Policy conditions 2022
Supplementary dental insurances BGZC

BGZC
Belangenbehartiging
Grensoverschrijdend
Zorg Collectief

Mr. F.J. Haarmanweg 16 • 4538 AR Terneuzen
www.bgzc.nl • info@bgzc.nl

Important information and service

If you have questions, or something you think we should know, we will be happy to offer our assistance!

Our website
Comprehensive information about your health insurance is available at bgzc.nl. This is where you can find answers to frequently-asked questions, calculate your premium, submit invoices online, find healthcare providers and review and compare all reimbursements from A to Z.

Contact
For current opening hours, please refer to bgzc.nl/contact. During the weeks in December when many people change providers, we offer expanded hours of operation in order to provide you with even better service.

Submitting care invoices
If you have received an invoice for care, you can digitally submit it for reimbursement through Mijn BGZC. First, log in securely and easily using iDIN. In order to use iDIN, you must first complete the one-time activation process. More information on logging in using iDIN can be found here. In the Mijn BGZC digital environment, you can also easily and conveniently edit your personal details, view your healthcare costs or make changes to your coverage package(s).

You can submit an invoice to us by regular mail as well. To do so, simply print out and fill in a declaration form and mail it, along with the original invoice, to the postal address below. The declaration form is available here.

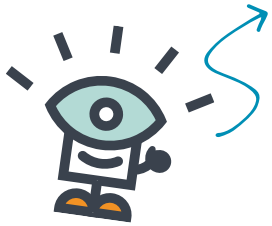
Postal/Visiting address
Mr. F.J. Haarmanweg 16
4538 AR Terneuzen

Need approval for care?
To find out which healthcare requires our approval in advance, please refer to the policy terms & conditions. You will need to send a request for approval for the treatment in question to the address above, for the attention of Medisch Advies.

Complaints
We do everything we can to provide BGZC clients like yourself with the best possible service. If you are unsatisfied with a decision we have taken regarding our service, or the service of one of your healthcare providers, please do not hesitate to let us know. For more information check page 15.

Find a healthcare provider
Healthcare providers have agreements in place with health insurance companies.
Such providers are referred to as 'contracted care providers'. They have signed contracts with the insurers that include agreements on things like quality of care. The healthcare providers with whom we have such agreements are listed in the CareFinder. Our CareFinder is available here.

Aevitaal
Health and vitality are incredibly important to us. This is why we are eager to help you stay healthy and fit as well. On the Aevitaal platform, you'll find information on health, vitality, employability and resilience. Are you experiencing symptoms or having trouble sleeping, or would you like to adopt a healthier lifestyle or enhance your employability? Go to Aevitaal and sign up today!



Contents

BGZ-22388 (B)

I Definitions of terms

The following definitions apply in this insurance agreement:

Additional Insurance Policy(s)
The insurances set out in these conditions of insurance.
Aevitae
The authorised agent to whom authorisation has been granted by the health insurance company, as meant in article 1.1 of the Financial Supervision Act, with regard to the implementation of health care insurances.
Basic health insurance / Health care insurance
The health insurance as laid down in the Dutch Health Care Insurance Act.
Calendar year
The period that runs from 1 January up to and including 31 December.
Centre for Special Dentistry
A university or centre considered as equivalent by the health care insurer providing dental treatment in special cases in which treatment requires a team approach and/or special expertise.
Consent (authorization)
A written consent for the purchase of certain care that is provided by or on behalf us or the insurer is provided to you, prior to the purchase of this certain care.
Dental surgeon
A dental specialist who is registered in the specialists' register for oral diseases and dental surgery of the Dutch Dental Association.
Dentist
A dentist who is registered as such in accordance with the conditions as referred to in article 3 of the Individual Health Care Professions Act.
EU and EEA state
Includes the following countries other than the Netherlands in the European Union: Belgium, Bulgaria, Cyprus (the Greek part), Denmark, Germany, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxemburg, Malta, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, the Czech Republic, the United Kingdom and Sweden. Under convention provisions, Switzerland is considered as equivalent to these countries.
The EEA states (states who are party to the Agreement on the European Economic Area) are Liechtenstein, Norway and Iceland.
Family
One adult or two married or permanently cohabiting persons and the unmarried own, step, foster or adoptive children under 30 years of age, who are entitled to child benefit, benefit under the Student Finance Act 2000 / Study Costs Allowances Act or deduction of extraordinary expenses under tax legislation.
Fraud
The intentional perpetration of or attempt to commit forgery of documents, deception, prejudice to creditors or rightful claimants and/or embezzlement through the realization and/or execution of a contract of general insurance, aimed at obtaining a payment, compensation or service to which no right exists or to obtain insurance coverage under false pretences.
Group health insurance contract
A collective agreement of health insurance (collective contract) concluded between Aevitae and an employer or legal entity with the aim of offering the affiliated participants the possibility of taking out health care insurance and any additional insurance cover under the conditions set out in this agreement.
Health care Insurer
The insurance company which has been authorized as such and provides (supplementary) insurance within the meaning of the Health Care Insurance Act. Your health care policy states which company this concerns.
Health care provider
The health care provider or health care providing organization that provides health care.
Hospital
An institution for medical specialist health care for nursing, examination and treatment of illnesses, which is approved as such in accordance with the rules drawn up by law.
Independent treatment centre
An institution for medical specialist health care for examination and treatment that is approved as such in accordance with the rules drawn up by law.
Insured person
Everyone named as such in the policy document.

Insurer
The health insurance company which has been authorized as an insurance company, providing (supplementary) insurance within the meaning of the Health Care Insurance Act.
Medical consultant
The physician who advises us in medical matters.
Medical specialist
A physician who is registered in the register maintained by the Medical Specialists Registration Committee of the Royal Dutch Medical Association.
Oral hygienist
An oral hygienist who has been trained in accordance with the oral hygienist's training requirements as listed in the so-called 'Dietician, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthopist and podiatrist Decree' and in the Health Care (Unsupervised Activities) Decree (Bulletin of Acts and Decrees 1997, 553)'.
Orthodontist
A dental specialist who is registered in the Specialists Register for Dentomaxillary orthopaedics maintained by the Dutch Dental Association.
Policyholder
The person who has entered into the insurance contract with us.
Policy schedule
The health insurance care policy (instrument) wherein the basic and supplementary insurances entered into between you (the policyholder) and the health insurance company are recorded.
Prosthodontist
A prostodontist who is trained in accordance with the so called 'Decree for training requirements and expertise for prosthodontists'.
Treaty country
Any state with which the Netherlands has concluded a social security treaty wherein an arrangement for the provision of medical care is included. These are defined as Australia (only temporary stay), Bosnia and Herzegovina, Cape Verde Islands, Croatia, Macedonia, Serbia-Montenegro, Tunisia and Turkey.
We/us
Aevitae B.V.
Wlz
The Long Term Care Act (Wet langdurige zorg).
Wmo
The Social Support Act (Wet maatschappelijke ondersteuning).
You/your
The person insured. This is stated to in the policy document. 'You (the policyholder)' means the person who has entered into the insurance with us.

II General terms and conditions

Article 1 Insured health care

1.1 Content and scope of the insured health care
Your additional insurance entitles you to (compensation of the costs of) health care as described in these insurance policy terms and conditions.

1.1.1 Collective health insurance agreement
The provisions of the collective agreement prevail if and insofar as they deviate from the conditions stated in these insurance policy terms and conditions. If those provisions no longer apply to the person covered by the insurance policy, then the provisions of the individual contract will be applicable again.

1.2 Medical need
You are entitled to (compensation of the costs of) health care as described in these insurance policy terms and conditions, provided you, within all fairness, rely on the content and scope of the type of health care and provided the type of health care is suitable and effective. The content and scope of the type of health care is partly determined by what the health care providers concerned 'usually provide'. The content and scope is also determined by the current level of scientific developments and standard practices, as defined using the Evidence Based Medicine (EBM) method. If there is no current level of scientific developments or no known standard practices, then the content and scope of the health care is

determined by what is considered responsible and appropriate care within the field concerned.

1.3 Health care providers

Your health care provider must meet certain conditions. These conditions are statutory for many health care providers and generally, their medical title is protected by law. This is the case, for example, for a general practitioner, medical specialist, dentist, physiotherapist and health care psychologist. The conditions to be met by a health care provider for whom we have set supplementary conditions can be found in the relevant health care article.

For a number of types of health care, we have contracted, appointed or recognized certain health care providers. You will receive no or reduced compensation if you use a non-contracted, non-appointed or non-recognized health care provider for these types of health care. This will be specified in the relevant health care articles. For the other types of health care, you are free to choose a health care provider provided that the other stipulations in these insurance policy terms and conditions are met.

An overview of the health care providers who have been contracted or appointed by us and of the compensation awarded for non-contracted health care providers is available on our website or can be requested by telephone. The recognized health care providers are listed in the relevant health care article. We have made specific agreements with some health care providers. They are our preferred health care providers. Preferred health care providers are specified in the relevant health care article.

1.4 Compensation of the cost of health care

You are entitled to compensation of the cost of health care up to the maximum Health Care Market Regulation Act rates applicable in the Netherlands. If no Health Care Market Regulation Act rates apply, the costs will be reimbursed up to a maximum of the reasonable market price applicable in the Netherlands. If you receive health care from a health care provider who is contracted by us, then the costs of the health care are reimbursed based on the rate which has been agreed wit the health care provider concerned.

If you receive treatment from a non-contracted health care provider, then it is possible that you will not be reimbursed or that you will receive less compensation. You can find more information in the relevant health care article or you can request further details.

If there is a budget for a certain type of health care, then the total compensation will not be more than the maximum amount of the budget stated in the relevant health care article.

1.5 Claiming compensation

Many health care providers send their invoices directly to us. If you receive an invoice yourself, then you can submit it online via My Aevitae.

You can also complete a declaration form and send this to us together with the original invoice. We do not accept copies of invoices or reminders. It is important that the invoice includes the name of the person covered by the insurance policy, the treatment, the date of the treatment, the invoice amount and the signature of the health care provider. The invoice must be itemized in such a way that it is immediately clear to us what compensation we have to pay. You can submit invoices up to three years after the start of the treatment.

Foreign invoices must have detailed specifications and be written in English, Spanish, French or German. If we deem it necessary, we can request you to have an invoice translated by a sworn translator. We will not reimburse you for the cost of the translation.

1.6 Direct payment

We have the right to pay the costs of health care directly to the health care provider. As a result, you have no right to compensation.

1.7 Settlement of the costs

If we pay the health care provider directly and pay more than we are obliged to pay or the costs of the health care are to be met by yourself, then you, as the policy holder, owe us the costs of the health care. We will charge you for these costs at a later date. You will be obliged to pay these costs. We can settle these costs with compensation still owed to you.

1.8 Referral, prescription or permission

For some types of health care, you require a referral, a prescription and/or prior, written permission which shows that you require the health care. You can find more information in the relevant health care article.

If a referral or a prescription is required, then you can request this from the health care provider stated in the article. This is usually the general practitioner. If permission is required, then you require our permission prior to receiving the health care. This permission is also referred to as authorization.

Contracted health care provider
If you receive health care from a health care provider who is contracted by us, this provider will assess for us whether you meet the requirements. For some types of health care, it has been agreed that we will assess the request for care ourselves. In that case, the health care provider will send us the request. If, for privacy reasons, you do not wish your request to be assessed by your health care provider, then you can also submit your request directly to us.

Non-contracted health care provider
If you receive health care from a non-contracted health care provider, then you must request permission from us to do so prior to receiving the health care.

1.9 Derived rights

You are entitled to (compensation of the costs of) health care if the treatment or delivery takes place during the term of the supplementary insurance. If treatment takes place over the course of two calendar years and the health care provider is allowed to send one total invoice (diagnosis-treatment combination), then the costs will be reimbursed provided the treatment commenced within the term of the supplementary heath insurance.

When these insurance policy terms and conditions refer to a (calendar) year, then the actual date of treatment or date of delivery stated by the health care provider determines the (calendar) year to which the costs involved should be attributed.

1.10 Exclusions

There is no right to health care or reimbursement of health care costs:

1.10.1 That are related to illnesses or abnormalities which existed before or during the time at which the insurance policy was taken out and which the person covered by the insurance policy knew of or should have known of or which he was experiencing the symptoms of and which Aevitae was not informed of in writing. This exclusion does not apply if and insofar as the insurance came into effect without medical or dental screening;

1.10.2 Of written certificates, administrative costs, costs of appointments not kept or costs incurred as a result of late payment of health care providers' invoices;

1.10.3 Incurred as a result of gross negligence or intent;

1.10.4 Consisting of personal contributions or excess payable under the terms of any other insurance, unless stipulated otherwise in these insurance policy terms and conditions;

1.10.5 That could be claimed under the Long-term Care Act (Wet langdurige zorg), the Youth Act (Jeugdwet) or the Social Support Act (Wet maatschappelijke ondersteuning), if the insured person is covered under the Act;

1.10.6 That could be claimed under another insurance policy, whether or not of a previous date or under any law or other provision provided the insurance coverage is not available from Aevitae. In that case, this insurance policy is the last insurance policy applicable. Only the costs which exceed the amount the person covered by the insurance policy could claim elsewhere will be eligible for reimbursement;

1.10.7 That can be claimed or could be claimed under the Health Care Insurance Act if you are obliged to be insured according to that law;

1.10.8 Caused by or resulting from armed conflict, civil war, uprising, civil disorder, riots or mutiny;

1.10.9 Caused by, incurred during or resulting from nuclear reactions, irrespective of how they came about. This exclusion does not apply in the case of damage caused by radioactive nuclides situated outside a nuclear facility that are used or intended to be used for industrial, commercial, agricultural, medical, scientific or security purposes, provided there is a valid permit issued by the national government for the manufacture, use, storage and disposal of radioactive substances (in this context, a 'nuclear facility' is a nuclear facility as defined in the Wet Aansprakelijkheid Kernongevallen (Nuclear Incidents (Third Party Liability) Act). The stipulations of the previous sentence do not apply insofar as a third party is liable under Dutch or foreign law for the damage sustained;

1.10.10 Or compensation for damage indirectly resulting from acts or omissions by Aevitae.

1.11 Entitlement to (compensation of the costs of) health care and other services as a result of terrorist actions

The following rule is applicable if you require health care as a result of one or more terrorist actions. If the total amount which is claimed in one year from damage insurers, life insurers or funeral insurers is greater than, according to the Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT) (Netherlands Reinsurance Company for Terrorism Losses), the maximum amount which this insurance company reinsures per year, you are only entitled to compensation of a certain percentage of the costs or of the value of the health care. The NHT determines this percentage. This applies to damage insurers, life insurers and funeral insurers (including health care insurers) to whom the Wet op het financieel toezicht (Financial Supervision Act) is applicable.

The exact definitions and stipulations with regard to the aforementioned entitlement are included in the Clauses Sheet Terrorism Cover by the Dutch Reinsurance Company for Terrorism Losses.

Article 2 General conditions

2.1 Basis of the health insurance

The health insurance agreement is agreed based on the information which you have specified on the application form or which you have given to us in writing.

2.2 Supplementary insurance

The health insurance agreement is applicable to the supplementary insurance stated on the policy summary sheet. These health insurance policy terms and conditions are part of the health insurance agreement and are applicable to the supplementary insurance.

If you have employee-related supplementary insurance based on the collective agreement agreed between your employer and Aevitae, then the compensation from the employee-related package is applicable to you. In that case, you are not entitled to (compensation of the costs of) this health care based on this supplementary insurance.

2.3 Accompanying documents

These health insurance policy terms and conditions refer to other documents. These documents are part of the terms and conditions as far as they are applicable. It concerns the following documents:

- Appendix 1 of the Besluit zorgverzekering (Health Care Insurance Decree);
- The Health Care Insurance Regulations;
- The Clauses Sheet Terrorism Cover;
- The list of contracted health care providers.

These documents can be found on our website or may be requested by telephone.

2.4 Fraud

Material inspection and fraud investigations are carried out in accordance with what has been stipulated for the health care insurance by or under the Health Care Insurance Act.
If you commit fraud, then you lose your right to (compensation of the costs of) health care. You will also have no right to (compensation of the costs of) health care for which you was not found to have committed fraud (partial fraud). We will also reclaim any compensation which has been paid to you.

The consequence of fraud is that we will register your personal details and the personal details of any accomplices or co-fraudsters in the Incident Register of the insurer. This Incident Register is registered with the Dutch Data Protection Authority (AP) and is managed by the health care insurer.
We may also register your personal details and the personal details of any accomplices or co-fraudsters:

- With the Centrum Bestrijding Verzekeringsfraude (Centre for Combating Insurance Fraud) of the Verbond van Verzekeraars (Association of Insurers).
- In the internal and external observation systems recognized by the financial institutions: the Internal Reference Register (IVR) and the External Reference Register (EVR).

The health care insurer may also report fraud to the police, the justice department and/or the Fiscal Information and Investigation Service/Economic Investigation Service (FIOD-ECD).

The consequence of fraud relating to an insurance policy you have with us is that your supplementary insurance policy and any (damage) insurance policy you may have with Aevitae or the health care insurer may be terminated. You will then not be able to agree any supplementary insurance policy or any damage insurance policy with Aevitae or the health care insurer for a period of 8 years.

We are entitled to claim back from you the required investigation costs.

2.5 Protection of personal information

We take your privacy very seriously. Collecting and processing your personal details is necessary for concluding and performing your healthcare or other insurance and any supplementary policies. We will enter your personal details in our system of insured persons records.

Your personal details will be processed for the following purposes:

- for concluding and performing your insurance contracts or financial services;
- for inspections and/or checks among insured, healthcare providers and/or suppliers to ensure the healthcare services have actually been delivered;
- for research into the quality of healthcare delivered as perceived by our insured;
- for statistical analysis;
- for compliance with statutory obligations;
- in the context of the security and integrity of the financial sector (preventing and combating fraud);
- if you participate in a group contract: for exchanging data with the contract party to the group contract for assessing your entitlement to premium discounts.

Processing your personal details is subject to privacy legislation, including the Private Data Protection Act, the ZN Code of Conduct for Processing Private Data Healthcare Insurers, the General provisions BSN Act, the Application of BSN in healthcare Act, and the Privacy Declaration of Coöperatie VGZ U.A. Please find the Code of Conduct and the Privacy Declaration on our website.

It is mandatory for us to use your BSN (citizen service number) in our administrative system and in communications (data exchange) with the healthcare providers. The BSN is also used in data exchange on expense forms. Both are completed on a statutory basis.

We may decide to check your data at CIS Foundation (CIS) for the security and integrity of the financial sector, www.stichtingcis.nl..

2.6 Announcements

You will be considered to have received all announcements sent to the last address known to us. We always use the address given in the municipal personal records database

2.7 Right of withdrawal period

When taking out a supplementary health insurance policy, you, as the policy holder, have the right to withdraw from the policy any time during the first 14 days. You can terminate the supplementary insurance policy in writing within 14 days after entering into the agreement or within 14 days after you have received the health care policy, whichever is the latter. The health care insurance policy will then be considered as not having been taken out.

2.8 Dutch law

The supplementary insurance is governed by Dutch law.

Article 3 Payments

3.1 Due premium

The policy holder is obliged to pay a premium. On the death of the policy holder, the premium is due until the day of death. If the supplementary insurance policy is altered, then we will recalculate the premium commencing from the date that the insurance policy was altered.

3.2 Premium reduction for a collective agreement

3.2.1 The premiums and terms and conditions as agreed in the collective agreement are applicable from the day that you participate in the collective agreement.

3.2.2 From the day that you are no longer entitled to participate in the collective agreement, the premium reduction and the terms and conditions agreed in the collective agreement will no longer apply. From that day, the supplementary insurance policy will be continued on an individual basis.

3.2.3 You may only participate in one collective agreement at a time.

3.3 Payment of the premium, (legal) excess, legal contributions and costs

3.3.1 Unless agreed otherwise, you are obliged to pay the premium and (foreign) legal contribution in advance for all the people covered by the insurance policy every month. If you pay the premium in advance for the whole year in a single payment, you will receive a reduction on the premium to be paid. The amount of this reduction is stated on the policy summary schedule.

3.3.2 For payments by deposit transfer, we charge € 1.50 per transfer.

3.3.3 You can grant us permission to direct debit the premium, the (legal) excess, the personal contributions and other costs. Two separate authorizations are required: one for granting permission for direct debiting the premium and one for direct debiting the (legal) excess, the personal contributions and other costs.

3.3.4 If you have authorized Aevitae B.V. to write off excess or other amounts by direct debet from your account, you (policyholder) will receive a notification of the direct debet by us. We try to send this notification to you (policyholder) a few days before we collect the outstanding amount.

3.4 Settlement

You may not settle any outstanding amounts of money against money which we owe you.

3.5 Non-timely payment

3.5.1 We will send you a reminder if you do not pay the premium, the (legal) excess, the personal contribution or any other costs on time. If you do not pay within the time stated on the reminder of at least 14 days, then we can suspend the insurance coverage. In that case, there is no right to (compensation of the costs of) health care from the last premium payment due day before the reminder. In the event of the insurance coverage being suspended, you are still obliged to pay the premium. You will be entitled to (compensation of the costs of) health care from the day following the day on which we receive the outstanding amount and any costs as stated in article 3.5.3.

3.5.2 In the event of non-timely payment, we also have the right to terminate any supplementary insurance policies. In the event of termination, the supplementary insurance can be re-applied for after payment of the outstanding amount and any additional costs as stated in article 3.5.3. This application must be received by us within one month of payment of the outstanding amount. You will then be entitled to (compensation of the costs of) health care from the day following the day on which we receive the outstanding amount and any additional costs. If we do not receive the application within one month, we will include the supplementary insurance again on 1st January of the next calendar year. If we do not receive an application at all, the additional insurance will not automatically be added after payment of the outstanding amount.

3.5.3 We may charge for the administration costs, (extra)judicial collection charges and statutory interest.

3.5.4 If you have previously received a reminder for the non-timely payment of the premium, legal contributions, personal contributions or other costs, we do not have to remind you in writing separately in the case of non-timely payment of a subsequent invoice.

3.5.5 We have the right to settle overdue premium payments and costs with any compensation of costs for health care you have claimed from us or other sums of money which we owe you.

3.5.6 If we terminate the supplementary insurance on account of the non-timely payment of the owed premium, we have the right to not enter into an insurance agreement with you for a period of five years.

Article 4 Other obligations

You are obliged:

- To ask the doctor in charge of your case to inform our medical consultant of the reason for admission;
- To cooperate with our medical consultant or employees who are charged with the task of ensuring that all the information necessary to fulfil the supplementary insurance is obtained;
- To inform us of facts which (may) result in the possibility of recovering costs from (possibly) liable third parties and to provide us with the necessary information in connection to this. You may not agree any arrangement with a third party without our prior, written approval. You must refrain from actions which may harm our interests;
- To inform us as soon as possible of facts and circumstances which are important for correctly fulfilling the supplementary insurance. This includes the starting and end dates of a period of detention, a divorce or separation, moving home, a birth, adoption or a change of bank account. We accept no responsibility in the case of omission from your side.

If you do not fulfil your obligations and our interests are damaged as a result, we may suspend your right to (compensation of the costs for) health care.

Article 5 Change in premium and conditions

5.1 Alterations to the premium and the terms and conditions

We have the right to alter the premium, as well as the terms and conditions, of the supplementary insurance at any time. We will inform you, as the policy holder, of this in writing. Any alterations will be implemented on a date to be determined by us.

5.2 Right of termination

If we alter the premium and/or the terms and conditions of the supplementary insurance in a way which is disadvantageous to you, you are entitled to terminate the insurance agreement up to a month after you have been informed of the alteration with effect from the day that the alteration takes effect. You do not have this right of termination

if an alteration to the insurance terms and conditions is a direct result of legal measures, legal regulations or legal stipulations.

Article 6 Start, duration and termination of the supplementary insurance

6.1 Start and duration

The insurance agreement comes into force on the day on which the health care insurance commences or the first day of the calendar year. If you apply for health care insurance from us, then you give us permission to terminate your old health care insurance with a Dutch insurer. This permission also applies to the supplementary insurance. If the supplementary insurance does not have to be terminated, then you must state this on the application form.

The supplementary insurance is entered into for the calendar year in which the supplementary insurance takes effect. After this period has expired, the supplementary insurance will be automatically extended for a period of one calendar year.

6.2 Acceptance for supplementary insurance

6.2.1 Health care insurance

You can agree the supplementary insurance as an addition to our health care insurance, but you are not obliged to do so. Medical selection may be required for the supplementary insurance. Furthermore, an age limit may apply. A supplement to the premium may be applicable in the following cases:

- You did not take out a basic health insurance with us;
- The health care insurer of your supplementary insurance is different from the health care insurer of your basic health insurance.

6.2.2 Family cover

All the people covered by the health insurance policy 18 years of age or older can agree supplementary insurance of their choice. Children younger than 18 years of age cannot receive more extensive insurance than the adult with the most extensive insurance covered by the health insurance policy.

6.2.3 Alterations to supplementary insurance

You can alter your supplementary insurance. The stipulations of 6.2.2 will then apply. The person covered by the insurance policy must inform us of the alteration by no later than 31st December. The change will then become effective as per 1 January 2020 (with retroactive effect if submitted after 1 January). Relating to healthcare subject to reimbursement periods of more than one calendar year, such terms will continue if supplementary insurance policies are amended within Aevitae. This means that any reimbursements paid out previously pursuant to a previous supplementary insurance policy will be transferred to the new supplementary insurance policy. This is subject to the condition that your new supplementary insurance policy covers reimbursement of this service or treatment.

6.3 Termination by law

6.3.1 The supplementary insurance is terminated by law on the day following the day on which:

- The health care insurer is no longer allowed to offer or provide insurance as a result of an alteration or withdrawal of its license to act as an insurance company;
- The person covered by the insurance policy passes away;
- The health care insurer stops offering and providing the supplementary insurance.

You, as insurance policy holder, are obliged to inform us as quickly as possible of the death of a person covered by the insurance policy or of any other facts and conditions concerning the person covered by the insurance policy which have led to or could lead to the end of the supplementary insurance. We will send you proof of termination as quickly as possible once we have determined that the supplementary insurance is terminated or will be terminated.

If the supplementary insurance ends because we stop offering the supplementary insurance concerned, we will inform you, as the insurance policy holder, of this no later than three months before the supplementary insurance ends.

6.4 Times when the insurance policy may be terminated

6.4.1 Annually

The policy holder can terminate the supplementary insurance on 1st January of every calendar year on the condition that we receive notice of such no later than 31st December of the previous year.

6.4.2 Interim

The policyholder may cancel the supplementary insurance interim in writing:

- In the event of an alteration to the premium and/or the terms and conditions as stated in article 5.2;
- At the same time as when the health care insurance is terminated.

6.4.3 To terminate the supplementary insurance as stated in articles 6.4.1 and 6.4.2, you may also use the termination service provided by the Dutch Health Care Insurers.

6.5 Termination, annulment or suspension of the supplementary insurance

We can terminate, annul or suspend the supplementary insurance in writing:

- On account of non-timely payment of money owed as stated in article 3.5;
- If fraud has been committed (see article 2.4);
- If you have deliberately not provided us with information, have deliberately provided us with incomplete information or have deliberately provided us with incorrect information which is (or can be) disadvantageous to us;
- If you have acted with the purpose to mislead us or if we would not have provided supplementary insurance if we had known the real state of affairs. In these cases, we can terminate the supplementary insurance within two months of discovery with immediate effect. In these cases, we are not obliged to pay any compensation or can opt to reduce the compensation. We can settle any money to be reclaimed with outstanding payments for compensation.

Article 7 Complaints and disputes

7.1 Complaint Management.

7.1.1 You can be sure that all matters concerning your supplementary insurance will be taken good care of. Nevertheless, it is possible that not everything will be as you would wish.
We will be glad to hear your complaints and suggestions. You can send your complaints to: Klachtenmanagement, Mr. F.J. Haarmanweg 16, 4538 AR Terneuzen, the Netherlands. You can also send an e-mail to klachtenmanagement@aevitae.com.
The Complaint Management department deals with complaints on behalf of the management.

7.1.2 Within 15 days you will receive a response to your complaint from us. If you are not satisfied with the decision or if you haven't received a response within 15 days, you can submit your complaint or dispute to the Dutch Authority on Healthcare Insurance Complaints and Disputes (Stichting Klachten en Geschillen (SKGZ)), P.O. Box 291, 3700 AG Zeist,www.skgz.nl. Instead of going to the SKGZ, you can also submit your complaint to the arbitrator for financial services in Malta (Office of the Arbiter for Financial Services, 1st Floor, St Calcedonius Square, Floriana FRN 1530, Malta, telephone +356 8007 2366 or +356 21 249 245 or complaint.info@financialarbiter.org.mt). Please note that the arbitrator in Malta will only handle cases once you have received a final decision from us on your complaint. You can also submit the dispute to the competent court.

7.2 Complaints about our forms

7.2.1 If you feel there is no need for a certain form or that a form is too complicated, then you can send your complaint to: Klachtenmanagement, Mr. F.J. Haarmanweg 16, 4538 AR Terneuzen, the Netherlands. You can also send an e-mail to klachtenmanagement@aevitae.com.

7.2.2 You will receive a reaction to your complaint within 30 days. If you are not satisfied with the answer or do not receive a reply within 30 days, you can place your complaint before the Dutch Health Care Authority, care of the Informatielijn/Meldpunt, PostbusBox 3017, 3502 GA Utrecht, the Netherlands or send an email to informatielijn@nza.nl. The website of the Dutch Health Care Authority (www.nza.nl) explains how to submit a complaint about forms.

Article 8 Health care and waiting list mediation

You have the right to mediation for health care if there is a unacceptably long waiting list for treatment by a health care provider who is allowed to provide the care according to the supplementary insurance policy. You can call upon our Medical Guarantee department for this health care mediation. You can also call upon this department for general questions about health care. Issues include finding a health care provider with specific expertise or needing help to find your way in the health care system. We will discuss what your options are.

III Reimbursements

Supplementary dental insurances (BGZC-T Basis, BGZC-T Start, BGZC-T Extra, BGZC-T Royaal and BGZC-T Excellent)

Dental care for insured persons of 18 years and older

Are you 18 years or older and have you taken out a supplementary dental insurance? Then we reimburse the costs of dental treatment by a dentist, dental surgeon, oral hygienist or dental prosthetician. A dental technician can perform a repair as described below under "Reimbursements for dental technician costs'.

Are you going to a dentist? Then we reimburse 100% of the costs of anesthetics (A codes), consultations (C codes) and a second opinion, gum treatments (codes T21 and T22), fillings (V codes), dental X-rays (X codes) and extractions (H codes).

From the BGZC-T Basis we reimburse 1 time a check (C11 or C13) and a maximum of 25 minutes of dental cleaning (M03) or 2 times a check (C11 or C13) and a maximum of 15 minutes of dental cleaning (M03). We reimburse codes A10 and A15, V codes and H codes from the BGZC-T Basic up to a maximum of € 60 per person per calendar year.

Reimbursement costs for other treatments

Do you have a BGZC-T Start, BGZC-T Extra or BGZC-T Royaal? Then we reimburse the costs of other treatments for a maximum of 75%. If you have a BGZC-T Excellent, the reimbursement is 100% with the exception of oral hygiene (M codes). We reimburse 75% of these costs.

Reimbursement of costs by a dental hygienist

Oral hygiene, treatment of gum disease and minor fillings may also be performed by a dental hygienist. Depending on which treatment you receive, the dental hygienist may declare both M codes and T codes (periodontic treatments). Does a dental hygienist declare M codes and / or T codes (other than codes T21 and T22)? Then we reimburse a maximum of 75% of the costs from the BGZC-T Start, BGZC-T Extra, BGZC-T Royaal and BGZC-T Excellent.

From the BGZC-T Basis we reimburse 1 time a check (C11 or C13) and a maximum of 25 minutes of dental cleaning (M03) or 2 times a check (C11 or C13) and a maximum of 15 minutes of dental cleaning (M03).

Reimbursement of costs by a dental surgeon

You are entitled to periodontal surgery, the fitting of a dental implant and an uncomplicated extraction (tooth or tooth extraction) by a dental surgeon. Surgical dental assistance of a specialist nature and the associated X-ray examination are not reimbursed by the supplementary dental insurance policy. These costs are reimbursed from your basic insurance).

Reimbursement of costs by a dental technician

You are entitled to minor repairs to a partial denture (plate or frame) by a dental technician if no operations are required in the mouth. This concerns the re-fixing or replacement of a tooth or molar and the repair of a crack in the partial dentures. Is there a break in your partial dentures? The repair must then be carried out by a dentist and not by a dental technician. In the event of a crack, your partial dentures are broken, but still one whole. In the event of a fracture, your partial dentures will fall apart into 2 or more parts.

Please note! We only reimburse the costs if the maximum reimbursement for the additional dental insurance you have chosen has not yet been reached.

What we do not reimburse

We do not reimburse the costs of:

a test reports and dental declarations (C70, C75 and C76)
b a missed appointment (C90);
c a non-restorative treatment of caries in the dairy teeth (M05);
d a fluoride treatment (M40);
e external whitening of teeth and molars (E97, E98 and E00);
f mandibular repositioning device (MRA: a brace against snoring) and the diagnostics and aftercare for this (G71, G72 and G73);
g orthodontics;
h subscriptions;
i full anesthesia and nitrous oxide;

j complicated extraction by a dental surgeon, this is reimbursed from the basic insurance;
k partially completed work.

Maximum reimbursements
The total maximum reimbursement depends on your package. Below you can read the reimbursements for the different packages.

BGZC-T Basis
- We reimburse 1 time a check (C11 or C13) and a maximum of 25 minutes of dental cleaning (M03) or 2 times a check (C11 or C13) and a maximum of 15 minutes of dental cleaning (M03).
- We reimburse treatments with A10, A15, V and H codes up to a maximum total of € 60 per calendar year.

BGZC-T Start
- We reimburse 100% of A codes, C codes, T21 and T22 codes, V codes, X codes and H codes.
- We reimburse 75% of the costs of other codes.
- The total reimbursement is a maximum of € 250 per person per calendar year.

BGZC-T Extra
- We reimburse 100% for A codes, C codes, T21 and T22 codes, V codes, X codes and H codes.
- We reimburse 75% of the costs of other codes.
- The total reimbursement is a maximum of € 500 per person per calendar year.

BGZC-T Royaal
- We reimburse 100% for A codes, C codes, T21 and T22 codes, V codes, X codes and H codes.
- We reimburse 75% of the costs of other codes.
- The total reimbursement is a maximum of € 1,000 per person per calendar year.

BGZC-T Excellent
- We reimburse M codes for 75%. We reimburse 100% of other codes
- The total reimbursement is a maximum of € 1.250,- per person per calendar year

Additional Abroad Clause

Have you taken out dental insurance? And does your care policy state that you are also insured for the Abroad Clause? Then you will receive the same reimbursement for treatments in Belgium and Germany from this package. This means that the rates as applied in Belgium and Germany apply. Maximum reimbursement as included in your dental insurance remains the same.

Conditions for reimbursement
1 We only reimburse the costs if we would also reimburse these in the Netherlands from the dental insurance policy.
2 The treatment must take place with recognized (or equivalent) care providers.

Belangenbehartiging
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Zorg Collectief

Need more info?
Our experienced customer service employees are happy to help! You can reach our customer service on working days from 08.30 until 17.30 on telephone number 0115 - 61 06 04.

You will find useful information and the answers to frequently asked questions on our website www.bgzc.nl

BGZC
Mr. F.J. Haarmanweg 16, 4538 AR Terneuzen
info@bgzc.nl