First aid, organized by the local first aid association, or via the online course offered by Eerste Hulp in Huis
- lymph oedema
- rheumatoid arthritis, arthrosis or Bechterew's disease
- type-2 diabetes
- basic CPR
- sleep therapy organized by Somnio. This online sleep course offers professional advice and practical solutions for better sleep.

**Condition**

The insured must submit to the Company proof of registration and payment.

**Reimbursement**

75% to a maximum of EUR 115 per course per insured per calendar year subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.37 Preventive medicine.

#### 2.3.37.1 We reimburse the costs of:

- vaccinations that are included in the national vaccination program and the costs of which cannot be directly charged to the national vaccination program
- tetanus vaccine

**Reimbursement**

100%

#### 2.3.37.2 Influenza vaccine

We reimburse the costs of an influenza vaccine.

**Exclusion**

Vaccines within the context of the National Influenza Prevention Programme (risk groups) fall within the scope of The Long Term Care Act (Wlz)

**Reimbursement**

100%

### 2.3.38 Preventive examinations

We reimburse the costs of examination by a GP or medical specialist for the early detection of:

- cervical cancer (Pap smear)
- breast cancer
- cardiovascular disease
- prostate cancer

**Condition**

The examination must be acceptable in accordance with the applicable legislation.

Exclusion
The costs are not reimbursed if the examination is part of a general population screening.

Reimbursement
100%
We also reimburse a periodic general check-up by a GP or medical specialist to a maximum of the EUR 75 (maximum once per two years).

### 2.3.39 Psoriasis treatment

We reimburse the costs of psoriasis treatment at the Psoriasis Day treatment centres.

Conditions
- The insured must provide the Psoriasis Day treatment centre in advance with an indication from the dermatologist.
- The Psoriasis Day treatment centre must have given the insured written permission in advance.

Reimbursement
A maximum of EUR 1,000 per insured per calendar year.

### 2.3.40 Ronald McDonald house

We reimburse the personal contribution for parents' stay in a Ronald McDonald house or similar accommodation affiliated with a hospital during a medically necessary admission of a child, subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.41 Sports medicine examination

We reimburse once in 24 months the costs of a sports medicine examination. The personal contribution per examination amounts to EUR 10. We reimburse the costs of an injury consultation and/or repeat consultation twice per calendar year.

### 2.3.42 Sterilisation

We reimburse the costs of sterilisation performed during a day treatment at a hospital or outpatient facility or Independent Treatment Centre.

Exclusion
The costs of a reversal are not reimbursed.

Reimbursement:
100%

### 2.3.43 Supportive pessary

We reimburse the costs of a supportive pessary dispensed by a GP to prevent or relieve prolapsus of the uterus.

### 2.3.44 Arch supports

We reimburse the costs of one pair of arch supports.

Condition
The arches must be dispensed by an orthopedic shoe technician recognized by the competent authorities.

Exclusion
The costs of podiatric and podological supporting arches from a podopost ural therapist are not eligible for reimbursement.

Reimbursement
Maximum one pair per insured per calendar year subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.45 Stutter therapy

We reimburse the treatment and stay at a facility for stutter therapy.

Condition
Insured must be referred by a GP, medical specialist or dentist.

Reimbursement
Maximum EUR 1,000 per insured for the entire duration of the supplementary insurance.

### 2.3.46 Dental care for insured's ages 18 and younger:

We reimburse the costs of dental treatments for insured's aged 18 and younger.

Condition
The treatment must be performed by a dentist or dental surgeon.

Reimbursement
100%

### 2.3.47 Dental care as result of accidents for insured's from the age of 18

We reimburse dental care for insured's aged 18 and older by a dentist, as long as the treatment is the result of an accident that occurred while this insurance was in effect; the treatment must take place within one year after the accident.

**Reimbursement**

75% to EUR 200 maximum per element, to a maximum of EUR 2,500 per accident.

### 2.3.48 Therapeutic camps

#### 2.3.48.1 Therapeutic holiday camp for children

We reimburse the costs of a stay at a therapeutic camp for children up to the age of 18.

**Condition**

The stay must be prescribed by the treating physician.

**Reimbursement**

Maximum EUR 10 per day to a maximum of 42 days per calendar year subject to the total maximum cost reimbursement per insured per calendar year.

#### 2.3.48.2 Therapeutic camp for disabled people

For insured's who are disabled we reimburse the costs of staying at a therapeutic holiday camp.

**Condition**

We must grant permission in advance.

**Reimbursement**

Maximum EUR 23 per day per insured per calendar year subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.49 UVB treatment

We reimburse UVB light treatment at home or at a facility upon referral by a medical specialist. For treatment at home the insured may claim reimbursement for the rental of the necessary equipment.

**Condition**

We must grant permission in advance.

**Reimbursement**

100% subject to the total maximum cost reimbursement per insured per calendar year.

### 2.3.50 Trans-therapy by neuromodulator (BioStim) and biofeedback equipment (FemiScan)

We reimburse the costs of renting the neuromodulator and biofeedback equipment for treatment of incontinence.

**Reimbursement**

100%

### 2.3.51 Vaccinations and medicines in connection with travel abroad

We reimburse the consultations, medicines and vaccinations to prevent the following diseases in the event of (holiday) travel abroad:

- malaria
- diphtheria, tetanus and poliomyelitis (DTP)
- yellow fever
- typhus
- cholera
- hepatitis A/B
- rabies
- Fruh Sommer Menigo Encephalitis (tick bite)

**Reimbursement**

A maximum of 75% of the aforementioned costs of consultations, medicines and vaccinations is reimbursed subject to a maximum of EUR 150 per insured per calendar year.

### 2.3.52 Accommodation costs

#### 2.3.52.1 Accommodation costs patient

We reimburse the costs incurred by a patient in connection with medical treatment outside his city/town of residence in a hospital.

**Reimbursement**

Maximum EUR 100 per day to a maximum of EUR 1,000 per incidence of illness.

**Condition**

The accommodation in the vicinity of the hospital must be necessary on medical grounds.
The indication for the accommodation must be evidenced by a statement concerning this from the treating physician.

**Exclusion**

Accommodation costs incurred in the Netherlands or the country of which the insured is a national are not eligible for reimbursement.

**2.3.52.2 Accommodation costs parents**

We reimburse the costs incurred by parents when their co-insured child has to receive medical treatment outside his or her city/town.

**Reimbursement**

Maximum EUR 100 per day for both parents jointly subject to a maximum of EUR 1000 per illness.

**Conditions**

- The stay in the vicinity of the hospital where the child has been admitted must be medically necessary. The necessity of the stay must be evidenced by a statement concerning this from the treating physician.
- The child to be treated must not be older than 16.

**Exclusion**

Accommodation costs incurred in the Netherlands or the country of which the insured is a national are not eligible for reimbursement.

**2.3.53 Transport in connection with illness**

We reimburse the medically necessary transport in case of illness (by taxi or own vehicle) insofar as this is connected with nursing, examination or treatment, the costs of which are entirely or partly at our expense and the transport cannot take place by public transport because of the insured's health condition, as evidenced by a statement from a doctor or medical specialist. If the insured is transported by means of own vehicle the reimbursement amounts to EUR 0.31 per kilometer. If there is or could be entitlement to reimbursement of the costs of illness-related transport on the basis of the primary insurance, the reimbursement from the primary insurance is deducted from the reimbursement based on this supplementary insurance. The statutory personal contribution owed for existing illness-related transport on the basis of the primary insurance is also eligible for reimbursement.

## C Special provision forms of care

Where specified in article 2 B, point 3 (Supplementary reimbursements) that certain forms of care can only be obtained in the Netherlands, during stay abroad reimbursement on restitution basis can be obtained of maximum EUR 750 per insured per calendar year, after advance permission from us. This is subject to the maximum reimbursement that applies (per component)

## D Repatriation and evacuation

1. If medical treatment, the costs of which are reimbursed under the coverage of this insurance, is not possible in the country where the insured resides and the treatment cannot be postponed, the Emergency assistance organization will ensure as speedy an evacuation as possible to the nearest medical facility that is equipped to provide the necessary care. An evacuation within the country of residence is only covered after explicit prior permission is granted by the Emergency assistance organization. If the doctor of the Emergency assistance organization, in consultation with the local treating physician, decides that the treatment can take place, or should be continued, in the home country, or country of residence, the Emergency assistance organization will take care of repatriating the insured. The decision as to the necessity of evacuation or repatriation as well as the manner of transport in these cases will be taken by the doctor of the Emergency assistance organization, in consultation with the local treating physician, taking into account the local circumstances, the seriousness of the injury or illness, the distance that must be traveled, as well as the general situation in which the insured finds himself.
2. In the event of repatriation in connection with childbirth, without being due to medical necessity, the repatriation costs of the woman are reimbursed after deduction of a deductible of 25% of the relevant costs. The flight costs of children born in the home country to the residence country of the parents are fully reimbursed in accordance with the relevant airline's rate for babies or toddlers.
3. In addition to the travel costs of the insured, the coverage of this insurance includes:
   - the costs of attendance, if and insofar as medically necessary;
   - the flight costs of an attendant in the case of repatriation or evacuation of a child under the age of 16, regardless of whether this accompaniment is medically necessary;
   - the flight costs that an insured incurs for the return trip to his or her place of residence;
   - the flight costs of one or more children, no older than 24 months, if the repatriation or evacuation of the mother is eligible for reimbursement under this insurance.
4. In the event of the death of the insured, the Emergency assistance organization will provide support regarding the necessary formalities and take care of the transport of the remains to an address specified in the home country, unless other agreements are made.
5. The flight costs of a scheduled flight or charter are reimbursed according to the rate that applies for tourist class. In all cases it applies that the most inexpensive manner of flying must be chosen.
6. The following special costs are also reimbursed:
   - The telecommunication costs that the insured incurs in connection with repatriation or evacuation to a maximum of EUR 125 per incident.
   - The costs of extending a flight ticket of an insured, necessary in connection with the illness or accidental injury of this insured, which arose during leave, to a maximum of EUR 1,250.--. If the illness or accidental injury is life-threatening, the costs to extend the flight tickets of insured family members are also eligible for reimbursement, also to a maximum of EUR 1,250.-- per person.
   - The travel and accommodation costs that one person incurs in traveling to the location of an insured if that insured dies or is in life-threatening condition. For reimbursement of accommodation costs a maximum of EUR 100.-- per day applies, to a maximum of EUR 2,000.-- per incident.
7. Costs of repatriation related to fertility treatments, sterilisation, pregnancy prevention and abortion, as well as the costs of repatriation related to treatments not covered under this insurance are not eligible for reimbursement.

8 We follow the opinion of the doctor of the Emergency assistance organization and reimburse the costs of repatriation and/or evacuation in accordance with the insurance terms and conditions. If the insured did not ask the doctor of the Emergency assistance organization for permission for evacuation or repatriation in advance, the guarantee of reimbursement of costs lapses and we decide afterwards whether these costs are eligible for reimbursement in accordance with the insurance terms and conditions. If an insured books or starts a trip against the medical advice of the doctor of the Emergency assistance organization, the guarantee of reimbursement of costs lapses and the we decide afterwards whether the repatriation or evacuation costs are eligible for reimbursement in accordance with the insurance terms and conditions. If and insofar as an action that can be attributed to the insured leads to extra cost for the insurer than would have been the case had the insured acted in accordance with the advice of the doctor of the Emergency assistance organization, we are entitled to reduce the payment accordingly.

9 How do you contact the Emergency assistance organization?
In any case in which you consider medical evacuation necessary, you must contact the Emergency assistance organization immediately. The telephone numbers are listed on your Health Insurance Card.

10 Other service provision
On the basis of this insurance, in addition to full coverage for repatriation or medical evacuation you can also make use of an extensive package of services from the Emergency assistance organization. You can also find these services on the website of the Emergency assistance organization.
The following services are available:

- Routine & Necessary Medical Advice.
  For immediate professional assistance and advice you can call the emergency service point available 24 hours per day.
- Medical & dental referrals.
  For a referral to the nearest doctor or dentist you can call the 24-hour per day emergency service point.
- Outpatient Case Management (day admission/outpatient).
  You can call the Emergency assistance organization for an appointment with a medical agency.
  Under certain circumstances the Emergency assistance organization can also stand as guarantor for the medical costs.
- In-Patient Case Management.
  Call the Emergency assistance organization to arrange hospital admission and, if requested, a guarantee for the payment of the medical costs.
- Provision of medications & medical equipment.
  The Emergency assistance organization will provide support in obtaining medicines and/or medical equipment if an insured needs prescribed treatment which cannot be obtained locally.
- Emergency Contact Service.
  The Emergency assistance organization will take care of emergency communication between family members and the insured, on the best possible basis that can be achieved.
- Advance of necessary financial support.
  The Emergency assistance organization will, if possible, provide the insured with a cash advance if the insured so wishes and on condition that the insured will repay this cash advance within 1 month after it has been provided.
- Fellow travellers.
  The Emergency assistance organization will coordinate the travel affairs of fellow travellers when they need to visit an insured who has been admitted to hospital.
- Return of minors.
  If children would have to remain abroad unaccompanied because of an accident or illness of the insured, the Emergency assistance organization will coordinate the travel.
- Personal service
  Call the Emergency assistance organization for referrals for legal or translation services. You can also call the Emergency assistance organization if you have lost your travel documents for advice on getting the documents back.

## Article 3 Special exclusions

There is no claim to reimbursement:

**3.1** If and insofar as you (the policyholder) or the insured can claim reimbursement of the insured costs or provision of nursing, examination or treatment pursuant to:

- a legally regulated insurance;
- a government scheme;
- a subsidy scheme;
- another contract.

**3.2** FOR COSTS OF PSYCHOANALYSIS, PSYCHOLOGICAL TESTS AND REMEDIAL EDUCATION

**3.3** MEDICAL EXAMINATIONS FOR HIRING PURPOSES AND OTHER EXAMINATIONS

**3.4** FOR MEDICINES PURCHASED IN BULK FOR USE OVER MORE THAN 12 MONTHS IN CONNECTION WITH STAY ABROAD

# Chapter 3: Supplementary insurance: Comfort Class

The right to reimbursement of the insured claims on grounds of the aforementioned supplementary coverage exists only if this supplementary insurance is noted on the policy schedule.

### A Scope of the coverage

Admission of the insured to a hospital recognized by the competent authorities for treatment which is covered by the insurance. The nursing, examination and/or treatment must be only able to be offered at a hospital, while uninterrupted treatment by a medical specialist must be necessary.

### B Costs

Costs of nursing, a medical specialist and additional medical costs related to the admission of the insured.

### C Reimbursement

The insurance offers cover for the difference in the costs listed above during the stay in a standard hospital room equipped to admit one or two persons and a standard hospital room equipped to admit more than two persons in the hospital to which the patient has been admitted.

# Chapter 4: Supplementary insurance: Dental Expenses

The right to reimbursement of the insured claims on grounds of the supplementary coverage listed above exists only if this supplementary insurance is noted on the policy schedule.

## Article 1 Supplementary insurance: Dental Expenses T START, T EXTRA OR T ROYAAL

(as long as the policy schedule indicates that one of the claims below is insured) We reimburse insureds the costs of dental treatments by a dentist, dental hygienist or dental prosthetician. For insureds the reimbursement of the supplementary dental insurance is a supplement to the reimbursement under the Choice Healthcare Plan. With regard to care provided by a dentist, we reimburse 100% of the costs of consultations (C codes) and a second opinion, oral hygiene (M codes), fillings (V codes) and extractions (H codes). Oral hygiene, minor fillings and sealings may also be performed by a dental hygienist when you are referred by a dentist. Depending on which treatment you receive, a dental hygienist can declare both M codes and T codes (paradontic treatment). When a dental hygienist declares a T code your reimbursement is 75% subject to the total maximum reimbursement. We reimburse 75% of the costs of the other treatments. Treatment of gum disorders may also be performed by a dental hygienist.

Exclusions

We do not reimburse the costs for the following codes:

- C70 and C75 (inspection reports) and C90 (no-shows for appointments).
- E97, E98 and E00 (external whitening of teeth).
- G71, G72 and G73 (Mandibular Repositioning Device (MRD)
- D codes (orthodontics).
- Z codes (subscriptions).

Reimbursements

The total maximum reimbursement depends on your package.

■ T Start

- C codes, M codes, V codes and H codes or treatments that correspond to these codes: 100%
- Other codes: 75%
- Total reimbursement is maximum EUR 250 per insured per calendar year.

■ T Extra

- C codes, M codes, V codes and H codes or treatments that correspond to these codes: 100%
- Other codes: 75%
- Total reimbursement is maximum EUR 500 per insured per calendar year.

■ T Royaal

- C codes, M codes, V codes and H codes or treatments that correspond to these codes: 100%
- Other codes: 75%
- Total reimbursement is maximum EUR 1,000 per insured per calendar year.

Contact

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