



Reimbursements and terms and conditions for 2024

General insurance policy

‘OHRA Zorgverzekering Combinatie’ (‘Combinatie’ health insurance policy)

Product number: 7200102

Valid from 01-01-2024 to 31-12-2024 (inclusive)

The previous terms and conditions of insurance are hereby superseded.

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Abroad

What you are insured for under your general insurance policy

Healthcare abroad (clause B.2.2.), healthcare in a treaty country (clause B.2.1.)

Insured healthcare

- Healthcare abroad.
Your general insurance policy provides worldwide cover. This means you are insured outside the Netherlands for the same healthcare and the same scope as within the Netherlands.
If you receive healthcare in a treaty country because you live there or because you are staying there temporarily, you can opt for the statutory arrangements that apply in that treaty country instead of reimbursement under your general insurance policy.

Your reimbursement

- You can choose from one of the following reimbursements:
 1. For healthcare abroad: same level and scope for which the healthcare is insured in the Netherlands or your country of residence.
 2. For healthcare in a treaty country: the statutory regulation in the treaty country.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for healthcare abroad (clause B.2.2.)

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- If you opt for reimbursement under the general insurance policy, the healthcare must meet the conditions that apply to healthcare in the Netherlands.
- If you opt for the statutory regulation in a treaty country, the healthcare must comply with the provisions of the EU social security regulations or the applicable treaty.

Do you need approval?

- You need approval from us for all non-urgent medical care that can be scheduled in advance for which approval is also required in the Netherlands.
You can see whether approval is required in the clause relating to that particular healthcare.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and is on the list of healthcare abroad that requires approval ('Lijst aanvragen zorg buitenland') (outpatient treatment).
This list is available on our website.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and is on the list of medicines abroad for which an authorisation must be requested prior to treatment ('lijst aanvragen medicijnen in het buitenland').
This concerns medicines that fall under specialist medical healthcare. This list is available on our website.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and for which you will be admitted for at least 1 night (inpatient care).
- Our customer services team would be happy to advise you in advance.
This way, you know the financial implications of using the foreign healthcare provider. In order to be able to give good advice, we often need more information than is provided as standard in a referral or treatment proposal; this can differ per condition and treatment.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- The healthcare provider abroad must comply with the requirements, laws and regulations of that country.

What is not reimbursed

- Healthcare that is not covered by your general insurance policy; this applies, for example, if the healthcare is not recognised in the Netherlands.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for healthcare in a treaty country (clause B.2.1.)

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- If you opt for reimbursement under the general insurance policy, the healthcare must meet the conditions that apply to healthcare in the Netherlands.
- If you opt for the statutory regulation in a treaty country, the healthcare must comply with the provisions of the EU social security regulations or the applicable treaty.

Do you need approval?

- You need approval from us for all non-urgent medical care that can be scheduled in advance for which approval is also required in the Netherlands.
You can see whether approval is required in the clause relating to that particular healthcare.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and is on the list of healthcare abroad that requires approval ('Lijst aanvragen zorg buitenland') (outpatient treatment).
This list is available on our website.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and is on the list of medicines abroad for which an authorisation must be requested prior to treatment ('lijst aanvragen medicijnen in het buitenland').
This concerns medicines that fall under specialist medical healthcare. This list is available on our website.
- You need approval from us for all non-urgent medical care that can be scheduled in advance and for which you will be admitted for at least 1 night (inpatient care).
- Our customer services team would be happy to advise you in advance.
This way, you know the financial implications of using the foreign healthcare provider. In order to be able to give good advice, we often need more information than is provided as standard in a referral or treatment proposal; this can differ per condition and treatment.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- The healthcare provider abroad must comply with the requirements, laws and regulations of that country.

What is not reimbursed

- Healthcare that is not covered by your general insurance policy; this applies, for example, if the healthcare is not recognised in the Netherlands.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Conditional healthcare

What you are insured for under your general insurance policy

Conditional healthcare (clause B.22.)

Insured healthcare

- Conditional healthcare.
The effectiveness of some healthcare has not yet been sufficiently demonstrated. Nonetheless, you may sometimes be temporarily entitled to this healthcare. Until 1 January 2019, the Minister of Health, Welfare and Sport was authorised to designate certain healthcare as 'conditionally authorised healthcare' for a certain period. For a summary of this healthcare, we refer you to clause 2.2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'), which you will find (in Dutch) at wetten.overheid.nl.

This includes (under clauses 2.2.2 and 2.2.3 of the regulation) recovery care provided by allied healthcare providers for patients who have suffered severe COVID-19. For more details see 'Recovery care after COVID-19 (coronavirus)'.

Your reimbursement

- Reimbursement of 100 % for conditional healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dietetics as recovery care after COVID-19 (coronavirus) (clause B.22.), extension of dietetics as recovery care after COVID-19 (coronavirus) (clause B.22.)

Insured healthcare

- Dietetics as recovery care after COVID-19 (coronavirus).

Your reimbursement

- Reimbursement of 7 hours of treatment, maximum, during a maximum of 6 months, until 1 January 2025 for dietetics as recovery care after COVID-19 (coronavirus); and
- Reimbursement of 7 hours of treatment, maximum, during a maximum of 6 months, until 1 January 2025 for extension of dietetics as recovery care after COVID-19 (coronavirus).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for dietetics as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- The prescription was issued within a period of six months from the acute stage of the severe case of COVID-19.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of dietetics as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing long-term consequences like serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- Prescription for extending this period up to 6 months after the initial 6-month treatment period.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- A medical specialist or general practitioner has determined that extension of healthcare is medically necessary.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Occupational therapy as recovery care after COVID-19 (coronavirus) (clause B.22.), extension of occupational therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

Insured healthcare

- Occupational therapy as recovery care after COVID-19 (coronavirus).

Your reimbursement

- Reimbursement of 10 hours of treatment, maximum, during a maximum of 6 months, until 1 January 2025 for occupational therapy as recovery care after COVID-19 (coronavirus); and
- Reimbursement of 10 hours of treatment, maximum, during a maximum of 6 months, until 1 January 2025 for extension of occupational therapy as recovery care after COVID-19 (coronavirus).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for occupational therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- The prescription was issued within a period of six months from the acute stage of the severe case of COVID-19.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of occupational therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing long-term consequences like serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- Prescription for extending this period up to 6 months after the initial 6-month treatment period.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- A medical specialist or general practitioner has determined that extension of healthcare is medically necessary.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus) (clause B.22.), extension of physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

Insured healthcare

- Physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus).

Your reimbursement

- Reimbursement of 50 sessions, maximum, during a maximum of 6 months, until 1 January 2025 for physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus); and
- Reimbursement of 50 sessions, maximum, during a maximum of 6 months, until 1 January 2025 for extension of physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- The prescription was issued within a period of six months from the acute stage of the severe case of COVID-19.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of physiotherapy and exercise therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing long-term consequences like serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- Prescription for extending this period up to 6 months after the initial 6-month treatment period.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- A medical specialist or general practitioner has determined that extension of healthcare is medically necessary.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Speech and language therapy as recovery care after COVID-19 (coronavirus) (clause B.22.), extension of speech and language therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

Insured healthcare

- Speech and language therapy as recovery care after COVID-19 (coronavirus).

Your reimbursement

- Reimbursement of 100 %, during a maximum of 6 months, until 1 January 2025 for speech and language therapy as recovery care after COVID-19 (coronavirus); and
- Reimbursement of 100 %, during a maximum of 6 months, until 1 January 2025 for extension of speech and language therapy as recovery care after COVID-19 (coronavirus).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for speech and language therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have had COVID-19 (coronavirus) and are experiencing serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- The prescription was issued within a period of six months from the acute stage of the severe case of COVID-19.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of speech and language therapy as recovery care after COVID-19 (coronavirus) (clause B.22.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:

- You have had COVID-19 (coronavirus) and are experiencing long-term consequences like serious complaints or limitations.

Terms and conditions

- This primary recovery care provided by allied healthcare providers is conditional healthcare. Conditional healthcare is healthcare that has not yet been definitively included in the general insurance policy, but which may be reimbursed for a certain period under the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
- Prescription for extending this period up to 6 months after the initial 6-month treatment period.
- The first treatment starts within one month of the date of it being prescribed.

Who to get a treatment proposal from

- A medical specialist or general practitioner has determined that extension of healthcare is medically necessary.

Where to go for this healthcare

- Healthcare provider who selects patients for the conditional healthcare study. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dietary preparations

What you are insured for under your general insurance policy

Dietary preparations (clause B.16.)

Insured healthcare

- The provision of polymer, oligomer, monomer and modular dietary preparations used for liquid nutrition and/or tube feeding.

Your reimbursement

- Reimbursement of 100 % for dietary preparations.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have a metabolic disorder.
 - You have a food allergy.
 - You have a disorder resulting in malabsorption.
 - You are, or are at risk of becoming malnourished due to a disease. This has been determined using a formally established method.
- You need dietary preparations in accordance with the relevant professional group's guidelines that apply in the Netherlands.

Terms and conditions

- Normal but adapted food and other special food products have not proven effective for you.
- The terms and conditions set out in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering') apply to dietary preparations.
The Dutch Health Insurance Regulations ('Regeling zorgverzekering') are available on the government website at wetten.overheid.nl (in Dutch).
- The dietary preparations are registered as such and are included in the 'G-Standaard' (the Dutch national database of medicines) administered by 'Z-Index'.
'Z-Index' is a register that verifies, manages and distributes all healthcare products available through public pharmacies and dispensing general practitioners and lists this information in the 'G-Standaard' database, which we use to see whether a product is registered, for example, or to check the price for that product.
- In the case of an allergy, the costs of the dietary preparations are only reimbursed from the moment that it is proven that the insured person has the allergy.
For example, it is suspected that you have a cow's milk protein allergy and so a double-blind, placebo-controlled food challenge is conducted. Costs incurred during the testing period prior to the final diagnosis are not reimbursed.

Who to get a treatment proposal from

- Medical specialist.
- Geriatric specialist.
- Doctor for the mentally disabled.
- Dietician.
- Clinical nurse specialist.

Do you need approval?

- A contracted healthcare provider will check a doctor's statement to see whether you meet the conditions. Our prior approval is not required in this case.
The healthcare provider prescribing the dietary preparation must complete the doctor's statement. If you purchase the dietary preparation from a non-contracted healthcare provider, the doctor's statement must be sent to us and we will check whether you meet the conditions.

For the approval, see the attached General terms and conditions, section [Approval](#).

What is not reimbursed

- Dietary supplements and vitamin preparations that are available without a prescription.
- Slimming products, also if they are registered as a dietary preparation.
- Special dietary products such as lactose-free cheese, gluten-free bread, goat's or horse's milk.
- Thickening powders.
- Nutrition administered directly into the bloodstream.
We reimburse this under another clause, see 'Medicines'.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dietetics

What you are insured for under your general insurance policy

Dietetics (clause B.11.)

Insured healthcare

- Dietetics with a medical purpose.

Your reimbursement

- Reimbursement of 3 hours of treatment, per year for dietetics.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- A referral is necessary if the treatment will be provided by a non-contracted healthcare provider. The referral must be drawn up by a general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, dentist, company doctor, nursing specialist or medical specialist.
- Referral is necessary if treatment at home is necessary.

Where to go for this healthcare

- Dietician.
Your healthcare provider is a dietician with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Dietician affiliated with ParkinsonNet.
The dietician must have this affiliation if you are receiving care because you have been diagnosed with Parkinson's disease.

What is not reimbursed

- Dietetics outside multidisciplinary care if you already receive dietetics as part of multidisciplinary care. Unless this relates to a different healthcare need based on a different indication. Also see the 'Dietetics as part of multidisciplinary care' clause.
- Combined lifestyle intervention and dietetics at the same time for the same indication.
- Dietetics on non-medical grounds, such as dietary advice for weight loss or sports.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dietetics as part of multidisciplinary care (clause B.11.)

Insured healthcare

- Dietetics as part of multidisciplinary care.

Your reimbursement

- Reimbursement of 100 % for dietetics as part of multidisciplinary care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have diabetes mellitus type 2 and are aged 18 years old or above.
 - You have an increased vascular risk (VRM).
 - You have the chronic lung condition chronic obstructive pulmonary disease (COPD).

- You have asthma.

Terms and conditions

- The claim is submitted through the principal contractor using one integrated rate. In this case, the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) applies.

Definition of multidisciplinary care.

Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances. Consultations may also be provided online if the healthcare programme has made arrangements for such.

- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- A referral is necessary if the treatment will be provided by a non-contracted healthcare provider. The referral must be drawn up by a general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, dentist, company doctor, nursing specialist or medical specialist.
- Referral is necessary if treatment at home is necessary.

Where to go for this healthcare

- Dietician who is affiliated with or contracted by a principal contractor. The dietician has 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Dietician who is affiliated with a contracted principal contractor in the case of asthma. The dietician has 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

- Dietetics as part of multidisciplinary care if you are already receiving dietetics outside multidisciplinary care prescribed on the same medical grounds. Also see the 'Dietetics' clause.
- Combined lifestyle intervention and dietetics at the same time for the same indication.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

District nursing and Personal Care Budget ('Persoonsgebonden Budget', PGB)

What you are insured for under your general insurance policy

District nursing (clause B.26.)

Insured healthcare

- District nursing. This includes nursing, care, coordination, observing and monitoring, prevention, and providing support for self-management and case management. Subject to certain terms and conditions, there is the option to apply for a Personal Care Budget for nursing and other care ('Persoonsgebonden Budget Verpleging en Verzorging', Zvw-pgb) to procure this care. We will set this budget based on the required number of hours of nursing and other care specified in the care needs assessment.

Your reimbursement

- Reimbursement of 100 % for district nursing.
- This is in-kind healthcare, so we reimburse:
 - for healthcare providers with a contract for this healthcare: 100% of the agreed rate.
 - for healthcare providers without a contract for this healthcare: 75% of your invoice up to 75% of the average rate agreed with healthcare providers with whom we have a contract.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - There is a need for nursing and other care, whereby this healthcare relates to the need for medical care.
This is medical care as referred to in Article 2.4 of the Dutch Health Insurance Decree ('Besluit zorgverzekering') or a high risk of that care.

Terms and conditions

- To qualify for the healthcare, you must be, in all reasonableness, reliant on care of that nature and to that extent.
- The care needs assessment and the healthcare to be provided must be appropriate to the condition. Nursing activities and care activities will be provided during one and the same visit to you wherever possible. If the healthcare you will be receiving only consists of care activities, you will be in regular contact with the nurse who assessed your care needs so that the nurse can check whether your situation has changed and adjust the care needs assessment and the care plan as necessary.
- The contents of the care plan and the care needs assessment must comply with the 'Standards framework for care needs assessment and nursing and other care organisation in the home environment' ('Normenkader voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving') drawn up by the Dutch Professional Organisation for Nurses and Professional Carers (Verpleegkundigen & Verzorgenden Nederland, V&VN).

A digital classification system is used for the care needs assessment.

The care needs assessment describes the type of nursing and other care you need and how often you need this. It also provides support for the assessment. The nurse (with a higher professional education degree) or clinical nurse specialist carrying out the care needs assessment and drawing up the treatment proposal records these in a care plan. This healthcare provider is involved in the healthcare provision on a continuous basis and will monitor whether the care needs assessment and the care plan (the healthcare provided) are still in line with the actual healthcare needs. This involvement and monitoring may be different if you have a Personal Care Budget. The conditions for this can be found in the Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care ('Reglement Zvw-pgb').

We assess whether the nursing process is clear from the care needs assessment report.

If you opt for a Personal Care Budget, we will use the conditions set out for this and your care needs assessment to determine whether you are eligible for nursing and other care under a Personal Care Budget ('pgb-verpleging en verzorging'). For more information, see the appendix Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care ('Reglement Zvw-pgb').

- The nurse (with a higher professional education degree) or clinical nurse specialist carrying out the care needs assessment and drawing up the treatment proposal is part of the network that organises healthcare and support in your area.

This is, for example, a district social support & care team, partnership of home care organisations and general practitioners and hospital.

- The healthcare provider or facility supplying the care must have an AGB code (administrative code assigned to healthcare professionals in the Netherlands) for district nursing and qualified staff. The healthcare provider supplying the care and claiming the costs therefore has access to at least one nurse with an AGB code (administrative code assigned to healthcare professionals in the Netherlands) for 'Nursing level 5' or higher who is permanently affiliated with the healthcare provider. Whether more than one level-5 nurse needs to be available depends on the nature of the healthcare being provided. You can ask us whether the healthcare provider meets these conditions.
- Certain forms of healthcare must be provided by specialist nurses. For example, certain nursing procedures and case management for people suffering from dementia. Our Healthcare Team ('Zorgteam') can help you find a suitable healthcare provider.
- The advice is to contact us for healthcare under different laws at the same time (integrated care). For example, healthcare under the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw), Dutch Youth Act ('Jeugdwet'), Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo) and Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz). We have made agreements with municipalities on the provision of integrated care so that we can coordinate the performance of both parties' statutory duties under the Dutch Health Insurance Act ('Zorgverzekeringswet') and the Dutch Social Support Act (Wmo). The agreements that are relevant to your health insurance can be found in these terms and conditions of insurance.
- If you opt for a Personal Care Budget, you must be able to carry out the tasks and obligations relating to the Personal Care Budget on your own.
 - we consider you able to fulfil the tasks and obligations that come with a Personal Care Budget under the Dutch Health Insurance Act, either independently or with the help of a legal or other representative. You can read about the aspects that we take into account in our assessment in the 'Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care'.
 - we consider you able to manage, either independently or with the help of a legal or other representative, the healthcare providers you have selected and align their care services in such a way that ensures responsible healthcare;
 - we consider you able to explain why you want a Personal Care Budget and why you believe that you can get the healthcare you need through a Personal Care Budget, either independently or with the help of a legal or other representative. If we do not consider you able to meet all the criteria, we will either deny you access to a Personal Care Budget under the Dutch Health Insurance Act or specify additional requirements that you must meet to qualify for a Personal Care Budget after all or again.
 - you will find the specific conditions and information on applying for a Personal Care Budget in the 'Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care'.
- As regards care paid for from a Personal Care Budget, it must concern care that you need for more than 1 year or otherwise palliative care. Palliative care means that your estimated life expectancy as determined by your attending doctor is under three months.

Who to get a treatment proposal from

- The care needs assessment for adults aged 18 years or older is carried out by at least a nurse with a higher professional education degree who is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG). The care needs assessment has been carried out in your presence and in your own environment.
- The care needs assessment for children under the age of 18 is carried out by at least a paediatric nurse with a higher professional education degree who is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG), or a clinical nurse specialist.
 - this clinical nurse specialist must have trained as a paediatric nurse;
 - this paediatric nurse or clinical nurse specialist must work for a BINKZ-affiliated healthcare provider (BINKZ is the sector organisation for integrated paediatric care)

- the care needs assessment is carried out in the child's own environment and in the presence of the child and the child's parent(s) or other legal representative (legal guardian, mentor or curator, for example).

Do you need approval?

- A contracted healthcare provider will assess whether you meet the conditions and whether the healthcare is covered under your insured healthcare. Our prior approval is not required in this case. A list of these healthcare providers is available on our website. Our approval is required, however, if the healthcare is provided by a non-contracted healthcare provider. The request for approval from a non-contracted healthcare provider is only valid if the indication is not older than 3 months.
- You need approval from us for a reassessment of your care needs. You can have your care needs reassessed by another nurse. The costs of this reassessment will only be reimbursed if we have given permission for this reassessment in advance. We may also appoint a different nurse for this reassessment. We may refuse such permission if, for example, you have already received a care needs assessment from several healthcare providers for the same period prior to requesting a reassessment. If we, on our part, have any doubts about the care needs identified by the first nurse, we can have your care needs reassessed on our own initiative.
- We will assess your request for a Personal Care Budget based on the completed forms you submit. You can read more about this in the appendix 'Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care'. The application form (in Dutch) for the Personal Care Budget under the Dutch Health Insurance Act ('Zvw-pgb-aanvraagformulier') is available on our website. You can also contact us by phone or by post to request a copy.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Nurse - level 4 or 5 registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Healthcare provider (professional staff) who is authorised and competent to perform the activities and can demonstrate this on request. Reserved activities are carried out in accordance with the applicable frameworks and standards. If you have any doubt as to whether a care worker's activities are legitimate, you can contact our Healthcare Team ('Zorgteam').
- If you purchase healthcare through a Personal Care Budget, this may also be a different healthcare provider to those listed above. You will find the qualifying criteria for the healthcare provider in the 'Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care'.

Where the treatment takes place

- At your home.
- Intensive care for children can also take place in a children's hospice or medical day care centre.

What is not reimbursed

- Obstetric care. We reimburse this healthcare under the 'Healthcare after childbirth' clause.
- District nursing in combination with a stay in a facility, except in the case of intensive care for children.
- You cannot purchase care through a Personal Care Budget in the case of intensive care for children in combination with a stay in a facility. Not even when this relates to intensive care for children in combination with a stay in a facility; in that case, only district nursing without the use of a Personal Care Budget ('Persoonsgebonden Budget', PGB) is possible.

- Healthcare for children under the age of 18 aimed at addressing a lack of independence in carrying out Activities of Daily Living (ADLs).
This healthcare comes under the Dutch Youth Act ('Jeugdwet') because the healthcare does not take place in a medical context.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Foot care

What you are insured for under your general insurance policy

Preventive foot care (clause B.23.)

Insured healthcare

- Foot care.
This involves preventive foot care.

Your reimbursement

- Reimbursement of 100 % for preventive foot care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies if a medical specialist at the hospital provides the healthcare and claims the costs as part of a diagnosis-treatment combination ('Diagnose Behandel Combinatie', DBC).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - Below the ankle, you have an increased risk of a wound through all layers of the skin (foot ulcers).
This is due to one of the following situations:
 - your feet have become less sensitive to pressure (loss of protective sensibility);
 - blood circulation in your feet has decreased;
 - the pressure on your skin has increased; this may be associated with fragile skin.

Or this is due to one of these indications as described in the position document on foot care for diabetes mellitus patients ('Standpunt voetzorg bij diabetes mellitus') and the memo clarifying the position on foot care for diabetes mellitus patients ('Notitie verduidelijking standpunt voetzorg voor mensen met diabetes mellitus') of 'Zorginstituut Nederland' (ZiNI):

- a foot ulcer or a previous amputation;
- inactive Charcot arthropathy (Charcot joint);
- end-stage kidney failure or kidney dialysis.

Terms and conditions

- Your complaints and symptoms are the result of a medical condition or medical treatment. Zorginstituut Nederland (ZiNI) has described them in:
 - the position document on foot care for diabetes mellitus patients ('Standpunt voetzorg bij diabetes mellitus'); and
 - the memo clarifying the position on foot care for diabetes mellitus patients ('Notitie verduidelijking standpunt voetzorg voor mensen met diabetes mellitus').
- There is an individual treatment plan that includes:

- the number of treatments and check-ups required; and
- the diagnostics used to determine the targeted treatment.
- The preventive foot care for type 2 diabetes can also be provided in the form of multidisciplinary care. See clause A.17.3.
- The claim is submitted through.
 - the principal contractor (possibly a podiatrist) in accordance with the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg); or - the individual, affiliated healthcare providers with what is known as 'costs for organisation and infrastructure', i.e. the overhead costs claimed by the principal contractor.

Definition of multidisciplinary care.

Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances. Consultations may also be provided online if the healthcare programme has made arrangements for such.

Who to get a referral from

- General practitioner, medical specialist, physician assistant or nursing specialist.
If a podiatrist, medical pedicurist or pedicurist with the DV (diabetes) certificate provides the healthcare.

Where to go for this healthcare

- Medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- General practitioner and/or other healthcare provider (e.g. medical specialist or medical pedicurist for diabetes) who is affiliated with or contracted by a principal contractor.
- Podiatrist.
A podiatrist with 'kwaliteitsgereregistreerd' (quality registered) status in the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') who is a member of the Dutch Association of Podiatrists ('Nederlandse Vereniging van Podothérapeuten', NVvP).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner

What you are insured for under your general insurance policy

General practitioner care for advice, examination, supervision and multidisciplinary care (clause B.3.1.)

Insured healthcare

- General practitioner care for advice, examination, supervision and multidisciplinary care.
Examples of this type of healthcare include:
 - health advice and preventive healthcare in areas such as quitting smoking (see the 'Quitting smoking' clause), problematic alcohol use, depression and being overweight;
 - treatment;

- diagnostic tests carried out by and at the general practice;
- request for MRI for indications specified in NHG ('Nederlands Huisartsen Genootschap', Dutch College of General Practitioners) guidelines and standards;
- pre-conception care to start a pregnancy as healthily as possible;
- multidisciplinary care if this relates to:
 - diabetes mellitus type II (DM Type II) in insured persons who are aged 18 or above;
 - cardiovascular/vascular risk management to manage cardiovascular disease for insured persons aged 18 and above;
 - chronic obstructive pulmonary disease (COPD);
 - asthma suffered by insured persons from the age of 16.

Your reimbursement

- Reimbursement of 100 % for general practitioner care for advice, examination, supervision and multidisciplinary care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible.
- From the age of 18, a deductible does apply to vaccinations and vaccines, for example (though not to the administration of such).
- From the age of 18, the deductible applies to an MRI, or laboratory or diagnostic tests carried out by a hospital or independent laboratory.

Terms and conditions

- In the case of multidisciplinary care, the principal contractor submits the claim. In accordance with the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg') defined on the basis of the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg).

Definition of multidisciplinary care.

Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances. Consultations may also be provided online if the healthcare programme has made arrangements for such.

- The integrated care is provided in accordance with the healthcare standards that apply for these conditions.

Also see the general 'Healthcare providers' clause and the definition of 'principal contractor'.

Where to go for this healthcare

- General practitioner.

A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.

- Healthcare provider within the general practice, out-of-hours general practitioner surgery or healthcare group.
The healthcare provider (such as a practice assistant, nurse, physician assistant) works under the ultimate responsibility of the general practitioner.
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home).
- General practitioner or other healthcare provider in multidisciplinary care.
 - for healthcare in the case of asthma or cardiovascular risk management for increased vascular risk, the healthcare provider is affiliated with a contracted principal contractor;
 - for healthcare in the case of COPD, DM type II or cardiovascular risk management for cardiovascular disease, the healthcare provider must meet the standards set out in the policy rule of the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) on general practitioner care and multidisciplinary care ('Huisartsenzorg en multidisciplinaire zorg').

The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). Or at the location where the healthcare provider (affiliated with a principal contractor or working in a regional partnership with several healthcare providers of different disciplines) works.

What is not reimbursed

- Medical screening or check-up at your request, i.e. without medical necessity.
- Advice and vaccinations for travel abroad.
This healthcare is described in another clause.
- Certificates, vaccinations and tests without a medical purpose.
For example, pre-employment and occupational screening, or tests in relation to your study, driving licence or pilot's licence.
- Population screening.
- Treatment that has an educational aim.
- Treatments for medical pedagogical issues.
- Intelligence test.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care for medical care (clause B.3.2.)

Insured healthcare

- General practitioner care for medical care.
This is medical care for which we have contracted your general practitioner or for which the Dutch Healthcare Authority has set performance descriptions in the Policy Rule on Other Medical Care ('Beleidsregel Overige Geneeskundige Zorg'). This includes procedures like:
 - (minor) surgical procedures;
 - injection therapy (Cyriax);
 - compression therapy for open wounds;
 - removal of a foreign object from the eye;
 - hearing tests (audiometry);
 - electrocardiograph (ECG tests);
 - blood vessel tests (Doppler test);
 - pulmonary function test (spirometry).

Your reimbursement

- Reimbursement of 100 % for general practitioner care for medical care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible.

Where to go for this healthcare

- General practitioner.

A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care for implanting or removing an IUD or contraceptive implant (e.g. Implanon) (clause B.3.2.)

Insured healthcare

- General practitioner care for implanting or removing an IUD or contraceptive implant (e.g. Implanon).
This involves medical healthcare for which we have a contract with your general practitioner, or for which the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) has given performance descriptions in its Policy Rule on Other Medical Care ('Beleidsregel Overige Geneeskundige Zorg').

Your reimbursement

- Reimbursement of 100 % for general practitioner care for implanting or removing an IUD or contraceptive implant (e.g. Implanon).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible.
- From the age of 18, the deductible applies to an IUD or Implanon rod (though not to the insertion or removal of such).

Who to get a referral from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- General practitioner.

A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.

- Obstetrician.

An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care for cow's milk allergy and the cow's milk allergy test (clause B.3.2.)

Insured healthcare

- General practitioner care for cow's milk allergy and the cow's milk allergy test.

Your reimbursement

- Reimbursement of 100 % for general practitioner care for cow's milk allergy and the cow's milk allergy test.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You are suspected to have an allergy to cow's milk.

Terms and conditions

- The cow's milk allergy test is a double-blind food challenge test. This test is carried out in accordance with the applicable youth healthcare guidelines on food allergies ('richtlijn Voedselovergevoeligheid') published by the Dutch Youth Health Care Services ('Jeugdgezondheidszorg', 'JGZ'). Test food containing cow's milk and free of cow's milk is offered under medical supervision over a number of sessions. No one (neither you, nor your child, nor the healthcare provider) knows which foods contain cow's milk.

Who to get a referral from

- General practitioner.
- Medical specialist.

Do you need approval?

- A contracted healthcare provider will check a doctor's statement to see whether the prescription and you meet the conditions. Our prior approval is not required in this case. The healthcare provider prescribing the dietary preparation must complete the doctor's statement. If you purchase the dietary preparation from a non-contracted healthcare provider, the doctor's statement must be sent to us and we will check whether the prescription and you meet the conditions. All the latest information on assessing medicines and preparations is available at www.znformulieren.nl (in Dutch). Go to 'Farmacie' (pharmacy) and then to 'Dieetpreparaten' (dietary preparations).

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Healthcare provider under the responsibility of a youth healthcare doctor. We have written agreements with the healthcare provider about carrying out this test.

What is not reimbursed

- The testing period prior to the final diagnosis.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care with a focus on tuberculosis and infectious diseases (clause B.3.2.)

Insured healthcare

- General practitioner care with a focus on tuberculosis and infectious diseases (e.g. a Mantoux test). This may involve referral, diagnosis, treatment and supervision. A Mantoux test may also be done.

Your reimbursement

- Reimbursement of 100 % for general practitioner care with a focus on tuberculosis and infectious diseases.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible.
- From the age of 18, a deductible does apply to vaccinations and vaccines, for example (though not to the administration of such).
- From the age of 18, the deductible applies to an MRI, or laboratory or diagnostic tests carried out by a hospital or independent laboratory.

Terms and conditions

- Only a contracted 'GGD' (regional health authority) can claim the costs of a Mantoux test for tuberculosis or infectious diseases (on a consultation basis).

Who to get a referral from

- General practitioner.
- Medical specialist.

Where to go for this healthcare

- Qualified and nationally registered doctor.
According to the Royal Dutch Medical Association's Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). This might be, for example, a doctor for the control of infectious diseases, employed by a 'GGD' (regional health authority).

What is not reimbursed

- Mantoux test as part of prevention before a trip to a foreign country.
This healthcare is described in the 'Prevention for travel abroad' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care for mental healthcare (clause B.3.3.)

Insured healthcare

- General practitioner care for mental healthcare.
 - healthcare to treat minor psychological complaints if you do not have (or yet have) a disorder as defined by DSM-5 criteria;
 - preventive healthcare for complaints that could develop into a psychological disorder, panic disorder or problematic alcohol use;
 - healthcare for a suspected minor psychiatric disorder. The disorder is non-complex, has a low risk and shows short-term symptoms;
 - healthcare and supervision in a stable, chronic situation for a mental health issue that has a low risk of relapse and is not crisis-sensitive.

Your reimbursement

- Reimbursement of 100 % for general practitioner care for mental healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have psychological complaints or addiction problems.

Terms and conditions

- The results of a targeted questionnaire and diagnostic consultation are required in order to be able to determine whether you can be treated by a general practitioner.

Where to go for this healthcare

- General practitioner, preferably supported by the primary care practice assistant specifically trained for mental healthcare ('POH GGZ').
The healthcare is provided by or under the responsibility of a general practitioner. This is a doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home).
- Online through a programme recognised by us.

What is not reimbursed

- Consultations and treatment for a psychological or psychiatric disorder that requires treatment under medical mental healthcare on either an inpatient or outpatient basis.
This healthcare is described in the 'Medical mental healthcare' clause; your general practitioner can refer you.
- Treatments for medical pedagogical issues.
- Treatment that has an educational aim.
- Intelligence test.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General practitioner care and combined lifestyle intervention from the age of 18 (clause B.3.4.)

Insured healthcare

- General practitioner care for combined lifestyle intervention for adults.
This care is aimed at bringing about a change in behaviour in order to achieve and maintain a healthy lifestyle. It is a combination of:
 - advice and guidance on nutrition and eating habits;
 - advice and guidance on healthy exercise, i.e. encouraging exercise and keeping you motivated, monitoring progress and pointing out exercise opportunities in the social sphere;
 - advice on and guidance towards establishing permanent behavioural change to acquire and maintain a healthy lifestyle;
 - healthcare-related feedback to the referring healthcare provider about the progress;
 - an evaluation, with a review of your wishes for a possible maintenance phase.

Your reimbursement

- From 18 year(s): reimbursement of 100 % for general practitioner care and combined lifestyle intervention from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a moderately high BMI (weight-related health risk).
One of the following situations applies to you. You have:
 - a BMI of 30kg/m² or more; or
 - a BMI of 25kg/m² or more with an increased risk of cardiovascular conditions and type 2 diabetes mellitus based on the cardiovascular risk, obesity and diabetes healthcare standards;
 - a BMI of 25kg/m² or more and osteoarthritis or sleep apnea.

Terms and conditions

- You may only take part in the maintenance phase of the programme after completing the treatment phase.
- The healthcare is provided in the form of a healthcare programme recognised by us. A list of such programmes is available on our website.
If you switch to another health insurer during the health care programme, you can continue with the programme at the expense of your new health insurer.

Who to get a referral from

- General practitioner, possibly in consultation with geriatric specialist, doctor for the mentally disabled and/or medical specialist.

Do you need approval?

- You only need our approval if you have received this healthcare before and you want to make use of it again.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Lifestyle coach.
The healthcare is provided by a healthcare provider registered as a lifestyle coach with the professional association of lifestyle coaches in the Netherlands ('Beroepsvereniging Leefstijl Coaches Nederland', BLCN), the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF), the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF) or the Dutch Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici'). This lifestyle coach works in consultation with and provides feedback to the referring healthcare provider.

What is not reimbursed

- Exercise or sport (or guidance during this).
- Day treatment and/or admission.
- Combined lifestyle intervention and dietetics at the same time for the same indication.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Healthcare and support for overweight and obese children (clause B.3.5.)

Insured healthcare

- Healthcare and support for overweight and obese children.
The healthcare consists of:
 - guidance and coordination under the responsibility of a central healthcare provider;
 - the collection of an expansive medical history.
This is an interview to gain insight into various factors that may play a role in becoming or remaining overweight;
 - the central healthcare provider organising a cross-domain multidisciplinary consultation.
This is to discuss the goals of the healthcare plan;
 - combined lifestyle intervention programme from the age of 2.
This is a programme providing advice and guidance concerning
 - a healthy diet
 - healthy eating habits
 - healthy exercise.The combined lifestyle intervention programme is aimed at bringing about a change in behaviour in order to achieve and maintain a healthy lifestyle.

Your reimbursement

- Up to and including 17 year(s): reimbursement of 100 %, maximum of 3.5 years for healthcare and support for overweight and obese children.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - Your child is overweight or obese and has at least a moderately increased weight-related health risk.
This can be:
 - a BMI of 30kg/m²; or
 - a BMI of 25kg/m² with an increased risk of cardiovascular conditions and type 2 diabetes mellitus based on the cardiovascular risk, obesity and diabetes healthcare standards; or
 - a BMI of 25kg/m² and osteoarthritis or sleep apnea.

Terms and conditions

- There must be an action plan that includes a combined lifestyle intervention programme.
- If your child turns 18 while in the programme, your child may complete the programme.
- In the event of no entitlement to reimbursement of the costs of this healthcare, your child may possibly be able to turn to your municipality for care and support.
- The healthcare forms part of the integrated care approach to childhood overweight and obesity ('Ketenaanpak voor kinderen met overgewicht en obesitas').
The healthcare providers involved make demonstrable collaboration agreements with parties in the social sphere.

Who to get a referral from

- General practitioner.
- Paediatrician.
- Youth healthcare doctor.
- Youth healthcare nurse.

Do you need approval?

- You only need our approval if the healthcare has been suspended in the meantime and the course of treatment needs to be restarted later.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Central healthcare provider for anamnesis, coordination, guidance and follow-up care.
This is a youth healthcare nurse with training as a central healthcare provider. Our website tells you which healthcare providers you can visit. You can also contact us for this information.
- Child lifestyle coach for the combined lifestyle intervention programme with a higher professional education degree.
Our website tells you which healthcare providers you can visit. You can also contact us for this information.

What is not reimbursed

- Switching to a combined lifestyle intervention programme for adults if your child turns 18 during the CLI programme.
- A follow-up combined lifestyle intervention programme for adults in continuance of the combined lifestyle intervention programme for children.
- Exercise or sport (or guidance during this).
- Combined lifestyle intervention and dietetics at the same time for the same indication.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Healthcare after childbirth

What you are insured for under your general insurance policy

Obstetric and midwifery care after childbirth at your home (clause B.7.)

Insured healthcare

- Midwifery care following childbirth at your home.
- Obstetric care following childbirth at your home.

Your reimbursement

- From 0 euros: reimbursement of 100 %, spread over a maximum of 6 weeks for obstetric and midwifery care after childbirth at your home.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- The statutory personal contribution for obstetric care is €5.10 per hour.
- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- You arrange the obstetric care yourself. You do so no later than your 20th week of pregnancy.
If you have any questions or anything is not clear, feel free to contact us.

- Registration and the initial interview for obstetric care take place before the birth of the child or the obstetric care.
This may be done at your home or by telephone. During the intake you will discuss the number of days of obstetric care and the number of hours per day.
- After childbirth, the obstetrician or medical specialist will determine how much obstetric care (number of hours and days) is needed.
This assessment is based on the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). Please ask us for a copy of this indication protocol, or download a copy from our website.
- The obstetric care is given immediately after childbirth.
The obstetric care is for:
 - the biological mother;
 - the carer (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines this;
 - the newborn(s).

Where to go for this healthcare

- Obstetric nurse.
The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions:
 - is qualified to nursing or obstetric nursing level 3 or equivalent;
 - is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg');
 - works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').
- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Obstetric and midwifery care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre (clause B.7.)

Insured healthcare

- Midwifery care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre. There were no medical grounds relating to the childbirth.
- Obstetric care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre. There were no medical grounds relating to the childbirth.

Your reimbursement

- From 0 euros: reimbursement of 100 %, spread over a maximum of 6 weeks, maximum of €143 per person per day for obstetric and midwifery care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €20 per person per day.
Statutory personal contribution and maximum reimbursement.
If you give birth in a facility on non-medical grounds:

- the reimbursement is 2 x €143 per day, for mother and child, meaning the total reimbursement for this childbirth is €286.
- however, from this we will deduct, for mother and child, the statutory personal contribution of €20, i.e. a total of €40.
- you will therefore receive €286 - €40 = a maximum of €246 per day from us.
- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- You arrange the obstetric care yourself. You do so no later than your 20th week of pregnancy. If you have any questions or anything is not clear, feel free to contact us.
- Registration and the initial interview for obstetric care take place before the birth of the child or the obstetric care.
This may be done at your home or by telephone. During the intake you will discuss the number of days of obstetric care and the number of hours per day.
- After childbirth, the obstetrician or medical specialist will determine how much obstetric care (number of hours and days) is needed.
This assessment is based on the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). Please ask us for a copy of this indication protocol, or download a copy from our website.
- The obstetric care is given immediately after childbirth.
The obstetric care is for:
 - the biological mother;
 - the carer (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines this;
 - the newborn(s).
- Obstetric care in a facility counts towards the total number of hours you have agreed for obstetric care at home.
During the intake for obstetric care, you agreed on a number of hours of obstetric care. If you give birth in a facility (hospital or birth centre) and stay there for several more days you will also receive obstetric care there. This is known as relocated obstetric care: the obstetric care that would have been provided at your home is provided at the facility instead. These hours of obstetric care are subtracted from the number of hours discussed during the intake.

Where to go for this healthcare

- Birth centre.
A facility for first-line midwifery care (also known as a birth clinic or childbirth centre) in a hospital. This is a place where you can give birth and, if necessary, stay for a period of time afterwards.
- Birth clinic.
A facility where you can stay after giving birth and receive obstetric care. You cannot give birth in a birth clinic.
- Obstetric nurse.
The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions:
 - is qualified to nursing or obstetric nursing level 3 or equivalent;
 - is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg');
 - works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').
- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Obstetric and midwifery care after childbirth in hospital on medical grounds (clause B.7.)

Insured healthcare

- Obstetric and midwifery care after childbirth in hospital on medical grounds.
This involves care after childbirth in a specialist medical healthcare facility. This healthcare includes any medicines, medical aids and dressings required for the specialist medical healthcare during a period of admission.

Your reimbursement

- Reimbursement of 100 % for obstetric and midwifery care after childbirth in hospital on medical grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- The obstetric care is given immediately after childbirth.
The obstetric care is for:
 - the biological mother;
 - the carer (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines this;
 - the newborn(s).
- In case of admission or a stay, obstetric care is included in the admission (nursing and other care).
The number of days of admission are used to calculate the number of hours/days of obstetric care that remain.
- You have medical grounds for this healthcare.
Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.

Who to get a referral from

- Obstetrician.
- General practitioner.
- Medical specialist.
- Physician assistant.
- Nursing specialist.

Where to go for this healthcare

- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

- **Medical specialist.**

A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.

The healthcare is provided in a hospital or independent treatment centre (ZBC).

Where the treatment takes place

- Facility for specialist medical healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Healthcare before childbirth

What you are insured for under your general insurance policy

Preconception care, midwifery care and preventive care on non-medical grounds (clause B.5.1.)

Insured healthcare

- Pre-conception care, midwifery care and preventive care on non-medical grounds.
This concerns the following healthcare:
 - insertion of IUD/implants and/or removal of an Implanon rod;
 - pre-conception consultation: advice and information at the request of the insured to promote a healthy start to an intended pregnancy. The focus is on medical history, lifestyle factors (alcohol, smoking, drugs and weight), taking folic acid, hereditary factors, environmental factors (such as working conditions), any previous pregnancy complications, current use of medication, and any childhood diseases and vaccinations;
 - obstetric and preventive care during pregnancy to promote good health for mother and child.

Your reimbursement

- Reimbursement of 100 % for preconception care, midwifery care and preventive care on non-medical grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.
- From the age of 18, the deductible applies to an IUD or Implanon rod (though not to the insertion or removal of such).

Where to go for this healthcare

- General practitioner who is registered with the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home).
- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Preconception care, midwifery care and preventive care on medical grounds (clause B.5.1.)

Insured healthcare

- Pre-conception care, midwifery care and preventive care on medical grounds.
 - pre-conception consultation: advice and information at the request of the insured to promote a healthy start to an intended pregnancy. The focus is on medical history, lifestyle factors (alcohol, smoking, drugs and weight), taking folic acid, hereditary factors, environmental factors (such as working conditions), any previous pregnancy complications, current use of medication, and any childhood diseases and vaccinations; and
 - obstetric and preventive care during pregnancy to promote good health for mother and child.

Your reimbursement

- Reimbursement of 100 % for preconception care, midwifery care and preventive care on medical grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.
- From the age of 18, the deductible applies to the insertion of an IUD or implantation or removal of an Implanon rod.

Terms and conditions

- You have medical grounds for this healthcare.
Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.

Who to get a referral from

- General practitioner.
- Physician assistant.
- Obstetrician.
- Nursing specialist.

Where to go for this healthcare

- Gynaecologist.

A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks.

The healthcare is provided in a hospital or independent treatment centre (ZBC).

Where the treatment takes place

- Facility for specialist medical healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

General routine ultrasound (clause B.5.2.)

Insured healthcare

- General routine ultrasound.

Your reimbursement

- Reimbursement of 100 % for general routine ultrasound.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Who to get a referral from

- General practitioner for treatment by a medical specialist or sonographer.
- Obstetrician for treatment by a medical specialist or sonographer.
- Physician assistant for treatment by a medical specialist or sonographer.
- A referral is not necessary if you are already being treated by a medical specialist for midwifery care.

Where to go for this healthcare

- Medical specialist.

A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.

The healthcare is provided in a hospital or independent treatment centre (ZBC).

- General practitioner.

A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).

The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.

- Obstetrician.

An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

- **Sonographer.**
An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians (KNOV) or the register administered by the Dutch Professional Association of Sonographers ('Beroepsvereniging Echoscopisten Nederland', BEN).
The healthcare takes place in an ultrasound centre or antenatal screening centre.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Specific diagnostic ultrasound (clause B.5.2.)

Insured healthcare

- Specific diagnostic ultrasound.

Your reimbursement

- Reimbursement of 100 % for specific diagnostic ultrasound.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Terms and conditions

- You have medical grounds for this healthcare.
Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.

Who to get a referral from

- General practitioner for treatment by a medical specialist or sonographer.
- Obstetrician for treatment by a medical specialist or sonographer.
- Physician assistant for treatment by a medical specialist or sonographer.
- A referral is not necessary if you are already being treated by a medical specialist for midwifery care.

Where to go for this healthcare

- **Medical specialist.**
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- **General practitioner.**
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- **Obstetrician.**
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).

- **Sonographer.**
An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians (KNOV) or the register administered by the Dutch Professional Association of Sonographers ('Beroepsvereniging Echoscopisten Nederland', BEN).
The healthcare takes place in an ultrasound centre or antenatal screening centre.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Antenatal screening on non-medical grounds (clause B.5.3.)

Insured healthcare

- Antenatal screening in the form of counselling.
During counselling, you are provided with information about the antenatal screening.

Your reimbursement

- Reimbursement of 100 % for antenatal screening on non-medical grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Where to go for this healthcare

- Antenatal screening counsellor.
An antenatal screening counsellor has a quality agreement with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') and meets the requirements as stated in the quality requirements for antenatal screening counselling ('Kwaliteitseisen counseling prenatale screening') published by the Dutch National Institute for Public Health and the Environment ('RIVM'). The antenatal screening counsellor also complies with the refresher training/upskilling requirements.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Antenatal screening on medical grounds (clause B.5.3.)

Insured healthcare

- Antenatal screening on medical grounds in the form of the non-invasive prenatal test (NIPT) and the invasive diagnostic test.

Your reimbursement

- Reimbursement of 100 % for antenatal screening on medical grounds.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Terms and conditions

- You have medical grounds for this healthcare.
Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.
- There are medical grounds for an invasive diagnostic test.
There may also be medical grounds for an invasive diagnostic test if a non-invasive prenatal test (NIPT) shows a significant risk of a foetus with a chromosome aberration.

Who to get a referral from

- General practitioner for treatment by a medical specialist or sonographer.
- Obstetrician for treatment by a medical specialist or sonographer.
- A referral is not necessary if you are already being treated by a medical specialist for midwifery care.

Where to go for this healthcare

- Medical specialist under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS) and that for antenatal screening: - is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO); or - works in partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
- General practitioner under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS) and that for antenatal screening: - is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO); or - works in partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
- Obstetrician under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV) and that for antenatal screening: - is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO); or - works in partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
The healthcare is provided at a birth centre, birth clinic, your home or your temporary place of residence.
- Sonographer under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians (KNOV) or the register administered by the Dutch Professional Association of Sonographers ('Beroepsvereniging Echoscopisten Nederland', BEN) and that for antenatal screening: - is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO); or - works in partnership with a Regional Antenatal Screening Centre ('Regionaal Centrum voor Prenatale Screening') that is licensed under the Dutch Population Screening Act ('Wet op het bevolkingsonderzoek', WBO).
The healthcare takes place in an ultrasound centre or antenatal screening centre.

Where the treatment takes place

- Blood lab must be recognised under the TRIDENT study because the non-invasive prenatal test (NIPT) is performed in the context of scientific research (the TRIDENT study).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Registration and initial interview for obstetric care (clause B.5.4.)

Insured healthcare

- Registration and initial interview for obstetric care.
The initial interview involves discussion about the obstetric care (the type and number of hours) you will receive after childbirth.

Your reimbursement

- Reimbursement of 100 %, once per pregnancy for registration and initial interview for obstetric care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Terms and conditions

- The number of hours of obstetric care is indicated on the basis of the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').
- The registration and initial interview may be performed at your home, or over the telephone.

Where to go for this healthcare

- Obstetric care facility.
- Obstetric nurse.

The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions:

- is qualified to nursing or obstetric nursing level 3 or equivalent;
- is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg');
- works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').

What is not reimbursed

- Costs for registration at a birth centre or birth clinic.
Unless you stay there for the entire period after giving birth and you no longer receive obstetric care at home.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Healthcare during childbirth

What you are insured for under your general insurance policy

Midwifery care during a home birth (clause B.6.)

Insured healthcare

- Home birth.
This involves midwifery care without medical grounds during childbirth. This includes pre-delivery and post-delivery care. You receive this care at home. This also includes the assistance of a nurse or obstetric nurse during the birth itself (partus assistance). This is provided on the basis of the Detailed Partus Assistance Framework ('Inhoudelijk Kader Partusassistentie') up to the maximum number of hours specified in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). Please ask us for a copy of this framework and indication protocol, or download a copy (in Dutch) from our website.

Your reimbursement

- Reimbursement of 100 % for midwifery care during a home birth.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- Childbirth means the end of pregnancy, at any time after week 16.
- The maximum reimbursement per day and the statutory personal contribution per day will remain the same, regardless of whether the birth involves one child or several children.

Where to go for this healthcare

- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).
- General practitioner.
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Nurse.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Obstetric nurse.
The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions:
 - is qualified to nursing or obstetric nursing level 3 or equivalent;
 - is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg');
 - works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Midwifery care in a hospital or birth centre (clause B.6.)

Insured healthcare

- Midwifery care in a hospital or birth centre.
This involves midwifery care without medical grounds during childbirth. This includes pre-delivery and post-delivery care. You receive this healthcare in a hospital (outpatient delivery in a midwifery unit) or in a birth centre.
This also includes the assistance of a nurse or obstetric nurse during the birth itself (partus assistance). This is provided on the basis of the Detailed Partus Assistance Framework ('Inhoudelijk Kader Partusassistentie') up to the maximum number of hours specified in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). Please ask us for a copy of this framework and indication protocol, or download a copy (in Dutch) from our website.

Your reimbursement

- Reimbursement of 100 %, maximum of €246 for midwifery care in a hospital or birth centre.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- If more than €246 is charged for the delivery, you will also have to pay any amount in excess of €246 yourself.
- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- Childbirth means the end of pregnancy, at any time after week 16.
- The maximum reimbursement per day and the statutory personal contribution per day will remain the same, regardless of whether the birth involves one child or several children.

Where to go for this healthcare

- Medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Obstetrician.
An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians ('Koninklijke Nederlandse Organisatie van Verloskundigen', KNOV).
- General practitioner.
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Nurse.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

- **Obstetric nurse.**
The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions:
 - is qualified to nursing or obstetric nursing level 3 or equivalent;
 - is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care (' Kenniscentrum Kraamzorg');
 - works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Midwifery care during childbirth in a hospital under the supervision of a specialist medical team (clause B.6.)

Insured healthcare

- Midwifery care during childbirth in a hospital under the supervision of a specialist medical team.
This involves midwifery care on medical grounds. This includes pre-delivery and post-delivery care. If medical grounds are deemed to exist in relation to your delivery, you will have to give birth in the hospital under the supervision of a specialist medical team. This also includes the assistance of a nurse or obstetric nurse during the birth itself (partus assistance). This is provided on the basis of the Detailed Partus Assistance Framework ('Inhoudelijk Kader Partusassistentie') up to the maximum number of hours specified in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg'). Please ask us for a copy of this framework and indication protocol, or download a copy (in Dutch) from our website.

Your reimbursement

- Reimbursement of 100 % for midwifery care during childbirth in a hospital under the supervision of a specialist medical team.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise.

Terms and conditions

- Childbirth means the end of pregnancy, at any time after week 16.
- The hours you stay in the facility after childbirth on medical grounds will be deducted from the total number of hours of obstetric care to which you would have been entitled at home.
This is known as relocated obstetric care; the indicated obstetric care that would have been provided at home is moved to the facility.
- You have medical grounds for this healthcare.
Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.

Who to get a referral from

- General practitioner.
- Obstetrician.

Where to go for this healthcare

- Medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Nurse.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Obstetric nurse.
The obstetric nurse works independently or is employed by a facility that organises the obstetric care.
The obstetric nurse meets all the following conditions:
 - is qualified to nursing or obstetric nursing level 3 or equivalent;
 - is listed on the Quality Register for Obstetric Nurses ('Kwaliteitsregister Kraamverzorgenden') at the Dutch Knowledge Centre for Obstetric Care ('Kenniscentrum Kraamzorg');
 - works in accordance with the National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical aids

What you are insured for under your general insurance policy

Hairpiece (wig) (clause B.17.6.)

Insured healthcare

- Hairpiece (wig).

Your reimbursement

- From 0 euros: reimbursement of 465 euros, maximum for hairpiece (wig).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have complete or partial baldness due to a medical condition or medical treatment.

Terms and conditions

- The medical aid is effective and appropriate to your personal situation.
There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation.
The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Attending doctor.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider must be accredited under the 'Erkenningsregeling Haarwerken' (Accreditation scheme for hairpieces) set up by SEMH and/or have an 'ANKO Haarwerk' specialist certificate.
SEHM is the 'Stichting Erkenningsregeling leveranciers Medische Hulpmiddelen' (Accreditation scheme foundation for suppliers of medical aids). ANKO is the 'Algemene Nederlandse Kappers Organisatie' (General Dutch Hairdressers Organisation).

What is not reimbursed

- Hairpieces for normal male hair loss (alopecia androgenetica).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Medical aids related to hearing disorders (clause B.17.8.)

Insured healthcare

- External medical aids related to hearing disorders (hearing).
This is the general description that may include several medical aids that have not been specifically described to compensate for the aforementioned functional limitation.
The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through objective, scientific research. An exception applies to conditionally authorised care, see the 'Conditional healthcare' clause.

Your reimbursement

- Reimbursement of 100 % for medical aids related to hearing disorders.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- From the age of 18, the deductible applies to medical aids that will be yours to keep. Medical aids on loan are not subject to the deductible, except for costs involved in the use of and consumables for the medical aid in question.

Terms and conditions

- The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through scientific research.
- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
A medical aid is considered to be a functioning medical aid if it is ready for use when delivered. Upon the first purchase, the medical aid must come with instructions for use, batteries or charging equipment, and the accessories needed to make the medical aid work properly.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary.
The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal. Replacement of any batteries never qualifies for reimbursement.
- You must take good care of the medical aid you own or have on loan.
You must, in any case, observe the guidelines or warranty conditions of the manufacturer or healthcare provider. As a result, replacement within the period of use will not be necessary. You must pay for damage (repair or replacement costs) caused by incorrect use or negligence on your part.
If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.
- For information, advice and guidance, you can contact our 'Medische Beoordelingen' (Medical Assessments) department.
- Depending on the medical aid, you can either borrow it or own it.

Who to get a referral from

- Doctor who is authorised for this.

Do you need approval?

- You need approval from us if you think you are entitled to a medical aid that we have not mentioned. Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- You need approval from us if you think you are entitled to a medical aid and you do not meet the terms and conditions stated.
Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- For a spare medical aid, the contracted healthcare provider will assess whether you meet the conditions and whether the medical aid is covered under your insured healthcare. Our prior approval is not required in this case.
In a number of cases, a spare medical aid is desirable and necessary. This is subject to medical grounds.
If you want to purchase a spare medical aid from a non-contracted healthcare provider, you must personally submit a (first or repeat) healthcare request to us for approval.

- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Medical aids that come under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Medical aids used during admission or specialist medical treatment. See the 'Specialist medical healthcare' clause.
- Costs of normal use of the medical aid such as energy consumption and battery replacement.
- Medical aids that are commonly used or that replace commonly used medical aids in everyday life. These are medical aids that do not have a direct relationship to a limitation or disorder and/or permanent medical aids that are not excessively expensive. For example: computers, mobile phones, caps, scarves and turbans, walking frames, adapted eating utensils, a jar opener or a reacher/grabber.
- Medical aids (or modifications to medical aids) if they are used exclusively or predominantly in the working or learning environment.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

- [Medical aids on loan](#) (definitions)
- [Owned medical aids](#) (definitions)

Calling apps for the deaf and hearing impaired (clause B.17.8.)

Insured healthcare

- Calling apps for the deaf and hearing impaired. Special software for Total Conversation using regular telephone or smartphone for video and text telephony.

Your reimbursement

- Reimbursement of 100 % for calling apps for the deaf and hearing impaired.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Medical aids on loan are not subject to the deductible. The costs involved in the use thereof and consumables for the medical aid are subject to the deductible.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- You are given this medical aid on loan.

Who to get a referral from

- Attending doctor.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Call charges.
- Use of the app, such as a subscription.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Medical aids on loan](#) (definitions)

Bone-anchored hearing aid with softband (clause B.17.8.)

Insured healthcare

- Bone-anchored hearing aid with softband.

Your reimbursement

- Reimbursement of 100 % for bone-anchored hearing aid with softband.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Medical aids on loan are not subject to the deductible. The costs involved in the use thereof and consumables for the medical aid are subject to the deductible.

Terms and conditions

- You are given this medical aid on loan.

Who to get a referral from

- ENT specialist.
- Audiology centre.

Do you need approval?

- You need approval from us for the first provision.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Medical aids on loan](#) (definitions)

Solo device (clause B.17.8.)

Insured healthcare

- Solo device.

Your reimbursement

- Reimbursement of 100 % for solo device.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Medical aids on loan are not subject to the deductible. The costs involved in the use thereof and consumables for the medical aid are subject to the deductible.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- The audiogram is not over 9 months old.
- The medical aid must be fitted as per the most recent version of the Hearing Protocol.
- You are given this medical aid on loan.

Who to get a referral from

- ENT specialist.
- Audiology centre.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Medical aids on loan](#) (definitions)

Alarm clock and alerting devices (clause B.17.8.)

Insured healthcare

- Alarm clock and alerting devices for hearing impaired people.

Your reimbursement

- Reimbursement of 100 % for alarm clock and alerting devices.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- The audiogram is not over 9 months old.
- The medical aid must be fitted as per the most recent version of the Hearing Protocol.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- ENT specialist.
- Audiology centre.

Do you need approval?

- You need approval from us for the first provision up 60dB.
Up to 55 decibels of hearing loss: not only a written request with a prescription and justification by an ENT specialist or audiology centre is needed, but also a clear specification of why the medical aid is needed, why the usual medical aids are inadequate and which other medical aids have been tried first.
- For the initial provision of an installation from 60 dB, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Hearing aids, tinnitus maskers and ear pieces up to and including the age of 17 (clause B.17.8.)

Insured healthcare

- Hearing aids and tinnitus maskers.
- Ear pieces.

Your reimbursement

- Up to and including 17 year(s): reimbursement of 100 % for hearing aids, tinnitus maskers and ear pieces up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- The hearing aid is included in the national hearing aids database.
You may qualify for a hearing aid that is not included in the national hearing aids database if:
 - you have tried at least two different hearing aids from the database first and
 - you have a functional prescription from the audiology centre showing that a hearing aid from that national database is not appropriate for you.
- The audiogram is not over 12 months old.
- The medical aid must be fitted as per the most recent version of the Hearing Protocol.
- You can normally keep using your hearing aid for at least 5 years.
If your hearing aid needs any adjustments or repairs before the end of this 5-year period, please contact the contracted healthcare provider that provided the hearing aid. We have an agreement with the healthcare provider about the costs of repairs or adjustments that are needed during the first 5 years. If you want to go to a different (contracted) healthcare provider, please contact us first.
- The medical aid is effective and appropriate to your personal situation.
There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
A medical aid is considered to be a functioning medical aid if it is ready for use when delivered. Upon the first purchase, the medical aid must come with instructions for use, batteries or charging equipment, and the accessories needed to make the medical aid work properly.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary.
The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal. Replacement of any batteries never qualifies for reimbursement.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Audiology centre.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us for a hearing aid that is not included in the national hearing aids database.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider is a triage hearing care professional, StAr-certified (StAr = Stichting Audicienregister) or CvC Audiciensregister registered.
This professionals works conform the most recent version of the Hearing Protocol.

What is not reimbursed

- Replacement of.
 - consumer batteries
 - special purpose batteries
 - accessories, with the exception of those needed for the device to operate.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Hearing aids, tinnitus maskers and ear pieces from the age of 18 (clause B.17.8.)

Insured healthcare

- Hearing aids and tinnitus maskers.
- Ear pieces.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 75 % for hearing aids, tinnitus maskers and ear pieces from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 25% of the purchase costs.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- The hearing aid is included in the national hearing aids database.
You may qualify for a hearing aid that is not included in the national hearing aids database if:
 - you have tried at least two different hearing aids from the database first and
 - you have a functional prescription from the audiology centre showing that a hearing aid from that national database is not appropriate for you.
- The audiogram is not over 12 months old.
- The medical aid must be fitted as per the most recent version of the Hearing Protocol.
- You can normally keep using your hearing aid for at least 5 years.
If your hearing aid needs any adjustments or repairs before the end of this 5-year period, please contact the contracted healthcare provider that provided the hearing aid. We have an agreement with the healthcare provider about the costs of repairs or adjustments that are needed during the first 5 years. If you want to go to a different (contracted) healthcare provider, please contact us first.
- The medical aid is effective and appropriate to your personal situation.
There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
A medical aid is considered to be a functioning medical aid if it is ready for use when delivered. Upon the first purchase, the medical aid must come with instructions for use, batteries or charging equipment, and the accessories needed to make the medical aid work properly.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary.
The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal. Replacement of any batteries never qualifies for reimbursement.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Contracted triage hearing care professional if you wear a hearing aid and are older than 18 years of age but younger than 67.
- ENT specialist or audiology centre if you do not wear a hearing aid and are 18 years or older but younger than 67.
- Contracted triage hearing care professional if you are 67 years of age or older.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us for a hearing aid that is not included in the national hearing aids database.

- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider is a triage hearing care professional, StAr-certified (StAr = Stichting Audicienregister) or CvC Audiciensregister registered. This professionals works conform the most recent version of the Hearing Protocol.

What is not reimbursed

- Replacement of.
 - consumer batteries
 - special purpose batteries
 - accessories, with the exception of those needed for the device to operate.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Hearing loops, infrared device, FM device and streamers (clause B.17.8.)

Insured healthcare

- Hearing loops, infrared device, FM device and streamers.

Your reimbursement

- Reimbursement of 100 % for hearing loops, infrared device, FM device and streamers.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - There is rehabilitation potential for the hearing in your ear and hearing loss of at least 35 decibels. This value was obtained by averaging the hearing loss at frequencies of 1000 Hz, 2000 Hz and 4000 Hz.
 - You have severe tinnitus.

Terms and conditions

- The audiogram is not over 12 months old.
- The medical aid must be fitted as per the most recent version of the Hearing Protocol.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Audiology centre if you are under the age of 18.
- Contracted triage hearing care professional if you wear a hearing aid and are older than 18 years of age but younger than 67.
- ENT specialist or audiology centre if you do not wear a hearing aid and are 18 years or older but younger than 67.

- Contracted triage hearing care professional if you are 67 years of age or older.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us if an additional facility is required.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider is a triage hearing care professional, StAr-certified (StAr = Stichting Audicienregister) or CvC Audiciensregister registered. This professionals works conform the most recent version of the Hearing Protocol.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Medical aids for urinary and faecal dysfunction (clause B.17.9.)

Insured healthcare

- External medical aids for urinary and faecal dysfunction.
This is the general description that may include several medical aids that have not been specifically described to compensate for the aforementioned functional limitation.
The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through objective, scientific research. An exception applies to conditionally authorised care, see the 'Conditional healthcare' clause.

Your reimbursement

- Reimbursement of 100 % for medical aids for urinary and faecal dysfunction.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- From the age of 18, the deductible applies to medical aids that will be yours to keep. Medical aids on loan are not subject to the deductible, except for costs involved in the use of and consumables for the medical aid in question.

Terms and conditions

- The medical aid must meet the 'latest practical and theoretical standards' criterion.
This means the medical aid's effectiveness and appropriateness must have been proven through scientific research.

- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid. 'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You must take good care of the medical aid you own or have on loan. You must, in any case, observe the guidelines or warranty conditions of the manufacturer or healthcare provider. As a result, replacement within the period of use will not be necessary. You must pay for damage (repair or replacement costs) caused by incorrect use or negligence on your part. If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.
- For information, advice and guidance, you can contact our 'Medische Beoordelingen' (Medical Assessments) department.
- Depending on the medical aid, you can either borrow it or own it.

Who to get a referral from

- Doctor who is authorised for this.

Do you need approval?

- You need approval from us if you think you are entitled to a medical aid that we have not mentioned. Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- You need approval from us if you think you are entitled to a medical aid and you do not meet the terms and conditions stated. Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- For a spare medical aid, the contracted healthcare provider will assess whether you meet the conditions and whether the medical aid is covered under your insured healthcare. Our prior approval is not required in this case. In a number of cases, a spare medical aid is desirable and necessary. This is subject to medical grounds. If you want to purchase a spare medical aid from a non-contracted healthcare provider, you must personally submit a (first or repeat) healthcare request to us for approval.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Medical aids that come under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).

- Medical aids used during admission or specialist medical treatment.
See the 'Specialist medical healthcare' clause.
- Costs of normal use of the medical aid such as energy consumption and battery replacement.
- Medical aids that are commonly used or that replace commonly used medical aids in everyday life.
These are medical aids that do not have a direct relationship to a limitation or disorder and/or permanent medical aids that are not excessively expensive. For example: computers, mobile phones, caps, scarves and turbans, walking frames, adapted eating utensils, a jar opener or a reacher/grabber.
- Medical aids (or modifications to medical aids) if they are used exclusively or predominantly in the working or learning environment.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

- [Medical aids on loan](#) (definitions)
- [Owned medical aids](#) (definitions)

Anal douche with accessories (clause B.17.9.)

Insured healthcare

- Anal douche with accessories.

Your reimbursement

- Reimbursement of 100 % for anal douche with accessories.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- There must be medical grounds for it.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- A referral with a medical diagnosis from the attending doctor is required.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions.
Our prior approval is not required in this case.
- You need approval from us for the initial provision of a special version of an anal douche.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Incontinence products (clause B.17.9.)

Insured healthcare

- Incontinence products.

Your reimbursement

- Reimbursement of 100 % for incontinence products.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are 3 or 4 years old and have a non-physiological (non-natural) form of incontinence.
 - You are 5 years or older and have long-term or chronic urinary or bowel incontinence (involuntary loss of urine or faeces).
This incontinence does not improve on its own within a short period and cannot be adequately treated within a reasonable time. Pelvic floor strengthening exercises or bladder training (pelvic floor therapy) do not help either.

Terms and conditions

- The medical aid is effective and appropriate to your personal situation.
There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- If pelvic therapy could help with your kind of incontinence, reimbursement is only possible at the moment you actually start this therapy.
Depending on the nature of the incontinence, pelvic therapy can resolve your problem.
Absorbent incontinence materials that you wear on your body, we can agree if you are actually willing to follow this therapy. These must concern situations in which you can reasonably be expected to do this therapy. If you are not prepared to do this, you do not have to rely on incontinence material because then it is not effective.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- General practitioner.
- Medical specialist.

- Physician assistant.
- Nursing specialist (Master's degree level 6).
- UCS nurse (degree from higher professional education; level 5).
This healthcare provider may write a letter of referral, but cannot determine the nature of the treatment.
- Continence nurse (intermediate professional education qualification; level 4).
This healthcare provider may write a letter of referral, but cannot determine the nature of the treatment.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us for the provision for children between the ages of 3 and 5 years old.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Cleaning and odour products.
- Skin protection products.
- Clothing (except for net pants).
- Bedwetting alarm for treatment of nocturnal enuresis (nocturnal bedwetting).
- Mattress protectors (except in the event of a special individual healthcare need).
- For nocturnal enureses (night-time bedwetting).
- Short-term incontinence.
For example, after an operation, pregnancy or bladder infection.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Stoma products (clause B.17.9.)

Insured healthcare

- Stoma products.

Your reimbursement

- Reimbursement of 100 % for stoma products.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- You acquire this medical aid; you are the owner.

Who to get a referral from

- Medical specialist.
- Stoma nurse.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider must at least hold an SEMH certificate with the stoma specialism.

What is not reimbursed

- Cleaning and odour products.
- Clothing.
- Mattress protectors (except in the event of a special individual healthcare need).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Orthopaedic shoes up to and including the age of 15 (clause B.17.10.1.)

Insured healthcare

- Orthopaedic shoes.

Your reimbursement

- From 0 euros, up to and including 15 year(s): reimbursement of 100 % for orthopaedic shoes up to and including the age of 15.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €65 per pair.
- This healthcare is not subject to the deductible.

Terms and conditions

- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- For low-complexity care: general practitioner or podiatrist.
- For high-complexity care: orthopaedic surgeon, rehabilitation doctor, rheumatologist, geriatric specialist, physician assistant or clinical nurse specialist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us for a replacement within the period of use.
- You need approval from us for temporary orthopaedic shoes.
- You need approval from us for other modifications to commercially available shoes (Orthopaedic modifications to commercially available shoes) above €400.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- Non-contracted healthcare provider must be accredited under the 'Erkenningsregeling Orthopedische Schoentechnische Bedrijven' (OSTB) (Accreditation scheme for orthopaedic shoemakers).

What is not reimbursed

- Work footwear.
- Medical aids used exclusively while playing sports.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Orthopaedic shoes from the age of 16 (clause B.17.10.1.)

Insured healthcare

- Orthopaedic shoes.

Your reimbursement

- From 0 euros, from 16 year(s): reimbursement of 100 % for orthopaedic shoes from the age of 16.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €130 per pair.

- Deductible applies from the age of 18.

Terms and conditions

- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid. 'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- For low-complexity care: general practitioner or podiatrist.
- For high-complexity care: orthopaedic surgeon, rehabilitation doctor, rheumatologist, geriatric specialist, physician assistant or clinical nurse specialist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You need approval from us for a replacement within the period of use.
- You need approval from us for temporary orthopaedic shoes.
- You need approval from us for other modifications to commercially available shoes (Orthopaedic modifications to commercially available shoes) above €400.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- Non-contracted healthcare provider must be accredited under the 'Erkenningsregeling Orthopedische Schoentechnische Bedrijven' (OSTB) (Accreditation scheme for orthopaedic shoemakers).

What is not reimbursed

- Work footwear.
- Medical aids used exclusively while playing sports.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Contact lenses, scleral contact lenses, bandage contact lenses and colour and coloured contact lenses for pathological myopia up to and including 17 years (clause B.17.11.)

Insured healthcare

- Contact lenses.
- Scleral contact lenses.
A scleral contact lens is a large hard lens shaped like a hat. The lens rests on the white of the eye and does not make contact with the cornea like normal contact lenses do. You need a medical indication for this.
- Bandage contact lenses.
These are special lenses used to protect the eye. Unless otherwise specified, the lenses will remain in your eye for a certain period of time, day and night. You need a medical indication for this.
- Coloured contact lenses.
These are special hand-coloured, custom-made contact lenses. You need a medical indication for this. Coloured lenses for cosmetic purposes are not included.
- Daily lenses.
But only if another type of lens is not possible for medical reasons.

Your reimbursement

- From 0 euros, up to and including 17 year(s): reimbursement of 100 % for contact lenses, scleral contact lenses, bandage contact lenses and colour and coloured contact lenses for pathological myopia up to and including 17 years.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €61 per calendar year in the case of a new lens on one side.
- Statutory personal contribution of €122 per calendar year in the case of a new lens on both sides.
- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have pathological myopia with a refractive error of at least -6 dioptres.

Terms and conditions

- Contact lenses, scleral contact lenses and bandage contact lenses are prescription lenses used for vision correction.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Referral with medical diagnosis from an ophthalmologist is necessary.

Do you need approval?

- You need approval from us for the initial provision of bandage contact lenses or contact lenses for certain indications.
Your healthcare provider will provide further details about this.
- For the initial provision of scleral contact lenses or coloured contact lenses, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider must be an optician who is an official contact lens specialist or optometrist.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Contact lenses, scleral contact lenses, bandage contact lenses and colour and coloured contact lenses for a medical condition or trauma (clause B.17.11.)

Insured healthcare

- Contact lenses.
- Scleral contact lenses.
A scleral contact lens is a large hard lens shaped like a hat. The lens rests on the white of the eye and does not make contact with the cornea like normal contact lenses do. You need a medical indication for this.
- Bandage contact lenses.
These are special lenses used to protect the eye. Unless otherwise specified, the lenses will remain in your eye for a certain period of time, day and night. You need a medical indication for this.
- Coloured contact lenses.
These are special hand-coloured, custom-made contact lenses. You need a medical indication for this. Coloured lenses for cosmetic purposes are not included.
- Daily lenses.
But only if another type of lens is not possible for medical reasons.

Your reimbursement

- From 0 euros: reimbursement of 100 % for contact lenses, scleral contact lenses, bandage contact lenses and colour and coloured contact lenses for a medical condition or trauma.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €61 per calendar year in the case of a new lens on one side.
- Statutory personal contribution of €122 per calendar year in the case of a new lens on both sides.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a medical condition or trauma where contact lenses can provide greater improvement than glasses would.
This concerns improvement of visual acuity or quality.

Terms and conditions

- Contact lenses, scleral contact lenses and bandage contact lenses are prescription lenses used for vision correction.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Referral with medical diagnosis from an ophthalmologist is necessary.

Do you need approval?

- You need approval from us for the initial provision of bandage contact lenses or contact lenses for certain indications.
Your healthcare provider will provide further details about this.
- For the initial provision of scleral contact lenses or coloured contact lenses, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider must be an optician who is an official contact lens specialist or optometrist.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Lenses for glasses and filter lenses up to and including 17 years (clause B.17.11.)

Insured healthcare

- Filter lenses.
These are special coloured lenses with a medical filter that filter certain parts of light but are not sunglasses. You need a medical indication for this.
- Lenses for glasses.

Your reimbursement

- From 0 euros, up to and including 17 year(s): reimbursement of 100 % for lenses for glasses and filter lenses up to and including 17 years.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution of €61 per calendar year in the case of a new lens on one side.
- Statutory personal contribution of €122 per calendar year in the case of a new lens on both sides.
- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have medical grounds for contact lenses, but wearing contact lenses is not desirable because of:
 - medical grounds for contact lenses (for pathological myopia with a refractive error of at least -6 dioptres) but wearing contact lenses is not preferred; or
 - surgery performed on one or both eyes because of a refractive error; or
 - pure accommodative esotropia.

Terms and conditions

- Lenses for glasses and filter lenses are prescription lenses used for vision correction.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Referral with medical diagnosis from an ophthalmologist is necessary.

Do you need approval?

- You need approval from us for the first provision.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- A non-contracted healthcare provider must be an optician who is an official contact lens specialist or optometrist.
- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Frame.
- self-tinting glasses, sunglasses.
- Treatments of the glass such as coatings and anti-reflection.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Medical aids for contraceptive purposes (clause B.17.13.)

Insured healthcare

- Medical aids for contraceptive purposes.

This is the general description that may include several medical aids that have not been specifically described to compensate for the aforementioned functional limitation.

The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through objective, scientific research. An exception applies to conditionally authorised care, see the 'Conditional healthcare' clause.

Your reimbursement

- Up to and including 20 year(s): reimbursement of 100 % for medical aids for contraceptive purposes.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- From the age of 18, the deductible applies to medical aids that will be yours to keep. Medical aids on loan are not subject to the deductible, except for costs involved in the use of and consumables for the medical aid in question.

Terms and conditions

- The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through scientific research.
- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid. 'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You must take good care of the medical aid you own or have on loan. You must, in any case, observe the guidelines or warranty conditions of the manufacturer or healthcare provider. As a result, replacement within the period of use will not be necessary. You must pay for damage (repair or replacement costs) caused by incorrect use or negligence on your part. If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.
- For information, advice and guidance, you can contact our 'Medische Beoordelingen' (Medical Assessments) department.
- Depending on the medical aid, you can either borrow it or own it.

Who to get a referral from

- Doctor who is authorised for this.

Do you need approval?

- You need approval from us if you think you are entitled to a medical aid that we have not mentioned. Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- You need approval from us if you think you are entitled to a medical aid and you do not meet the terms and conditions stated. Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- For a spare medical aid, the contracted healthcare provider will assess whether you meet the conditions and whether the medical aid is covered under your insured healthcare. Our prior approval is not required in this case. In a number of cases, a spare medical aid is desirable and necessary. This is subject to medical grounds. If you want to purchase a spare medical aid from a non-contracted healthcare provider, you must personally submit a (first or repeat) healthcare request to us for approval.

- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Medical aids that come under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Medical aids used during admission or specialist medical treatment. See the 'Specialist medical healthcare' clause.
- Costs of normal use of the medical aid such as energy consumption and battery replacement.
- Medical aids that are commonly used or that replace commonly used medical aids in everyday life. These are medical aids that do not have a direct relationship to a limitation or disorder and/or permanent medical aids that are not excessively expensive. For example: computers, mobile phones, caps, scarves and turbans, walking frames, adapted eating utensils, a jar opener or a reacher/grabber.
- Medical aids (or modifications to medical aids) if they are used exclusively or predominantly in the working or learning environment.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

- [Medical aids on loan](#) (definitions)
- [Owned medical aids](#) (definitions)

Diaphragms and copper IUDs (clause B.17.13.)

Insured healthcare

- Diaphragms and copper IUDs.

Your reimbursement

- Up to and including 20 year(s): reimbursement of 100 % for diaphragms and copper IUDs.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- Your general practitioner inserts the diaphragm or copper IUD. If the medical aid is inserted by a medical specialist, the medical aid comes under the 'Specialist medical healthcare' clause.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Attending doctor.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.

- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Medical aids for monitoring and regulation of blood glucose disorders (clause B.17.19.)

Insured healthcare

- External medical aids for monitoring and regulation of blood glucose disorders. This is the general description that may include several medical aids that have not been specifically described to compensate for the aforementioned functional limitation. The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through objective, scientific research. An exception applies to conditionally authorised care, see the 'Conditional healthcare' clause.

Your reimbursement

- Reimbursement of 100 % for medical aids for monitoring and regulation of blood glucose disorders.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- From the age of 18, the deductible applies to medical aids that will be yours to keep. Medical aids on loan are not subject to the deductible, except for costs involved in the use of and consumables for the medical aid in question.

Terms and conditions

- The medical aid must meet the 'latest practical and theoretical standards' criterion. This means the medical aid's effectiveness and appropriateness must have been proven through scientific research.
- The medical aid is effective and appropriate to your personal situation. There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You must take good care of the medical aid you own or have on loan.
You must, in any case, observe the guidelines or warranty conditions of the manufacturer or healthcare provider. As a result, replacement within the period of use will not be necessary. You must pay for damage (repair or replacement costs) caused by incorrect use or negligence on your part.
If the medical aid is stolen, you must report this to the police, to us and to the healthcare provider.
- For information, advice and guidance, you can contact our 'Medische Beoordelingen' (Medical Assessments) department.
- Depending on the medical aid, you can either borrow it or own it.

Who to get a referral from

- Doctor who is authorised for this.

Do you need approval?

- You need approval from us if you think you are entitled to a medical aid that we have not mentioned.
Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- You need approval from us if you think you are entitled to a medical aid and you do not meet the terms and conditions stated.
Based on your request, we will then assess whether we can, in your case, reimburse the cost of the medical aid after all, though we may need additional information from you.
- For a spare medical aid, the contracted healthcare provider will assess whether you meet the conditions and whether the medical aid is covered under your insured healthcare. Our prior approval is not required in this case.
In a number of cases, a spare medical aid is desirable and necessary. This is subject to medical grounds.
If you want to purchase a spare medical aid from a non-contracted healthcare provider, you must personally submit a (first or repeat) healthcare request to us for approval.
- You always need our prior approval if you want to see a non-contracted healthcare provider.
You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Medical aids that come under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Medical aids used during admission or specialist medical treatment.
See the 'Specialist medical healthcare' clause.
- Costs of normal use of the medical aid such as energy consumption and battery replacement.
- Medical aids that are commonly used or that replace commonly used medical aids in everyday life.
These are medical aids that do not have a direct relationship to a limitation or disorder and/or permanent medical aids that are not excessively expensive. For example: computers, mobile phones, caps, scarves and turbans, walking frames, adapted eating utensils, a jar opener or a reacher/grabber.

- Medical aids (or modifications to medical aids) if they are used exclusively or predominantly in the working or learning environment.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

- [Medical aids on loan](#) (definitions)
- [Owned medical aids](#) (definitions)

Real-Time Continuous Glucose Monitoring (clause B.17.19.)

Insured healthcare

- Real-time Continuous Glucose Monitoring.

Your reimbursement

- Reimbursement of 100 % for real-Time Continuous Glucose Monitoring.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have diabetes mellitus type 1.
 - You have type 2 diabetes mellitus and receive intensive insulin therapy.
 - You have type 2 diabetes mellitus and are pregnant.
You use insulin but do not receive intensive insulin therapy.
 - You have pre-existing type 2 diabetes and wish to become pregnant.
You use insulin but do not receive intensive insulin therapy.

Terms and conditions

- The conditions specified on the most recent 'Zorginstituut Nederland' form are the starting point.
- If you can prove that you do not have a suitable telephone, reimbursement for a reader is possible.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- General practitioner.
- Paediatrician.
- Internist.
- Endocrinologist.
- Diabetologist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Real-Time Continuous Glucose Monitoring (clause B.17.19.)

Insured healthcare

- Flash Glucose Monitoring.

Your reimbursement

- Reimbursement of 100 % for real-Time Continuous Glucose Monitoring.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have type 1 diabetes mellitus and are under the age of 18.
 - You have hard-to-manage type 1 diabetes, i.e. permanently high HbA1c (over 8% or over 64 mmol/mol) despite standard monitoring.
 - You have type 1 or 2 diabetes mellitus and are pregnant.
 - You have pre-existing type 1 or 2 diabetes and wish to become pregnant.
 - You have type 1 diabetes mellitus and serious hypoglycaemia and/or you are unable to notice hypoglycaemia (hypo-unawareness).

Terms and conditions

- The conditions specified on the most recent 'Zorginstituut Nederland' form are the starting point.
- If you can prove that you do not have a suitable telephone, reimbursement for a reader is possible.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- Paediatrician.
- Internist.
- Endocrinologist.
- Diabetologist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Insulin pump and accessories (clause B.17.19.)

Insured healthcare

- Insulin pump and accessories.

Your reimbursement

- Reimbursement of 100 % for insulin pump and accessories.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- From the age of 18, the deductible applies to medical aids that will be yours to keep. Medical aids on loan are not subject to the deductible, except for costs involved in the use of and consumables for the medical aid in question.

Terms and conditions

- Depending on the medical aid, you can either borrow it or own it.

Who to get a referral from

- Paediatrician.
- Internist.
- Endocrinologist.
- Diabetologist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

- Replacement of.
 - consumer batteries
 - special purpose batteries
 - accessories, with the exception of those needed for the device to operate.

- Pump holder, pump bag or protective cover.
You will receive this on the initial provision; afterwards, you are responsible for the costs or this is part of the service provided by the product supplier.
- Replacement of.
 - consumer batteries
 - special purpose batteries
 - accessories, with the exception of those needed for the device to operate.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

- [Medical aids on loan](#) (definitions)
- [Owned medical aids](#) (definitions)

Diabetes supplies (clause B.17.19.)

Insured healthcare

- Diabetes supplies:
 - equipment for self-blood collection and associated lancets;
 - blood glucose meter and associated test strips;
 - lancing device;
 - a modified version.

Your reimbursement

- Reimbursement of 100 % for diabetes supplies.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You are insulin-dependent or have virtually exhausted all treatment avenues with oral medication in an attempt to lower blood glucose levels.

Terms and conditions

- Blood glucose meters must meet the requirements of the consensus document on quality criteria for optimum and efficient use of diabetes aids.
- The medical aid is effective and appropriate to your personal situation.
There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The healthcare provider looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness.

Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

- You are entitled to a functioning medical aid.
'Functioning' is taken to mean that the medical aids are ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation.
For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have a functioning, appropriate and/or suitable medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner.

Who to get a referral from

- General practitioner.
- Paediatrician.
- Internist.
- Endocrinologist.
- Diabetologist.

Do you need approval?

- For the initial provision, the contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Owned medical aids](#) (definitions)

Personal alarm equipment (clause B.17.23.)

Insured healthcare

- Personal alarm equipment.

Your reimbursement

- Reimbursement of 100 % for personal alarm equipment.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Medical aids on loan are not subject to the deductible. The costs involved in the use thereof and consumables for the medical aid are subject to the deductible.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:

- You have a physical disability and a medical need for immediate medical or technical help in the event of an emergency.
- You have to care for yourself for a lengthy period of time.
- You are unable to independently operate the telephone in an emergency.

Terms and conditions

- You are given this medical aid on loan.

Who to get a referral from

- Attending doctor.

Do you need approval?

- You need approval from us for the first provision.
- You always need our prior approval if you want to see a non-contracted healthcare provider. You must always request our prior approval if you want a healthcare provider with whom we do not have a contract to provide a medical aid. This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Our website tells you which healthcare provider you can go to for this healthcare.
- A non-contracted healthcare provider must have the 'Ketenkeurmerk Persoonsgebonden Alarmeringsdiensten' (value chain quality mark for personal alerting services). Under this quality mark issued by the trade association WDTM-QAEH, this healthcare provider is certified to (at a minimum) take on the Provider role and works together with parties that are certified for the roles of Supplier (manufacturer), Certified Installer, and Emergency Response Centre under this quality mark. This cooperation is contractually agreed and demonstrable to us.

What is not reimbursed

- Subscription fee for the emergency centre.
- Personal alarm equipment if you have a medical indication that places you under the Dutch Long-Term Care Act (Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

See also:

[Medical aids on loan](#) (definitions)

Medical care for specific patient groups

What you are insured for under your general insurance policy

Medical care for specific patient groups by a geriatric specialist or doctor for the mentally disabled (clause B.28.2.)

Insured healthcare

- Primary medical healthcare for specific patient groups by the geriatric specialist or doctor for the mentally disabled.

Your reimbursement

- Reimbursement of 100 % for medical care for specific patient groups by a geriatric specialist or doctor for the mentally disabled.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.

Terms and conditions

- You (still) live at home.
- The healthcare may be provided in a place other than where the healthcare provider normally works.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Geriatric specialist.
A doctor listed as a geriatric specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
- Doctor for the mentally disabled.
This is a doctor listed as a doctor for the mentally disabled on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical care for specific patient groups by behavioural scientist (clause B.28.3.)

Insured healthcare

- Primary medical healthcare for specific patient groups by behavioural scientist.
The healthcare is aimed at recovery and/or learning new skills or behaviour.

Your reimbursement

- Reimbursement of 100 % for medical care for specific patient groups by behavioural scientist.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:

- You have confirmed or suspected dementia, multiple sclerosis, Parkinson's disease, intellectual disability, an acquired brain injury.
Or another chronic or complex disease or condition that has an impact on your psychological and cognitive functioning.
- Your multiple morbidities are often degenerative and progressive in nature.
You are at a very advanced age with an accumulation of somatic symptoms and, for example, a lack of meaning and purpose.

Terms and conditions

- You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Behavioural scientist.
A behavioural scientist with expertise in the specific condition and treatments and who is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG), provides the healthcare and acts as a coordinating practitioner.

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

First-line allied healthcare for specific patient groups (clause B.28.4.)

Insured healthcare

- Individual primary allied healthcare (physiotherapy, exercise therapy, occupational therapy, speech and language therapy and/or dietetics) for specific patient groups.

Your reimbursement

- Reimbursement of 100 % for first-line allied healthcare for specific patient groups.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.

Terms and conditions

- You (still) live at home.
- The healthcare may be provided in a place other than where the healthcare provider normally works.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Occupational therapist.
Your healthcare provider is an occupational therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Speech and language therapist.
Your healthcare provider is a speech and language therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Dietician.
Your healthcare provider is a dietician with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical care in a group setting for vulnerable patients (clause B.28.5.)

Insured healthcare

- Primary medical healthcare for specific vulnerable patient groups.
The healthcare includes:
 - recovery of or learning new skills or behaviour;
 - stabilising the functioning and preventing the limitations from worsening;
 - learning to deal with physical and/or cognitive limitations.

Your reimbursement

- Reimbursement of 100 % for medical care in a group setting for vulnerable patients.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.
 - You have somatic, psychogeriatric or cognitive problems.
 - You have an intensive need for care.

Terms and conditions

- The concrete and feasible treatment goals are set out in an individual treatment plan.
- You (still) live at home.
- You receive the healthcare in a group setting.
This means the healthcare is an integral course of treatment ('prestatie') and therefore may not be charged as an individual course of treatment at the same time.
- The healthcare may be provided in a place other than where the healthcare provider normally works.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Occupational therapist.
Your healthcare provider is an occupational therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Speech and language therapist.
Your healthcare provider is a speech and language therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Dietician.
Your healthcare provider is a dietician with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical care in a group setting for people with acquired brain injury (clause B.28.6.)

Insured healthcare

- Primary medical healthcare for specific patient groups with a physical disability or with an acquired brain injury.
You learn to deal with the condition and limitations you have. The healthcare is aimed at:
 - maintaining and advancing your functional autonomy;
 - preventing deterioration and escalation;
 - making behaviour manageable;
 - improving physical and psychological functioning.

Your reimbursement

- Reimbursement of 100 % for medical care in a group setting for people with acquired brain injury.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have a physical disability.
This also includes an organ disorder or neuro-motor disorder
 - You have an acquired brain injury.

Terms and conditions

- You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.
- The concrete and feasible treatment goals are set out in an individual treatment plan.
- You (still) live at home.
- You receive the healthcare in a group setting.
This means the healthcare is an integral course of treatment ('prestatie') and therefore may not be charged as an individual course of treatment at the same time.
- The healthcare may be provided in a place other than where the healthcare provider normally works.
- The healthcare does not replace specialist medical rehabilitation or geriatric rehabilitation.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Coordinating practitioner in collaboration with the behavioural scientists, expressive therapists and allied healthcare providers.
The coordinating practitioner is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG) and is responsible for implementing the healthcare and treatment plan in a multidisciplinary context in collaboration with other healthcare providers.

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical care in a group setting for people with Huntington's disease (clause B.28.7.)

Insured healthcare

- Primary medical healthcare for patients with Huntington's disease.
If medically necessary, nursing care can also form part of the treatment.

Your reimbursement

- Reimbursement of 100 % for medical care in a group setting for people with Huntington's disease.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:

- You have Huntington's disease.
- You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.

Terms and conditions

- The concrete and feasible treatment goals are set out in an individual treatment plan.
- You (still) live at home.
- You receive the healthcare in a group setting.
This means the healthcare is an integral course of treatment ('prestatie') and therefore may not be charged as an individual course of treatment at the same time.
- The healthcare is provided in the form of day treatment.
- The healthcare may be provided in a place other than where the healthcare provider normally works.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Coordinating practitioner who is an expert in Huntington's disease, in collaboration with a multidisciplinary team.
The coordinating practitioner is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG) and is responsible for implementing the healthcare and treatment plan in a multidisciplinary context in collaboration with other healthcare providers.

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical care in a group setting for people with severely disturbed behaviour and mild intellectual disabilities (clause B.28.8.)

Insured healthcare

- Primary medical healthcare for patients with severely disturbed behaviour and mild intellectual disabilities.

The stepped care approach is used for the provision of this healthcare and comprises:

- integrated, multidisciplinary diagnosis of behavioural problems;
- multidisciplinary treatment of the behavioural problems.

The healthcare is aimed at increasing your competencies, your support system and your professional network with regard to you learning to deal with your impairments in intellectual and adaptive functioning.

Your reimbursement

- Reimbursement of 100 % for medical care in a group setting for people with severely disturbed behaviour and mild intellectual disabilities.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You are vulnerable in your home and have complex or highly complex problems.
You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.
 - You have an intellectual disability combined with one or more psychiatric disorders and serious behavioural problems.
The behavioural problems are related to the intellectual disability and the psychiatric disorder(s).

Terms and conditions

- The concrete and feasible treatment goals are set out in an individual treatment plan.
- You (still) live at home.
- You receive the healthcare in a group setting.
This means the healthcare is an integral course of treatment ('prestatie') and therefore may not be charged as an individual course of treatment at the same time.
- The healthcare may be provided in a place other than where the healthcare provider normally works.
- Mutual services.
Healthcare providers can make mutual agreements and settle their services. As a result, an implementing healthcare provider can charge the healthcare provided to a commissioning healthcare provider. This commissioning healthcare provider is your first point of contact and coordinates the healthcare process. The commissioning healthcare provider guarantees the authority and competence of the other healthcare providers involved.

Who to get a referral from

- General practitioner on the advice of a medical specialist or coordinating practitioner.
Coordinating practitioner who is a specialist in geriatric medicine, a doctor for the mentally disabled or a behavioural scientist.

Where to go for this healthcare

- Coordinating practitioner in collaboration with a multidisciplinary team.
The coordinating practitioner is registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG) and is responsible for implementing the healthcare and treatment plan in a multidisciplinary context in collaboration with other healthcare providers.
The multidisciplinary team consists of, alongside a doctor for the mentally disabled, other healthcare providers who, according to these terms and conditions, are allowed to provide specialist mental healthcare.

What is not reimbursed

- Healthcare that comes under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medical mental healthcare

What you are insured for under your general insurance policy

Outpatient mental healthcare from the age of 18 (clause B.19.1.)

Insured healthcare

- Medical mental healthcare: psychological, psychotherapeutic and psychiatric healthcare (also in the form of eHealth) on an outpatient basis.

Mental healthcare is medical care and is focused on recovery from or prevention of worsening of a psychological disorder or psychiatric condition. The healthcare provider will determine which mental healthcare you need based on the diagnosed or suspected DSM-5-listed disorder, the severity and problems, the risk, the complexity and the course of the complaints.

This concerns the following healthcare:

- diagnostics (i.e. identification of a suspected condition) with the intention of starting treatment;
- the treatment of a DSM-5-listed disorder. This can be done on an individual basis or in a group setting and can also be provided in the form of eHealth. eHealth is a complete programme of treatment initiated and completed under the responsibility of a healthcare provider.

Your reimbursement

- From 18 year(s): reimbursement of 100 % for outpatient mental healthcare from the age of 18.
- This is in-kind healthcare, so we reimburse:
 - for healthcare providers with a contract for this healthcare: 100% of the agreed rate.
 - for healthcare providers without a contract for this healthcare: 75% of your invoice up to 75% of the average rate agreed with healthcare providers with whom we have a contract.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a suspected or diagnosed DSM-5-listed disorder.
There must be a suspected or diagnosed DSM-5 disorder. DSM stands for 'Diagnostic and Statistical Manual of Mental Disorders'. DSM-5 provides criteria for a clear diagnosis.

Terms and conditions

- Mental healthcare is based on DSM-5, the list of mental healthcare interventions, and the applicable national mental healthcare quality regulations:
 - a psychological disorder is categorised based on DSM-5, a classification system using a common language and standard criteria for specific psychological disorders;
 - list of mental healthcare interventions ('Lijst interventies binnen de GGZ'; see our website);
 - the currently valid national mental healthcare quality regulations (see www.zorginzicht.nl).

You will find the positions regarding the insured healthcare (in Dutch) at www.zorginstituutnederland.nl. Go to 'Zvw Kompas' and click the link for medical mental healthcare, 'Geneeskundige Geestelijke Gezondheidszorg (geneeskundige GGZ)'.

- Your healthcare provider has approved, valid mental healthcare quality regulations and acts in accordance with these regulations.

Your healthcare provider's quality regulations have been assessed against the most recent national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). This states what your mental healthcare provider must have arranged in terms of quality and accountability, this way providing assurance that the right support will be provided at the right place and by the right healthcare provider within a professional, high-quality network.

If you have any questions, you can also talk to your healthcare provider; they know about the exclusions, the regulations on mental health reimbursement under the Dutch Health Insurance Act ('Zorgverzekeringswet'), and the positions of the Dutch National Healthcare Institute ('Zorginstituut Nederland').

as included in the Register for Quality Standards and Measuring Instruments ('Register voor kwaliteitsstandaarden en Meetinstrumenten') of 'Zorginstituut Nederland' (ZiNI). You can find the healthcare providers at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.

Who to get a referral from

- General practitioner (preferably supported by the practice assistant specifically trained for mental healthcare), company doctor, emergency care doctor, medical specialist, coordinating practitioner (if it concerns a referral within the scope of mental healthcare), or a doctor for the homeless.
 - you have a referral before the start of treatment. This referral may not be older than 9 months at the start of the treatment.
 - the referring doctor will ensure an objective and substantiated referral. The referral will therefore specify that the case concerns a diagnosed or suspected DSM-5-listed disorder for which treatment is needed as part of mental healthcare. The following is required for this
 - a diagnostic consultation; and
 - preferably also a reliable and valid system (digital resource) that supports the decision.
 - the objective outcome produced by the decision support system must indicate which level of healthcare is appropriate for your specific healthcare needs.
 - the objective outcome produced by the decision support system is part of the referral and must be available from both the general practitioner or other referring doctor and the mental healthcare provider.
 - the referral, the outcome produced by the decision support system, the formulated treatment plan (treatment proposal) and any amendments will all be recorded in your medical file.

Who to get a treatment proposal from

- The coordinating practitioner determines that the healthcare is medically necessary. The coordinating practitioner checks whether the healthcare comes within the scope of mental healthcare and records the prescription in a treatment plan. This treatment plan is discussed with you and then finalised.

Do you need approval?

- You need approval from us for treatment with Esketamine nasal spray (Spravato) by a non-contracted healthcare provider. This concerns uncontracted healthcare providers and contracted healthcare providers without an agreement for the supply of Spravato.
- For treatment abroad, an application form for receiving healthcare abroad ('Aanvraagformulier zorg in het buitenland') can be found on our website. Also see the list of healthcare abroad that requires approval ('Lijst aanvragen zorg buitenland').

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- The coordinating practitioner (responsible for drawing up the care needs assessment and coordinating) has ultimate responsibility for the healthcare.

The coordinating practitioner (as designated and appointed under the applicable national mental healthcare quality regulations ['Landelijk Kwaliteitsstatuut GGZ']) has ultimate responsibility for making the diagnosis and for the drafting and implementation of the treatment plan. In addition, we endorse the field agreements for mental healthcare. This means that with an independently established healthcare provider, the coordinating practitioner may only be a healthcare psychologist, a psychotherapist, a clinical psychologist, clinical neuropsychologist, or a psychiatrist.

- A treatment started under the Dutch Youth Act ('Jeugdwet') that continues after the age of 18 can continue under the current coordinating practitioner.

This coordinating practitioner is included in the transitional arrangement under the applicable national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.

- Highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare.

This concerns very serious or uncommon problems or a combination of complaints that are difficult to treat. This healthcare is very specialised and provided in a facility.

Where the treatment takes place

- The practice of the attending healthcare provider.
- A facility permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza).

What is not reimbursed

- Under no circumstances does mental healthcare include:
 - psychosocial healthcare;
 - neurofeedback;
 - intelligence test;
 - support of a non-medical nature, such as training, coaching and courses;
 - remedial education;
 - counselling for work, school and relationship problems;
 - treatment of adjustment disorders;
 - only diagnostics without the intention of mental healthcare being provided;
 - treatment of obesity (excess weight) and compulsive eating, unless the condition is directly related to a psychological disorder that is included in the DSM-5 manual;
 - tests, such as to assess the ability to drive;
 - medical psychological care (see clause B.4.3. Specialist medical healthcare);
 - we do not reimburse mental healthcare provided by your general practitioner or practice assistant for mental healthcare ('POH-GGZ') under this clause; this is, however, covered under the 'General practitioner care with a focus on medical mental healthcare' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Mental healthcare with admission from the age of 18 (clause B.19.3.)**Insured healthcare**

- Medical mental healthcare: psychological, psychotherapeutic and psychiatric healthcare on a medically necessary inpatient basis.

Mental healthcare is medical care and is focused on recovery from or prevention of worsening of a psychological disorder or psychiatric condition. The healthcare provider will determine which mental healthcare you need based on the diagnosed or suspected DSM-listed disorder, the severity and problems, the risk, the complexity and the course of the complaints. This concerns the following healthcare:

- diagnostics (i.e. identification of a suspected condition) with the intention of starting treatment;

- the treatment of a DSM-5-listed disorder. This can be done on an individual basis or in a group setting. The healthcare includes psychiatric treatment, associated allied healthcare (such as physiotherapy or occupational therapy), daytime activities, and professional therapy (e.g. music therapy or psychomotor therapy);
- nursing and other care, associated medicines, medical aids and dressings.

Your reimbursement

- From the 1st day of admission, from 18 year(s): reimbursement of 100 %, maximum of 3 years (1095 days) for mental healthcare with admission from the age of 18.
- This is in-kind healthcare, so we reimburse:
 - for healthcare providers with a contract for this healthcare: 100% of the agreed rate.
 - for healthcare providers without a contract for this healthcare: 75% of your invoice up to 75% of the average rate agreed with healthcare providers with whom we have a contract.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a complex or highly complex psychological or psychiatric DSM-5-listed disorder resulting in grounds for admission.
This is a disorder which, in terms of the severity of the healthcare need, cannot (or can no longer) be treated as part of general basic mental healthcare and cannot (or can no longer) be treated without admission.

Terms and conditions

- Your healthcare provider has approved, valid mental healthcare quality regulations and acts in accordance with these regulations.
Your healthcare provider's quality regulations have been assessed against the most recent national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). This states what your mental healthcare provider must have arranged in terms of quality and accountability, this way providing assurance that the right support will be provided at the right place and by the right healthcare provider within a professional, high-quality network.
If you have any questions, you can also talk to your healthcare provider; they know about the exclusions, the regulations on mental health reimbursement under the Dutch Health Insurance Act ('Zorgverzekeringswet'), and the positions of the Dutch National Healthcare Institute ('Zorginstituut Nederland').

as included in the Register for Quality Standards and Measuring Instruments ('Register voor kwaliteitsstandaarden en Meetinstrumenten') of 'Zorginstituut Nederland' (ZiNI). You can find the healthcare providers at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.

- Mental healthcare is based on DSM-5, the list of mental healthcare interventions, and the applicable national mental healthcare quality regulations:
 - a psychological disorder is categorised based on DSM-5, a classification system using a common language and standard criteria for specific psychological disorders;
 - list of mental healthcare interventions ('Lijst interventies binnen de GGZ'; see our website);
 - the currently valid national mental healthcare quality regulations (see www.zorginzicht.nl).

You will find the positions regarding the insured healthcare (in Dutch) at www.zorginstituutnederland.nl. Go to 'Zvw Kompas' and click the link for medical mental healthcare, 'Geneeskundige Geestelijke Gezondheidszorg (geneeskundige GGZ)'.

- A stay for more than one year.
If you still need to remain in the facility after 365 days, the coordinating practitioner must determine the legitimacy of the extended stay. To do so, the coordinating practitioner completes a questionnaire that is included in your medical file. The following conditions also apply:
 - there must be a psychiatric disorder, possibly with additional problems, for which you have remained as an inpatient in the facility for 365 consecutive days;
 - the facility has justified the need for the extended stay, stating
 - improvement, stabilisation or prevention of deterioration;
 - prognosis or development of the disorder(s); and
 - the expected duration of the stay.

After 1095 days, you may still be entitled to this kind of mental healthcare under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz). Subject to conditions, you may even be entitled to cover under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) before the end of this period.

Who to get a referral from

- General practitioner (preferably supported by the practice assistant specifically trained for mental healthcare), company doctor, emergency care doctor, medical specialist, coordinating practitioner (if it concerns a referral within the scope of mental healthcare), or a doctor for the homeless.
 - you have a referral before the start of treatment. This referral may not be older than 9 months at the start of the treatment.
 - the referring doctor will ensure an objective and substantiated referral. The referral will therefore specify that the case concerns a diagnosed or suspected DSM-5-listed psychiatric disorder for which admission to a mental healthcare facility is required. The following is required for this
 - a diagnostic consultation; and
 - preferably also a reliable and valid system (digital resource) that supports the decision.
 - the objective outcome produced by the decision support system must indicate which level of healthcare is appropriate for your specific healthcare needs.
 - the objective outcome produced by the decision support system is part of the referral and must be available from both the general practitioner or other referring doctor and the mental healthcare provider.
 - the referral, the outcome produced by the decision support system, the formulated treatment plan (treatment proposal) and any amendments will all be recorded in your medical file.

Who to get a treatment proposal from

- The coordinating practitioner determines that the healthcare is medically necessary.
The coordinating practitioner checks whether the healthcare comes within the scope of mental healthcare and records the prescription in a treatment plan. This treatment plan is discussed with you and then finalised.

Do you need approval?

- A contracted healthcare provider will assess whether your condition is covered under your insured healthcare. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. However, if the treatment is provided by a non-contracted healthcare provider our approval is required prior to admission.
- You need approval from us for treatment with Esketamine nasal spray (Spravato) by a non-contracted healthcare provider.
This concerns uncontracted healthcare providers and contracted healthcare providers without an agreement for the supply of Spravato.
- For treatment abroad, an application form for receiving healthcare abroad ('Aanvraagformulier zorg in het buitenland') can be found on our website. Also see the list of healthcare abroad that requires approval ('Lijst aanvragen zorg buitenland').

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- The coordinating practitioner (responsible for drawing up the care needs assessment and coordinating) has ultimate responsibility for the healthcare.

The coordinating practitioner (as designated and appointed under the applicable national mental healthcare quality regulations ['Landelijk Kwaliteitsstatuut GGZ']) has ultimate responsibility for making the diagnosis and for the drafting and implementation of the treatment plan. In addition, we endorse the field agreements for mental healthcare. This means that with an independently established healthcare provider, the coordinating practitioner may only be a healthcare psychologist, a psychotherapist, a clinical psychologist, clinical neuropsychologist, or a psychiatrist.

- A treatment started under the Dutch Youth Act ('Jeugdwet') that continues after the age of 18 can continue under the current coordinating practitioner.

This coordinating practitioner is included in the transitional arrangement under the applicable national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.

- Highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare.

This concerns very serious or uncommon problems or a combination of complaints that are difficult to treat. This healthcare is very specialised and provided in a facility.

Where the treatment takes place

- A facility permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza).

This can be a psychiatric ward of a hospital (institution for specialist medical care) if it concerns healthcare under the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) or it can be a facility for specialist mental healthcare if this concerns healthcare covered by the Dutch Health Insurance Act (Zvw) and/or the Dutch Long-Term Care Act (Wlz).

What is not reimbursed

- Under no circumstances does mental healthcare include:
 - psychosocial healthcare;
 - neurofeedback;
 - intelligence test;
 - support of a non-medical nature, such as training, coaching and courses;
 - remedial education;
 - counselling for work, school and relationship problems;
 - treatment of adjustment disorders;
 - only diagnostics without the intention of mental healthcare being provided;
 - treatment of obesity (excess weight) and compulsive eating, unless the condition is directly related to a psychological disorder that is included in the DSM-5 manual;
 - tests, such as to assess the ability to drive;
 - medical psychological care (see clause B.4.3. Specialist medical healthcare);
 - we do not reimburse mental healthcare provided by your general practitioner or practice assistant for mental healthcare ('POH-GGZ') under this clause; this is, however, covered under the 'General practitioner care with a focus on medical mental healthcare' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medicines

What you are insured for under your general insurance policy

Medicines under the Medicines Reimbursement System (GVS) (clause B.15.1.)

Insured healthcare

- Medicines that are included in the Medicines Reimbursement System (GVS).
This concerns dispensing the medicines and providing the associated advice and guidance. The Dutch Ministry of Health, Welfare and Sport determines which pharmaceutical healthcare and medicines are eligible for reimbursement and what terms and conditions apply. This ministry has developed the Medicines Reimbursement System ('Geneesmiddelenvergoedingssysteem', or 'GVS'), which specifies whether a medicine will be reimbursed in full, or whether a statutory personal contribution applies. The health insurer may set preconditions relating to the healthcare.
The Medicines Reimbursement System covers the registered medicines listed in appendices 1 and 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering'):
 - appendices 1A and 1B — Medicines Reimbursement System (GVS): appendix 1A contains registered medicines that are interchangeable, while appendix 1B contains registered medicines that are not interchangeable.
Interchangeable medicines are medicines that are
 - administered in the same way; and
 - prescribed on the same medical grounds; and
 - intended in general for people in the same age bracket.

Non-interchangeable medicines have different characteristics. For example, the effect of the medicine and the indication for which you use the medicine are different. These medicines are not subject to a personal contribution.

- appendix 2 of the Medicines Reimbursement System (GVS) lists registered medicines to which further terms and conditions apply. For example, in relation to the medical grounds. These appendix 2 medicines and terms and conditions are regularly amended by the Ministry of Health, Welfare and Sport.
All the latest information on assessing medicines and preparations is available at www.znformulieren.nl (in Dutch)
Appendices 1 and 2 are available in the Dutch Health Insurance Regulations ('Regeling zorgverzekering') at wetten.overheid.nl (in Dutch). To find the relevant appendices in Dutch, type 'Regeling zorgverzekering' in the 'In de titel' box. You can scroll to the appendices ('bijlagen') using the sidebar.
- There is also an appendix 3, which covers compounded medicines. These are described in the 'Medicines prepared by the pharmacy' clause.

Your reimbursement

- Reimbursement of 100 % for medicines under the Medicines Reimbursement System (GVS).

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution maximum of €250.
Example calculation of personal contribution.
Some medicines are not reimbursed in full under the Medicines Reimbursement System (GVS); the part that is not reimbursed is the statutory personal contribution.

For example, your medicine costs €100, €25 of which you have to pay yourself (personal contribution). The remaining €75 is set off against your deductible. If you need this medicine on a regular basis (and you are not taking any other medicine to which a personal contribution applies) the maximum amount you will pay is 10 times this personal contribution:

$10 \times €25 = €250$. After receiving that particular medicine 10 times in one year, the full amount for the medicine (€100) will be set off against any outstanding deductible.

If the general insurance policy starts or ends during the course of the year, the invoices already submitted will be recalculated proportionally and rounded off to whole euros. In that case, you only pay a proportional part of the statutory personal contribution for the part of the year that the health insurance policy was in effect.

Recalculation example:

- you were insured with us on 1 January and your policy ended on 1 March. During that period, you paid a total of €50 by way of your personal contribution for medicine under the Medicines Reimbursement System (GVS).
- a year has 365 days. The period 1 January to 1 March has 61 days
- $€250 / 365 = €0.6849$ personal contribution per day
- $€0.6849 \times 61 \text{ days} = €41.78$. We round this amount off, meaning your personal contribution for the period 1 January to 1 March is €42.
- you have already paid €50. €50 minus €42 is €8, so we repay you €8.
- Deductible applies from the age of 18.
- You do not pay a deductible for a preferred medicine for which the active ingredient, brand and Z-index code are on our list of preferred medicines ('Lijst voorkeursgeneesmiddelen').
- You do not pay a deductible for products associated with a quit smoking course; see the 'Quitting smoking' course clause.

Terms and conditions

- A maximum reimbursement applies to each group of interchangeable medicines (appendix 1A).

A doctor can choose from between two or more interchangeable medicines for you. For each group of interchangeable medicines, the government has set a maximum reimbursement. If the price of the medicine prescribed for you from that group is higher, you will have to pay the excess yourself as a 'personal contribution'.

- Within the group of interchangeable medicines (appendix 1A), you are only insured for the preferred medicines.

Within the group of interchangeable medicines from the Medicines Reimbursement System (GVS) (Appendix 1A), we designate one or more as preferred medicines, on the basis of the best price. Within this group, you are only insured for the preferred medicine.

The active ingredient in a medicine determines the medicine's effect. There are often multiple medicines with the same active ingredient. These medicines differ in price, but have the same effect. There will always be at least one medicine available to you containing the prescribed active ingredient.

Our preferred medicines are specified on the list of preferred medicines ('Lijst Voorkeursgeneesmiddelen') on our website. We may amend the list from time to time, in which case we will tell you about it on our website.

- The preferred medicine policy also applies if you live in the Netherlands but prefer to buy your medicines abroad, for example because you live close to the border.

- The costs of a medicine other than the preferred medicine will be reimbursed only if the use of this other medicine is medically necessary.

If your doctor believes that treatment with a medicine designated by us (from the list of preferred medicines ['Lijst Voorkeursgeneesmiddelen']) is not medically responsible, your doctor can indicate this by including 'Medische Noodzaak' (medically necessary) on the prescription.

You may experience different side effects or have an intolerance to the same medicine from a different manufacturer. This can happen due to the use of certain additions such as colouring agents or fillers. Such side effects may go away after a few days. If, after 15 days of use, unacceptable side effects have not disappeared, please contact your pharmacist. Your pharmacist may, in consultation with your doctor, examine whether the preferred medicine may not be suitable for you because of unacceptable side effects.

Your doctor will assess whether you should switch to a medicine from the Medicines Reimbursement System (GVS) other than the preferred medicine. You will be entitled to that other medicine with the same active ingredient, the appropriate strength and method of administration, as long as that other medicine is not unnecessarily expensive. This will generally not be the original branded medicine.

Your pharmacist will check the prescription for 'Medical Necessity'. Under Article 2.8, clause 4 of the Dutch Health Insurance Decree ('Besluit zorgverzekering'), you are then entitled to reimbursement of the costs of the medicine prescribed by your doctor.

- Medicines may only be supplied to the insured person for whom they are intended.

This may also be the carer, or the healthcare provider responsible for the administration.

- General advice and guidance is included as part of the supply of your medicine.

As a minimum, this applies to:

- guidance in relation to the use of a new medicine (first dispensation) or additional guidance if you have not used a medicine over the last 12 months;
- instruction in relation to a medicine that also requires the use of a medical aid;
- pharmacological support during visits to an outpatient clinic, hospitalisation and/or discharge from a hospital.

- A deductible always applies to the costs of the pharmacy's services, even when this concerns a preferred medication.

This applies to:

- dispensing: gathering and checking your medicine when you collect it or have it delivered;
- guidance: explaining the use of your medicine when you are given a new medicine or if you have not used the medicine over the last 12 months;
- additional costs, for example if the pharmacist has to prepare your medicine personally or if it concerns partial delivery or weekend or evening rates.

- What happens if your preferred medicine is not available?

Your pharmacy will then ensure that you receive another medicine with the same active ingredient. This medicine will be subject to a deductible.

- Medicines must be supplied on prescription (treatment proposal) for a specified period.

A prescription is valid for a certain period, which can be different for each type of medicine or medicine category. If a medicine comes under several of these categories, the shortest period applies.

The following supply periods apply to each prescription (treatment proposal):

- 15 days or the smallest package for a medicine that you are taking for the first time;
- 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy;
- 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics);
- a maximum of 30 days for medicines listed in the Dutch Opium Act ('Opiumwet'), with the exception of medicines for the treatment of ADHD, for which up to a 3-month supply may be provided;
- 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy;
- 12 months for 'the pill' (oral contraceptives);
- 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.

- Partial delivery consisting of a two, three or four-week supply is possible where medically necessary. This is only possible if a medicine has been prescribed for an extended period of time and no one is able to manage the medicine on your behalf. The supply of these pill packets or medication rolls containing one or more medicines that must be taken at a certain time of day is referred to as 'personalised distribution'. These pill packets are linked together on a roll.
- If you need to buy prescription medicines abroad, all the following conditions apply:
 - the active ingredient, dosage and method of administration of the medicine must be listed in the Dutch Medicines Reimbursement System (GVS);
 - reimbursement is in line with the Dutch reimbursement limit;
 - invoices for medicines must be legible and complete;
 - if the name, strength, quantity and method of administration of the medicine are not stated in full on the invoice, you must send us the patient information leaflet, box or labels (or a photo of these) along with your invoice.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.
- Geriatric specialist.
- 'GGD' regional healthcare authority doctor specialising in infectious diseases.
- Dental surgeon.
- Dentist.
- Doctor for the mentally disabled.
- Physician assistant.

For the additional conditions relating to the authority of a physician assistant in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).
- Nursing specialist with additional terms and conditions regarding authority in relation to writing prescriptions.

For the additional conditions relating to the authority of a specialist nurse in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).
- Obstetrician, taking into account authority in relation to writing prescriptions and field of expertise.

All the information relating to this is provided in Article 36 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', 'Wet BIG'), which you will find (in Dutch) at wetten.overheid.nl.
- One of the healthcare providers abroad stated above.

This healthcare provider complies with the requirements, laws and regulations that apply to their profession in the country concerned.
- You do not need a repeat prescription for contraceptive medicines.

There is no maximum period of validity per prescription for contraceptives in tablet form. You only need a prescription for these medicines once. Your general insurance policy covers no more per year than the amount required for a 12-month period. A new prescription will be required if the medicine, dosage and/or the use of the medicine changes.
- You do not need a repeat prescription for insulin.

There is no maximum period of validity per prescription for insulin for diabetes. You only need a prescription for these medicines once. Your general insurance policy covers no more per year than the amount required for a 12-month period. A new prescription will be required if the medicine, dosage and/or the use of the medicine changes.

Do you need approval?

- You need approval from us for certain medicines listed in Appendix 2.
 - Certain medicines (active ingredients) from Appendix 2 must be assessed by us. You will find a list of these medicines on our website.
You can find all the latest information on assessing medicines at www.zn.nl/zn-formulieren (in Dutch). This page also includes the medicines your pharmacy assesses.
 - For many of the Appendix 2 medicines your attending doctor can complete a doctor's statement; your pharmacy will then assess whether you are entitled to reimbursement of the costs. To find out more, your doctor can consult our site for healthcare providers.
- Objection to your pharmacy's assessment.
If you do not want your pharmacist or supplier to make the assessment, you can send the statement completed by your prescriber to our 'Medische Beoordelingen' (Medical Assessments) department directly, stating your objection.
- If we do give our approval, costs can be reimbursed only from the date we received the request for approval.
So it is important that you request approval before you start taking the medicine. Submitting an application for reimbursement does not guarantee that we will issue approval.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Pharmacy.
This is a pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').
You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Dispensing doctor or general practitioner.
This is a doctor or general practitioner with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').
You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Pharmacist, dispensing general practitioner or dispensing doctor abroad.
This healthcare provider has a licence to supply medicines in the country concerned and complies with the requirements, laws and regulations set out for their profession in the country concerned.

What is not reimbursed

- Medicines that are used for indications other than those specified in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
And if the other terms and conditions are not met.
- Medicines for research or experimental use.
Or medicines that are part of specialist medical healthcare. These come under 'Specialist medical healthcare'.
- A medicine for which we have no preference, while there is an equivalent and suitable medicine on the list of preferred medicines ('Lijst voorkeursgeneesmiddelen').
More information on preferred medicines can be found in our Pharmacy Regulations ('Reglement Farmacie').
- Non-registered medicines.
A pharmacy preparation (compounded medicine) or a medicine that is registered abroad may, under certain conditions, be eligible for reimbursement. These medicines are described in the 'Medicines prepared by the pharmacy' and 'Medicines from foreign countries' clauses.
- A medicine that is equivalent or almost equivalent to a registered medicine that is not included in the Medicines Reimbursement System (GVS) unless stipulated otherwise in a ministerial regulation.
See the 'Medicines prepared by the pharmacy' clause.
- Medicines (as well as information and advice) that are precautionary, or aimed at preventing illness in relation to trips abroad.

- Over-the-counter medicines (and information and advice) and medicines used in a hospital.
This applies insofar as they are not covered by your health insurance, in accordance with Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described under the 'External medical aids related to visual function disorders' clause under moisture chamber glasses and ptosis crutches.
- Medicines whereby a claim can be made under a compensation scheme, following the failure of the method of administration.
This concerns methods of administration related to a medical aid or consumer item with a manufacturer's warranty or other compensation scheme.
- Medicines that are financed in another way.
For example, medicines that come under the entitlement under of the Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo), government funding, or a subsidy scheme.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under 'treatment proposal'.
- Personal care products and cosmetic products, or products of a similar nature.
Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs for submitting prescriptions and collecting medicines outside normal opening hours.
This will be reimbursed in urgent situations.
- Statutory personal contributions for medicines under the Medicines Reimbursement System (GVS).
These come under the 'Medicines, statutory personal contribution' clause in an additional insurance package.
- Provision of and instruction in the use of medical aids, where the associated medicines are paid for by the hospital.
- Instruction in the use of medical aids that are required for medicines if the medical aids have not been supplied by a pharmacist or dispensing general practitioner.
- Additional costs, e.g. administrative, import and/or postage costs.
- Medicines, as referred to in Article 40, clause 3, paragraph f of the Dutch Medicines Act ('Geneesmiddelenwet').
- Alternative medicines.
For example, homoeopathic and anthroposophic medicines. The clause on 'Alternative and psychosocial healthcare' applies to these medicines.
- Esketamine nasal spray (Spravato).
This healthcare is described in the 'Mental healthcare' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medication assessment (clause B.15.2.)

Insured healthcare

- Medication assessment (periodic assessment).
- Pharmaceutical self-management information for a patient group.
Depending on the agreements we have made with your pharmacy, you may also be insured for pharmaceutical self-management information for a patient group ('Voorlichting farmaceutisch zelfmanagement voor patiëntengroep') and the conditional pharmaceutical support services ('facultatieve prestaties farmaceutische zorg') as described in the policy rule of the 'Nederlandse Zorgautoriteit' (Dutch Healthcare Authority, NZa):
 - improving medications adherence of patients with asthma/COPD;
 - medication optimisation and support for patients receiving complex pharmaceutical healthcare;
 - guidance for chronic use of prescription-only medicines (POMs);
 - guidance for asthma and/or COPD medicines.

Your reimbursement

- Zo nodig vaker: reimbursement of 1 times per 12 months for medication assessment.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You use several medicines on a chronic basis and there is a medical and pharmaceutical need.

Terms and conditions

- You use multiple medicines chronically.
- The healthcare provider drawing up the treatment proposal has established the medical and pharmaceutical necessity.
The criteria for this can be found in the Medication Assessment guideline ('richtlijn Medicatiebeoordeling') of the Royal Dutch Pharmacists Association (KNMP) at www.knmp.nl.
- A medication assessment concerns medicines that meet the conditions for medicines set out in the Medicines Reimbursement System (GVS).
If you also use medicines that do not meet these conditions, these will still be included in the medication assessment.
- The medication assessment is conducted in consultation with you, your attending doctor, and the other healthcare providers involved.
- The healthcare provider must follow the current performance description of the Dutch Healthcare Authority ('NZa Prestatiebeschrijving') and the multidisciplinary guideline for geriatric polypharmacy ('Multidisciplinaire Richtlijn Polyfarmacie bij ouderen').

Who to get a treatment proposal from

- Pharmacist.
- Dispensing general practitioner.
- Medical specialist.
- Doctor for the mentally disabled.
- Geriatric specialist.

Do you need approval?

- You need approval from us for a medication assessment if the general terms and conditions for such are not met, but you still require this medication assessment for other medical or pharmaceutical reasons.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Pharmacist or dispensing general practitioner with medication assessment training.
A pharmacist or dispensing general practitioner who has successfully completed a supplementary training course that we consider sufficient for carrying out a medication assessment.
The healthcare takes place in the practice of a dispensing general practitioner or a government-recognised pharmacy (local or in a hospital) or your home or temporary place of residence.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medicines prepared by the pharmacy (clause B.15.4.)

Insured healthcare

- Medicines prepared by the pharmacy (pharmaceutical compounding).
These are non-registered medicines prepared for a specific prescription by a pharmacist. Your doctor will prescribe a medicine that the pharmacy will prepare especially for you. This is what is referred to as a compounded medicine. This may also involve a non-registered medicine that your pharmacist instructs a different pharmacy to prepare. This is known as a 'third-party compound'.

Your reimbursement

- Reimbursement of 100 % for medicines prepared by the pharmacy.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- A statutory personal contribution of a maximum of €250 applies to compounded medicines that include an active ingredient for which a statutory personal contribution applies.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - An existing medicine is not suitable for you, for example because the strength or form is not suitable for you or the active ingredient is not available as a registered drug.

Terms and conditions

- We only reimburse a compounded medicine that is equivalent or almost equivalent to a registered medicine not included in the Medicines Reimbursement System (GVS) if stipulated in a ministerial regulation.

The government can designate a medicine if it is:

- a compound for use during a 'bridging period', i.e. an application for the medicine to be included in the Medicines Reimbursement System (GVS) has been submitted, but a decision has not yet been made;
- one that has not been included in the Medicines Reimbursement System (GVS) because it is too expensive, while the price of the compounded medicine would be acceptable.
- The healthcare must involve rational pharmacotherapy.
This means that the medicine must meet all these conditions:
 - it is in a form that is suitable for the patient. For example, a liquid solution for a child that cannot swallow tablets yet;
 - it has been proven to be efficient and effective, meaning that adequate scientific research has been conducted into the medicine showing that it is effective in treating your symptoms or illness;
 - it is the most economical for the health insurance. It must, for example, not be more expensive than comparable medicines that are equally or more effective.

For certain preparations, we will need additional information in order to assess whether they qualify as rational pharmacotherapy.

- Medicines may only be supplied to the insured person for whom they are intended.
This may also be the carer, or the healthcare provider responsible for the administration.
- General advice and guidance is included as part of the supply of your medicine.
As a minimum, this applies to:
 - guidance in relation to the use of a new medicine (first dispensation) or additional guidance if you have not used a medicine over the last 12 months;
 - instruction in relation to a medicine that also requires the use of a medical aid;
 - pharmacological support during visits to an outpatient clinic, hospitalisation and/or discharge from a hospital.

- Medicines must be supplied on prescription (treatment proposal) for a specified period.
A prescription is valid for a certain period, which can be different for each type of medicine or medicine category. If a medicine comes under several of these categories, the shortest period applies.
The following supply periods apply to prescriptions (treatment proposal):
 - 15 days or the smallest package for a medicine that you are taking for the first time;
 - 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy;
 - 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics);
 - a maximum of 30 days for medicines listed in the Dutch Opium Act ('Opiumwet'), with the exception of medicines for the treatment of ADHD, for which up to a 3-month supply may be provided;
 - 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy;
 - 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.
- Partial delivery consisting of a two, three or four-week supply is possible where medically necessary.
This is only possible if a medicine has been prescribed for an extended period of time and no one is able to manage the medicine on your behalf.
The supply of these pill packets or medication rolls containing one or more medicines that must be taken at a certain time of day is referred to as 'personalised distribution'. These pill packets are linked together on a roll.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.
- Geriatric specialist.
- Clinical nurse specialist.
- Doctor for the mentally disabled.
- 'GGD' regional healthcare authority doctor specialising in infectious diseases.
- Dentist.
- Dental surgeon.
- Physician assistant.

Where to go for this healthcare

- Pharmacy.
This is a pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').
You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Dispensing doctor or general practitioner.
This is a doctor or general practitioner with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').
You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.

What is not reimbursed

- A medicine that is equivalent or almost equivalent to a non-registered medicine and that is not included in the Medicines Reimbursement System (GVS).
You can find a list of these medicines at [wetten.overheid.nl](https://www.wetten.overheid.nl).
- Medicines for research or experimental use.
Or medicines that are part of specialist medical healthcare. These come under 'Specialist medical healthcare'.
- Compounds that are precautionary, or aimed at preventing illness in relation to trips.

- Over-the-counter medicines (and information and advice) and medicines used in a hospital. This applies insofar as they are not covered by your health insurance, in accordance with Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described under the 'External medical aids related to visual function disorders' clause under moisture chamber glasses and ptosis crutches.
- Medicines whereby a claim can be made under a compensation scheme, following the failure of the method of administration. This concerns methods of administration related to a medical aid or consumer item with a manufacturer's warranty or other compensation scheme.
- Medicines that are financed in another way. For example, medicines that come under the entitlement under of the Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo), government funding, or a subsidy scheme.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under 'treatment proposal'.
- Personal care products and cosmetic products, or products of a similar nature. Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs for submitting prescriptions and collecting medicines outside normal opening hours. This will be reimbursed in urgent situations.
- Statutory personal contributions for medicines under the Medicines Reimbursement System (GVS). These come under the 'Medicines, statutory personal contribution' clause in an additional insurance package.
- Additional costs, e.g. administrative, import and/or postage costs.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Medicines imported from abroad (clause B.15.5.)

Insured healthcare

- Medicines your pharmacy imports from abroad and which are not registered in the Netherlands.

Your reimbursement

- Reimbursement of 100 % for medicines imported from abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- You have an illness that does not occur more frequently in the Netherlands than in 1 in 150,000 inhabitants.
- No treatment is possible with a medicine registered in the Netherlands or one prepared in the Netherlands through pharmaceutical compounding.
- The treatment, prevention or diagnostics are in a form that is suitable for you.
- The efficacy and effectiveness has been proven in scientific literature.
- The treatment is the most economical for you and the health insurance.
- All the conditions listed above are the rules according to Article 2.8(1)(b) of the Dutch Health Insurance Decree ('Besluit zorgverzekering').
- Medicines may only be supplied to the insured person for whom they are intended. This may also be the carer, or the healthcare provider responsible for the administration.

- Medicines must be supplied on prescription (treatment proposal) for a specified period. A prescription is valid for a certain period, which can be different for each type of medicine or medicine category. If a medicine comes under several of these categories, the shortest period applies. The following supply periods apply to each prescription (treatment proposal):
 - 15 days or the smallest package for a medicine that you are taking for the first time;
 - 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy;
 - 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics);
 - a maximum of 30 days for medicines listed in the Dutch Opium Act ('Opiumwet'), with the exception of medicines for the treatment of ADHD, for which up to a 3-month supply may be provided;
 - 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy;
 - 12 months for 'the pill' (oral contraceptives);
 - 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.

Who to get a treatment proposal from

- General practitioner.
- Medical specialist.
- Geriatric specialist.
- 'GGD' regional healthcare authority doctor specialising in infectious diseases.
- Dental surgeon.
- Dentist.
- Doctor for the mentally disabled.
- Physician assistant.
- Nursing specialist with additional terms and conditions regarding authority in relation to writing prescriptions.

For the additional conditions relating to the authority of a specialist nurse in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions ('Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants') produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).

- Obstetrician, taking into account authority in relation to writing prescriptions and field of expertise. All the information relating to this is provided in Article 36 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', 'Wet BIG'), which you will find (in Dutch) at wetten.overheid.nl.

Do you need approval?

- The prescriber must request approval from us in advance. Approval will only be given if all the conditions have been met.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- A pharmacist or a dispensing doctor/dispensing general practitioner with a dispensation from the Dutch Health and Youth Care Inspectorate ('Inspectie Gezondheidszorg en Jeugd') for the import of the medicine.

This is a pharmacist or a dispensing doctor/dispensing general practitioner under the terms of the Dutch Medicines Act ('Geneesmiddelenwet'). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.

What is not reimbursed

- Medicines that are used for indications other than those specified in Appendix 2 of the Dutch Health Insurance Regulations ('Regeling zorgverzekering').
And if the other terms and conditions are not met.
- Medicines for research or experimental use.
Or medicines that are part of specialist medical healthcare. These come under 'Specialist medical healthcare'.
- A pharmacy preparation (compounded medicine): these are described in the 'Medicines prepared by the pharmacy' clause.
For example, a pharmacy preparation (compounded medicine): these medicines are described in the 'Medicines prepared by the pharmacy' clause, or a medicine imported from abroad: these are described in the 'Medicines from foreign countries' clause.
- A medicine that is equivalent or almost equivalent to a non-registered medicine and that is not included in the Medicines Reimbursement System (GVS).
You can find a list of these medicines at wetten.overheid.nl.
- Medicines (as well as information and advice) that are precautionary, or aimed at preventing illness in relation to trips abroad.
- Over-the-counter medicines (and information and advice) and medicines used in a hospital.
This applies insofar as they are not covered by your health insurance, in accordance with Dutch Health Insurance Regulations ('Regeling zorgverzekering'). Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described under the 'External medical aids related to visual function disorders' clause under moisture chamber glasses and ptosis crutches.
- Medicines whereby a claim can be made under a compensation scheme, following the failure of the method of administration.
This concerns methods of administration related to a medical aid or consumer item with a manufacturer's warranty or other compensation scheme.
- Medicines that are financed in another way.
For example, medicines that come under the entitlement under of the Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo), government funding, or a subsidy scheme.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under 'treatment proposal'.
- Personal care products and cosmetic products, or products of a similar nature.
Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs for submitting prescriptions and collecting medicines outside normal opening hours.
This will be reimbursed in urgent situations.
- Provision of and instruction in the use of medical aids, where the associated medicines are paid for by the hospital.
- Instruction in the use of medical aids that are required for medicines if the medical aids have not been supplied by a pharmacist or dispensing general practitioner.
- Additional costs, e.g. administrative, import and/or postage costs.
- Esketamine nasal spray (Spravato).
This healthcare is described in the 'Mental healthcare' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Occupational therapy

What you are insured for under your general insurance policy

Occupational therapy (clause B.9.)

Insured healthcare

- Occupational therapy.
Occupational therapy includes advice, instruction, training and/or treatment, aimed at helping you achieve, or regain, your independence and ability to look after yourself

Your reimbursement

- Reimbursement of 10 hours of treatment, per year for occupational therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- Referral required for a non-contracted healthcare provider.
If the treatment is provided by a non-contracted healthcare provider, a referral is required, before the start of the treatment, from a:
 - general practitioner;
 - nurse (level 5);
 - doctor for the mentally disabled;
 - geriatric specialist;
 - company doctor;
 - nursing specialist;
 - medical specialist.

Where to go for this healthcare

- Occupational therapist.
Your healthcare provider is an occupational therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Occupational therapist affiliated with ParkinsonNet.
The occupational therapist must have this affiliation if you are receiving care because you have been diagnosed with Parkinson's disease.

Where the treatment takes place

- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Oral care

What you are insured for under your general insurance policy

Oral care in exceptional circumstances (clause B.12.1.)

Insured healthcare

- Oral care in exceptional circumstances.
This relates to oral care if you have a severe condition of the face, mouth, jaws or teeth, or if you have a mental or physical condition that makes regular oral care impossible. The treatment can also be done under general anaesthesia or sedation.

Your reimbursement

- Reimbursement of 100 % for oral care in exceptional circumstances.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have a severe developmental or growth disorder of the teeth/jaw/mouth.
 - You have an acquired disorder of the teeth/jaw/mouth.
 - You suffer from a non-dental physical or mental condition.
 - You receive medical treatment that has demonstrably inadequate results without dental care.
This generally involves ensuring that the mouth is kept free of infection through, for example, the use of periodontal treatment, the extraction of teeth and/or the administration of antibiotics.

Terms and conditions

- Without special oral care, you would not be able to maintain the function of your teeth.
Or your teeth would not function as they would if you were not to have one of the conditions mentioned.

Who to get a referral from

- Dentist, orthodontist or dental implantologist in the case of fitting dental implants.

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.

Do you need approval?

- You need approval from us.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
We can withdraw our approval if one of the following situations occurs:
 - if the oral care is no longer necessary;
 - if you seriously neglect your oral hygiene;
 - if you fail to follow the advice provided by the healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Dental hygienist.
The dental hygienist manages the practice at their own expense and on their own responsibility.
- Dental surgeon.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The dental surgeon is responsible for the healthcare provided by other authorised healthcare providers to whom he has delegated tasks.
- Orthodontist.
The orthodontist is a dental specialist listed on the specialist register for odontomaxillary surgery administered by the Royal Dutch Dental Organisation ('Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde').
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- For treatment performed under general anaesthetic or sedation: an authorised healthcare provider in a centre for dental care in exceptional circumstances that is recognised by the Dutch Central Consultative Body for Dental Care in Exceptional Circumstances ('Centraal Overleg Bijzondere Tandheelkunde', COBIJT).
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- For treatment under general anaesthetic or sedation: an authorised healthcare provider with whom we have made agreements about these treatments.

What is not reimbursed

- Mandibular repositioning device (MRD).
Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001).
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002).
- External whitening per jaw (code K003).
- Incomplete cosmetic dentistry (K004).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Implant insertion in toothless jaw (clause B.12.2.)**Insured healthcare**

- Insertion of a dental implant.

Your reimbursement

- Reimbursement of 100 % for implant insertion in toothless jaw.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- A statutory personal contribution applies to the full denture attached to a dental implant.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a severely shrunken, toothless jaw, to which the removable denture can be attached.

Who to get a referral from

- Dentist.
- Dental implantologist.

The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.

Do you need approval?

- You need approval from us for the placement of one or more implants in your upper jaw.
The request for approval must be supported by a written statement of the reasons from your dentist or dental surgeon, along with a written treatment plan.
You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.
- For the lower jaw, a contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case.
Our approval is always required if the treatment is provided by a non-contracted healthcare provider. The request for approval must be supported by a written statement of the reasons from your dentist or dental surgeon, along with a written treatment plan.
You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Dental surgeon.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The dental surgeon is responsible for the healthcare provided by other authorised healthcare providers to whom he has delegated tasks.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Orthodontic care in exceptional circumstances (clause B.12.3.)

Insured healthcare

- Orthodontic care in exceptional circumstances.

Your reimbursement

- Reimbursement of 100 % for orthodontic care in exceptional circumstances.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a severe developmental or growth disorder of the teeth/jaw/mouth.
This always involves a very severe disorder which requires the involvement of other disciplines besides dental care for treatment.

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.
- A treatment plan is required for prosthetic follow-up treatment.
If, in the case of combined orthodontic treatment and dental surgery, prosthetic follow-up treatment is required, a multidisciplinary treatment plan will need to be drawn up in advance by all of the healthcare providers involved.

Do you need approval?

- You need approval from us.
Your request for approval must be supported by a treatment plan and a written explanation of the reasons from your orthodontist or from your dentist for orthodontics who meets the additional requirements of the Dutch Association of Dentists for Orthodontics ('VTvO').

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Orthodontist.
The orthodontist is a dental specialist listed on the specialist register for odontomaxillary surgery administered by the Royal Dutch Dental Organisation ('Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde').
- Dentist for orthodontics who meets the additional requirements of the Dutch Association of Dentists for Orthodontics ('VTvO').
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.

The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

What is not reimbursed

- Orthodontic care required as a result of the insertion of autografts (codes H36, H37, H38 and H39).
- Brace repair or replacement (code F811A*).
- Brace repair or replacement (code F811B*).
- Brace repair or replacement (code F811C*).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Regular oral care (clause B.13.)

Insured healthcare

- Regular examination.
- Incidental dental consultation.
- Removal of tartar.
- Fluoride treatment once permanent teeth have started to come through.
- Application of protective enamel to the crests of molars (i.e. cavity-sealing enamel).
- Treatment of the teeth's supporting tissue, e.g. the gums (i.e. periodontal care).
- Restoration (filling) of tooth or molar with plastic material.
- New patient intake.

Your reimbursement

- Up to and including 17 year(s): reimbursement of 100 % for regular oral care .

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.

Do you need approval?

- You need approval from us for certain oral care.
If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you need approval from us if this concerns:
treatment of the teeth's supporting tissue, e.g. the gums (periodontal care).

You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.

- approval is always required for oral care in a centre for dental care in exceptional circumstances.
- your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- We can withdraw our approval if one of the following situations occurs
- if the oral care is no longer necessary;
- if you fail to follow the advice provided by the healthcare provider;
- if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for oral care.

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Authorised healthcare provider affiliated with a facility for youth dental care.
- Authorised healthcare provider affiliated with hospital or independent treatment centre (ZBC).
A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza), by which we mean: - an independent treatment centre (ZBC) - a general hospital - a specialist hospital (hospital that provides healthcare for just one or a limited number of specialist fields, such as a burns unit or psychiatric hospital) - a university hospital.
- Dental hygienist.
The dental hygienist manages the practice at their own expense and on their own responsibility.

What is not reimbursed

- Crown, bridge and implant.
For oral care in exceptional circumstances, or if a front tooth, incisor or canine is missing as a direct result of an accident or because it has not developed, these costs will be reimbursed.
- Orthodontic care and associated X-ray.
For oral care in exceptional circumstances, this healthcare will be reimbursed.
- Gum shields (code M61).
Except in the case of oral care in exceptional circumstances.
- External whitening (code E97).
- Shaping and/or treatment of milk teeth (code M05).
- Mandibular repositioning device (MRD).
Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- Simple bacteriological examination (code M32).
- Treatment of white spots (codes M80* and M81*).
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37, H38 and H39).
- Extensive examination for the integral treatment plan (code C012).
- Making and discussing a restorative model (code C016*).
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001).
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002).
- External whitening per jaw (code K003).
- Incomplete cosmetic dentistry (K004).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Regular and specialist oral care (clause B.13.)

Insured healthcare

- Anaesthesia (local anaesthetic).
- Root canal treatment (endodontic care).
- Treatment of the masticatory (chewing) system (gnathology).
- Implant with crown to replace a missing permanent incisor or canine.
This is necessary when permanent incisors or canines have not developed or these teeth are missing entirely as a direct result of an accident. This can relate to one or more elements.
- Surgical dental care.
Except the fitting of dental implants.
- X-ray examination needed for regular oral care.

Your reimbursement

- Up to and including 17 year(s): reimbursement of 100 % for regular and specialist oral care.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.

Do you need approval?

- You need approval from us for certain oral care.
If it concerns one of these treatments:
 - replacement and/or filling of teeth with non-plastic materials;
 - insertion of dental implants that are required in order to replace one or more permanent incisors or canines that are missing as a direct result of an accident or because they have not developed;
 - insertion of dental implants for teeth that have not developed in the case of oligodontia, for the purpose of re-establishing the dental function;
 - a panoramic dental X-ray (OPT, indicated by code X21);
 - inserting autografts (autologous implants; codes H36, H37, H38 and H39). The application is submitted by the head of the treatment team using the special application form for this treatment.

If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you need approval from us if this concerns one of the following treatments:

- extraction of teeth under general anaesthetic or sedation;
- jaw surgery (osteotomy);
- insertion of a dental implant.

You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.

- approval is always required for oral care in a centre for dental care in exceptional circumstances.
- your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- We can withdraw our approval if one of the following situations occurs
- if the oral care is no longer necessary;
- if you fail to follow the advice provided by the healthcare provider;
- if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.

The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

- Authorised healthcare provider affiliated with a facility for youth dental care.

- Authorised healthcare provider affiliated with hospital or independent treatment centre (ZBC).
A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza), by which we mean: - an independent treatment centre (ZBC) - a general hospital - a specialist hospital (hospital that provides healthcare for just one or a limited number of specialist fields, such as a burns unit or psychiatric hospital) - a university hospital.
- The head of a team who has followed the specific training programme and has demonstrable specific expertise in the case of inserting autografts (autologous implants), codes H36, H37, H38 and H39.

What is not reimbursed

- Crown, bridge and implant.
For oral care in exceptional circumstances, or if a front tooth, incisor or canine is missing as a direct result of an accident or because it has not developed, these costs will be reimbursed.
- Gum shields (code M61).
Except in the case of oral care in exceptional circumstances.
- External whitening (code E97).
- Shaping and/or treatment of milk teeth (code M05).
- Mandibular repositioning device (MRD).
Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- X-ray examination for orthodontic care.
- Insertion of skeletal anchorage devices in the context of orthodontic care.
Except in the case of orthodontic care in exceptional circumstances. See the 'Orthodontic care in exceptional circumstances' clause.
- Orthodontic care and associated X-ray.
For oral care in exceptional circumstances, this healthcare will be reimbursed.
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37, H38 and H39).
- Extensive examination for the integral treatment plan (code C012).
- Making and discussing a restorative model (code C016*).
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001).
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002).
- External whitening per jaw (code K003).
- Incomplete cosmetic dentistry (K004).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dentures up to and including the age of 17 (clause B.13.)

Insured healthcare

- Full dentures.
Removable conventional dentures including associated material and technical costs.
- Partial dentures (removable partial dentures).
Metal plate denture including associated material and technical costs.

Your reimbursement

- Up to and including 17 year(s): reimbursement of 100 % for dentures up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Who to get a referral from

- Dentist in the event of treatment by a prosthodontist if you still have your own teeth and/or dental implants.

Who to get a treatment proposal from

- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this.

Do you need approval?

- You need approval from us for certain oral care.
In these situations:
 - if the total costs (including technical costs) for the full upper or lower denture to be made and inserted by a dentist or prosthodontist amount to more than €760 per jaw;
 - if the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you also need approval from us if this concerns extraction of teeth under general anaesthetic or sedation;
 - approval is always required for oral care in a centre for dental care in exceptional circumstances.

Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.

- We can withdraw our approval if one of the following situations occurs
 - if the oral care is no longer necessary;
 - if you fail to follow the advice provided by the healthcare provider;
 - if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Authorised healthcare provider affiliated with a facility for youth dental care.
- Authorised healthcare provider affiliated with hospital or independent treatment centre (ZBC).
A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza), by which we mean: - an independent treatment centre (ZBC) - a general hospital - a specialist hospital (hospital that provides healthcare for just one or a limited number of specialist fields, such as a burns unit or psychiatric hospital) - a university hospital.
- Prosthodontist insofar as authorised.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Extensive examination for the integral treatment plan (code C012).
- Making and discussing a restorative model (code C016*).
- Incomplete cosmetic dentistry (K004).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Dental surgery from the age of 18 (clause B.14.a.)

Insured healthcare

- Dental surgery.
This is oral care for surgery of the mouth, jaw and face that is performed by a medical specialist (dental surgeon). All of the following are part of oral care:
 - specialist surgical oral care;
 - associated X-ray examination;
 - admission in the lowest nursing care category of a hospital (facility for specialist medical healthcare).

Your reimbursement

- From 18 year(s): reimbursement of 100 % for dental surgery from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- In case of admission, it must be medically necessary for specialist surgical oral care.

Who to get a referral from

- Dentist.
- Orthodontist.
- General practitioner.

Do you need approval?

- You need approval from us for certain dental surgery.
If it concerns one of these treatments:
 - treatment of the teeth's supporting tissue, e.g. the gums (periodontal care);
 - extraction of teeth under general anaesthetic or sedation;
 - jaw surgery (osteotomy).

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dental surgeon.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The dental surgeon is responsible for the healthcare provided by other authorised healthcare providers to whom he has delegated tasks.

Where the treatment takes place

- Hospital (facility for specialist medical healthcare).

What is not reimbursed

- Periodontal surgery by a dental surgeon.
Surgery on the teeth's supporting tissue, e.g. the gums.
- Uncomplicated extraction (extraction of tooth or molar).
- Insertion of a dental implant.
- Mandibular repositioning device (MRD).
Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37, H38 and H39).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Full dentures for upper and/or lower jaw without implants, from the age of 18 (clause B.14.b.)

Insured healthcare

- Full dentures.
This concerns one of the following types of dentures without implants:
 - removable full dentures (conventional dentures) for the upper and/or lower jaw;
 - temporary full dentures;
 - a removable full replacement denture;
 - a removable full implant overdenture fitted to one or more natural teeth (i.e. your own teeth), for the upper and/or lower jaw.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 75 % for full dentures for upper and/or lower jaw without implants, from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 25%.
- Deductible applies from the age of 18.

Terms and conditions

- In the case of treatment for which you need approval, the entitlement is not higher than the amount for which we have granted approval.
- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for costs above €760 per jaw if the dentures are made and fitted by a dentist or prosthodontist.
This relates to the total costs (including technical costs) for the full upper or lower denture.
Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.
- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Repairing and rebasing full dentures from the age of 18 (clause B.14.b.)

Insured healthcare

- Repair and filling (rebasings) of full dentures (removable full implant overdentures).

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 90 % for repairing and rebasing full dentures from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 10%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist for dentures (possibly involving dental implants), not on natural elements.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Implant-retained lower denture from the age of 18 (clause B.14.c.)

Insured healthcare

- Full implant-retained dentures in the lower jaw.
Removable full implant overdenture in the lower jaw. This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 90 % for implant-retained lower denture from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 10%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.
- You need approval from us for treatment by a non-contracted healthcare provider.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our approval if that is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

- Prosthodontist if you have been referred by the dentist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Insertion of a dental implant.
- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Implant-retained upper denture from the age of 18 (clause B.14.c.)

Insured healthcare

- Full implant-retained dentures in the upper jaw.
Removable full implant overdenture in the upper jaw. This includes inserting the fixed part of the suprastructure (the snap-on system) in the mouth.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 92 % for implant-retained upper denture from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 8%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.
- You need approval from us for treatment by a non-contracted healthcare provider.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our approval if that is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Insertion of a dental implant.
- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Repair or rebasing of a removable, implant-retained denture (clause B.14.b.)

Insured healthcare

- Repair and rebasing of removable full implant-retained dentures (including snap-on system).
- Repair of the fixed part of the suprastructure fitted to the implants and/or the part of the suprastructure in the denture.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 90 % for repair or rebasing of a removable, implant-retained denture.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Statutory personal contribution 10%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- You need a referral from a dentist or centre for dental care in exceptional circumstances if a prosthodontist makes the request.

Do you need approval?

- You need approval from us for treatment by a non-contracted healthcare provider.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our approval if that is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist for dentures (possibly involving dental implants), not on natural elements.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Implant with crown to replace an incisor or canine, from the age of 18 (clause B.14.e.)

Insured healthcare

- Implant with crown.
Replacing incisors or canines with non-plastic materials (crown) and fitting a dental implant.

Your reimbursement

- Up to and including 22 year(s): reimbursement of 100 % for implant with crown to replace an incisor or canine, from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are missing one or more permanent incisors or canines because they have not developed.
 - You are missing one or more permanent incisors or canines as a direct result of an accident before the age of 18.
This also applies to situations in which:
 - as the result of an accident, a tooth has broken to such an extent that only a small part of the root remains. The remaining part of the root needs to be left in place so as not to disrupt the development of the jaw. This will need to be removed later because it will not be able to support a prosthetic device;
 - a tooth that has been knocked out in an accident has been put back in the socket and secured so as not to disrupt the development of the jaw, even though there is little chance that the tooth can ultimately be saved.

Terms and conditions

- The treatment history must show that the accident occurred and was recorded before the age of 18.
- The remaining part of the root or the reinserted front tooth needs to be removed before the age of 23, right before the insertion of an implant.
- In case of admission, it must be medically necessary for specialist surgical oral care.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Dental surgeon for the fitting of the implants.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The dental surgeon is responsible for the healthcare provided by other authorised healthcare providers to whom he has delegated tasks.

Where the treatment takes place

- Dental practice.
- Hospital (facility for specialist medical healthcare).

What is not reimbursed

- X-ray examination for orthodontic care.
- Insertion of skeletal anchorage devices in the context of orthodontic care.
Except in the case of orthodontic care in exceptional circumstances. See the 'Orthodontic care in exceptional circumstances' clause.
- Orthodontic care and associated X-ray.
For oral care in exceptional circumstances, this healthcare will be reimbursed.
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37, H38 and H39).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Full denture for one jaw combined with full implant-retained denture for the other jaw, from the age of 18 (clause B.14.d.), associated mesostructure for the implant-retained dentures for the lower jaw, from the age of 18 (clause B.14.d.), associated mesostructure for implant-retained dentures for the upper jaw, from the age of 18 (clause B.14.d.)

Insured healthcare

- Full dentures for one jaw combined with implant-retained dentures (including snap-on system) for the other jaw.
Removable full conventional dentures together with full implant-retained dentures on the other jaw. These costs are claimed under code J080. This includes insertion of the fixed part of the suprastructure (the snap-on system).
- Mesostructure for the lower or upper jaw.
This is part of the combination of dentures for one jaw combined with implant-retained dentures for the other jaw.

Your reimbursement

- From 0 euros, from 18 year(s): reimbursement of 83 % for full denture for one jaw combined with full implant-retained denture for the other jaw, from the age of 18 ; and
- From 0 euros, from 18 year(s): reimbursement of 90 % for associated mesostructure for the implant-retained dentures for the lower jaw, from the age of 18; and
- From 0 euros, from 18 year(s): reimbursement of 92 % for associated mesostructure for implant-retained dentures for the upper jaw, from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for full denture for one jaw combined with full implant-retained denture for the other jaw, from the age of 18 (clause B.14.d.)

The amount you pay yourself

- Personal contribution 17%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Insertion of a dental implant.
- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for associated mesostructure for the implant-retained dentures for the lower jaw, from the age of 18 (clause B.14.d.)

The amount you pay yourself

- Statutory personal contribution 10%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.
- You need approval from us for treatment by a non-contracted healthcare provider.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our approval if that is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprothetisch').

What is not reimbursed

- Insertion of a dental implant.
- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for associated mesostructure for implant-retained dentures for the upper jaw, from the age of 18 (clause B.14.d.)

The amount you pay yourself

- Statutory personal contribution 8%.
- Deductible applies from the age of 18.

Terms and conditions

- This healthcare is subject to a statutory personal contribution that can be reimbursed under the 'Statutory personal contribution for dentures' clause if you have additional insurance cover for this.

Who to get a referral from

- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances.

Do you need approval?

- You need approval from us for a replacement within 5 years.
If the full upper and/or lower denture are replaced within five years of purchase. Your request must be supported by a written statement from your dentist of the reasons for the treatment and an estimate of the costs.
- You need approval from us for treatment by a non-contracted healthcare provider.
Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our approval if that is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Dentist.
The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed

- Insertion of a dental implant.
- Uncomplicated extraction (extraction of tooth or molar).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy

What you are insured for under your general insurance policy

Physiotherapy and exercise therapy up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy.
By this we mean physiotherapy or recognised specialist physiotherapy.
- Cesar or Mensendieck exercise therapy.
- Oedema therapy.

Your reimbursement

- From the first session, up to and including 17 year(s): reimbursement of 9 sessions, per condition, per year, en zo nodig 9 behandelingen extra voor dezelfde aandoening for physiotherapy and exercise therapy up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a (temporary) complaint or injury.
In most cases, physiotherapy relates to a short-term, acute complaint. If you have any doubts, please ask your physiotherapist or exercise therapist or attending doctor.

Terms and conditions

- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- If the sessions are group sessions, the group may not have more than 10 participants.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- You need a referral to receive physiotherapy or exercise therapy at home.
You need a referral from your doctor for physiotherapy or exercise therapy at home. The doctor must state on the referral why treatment at home is medically necessary in your case. These doctors may make the referral:
 - general practitioner
 - doctor for the mentally disabled
 - geriatric specialist
 - youth healthcare doctor
 - dentist
 - company doctor, or
 - medical specialist.

Do you need approval?

- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Skin therapist or oedema physiotherapist provides oedema therapy.
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy for whiplash up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy.
By this we mean physiotherapy or recognised specialist physiotherapy.
- Cesar or Mensendieck exercise therapy.

Your reimbursement

- From the first session, up to and including 17 year(s): reimbursement of 100 %, during a maximum of 3 months, and, if necessary, extension for a maximum period of 6 months for physiotherapy and exercise therapy for whiplash up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have whiplash.

Terms and conditions

- This period can only be extended if loss of motor function, exercise intolerance and cognitive disorders (all three) continue after 3 months.
- If the sessions are group sessions, the group may not have more than 10 participants.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.

A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

- You need approval from us for treatment by 2 or more different healthcare providers.

If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.

- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- **Physiotherapist.**
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- **Cesar or Mensendieck exercise therapy.**
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- **Skin therapist or oedema physiotherapist provides oedema therapy.**
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and/or exercise therapy for whiplash from the age of 18 (clause B.8.1.)

Insured healthcare

- **Physiotherapy.**
By this we mean physiotherapy or recognised specialist physiotherapy.
- **Cesar or Mensendieck exercise therapy.**

Your reimbursement

- From the 21st session, from 18 year(s): reimbursement of 100 %, during a maximum of 3 months, and, if necessary, extension for a maximum period of 6 months for physiotherapy and/or exercise therapy for whiplash from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have whiplash.

Terms and conditions

- This period can only be extended if loss of motor function, exercise intolerance and cognitive disorders (all three) continue after 3 months.
- If the sessions are group sessions, the group may not have more than 10 participants.

- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Skin therapist or oedema physiotherapist provides oedema therapy.
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy for juvenile osteochondrosis up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy.
By this we mean physiotherapy or recognised specialist physiotherapy.
- Cesar or Mensendieck exercise therapy.
- Oedema therapy.

Your reimbursement

- From the first session, up to and including 17 year(s): reimbursement of 100 % for physiotherapy and exercise therapy for juvenile osteochondrosis up to and including the age of 17 .

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have juvenile osteochondrosis.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.

A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Skin therapist or oedema physiotherapist provides oedema therapy.
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy for juvenile osteochondrosis from 18 to 21 years of age inclusive (clause B.8.1.)

Insured healthcare

- Physiotherapy.
By this we mean physiotherapy or recognised specialist physiotherapy.
- Cesar or Mensendieck exercise therapy.
- Oedema therapy.

Your reimbursement

- From the 21st session, from 18 up to and including 21 year(s): reimbursement of 100 % for physiotherapy and exercise therapy for juvenile osteochondrosis from 18 to 21 years of age inclusive.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have juvenile osteochondrosis.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.

- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Skin therapist or oedema physiotherapist provides oedema therapy.
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy according to the list of conditions from the age of 18 (clause B.8.1.)

Insured healthcare

- Physiotherapy.
By this we mean physiotherapy or recognised specialist physiotherapy.
- Cesar or Mensendieck exercise therapy.
- Oedema therapy.

Your reimbursement

Reason	Reimbursement for from 18 year(s) (clause B.8.1.)	Reimbursement for up to and including 17 year(s) (clause B.8.3.)
<p>You have had a CVA (cerebrovascular accident).</p> <p>You have a spinal cord condition as a result of a disorder in the nervous system.</p> <p>You have MS (multiple sclerosis).</p> <p>You have peripheral neuropathy with loss of motor function.</p> <p>You have an extrapyramidal condition.</p> <p>You have a congenital defect of the central nervous system.</p> <p>You have a cerebellar condition.</p> <p>You have neurological paralysis symptoms as a result of brain damage or a tumour in the brain or spinal cord.</p> <p>You have a neuromuscular disease as a result of a disorder in the nervous system.</p> <p>You have myasthenia gravis.</p> <p>You have a congenital defect of the musculoskeletal system.</p> <p>You have progressive scoliosis.</p> <p>You have reflex dystrophy.</p> <p>You have a fracture due to bone metastases, Kahler's disease, or Paget's disease.</p> <p>You have Forestier's disease (hyperostotic spondylosis).</p> <p>You have a collagen disease.</p> <p>You have had an amputation.</p> <p>You have a congenital defect of the respiratory tract.</p> <p>You have lymphedema.</p> <p>You have scar tissue of the skin after a trauma or otherwise.</p> <p>You have diffuse interstitial lung disease with ventilatory defect or diffusion disorder.</p>	<p>From the 21st session, from 18 year(s): reimbursement of 100 %.</p>	
<p>You have a radicular syndrome with loss of motor function.</p> <p>You have pelvic instability after childbirth (postpartum).</p>	<p>From the 21st session, from 18 year(s): reimbursement of 100 %, during a maximum of 3 months.</p>	<p>From the first session, up to and including 17 year(s): reimbursement of 100 %, during a maximum of 3 months.</p>

Reason	Reimbursement for from 18 year(s) (clause B.8.1.)	Reimbursement for up to and including 17 year(s) (clause B.8.3.)
You have had a fracture that has been treated conservatively.	From the 21st session, from 18 year(s): reimbursement of 100 %, during a maximum of 6 months.	From the first session, up to and including 17 year(s): reimbursement of 100 %, during a maximum of 6 months.
You have a frozen shoulder (adhesive capsulitis). You have Fontaine stage 3 peripheral artery disease.	From the 21st session, from 18 year(s): reimbursement of 100 %, during a maximum of 12 months.	From the first session, up to and including 17 year(s): reimbursement of 100 %, during a maximum of 12 months.
You were admitted to a hospital, a nursing facility, a rehabilitation facility or for day treatment at a rehabilitation facility.	From the 21st session, from 18 year(s): reimbursement of 100 %, during a maximum of 12 months following discharge or termination of treatment at the facility.	From the first session, up to and including 17 year(s): reimbursement of 100 %, during a maximum of 12 months following discharge or termination of treatment at the facility.
You have a soft tissue tumour.	From the 21st session, from 18 year(s): reimbursement of 100 %, for up to 2 years after radiotherapy.	From the first session, up to and including 17 year(s): reimbursement of 100 %, for up to 2 years after radiotherapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- See table above

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- **Physiotherapist.**
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- **Cesar or Mensendieck exercise therapy.**
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- **Skin therapist or oedema physiotherapist provides oedema therapy.**
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy according to the list of conditions up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- **Physiotherapy.**
By this we mean physiotherapy or recognised specialist physiotherapy.
- **Cesar or Mensendieck exercise therapy.**
- **Oedema therapy.**

Your reimbursement

- From the first session, up to and including 17 year(s): reimbursement of 100 % for physiotherapy and exercise therapy according to the list of conditions up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have had a CVA (cerebrovascular accident).
 - You have a spinal cord condition as a result of a disorder in the nervous system.
 - You have MS (multiple sclerosis).
 - You have peripheral neuropathy with loss of motor function.
 - You have an extrapyramidal condition.
 - You have a congenital defect of the central nervous system.
 - You have a cerebellar condition.
 - You have neurological paralysis symptoms as a result of brain damage or a tumour in the brain or spinal cord.
 - You have a neuromuscular disease as a result of a disorder in the nervous system.
 - You have myasthenia gravis.
 - You have a congenital defect of the musculoskeletal system.
 - You have progressive scoliosis.
 - You have reflex dystrophy.
 - You have a fracture due to bone metastases, Kahler's disease, or Paget's disease.
 - You have Forestier's disease (hyperostotic spondylosis).
 - You have a collagen disease.
 - You have had an amputation.
 - You have a congenital defect of the respiratory tract.
 - You have lymphedema.
 - You have scar tissue of the skin after a trauma or otherwise.
 - You have diffuse interstitial lung disease with ventilatory defect or diffusion disorder.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- **Physiotherapist.**
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- **Cesar or Mensendieck exercise therapy.**
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- **Skin therapist or oedema physiotherapist provides oedema therapy.**
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy and exercise therapy for motor retardation or a developmental disorder of the central nervous system up to and including the age of 16 (clause B.8.3.)

Insured healthcare

- **Physiotherapy.**
By this we mean physiotherapy or recognised specialist physiotherapy.
- **Cesar or Mensendieck exercise therapy.**
- **Oedema therapy.**

Your reimbursement

- From the first session, up to and including 16 year(s): reimbursement of 100 % for physiotherapy and exercise therapy for motor retardation or a developmental disorder of the central nervous system up to and including the age of 16 .

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:

- You have motor retardation or a developmental disorder of the central nervous system and are younger than 17 years of age.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Dentist.
- Company doctor.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. For patients diagnosed with Parkinson's disease, a contracted healthcare provider is a physiotherapist or a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Skin therapist or oedema physiotherapist provides oedema therapy.
The skin therapist is registered with 'kwaliteitsgeregistreerd' (quality registered) status on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici') and has a valid AGB code (administrative code assigned to healthcare professionals in the Netherlands) upon commencement of the treatment.
This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Pelvic physiotherapy for urinary incontinence from the age of 18 (clause B.8.2.)

Insured healthcare

- Pelvic physiotherapy.
Specialist physiotherapy aimed at treating pelvic floor problems.

Your reimbursement

- From 18 year(s): reimbursement of 9 sessions, maximum, once per insured person for pelvic physiotherapy for urinary incontinence from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have urinary incontinence.

Terms and conditions

- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- If the sessions are group sessions, the group may not have more than 10 participants.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Youth healthcare doctor.
- Company doctor.
- Nursing specialist.
- Medical specialist.
- Dentist.

Do you need approval?

- A contracted healthcare provider assesses whether pelvic physiotherapy is required to help treat urinary incontinence. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Pelvic physiotherapist.
Pelvic physiotherapy is provided by a pelvic physiotherapist. This is a physiotherapist listed as a pelvic physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy (supervised walking therapy) for intermittent claudication from the age of 18 (clause B.8.4.)

Insured healthcare

- Supervised walking therapy for intermittent claudication.
This physiotherapy promotes your self-management so that you can practice independently and is aimed at:
 - limiting the complaints caused by reduced oxygen in the legs and
 - reducing the risk factors of atherosclerosis.

Your reimbursement

- From 18 year(s): reimbursement of 37 sessions, during a maximum of 12 months for physiotherapy (supervised walking therapy) for intermittent claudication from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have intermittent claudication with peripheral artery disease at Fontaine stage 2.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- A healthcare provider who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This healthcare provider will assess whether it involves peripheral artery disease at Fontaine stage 2. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Physiotherapy (supervised exercise therapy) for osteoarthritis in the hip or knee joint from the age of 18 (clause B.8.5.)

Insured healthcare

- Supervised exercise therapy for osteoarthritis.
This physiotherapy promotes your self-management so that you can practice independently.

Your reimbursement

- From 18 year(s): reimbursement of 12 sessions, during a maximum of 12 months for physiotherapy (supervised exercise therapy) for osteoarthritis in the hip or knee joint from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have osteoarthritis in the hip or knee joint.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Nursing specialist.
- Medical specialist.

Do you need approval?

- A contracted healthcare provider assesses whether you have osteoarthritis in the hip or knee joint. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Exercise therapy for COPD stage II or higher for Group A (clause B.8.6.)

Insured healthcare

- Exercise therapy for chronic obstructive pulmonary disease (COPD).
This concerns supervised exercise therapy. This is a form of physiotherapy.

Your reimbursement

- From the first session, from 18 year(s): reimbursement of 5 sessions, during a maximum of 12 months for exercise therapy for COPD stage II or higher for Group A.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You have COPD stage II or higher, Group A.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group A for symptoms.
 - There is a risk of exacerbation.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry and GOLD classification class A for symptoms.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.

- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Respiratory nurse specialist.

Do you need approval?

- A physiotherapist who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This physiotherapist will assess whether it is a case of COPD stage II or higher and, if so, which group applies. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted physiotherapist.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Exercise therapy for COPD stage II or higher for Group B1 (clause B.8.6.), extension of exercise therapy for COPD stage II or higher for Group B1 (clause B.8.6.)

Insured healthcare

- Exercise therapy for chronic obstructive pulmonary disease (COPD).
This concerns supervised exercise therapy. This is a form of physiotherapy.

Your reimbursement

- From the first session, from 18 year(s): reimbursement of 27 sessions, during a maximum of 12 months from the start of the treatment for exercise therapy for COPD stage II or higher for Group B1; and
- In the subsequent years, from 18 year(s): reimbursement of 3 sessions, per 12 months for extension of exercise therapy for COPD stage II or higher for Group B1.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for exercise therapy for COPD stage II or higher for Group B1 (clause B.8.6.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You have COPD stage II or higher, Group B1.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group B1 for symptoms.
 - There is a risk of exacerbation.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry and GOLD classification class A for symptoms.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Respiratory nurse specialist.

Do you need approval?

- A physiotherapist who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This physiotherapist will assess whether it is a case of COPD stage II or higher and, if so, which group applies. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted physiotherapist.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of exercise therapy for COPD stage II or higher for Group B1 (clause B.8.6.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You have COPD stage II or higher, Group B1.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group B1 for symptoms.
 - There is a risk of exacerbation.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry and GOLD classification class A for symptoms.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Respiratory nurse specialist.

Do you need approval?

- A physiotherapist who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This physiotherapist will assess whether it is a case of COPD stage II or higher and, if so, which group applies. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted physiotherapist.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.
- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Physiotherapist.
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- Cesar or Mensendieck exercise therapy.
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Exercise therapy for COPD stage II or higher for Group B2, C or D (clause B.8.6.), extension of exercise therapy for COPD stage II or higher for Group B2, C or D (clause B.8.6.)

Insured healthcare

- Exercise therapy for chronic obstructive pulmonary disease (COPD).
This concerns supervised exercise therapy. This is a form of physiotherapy.

Your reimbursement

- From the first session, from 18 year(s): reimbursement of 70 sessions, during a maximum of 12 months from the start of the treatment for exercise therapy for COPD stage II or higher for Group B2, C or D; and
- In the subsequent years, from 18 year(s): reimbursement of 52 sessions, per 12 months for extension of exercise therapy for COPD stage II or higher for Group B2, C or D.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for exercise therapy for COPD stage II or higher for Group B2, C or D (clause B.8.6.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You have COPD stage II or higher, Group B2, C or D.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group B2, C or D for symptoms.
 - There is a risk of exacerbation.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry and GOLD classification class A for symptoms.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Respiratory nurse specialist.

Do you need approval?

- A physiotherapist who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This physiotherapist will assess whether it is a case of COPD stage II or higher and, if so, which group applies. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted physiotherapist.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.

- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- **Physiotherapist.**
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- **Cesar or Mensendieck exercise therapy.**
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for extension of exercise therapy for COPD stage II or higher for Group B2, C or D (clause B.8.6.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- All of the following medical indications or situations apply to you:
 - You have COPD stage II or higher, Group B2, C or D.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group B2, C or D for symptoms.
 - There is a risk of exacerbation.
This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry and GOLD classification class A for symptoms.

Terms and conditions

- If the sessions are group sessions, the group may not have more than 10 participants.
- The number of sessions specified is a maximum. You, your physiotherapist and, where applicable, the person who referred you, will agree the number of sessions required.
- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Respiratory nurse specialist.

Do you need approval?

- A physiotherapist who has a contract with us to provide this healthcare is affiliated with Chronisch ZorgNet. This physiotherapist will assess whether it is a case of COPD stage II or higher and, if so, which group applies. Our prior approval is not required in this case.
A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted physiotherapist.
- You need approval from us for treatment by 2 or more different healthcare providers.
If, at any time, you are receiving physiotherapy and exercise therapy at the same time, or you are being treated by 2 different physiotherapists or 2 different exercise therapists, you will need to ask us for approval in advance.

- You need approval from us if more than one session (other than the intake and examination) is required in one day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- **Physiotherapist.**
Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- **Cesar or Mensendieck exercise therapy.**
Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Fall prevention exercise programme (clause B.8.7.)

Insured healthcare

- Physiotherapy in the form of an exercise programme for fall prevention.

Your reimbursement

- From 65 year(s): reimbursement of 100 %, once per year for fall prevention exercise programme.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a high risk of falling in combination with underlying or additional physical or psychological problems.
As a result, you need support from a physiotherapist or exercise therapist.

Terms and conditions

- If there are no underlying or additional problems but you are still at risk of falling, you may be able to enter a fall prevention exercise programme through your municipality.

Who to get a referral from

- General practitioner.
- Nursing specialist.
- Medical specialist.
- Geriatric specialist.

Who to get a treatment proposal from

- The general practitioner's practice assistant carries out a fall analysis to determine whether the exercise programme is medically necessary.

Where to go for this healthcare

- Physiotherapist or exercise therapist working through a nationally recognised care programme that we have contracted.

You will find these programmes listed on our website, or ask us for more information.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Prevention

What you are insured for under your general insurance policy

Support with quitting smoking (clause B.21.2.)

Insured healthcare

- Support with quitting smoking.
Quit smoking coaching consists of interventions aimed at a change in behaviour, if necessary with the help of 'proven effective' medicines or nicotine substitutes (pharmacotherapy). The healthcare provider tailors the actual healthcare and guidance under the quit smoking coaching to you personally and, if necessary, gradually adjusts this during the healthcare process.

Your reimbursement

- Reimbursement of 1 attempt to quit, per year for support with quitting smoking.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Coaching and support during a quit smoking course are not subject to the deductible if you go to a healthcare provider that we have contracted for this healthcare.
- Medicines or nicotine substitutes are not subject to the deductible if they are prescribed by a contracted quit smoking healthcare provider and are prescribed as part of the quit smoking course.

Terms and conditions

- If medicines or nicotine substitutes (pharmacotherapy) are required, they must be used in combination with behavioural support from the quit smoking course.
The pharmacotherapy must therefore be part of the behavioural support in the form of individual coaching and support by telephone, online or through group coaching and support. A quit smoking coach is involved in this, in accordance with a quit smoking course that has proven to be effective.
- Medicines that are listed in the Medicines Reimbursement System (GVS) are not reimbursed under the provisions of this clause, but under the 'Medicines under the Medicines Reimbursement System' clause.
- If you are being treated for another addiction as part of mental healthcare, the quit smoking course will also come under the mental healthcare programme for the other addiction.

Who to get a treatment proposal from

- General practitioner or healthcare provider contracted for quit smoking interventions for a prescription for medicines or for nicotine substitutes (pharmacotherapy).

- if the pharmacotherapy for the quit smoking coaching is prescribed by your general practitioner, a prescription with the letters SMR (initialisation for the Dutch term for quit smoking) is sufficient. - healthcare providers contracted for quit smoking interventions must prescribe the pharmacotherapy using the quit smoking medicines application form ('Geneesmiddelen bij het stoppen met roken'). This form, which can be downloaded from our website, includes a description of the prescribed procedure. - healthcare providers who do not have a contract with us for quit smoking interventions will need to refer you to your general practitioner for the pharmacotherapy.
- Not necessary if it only concerns the quit smoking coaching and support.

Where to go for this healthcare

- General practitioner for quit smoking interventions.
The healthcare is provided by or under the responsibility of a general practitioner. This is a doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). Furthermore, the general practitioner must be listed on the Quality Register for Quit Smoking Coaches ('Kwaliteitsregister Stoppen met Roken') and have been trained to provide intensive counselling for those trying to quit smoking.
- Quit smoking medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism. Furthermore, the specialist must be listed on the Quality Register for Quit Smoking Coaches ('Kwaliteitsregister Stoppen met Roken') and have been trained to provide intensive counselling for those trying to quit smoking.
- Quit smoking coach.
The healthcare provider who provides the programme and is listed in the Quality Register for Quit Smoking Coaches ('Kwaliteitsregister Stoppen met Roken') who has been trained to provide intensive counselling for those trying to quit smoking.
- Healthcare psychologist.
Healthcare psychologist ('GZ-psycholoog') is a legally protected title in the Netherlands; this title may only be used by someone registered as such under the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG). This means not every psychologist working in healthcare is a 'GZ-psycholoog'.
- Pharmacy for dispensing medicines or nicotine substitutes.
A pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet').
- Contracted quit smoking supplier for the provision of medicines or nicotine substitutes.
Please see our website to find out which suppliers we have contracted. Simply enter 'Stoppen met roken' in the search box.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Sensory impairment care

What you are insured for under your general insurance policy

Sensory impairment care (clause B.25.), sensory impairment care with a stay or admission (clause B.25.)

Insured healthcare

- Multidisciplinary medical sensory impairment care.
The healthcare is aimed at having the insured person learn to cope with, overcome or compensate for the impairment, so the person is able to function as independently as possible.
- Multidisciplinary medical sensory impairment care with stay or admission.
The healthcare is aimed at having the insured person learn to cope with, overcome or compensate for the impairment, so the person is able to function as independently as possible.

Your reimbursement

- Reimbursement of 100 % for sensory impairment care; and
- Reimbursement of 100 % for sensory impairment care with a stay or admission.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for sensory impairment care (clause B.25.)

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have an auditory impairment (hearing).
 - You have a communication impairment (speech) as a result of a language development disorder.
For non-autistic children and young adults up to the age of 23.
 - You have a visual impairment (sight).

Terms and conditions

- Auditory impairment based on the diagnostics guidelines of the Federation of Dutch Audiology Centres ('Federatie van Nederlandse Audiologische Centra', FENAC).
The hearing loss in the audiogram is at least 35 dB, or the hearing loss is greater than 25 dB.
- Communication impairment resulting from a language development disorder, determined based on the diagnostics guidelines of the Federation of Dutch Audiology Centres ('Federatie van Nederlandse Audiologische Centra', FENAC).
 - the disorder can be traced back to neurobiological and/or neuropsychological factors; - the language development disorder is the primary condition, meaning that other problems (of a psychiatric, physiological or neurological nature) are subordinate to the language development disorder.
- Visual impairment based on the diagnostics guidelines of the Netherlands Ophthalmology Society ('Nederlands Oogheelkundig Gezelschap', NOG).
 - a visual acuity of less than 0.3 logMAR in the better eye; or - the field of vision is less than 30 degrees;
 - or - a visual acuity of between 0.3 and 0.5 logMAR in the better eye, with serious problems with day-to-day functioning as a result.

Who to get a referral from

- Medical specialist for a new disorder.
If the disorder or impairment has not been previously diagnosed or if the disorder or impairment has changed. A medical specialist refers the patient on the basis of the national Netherlands Ophthalmology Society ('Nederlands Oogheelkundig Gezelschap', NOG) referral guideline for visual healthcare.
- Clinical physicist for a new disorder.
If the disorder or impairment has not been previously diagnosed or if the disorder or impairment has changed.
- General practitioner for additional healthcare needs.
If the disorder/impairment has been diagnosed before but an additional need for related healthcare has arisen since. A referral is not required if the healthcare being provided is simple rehabilitation by a contracted healthcare facility for insured persons with a visual impairment. Your healthcare facility can tell you whether the care is simple rehabilitation.
- Youth healthcare doctor for additional healthcare needs.
If the disorder/impairment has been diagnosed before but an additional need for related healthcare has arisen since. A referral is not required if the healthcare being provided is simple rehabilitation by a contracted healthcare facility for insured persons with a visual impairment. Your healthcare facility can tell you whether the care is simple rehabilitation.

Where to go for this healthcare

- Multidisciplinary team in a facility for persons with sensory impairment.
The healthcare providers within the multidisciplinary team, their activities and the associated terms and conditions are set out in Article 2.5a of the Dutch Health Insurance Decree ('Besluit zorgverzekering').
- Healthcare psychologist (on behalf of the remedial education generalist) is ultimately responsible for audiological and communicative healthcare.
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Ophthalmologist, healthcare psychologist or clinical physicist bears ultimate responsibility for the visual healthcare provided.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

Where the treatment takes place

- The healthcare can be provided at your home if this is medically necessary and stated in the referral.

What is not reimbursed

- Treatment of language development disorder and/or articulation problems related to dialect and/or being a non-native speaker.
- Treatment that has an educational aim.
- Language or spelling testing.
- Treatment or research related to dyslexia.
- Treatments for medical pedagogical issues.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for sensory impairment care with a stay or admission (clause B.25.)**The amount you pay yourself**

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have medical grounds for a stay in accordance with the indication protocol.

Terms and conditions

- The terms and conditions in the indication protocol apply.

Do you need approval?

- You need approval from us for a stay lasting longer than 1 year. Healthcare facilities offering these stays will know whether you qualify for the stay and when approval is required.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Multidisciplinary team in a facility for persons with sensory impairment. The healthcare providers within the multidisciplinary team, their activities and the associated terms and conditions are set out in Article 2.5a of the Dutch Health Insurance Decree ('Besluit zorgverzekering').

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Short-term stays in a facility

What you are insured for under your general insurance policy

Short-term stays in a facility (clause B.27.)

Insured healthcare

- Short-term stay and primary healthcare in a facility. The stay is medically necessary. This concerns the following healthcare:
 - nursing and other care;
 - medical healthcare including first-line diagnostics;
 - physiotherapy, Mensendieck/Cesar exercise therapy, speech and language therapy, dietetics and occupational therapy relating to the indication for this short-term stay.

This healthcare is aimed at recovery and a return home (except in the case of palliative care).

Your reimbursement

- From 18 year(s): reimbursement of 100 %, maximum of 3 months, extension is possible if the goal is justified in a care plan for short-term stays in a facility.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have an immediate and demonstrable risk of a deterioration in health and you are temporarily unable to stay at home.

Terms and conditions

- We reimburse medicines and dietary preparations during this stay in accordance with the 'Medicines' and 'Dietary preparations' clauses.

Who to get a referral from

- General practitioner.

Who to get a treatment proposal from

- The general practitioner carries out the care needs assessment together with the district nurse. And they consult with the geriatric specialist, doctor for the mentally disabled or medical specialist.

Where to go for this healthcare

- General practitioner.
A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner's laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Geriatric specialist.
The healthcare is provided by or under the ultimate responsibility of a geriatric specialist. This is a doctor listed as a geriatric specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare takes place in a hospital, independent treatment centre (ZBC), or at the medical specialist's practice.
- Doctor for the mentally disabled.
This is a doctor listed as a doctor for the mentally disabled on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS).
The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Professional carer or nurse.
In consultation with the general practitioner and the geriatric specialist or doctor for the mentally disabled.
- Allied health professional provides allied healthcare.
Allied health professionals can be: physiotherapist, manual therapist, pelvic physiotherapist, physiotherapist specialising in children, geriatric physiotherapist, oedema therapist, remedial therapist, occupational therapist, speech and language therapist, dietician.

Where the treatment takes place

- A facility for nursing and personal care permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza).
This facility has at least one staff member with a 'Nursing level 4 or 5' AGB code (administrative code assigned to healthcare professionals in the Netherlands).

What is not reimbursed

- Care under the Dutch Youth Act ('Jeugdwet'), Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and/or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
For example, if it concerns respite care or if you receive your care in a form of clustered accommodation under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Specialist medical healthcare

What you are insured for under your general insurance policy

Skinvision (clause B.4.3.)

Insured healthcare

- Digital specialist medical healthcare (Skinvision).
Specialist medical healthcare is also available using digital applications that we have designated. One of these is the SkinVision app, which you can use to take a photo of a spot on your skin and have this assessed to see whether it presents a risk of skin cancer. If a high risk is detected, you will receive medical advice.

Your reimbursement

- From 18 year(s): reimbursement of 100 % for skinvision.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare is not subject to the compulsory deductible.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have a spot on your skin.

Terms and conditions

- The app account must be linked to your customer number.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Specialist medical healthcare (clause B.4.3.), admission for specialist medical healthcare (clause B.4.2.)

Insured healthcare

- Specialist medical healthcare.
This concerns the following healthcare:
 - specialist medical treatments (medical healthcare);
 - additional medical procedures (such as applying a plaster cast or an ECG test);
 - medicines, medical aids and dressings that are part of the treatment;
 - laboratory tests;
 - nursing.
- Admission for specialist medical healthcare.
This concerns the following healthcare:
 - admission in the lowest nursing care category of a facility for specialist medical healthcare;
 - nursing and other care.

Your reimbursement

- Reimbursement of 100 % for specialist medical healthcare; and
- Reimbursement of 100 %, maximum of 3 years (1095 days) for admission for specialist medical healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for specialist medical healthcare (clause B.4.3.)

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- Plastic surgery, organ transplants, geriatric rehabilitation, fertility treatment and conditional healthcare are also specialist medical healthcare, but are described in a separate clause.

Who to get a referral from

- General practitioner.
- Obstetrician.
- Medical specialist.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Nursing specialist.
- Physician assistant.
- Sports doctor.
- Youth healthcare doctor.
- Company doctor.
- Optometrist of orthoptist.
This healthcare provider may refer you to an ophthalmologist in the case of eye conditions.
- 'GGD' regional healthcare authority doctor in the case of general infectious disease control or an STD.
- Triage hearing care professional.
A triage hearing care professional may refer to an ENT specialist or audiology centre in the case of a hearing disorder.
- Clinical physicist in audiology.
A clinical physicist in audiology may provide the referral for audiology care

Do you need approval?

- In specific situations, your medical specialist must request our prior approval for add-on medicines and coagulation factors.
Add-on medicines are expensive medicines that the hospital may bill separately from the treatment (i.e. in addition to the DBC healthcare product). Your medical specialist will know when to request our approval for this.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

- Treatment using a cranial orthosis for plagiocefaly and brachycefaly without craniosynostosis.
- Treatments for snoring by way of uvuloplasty.
- Circumcision without medical necessity.
- Sterilisation treatments and treatments to reverse sterilisation.
- Correction of the position of the ears (protruding ears).
- Periodontal surgical healthcare as part of dental surgery.

- Laboratory tests at the request of an alternative healthcare provider.
- Healthcare and/or aids required after treatment (or associated with continued treatment).
- Population screening.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for admission for specialist medical healthcare (clause B.4.2.)

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- Your health insurance covers the admission up to a maximum of 1095 days.
Days are counted using the following rules:
 - if your admission is interrupted for a period of time less than 31 days, the number of days of the interruption does not count towards the total number of days. The count will resume after the interruption.
 - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning and you are again entitled to healthcare and reimbursement of such for the total number of days.
 - if your admission is interrupted for weekend/holiday leave, the number of days of interruption counts towards the total number of days.
- The Dutch nursing rate applies to admission in a foreign country.
A hospital or facility for specialist medical healthcare in a foreign country can have two or more different categories of nursing care. The Dutch nursing rate applies to the amount of the reimbursement.
- Admission is a medical necessity in terms of medical healthcare.

Do you need approval?

- In specific situations, your medical specialist must request our prior approval for add-on medicines and coagulation factors.
Add-on medicines are expensive medicines that the hospital may bill separately from the treatment (i.e. in addition to the DBC healthcare product). Your medical specialist will know when to request our approval for this.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Hospital or independent treatment centre (ZBC).
A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza), by which we mean: - an independent treatment centre (ZBC) - a general hospital - a specialist hospital (hospital that provides healthcare for just one or a limited number of specialist fields, such as a burns unit or psychiatric hospital) - a university hospital.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Plastic surgery (clause B.4.5.)

Insured healthcare

- Plastic surgery.
This concerns treatment of a cosmetic surgery nature. In addition, the medicines, medical aids and dressings that are part of the treatment and laboratory tests. If admission is required, the healthcare also includes admission in the lowest nursing care category of a facility for specialist medical healthcare, admission, nursing and other care.

Your reimbursement

- Reimbursement of 100 % for plastic surgery.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You have an abnormality in your appearance with demonstrable disorders of physical function. This relates to physical complaints, which objective tests have shown to be caused by the physical abnormality to be corrected. An example of this is untreatable, constantly-present blemishes in the folds of skin associated with a severely overhanging abdomen.
 - You have a disfigurement that has arisen as the result of illness, an accident or a medical procedure. This is the case where a severe disfigurement is immediately obvious in daily life, for example: disfigurement resulting from burns, or amputated legs, arms or breasts.
 - You have paralysed or drooping upper eyelids. The paralysis or drooping has led to severe limitations to the field of vision, or is the result of a congenital defect or the existence of a chronic condition at birth.
 - You have agenesis/aplasia of the breasts (failure of the breasts to develop) in women and in man-to-woman transgender people. The procedure consists of the surgical insertion or replacement of a breast prosthesis in women and a comparable situation in transgender women. In the case of transgender women, the person's gender dysphoria must be established by a healthcare provider who participates in a transgender network.
 - You have been diagnosed with gender dysphoria (transsexuality) and require correction of primary sexual characteristics as a result.
 - You have a congenital disfigurement. such as cleft lip, jaw or palate, disfigurement of the facial bones, uncontrolled growth of blood vessels, lymphatic vessels or connective tissue, birthmarks, or disfigurement of the urinary tract and genitalia.
 - You need a breast reduction. This applies in the case of you having a cup size that is DD/E or greater (or cup size D if you are less than 1.60m in height) and you suffer from a demonstrable physical complaint. The complaint is the consequence of the weight of your breasts and causes severe restriction. Other treatments and therapies must have been unsuccessful in relieving your complaint. Your weight is stable and not excessive.
 - You need laser treatment of the skin. This applies in the case of (immediately noticeable) disfigurement or demonstrable disorders of physical function. Most disfigurements do not meet these criteria.
 - You need nose correction surgery. This applies in a situation where the function of the nose is significantly limited and this cannot be treated in any other way. Corrective surgery in connection with deformity or congenital disfigurement is rare.

Terms and conditions

- If you need to be admitted, your health insurance covers the admission up to a maximum of 1095 days. Days are counted using the following rules:
 - if your admission is interrupted for a period of time less than 31 days, the number of days of the interruption does not count towards the total number of days. The count will resume after the interruption.
 - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning and you are again entitled to healthcare and reimbursement of such for the total number of days.

- if your admission is interrupted for weekend/holiday leave, the number of days of interruption counts towards the total number of days.
- For admission, this must be medically necessary in terms of medical healthcare.
- The 'VAV Werkwijzer' (Manual published by the Dutch Association of Public Health Doctors ('Vereniging Artsen Volksgezondheid')) will be used for all plastic surgery procedures.
The 'Werkwijzer' is available at vavolksgezondheid.nl under 'Werkwijzers VAGZ/VAV'.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Medical specialist.
- Nursing specialist.
- Physician assistant.
- Youth healthcare doctor.
- Company doctor.

Do you need approval?

- You need approval from us for any treatment that appears on the latest national list of procedures requiring prior approval ('Limitatieve lijst machtigingen medisch specialistische zorg ZN'). This list (in Dutch) can be found on our website.
- The contracted healthcare provider will determine whether or not your indication satisfies the provisions of the Dutch Health Insurance Act ('Zorgverzekeringswet'). Our prior approval is not required in this case. A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Medical specialist.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom the medical specialist has delegated tasks relating to their own medical specialism.
The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

- Abdominal liposuction.
- Removal of a breast prosthesis without medical necessity.
- Insertion or replacement of breast prostheses.
In situations that do not involve:
 - a total or partial mastectomy; or
 - agenesis/aplasia of the breast in women and the comparable situation in transgender women.
- The costs of photos we may require as part of the request for approval.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Rehabilitation

Insured healthcare

- Rehabilitation.
Specialist medical rehabilitation involves the most suitable healthcare for preventing, mitigating and/or overcoming your handicap. This healthcare is provided in the form of:
 - part-time or day treatment; or
 - admission when it is expected that this will achieve better results than outpatient rehabilitation.

Rehabilitation consists of tests, advice and treatment of a specialist medical, allied health, behavioural science and rehabilitation nature. Rehabilitation doctors have ultimate medical responsibility for the content and quality of specialist medical rehabilitation.

Rehabilitation healthcare is provided by a coherent, interdisciplinary team, in which all members cooperate closely in working towards the same treatment goal for the patient. The team is associated with a facility for rehabilitation.

Your reimbursement

- Reimbursement of 100 % for rehabilitation.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have complex, interrelated problems with movement, feeling, intellectual capacity, speech, language and/or behaviour.
These problems are caused by:
 - mobility disorders or restrictions; or
 - a disorder of the central nervous system that results in limitations in communication, mental capacity and/or behaviour.

Terms and conditions

- You strive to function as independently as possible given your limitations.
Rehabilitation focuses on improving and/or preventing problems in daily life and social functioning that arise as a result of an accident, operation or serious illness.

Who to get a referral from

- General practitioner.
- Doctor for the mentally disabled.
- Geriatric specialist.
- Medical specialist.
- Nursing specialist.
- Physician assistant.
- Sports doctor.
- Company doctor.

Do you need approval?

- You need approval from us for outpatient rehabilitation.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Rehabilitation doctor with interdisciplinary team.
A cohesive, interdisciplinary team under the ultimate responsibility of the rehabilitation doctor.
The healthcare takes place in a rehabilitation centre.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Geriatric rehabilitation (clause B.4.6.2.)

Insured healthcare

- Geriatric rehabilitation.
Geriatric rehabilitation comprises integrated, multidisciplinary rehabilitation healthcare. The healthcare is intended to reduce your functional limitations, so you can return home. The duration of the healthcare may not be more than 6 months.

Your reimbursement

- Reimbursement of 100 %, during a maximum of 6 months for geriatric rehabilitation.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - There is vulnerability, complex multimorbidity and reduced learning and training capacity.

Terms and conditions

- The geriatric rehabilitation follows within a week of admission and treatment in a facility for specialist medical healthcare.
The start of the rehabilitation is accompanied by admission. Prior to that, there was no stay under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).
- Geriatric rehabilitation may also be necessary for sudden changes in your situation.
This relates to sudden mobility disorders or a decrease in independence due to a condition for which you have already received specialist medical healthcare. In this case, it must be established by a geriatrician in the accident and emergencies department or by means of an emergency consultation at the geriatric outpatient clinic that you belong to the target group for geriatric rehabilitation.
- Geriatric assessment is necessary when treating the sudden onset of a medical condition or trauma.
A geriatric assessment (examination) must have been conducted by a multidisciplinary team under the responsibility of a geriatric internist and/or a clinical geriatrician.

Who to get a referral from

- Doctor for the mentally disabled.
- Medical specialist.
- Physician assistant.
- Nursing specialist.

Do you need approval?

- You need approval from us for geriatric rehabilitation lasting longer than 6 months.
Geriatric rehabilitation required for more than 6 months occurs in exceptional circumstances.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- A coherent, interdisciplinary team in a rehabilitation centre that works together closely in order to achieve the common goal of the patient's treatment, under the ultimate responsibility of the geriatric specialist.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Organ transplant, healthcare for the recipient (clause B.4.7.1.)

Insured healthcare

- Healthcare for the recipient of an organ transplant.
As the insured person and recipient of an organ, this comprises all of the following healthcare:
 - organ and tissue transplants;
 - specialist medical healthcare associated with the transplant of the organ(s)/tissue from the donor to you (the recipient); and
 - testing, removal, storage and transport of the organ(s)/tissue to be transplanted in connection with the transplant.

Your reimbursement

- Reimbursement of 100 % for organ transplant, healthcare for the recipient.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- Transplant on the basis of an indication that is accepted for the form of transplant in question, in accordance with the latest practical and theoretical standards.
- Transplant in EU or EEA.
The organ and tissue transplants can be performed in: - a European Union member state; or - a state that is party to the Agreement on the European Economic Area.
If the donor organ is donated by the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative, the transplant may also take place in the donor's country of residence (outside the EU or EEA).
- The healthcare provider must comply with the statutory minimum requirements for organ and tissue transplants and must be affiliated with a transplant centre that has been authorised and recognised by law.

Who to get a referral from

- Medical specialist.
- Nurse.
- Physician assistant.

Where to go for this healthcare

- Medical specialist who complies with the statutory minimum requirements for organ and tissue transplants.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism.

Where the treatment takes place

- Transplant centre that has been recognised by law.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Liver transplant: healthcare for the donor (clause B.4.7.2.)

Insured healthcare

- Liver transplant: healthcare for the donor.
Healthcare for the donor involved in an organ transplant (i.e. the person who donates an organ/tissue to the recipient) concerns:
 - admission and specialist medical healthcare in relation to the selection or removal of the organ(s)/tissue to be transplanted;
 - transport within the Netherlands in relation to the selection and admission and discharge, on the basis of the lowest class of public transport;
 - transport by car or taxi instead of public transport if this is medically necessary;
 - transport to and from the Netherlands, if the donor lives outside the Netherlands, in cases of a transplant for an insured person in the Netherlands;
 - costs incurred by the donor in connection with the transplant, where the costs relate to the fact that the donor lives abroad. This refers to costs that are incurred in relation to the fact that the screening and selection of donors takes place abroad. For example, travel costs to and from a facility in the foreign country where the screening takes place, and the costs associated with the selection and transport of blood samples.

Your reimbursement

- Reimbursement of 100 %, up to a maximum of 6 months after admission at the expense of the recipient, after 6 months at the expense of the donor for liver transplant: healthcare for the donor.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare and the transport are not subject to the deductible.

Terms and conditions

- Healthcare for the donor is charged to the recipient for the initial period after the donor is admitted.
In the case of a liver transplant, healthcare for the donor is covered by the insurance of the recipient of the organ for a maximum of 6 months after the end of the admission.
In the case of other transplants, healthcare for the donor is covered by the insurance of the recipient of the organ for a maximum of 13 weeks after the end of the admission.
The donor is also regarded as an insured person under the recipient's insurance, solely for this healthcare period.
If the donor has his/her own general insurance policy or is co-insured, transport of the donor (or the costs thereof) will be covered under the donor's own general insurance policy.
- Transplant on the basis of an indication that is accepted for the form of transplant in question, in accordance with the latest practical and theoretical standards.
- Transplant in EU or EEA.
The organ and tissue transplants can be performed in: - a European Union member state; or - a state that is party to the Agreement on the European Economic Area.
If the donor organ is donated by the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative, the transplant may also take place in the donor's country of residence (outside the EU or EEA).
- The healthcare provider must comply with the statutory minimum requirements for organ and tissue transplants and must be affiliated with a transplant centre that has been authorised and recognised by law.

Who to get a referral from

- Medical specialist.
- Nurse.
- Physician assistant.

Where to go for this healthcare

- Medical specialist who complies with the statutory minimum requirements for organ and tissue transplants.

A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism.

Where the treatment takes place

- Transplant centre that has been recognised by law.

What is not reimbursed

- Accommodation costs in the Netherlands for a foreign donor.
- Loss of income.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Healthcare for the donor in the case of other organs (clause B.4.7.2.)

Insured healthcare

- Healthcare for the donor in the case of transplant of an organ other than the liver.
Healthcare for the donor involved in an organ transplant (i.e. the person who donates an organ/tissue to the recipient) concerns:
 - admission and specialist medical healthcare in relation to the selection or removal of the organ(s)/tissue to be transplanted;
 - transport within the Netherlands in relation to the selection and admission and discharge, on the basis of the lowest class of public transport;
 - transport by car or taxi instead of public transport if this is medically necessary;
 - transport to and from the Netherlands, if the donor lives outside the Netherlands, in cases of a kidney or bone marrow transplant for an insured person in the Netherlands;
 - costs incurred by the donor in connection with the transplant, where the costs relate to the fact that the donor lives abroad. This refers to costs that are incurred in relation to the fact that the screening and selection of donors takes place abroad. For example, travel costs to and from a facility in the foreign country where the screening takes place, and the costs associated with the selection and transport of blood samples.

Your reimbursement

- Reimbursement of 100 %, up to a maximum of 13 weeks after admission at the expense of the recipient, after 13 weeks at the expense of the donor for healthcare for the donor in the case of other organs.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- This healthcare and the transport are not subject to the deductible.

Terms and conditions

- Healthcare for the donor is charged to the recipient for the initial period after the donor is admitted.
In the case of a liver transplant, healthcare for the donor is covered by the insurance of the recipient of the organ for a maximum of 6 months after the end of the admission.
In the case of other transplants, healthcare for the donor is covered by the insurance of the recipient of the organ for a maximum of 13 weeks after the end of the admission.
The donor is also regarded as an insured person under the recipient's insurance, solely for this healthcare period.
If the donor has his/her own general insurance policy or is co-insured, transport of the donor (or the costs thereof) will be covered under the donor's own general insurance policy.
- Transplant on the basis of an indication that is accepted for the form of transplant in question, in accordance with the latest practical and theoretical standards.
- Transplant in EU or EEA.
The organ and tissue transplants can be performed in: - a European Union member state; or - a state that is party to the Agreement on the European Economic Area.
If the donor organ is donated by the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative, the transplant may also take place in the donor's country of residence (outside the EU or EEA).
- The healthcare provider must comply with the statutory minimum requirements for organ and tissue transplants and must be affiliated with a transplant centre that has been authorised and recognised by law.

Who to get a referral from

- Medical specialist.
- Nurse.
- Physician assistant.

Where to go for this healthcare

- Medical specialist who complies with the statutory minimum requirements for organ and tissue transplants.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism.

Where the treatment takes place

- Transplant centre that has been recognised by law.

What is not reimbursed

- Accommodation costs in the Netherlands for a foreign donor.
- Loss of income.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

The costs of electricity for mechanical ventilation when this is provided in your home (clause B.4.9.)

Insured healthcare

- The costs of electricity for mechanical ventilation when this is provided in your home.

Your reimbursement

- Reimbursement of 13.140 euros, per quarter for the costs of electricity for mechanical ventilation when this is provided in your home.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- You can claim costs on a quarterly basis.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Fertility treatment IVF and ICSI (clause B.4.14.)

Insured healthcare

- IVF/ICSI fertility treatment.
For each desired pregnancy, the healthcare includes: in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) treatment, and the medicines used for this in accordance with the Medicines Reimbursement System (GVS).

Your reimbursement

- Up to and including 42 year(s): reimbursement of 3 attempts for fertility treatment IVF and ICSI.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - You have fertility problems.

Terms and conditions

- Terms and conditions under which IVF and ICSI are covered under the healthcare.
 - if you are younger than 38, and no more than one embryo is transferred in each of the 1st and 2nd IVF attempts (up to 2 embryos in the 3rd attempt);
 - if you are between 38 and 42 years old, and a maximum of 2 embryos are transferred in each attempt;
 - if you are 43 or older, but were younger than 43 when the treatment commenced: you will be entitled to conclude the current attempt.

Fertility treatment: IVF examples.

- you are undergoing your 3rd attempt. Although the follicular aspiration is successful, it does not result in pregnancy. A subsequent (4th) attempt is not covered by your health insurance. - you are undergoing your 3rd attempt. You did not become pregnant as a result of embryo transfer, but a few frozen embryos remain. All of the remaining frozen embryos can be transferred, up to a maximum of two at a time. This applies even if you have reached the age of 43: this is still considered to be part of the 3rd attempt which started when you were not yet 43. If it were the 1st or 2nd attempt, and you were younger than 38, only one embryo at a time could be transferred. - you are undergoing your 3rd attempt. An embryo is transferred, but the pregnancy ends 14 weeks after the date of follicular aspiration. You will again be entitled to three attempts (if you are younger than 43), since you had a successful pregnancy. - you have had three attempts without success. After a period of time you become pregnant naturally. Assuming you are younger than 43, you are then entitled to three more attempts.

- Following a successful pregnancy, you will be entitled to this healthcare again.
A successful pregnancy means: - a term of pregnancy of at least 9 weeks and 3 days, calculated from the date of implantation in the case of transfer of cryopreserved (frozen) embryos; or - a term of pregnancy of at least 10 weeks, calculated from the date of follicular aspiration; or - a term of pregnancy of at least 12 weeks, calculated from the first day of the last period, in the case of a spontaneous (physiological) pregnancy.
- An IVF attempt is deemed to have been made if follicular aspiration is successful.
In vitro fertilisation (one IVF attempt) is deemed to have occurred if stage 2, follicular aspiration (retrieval of mature egg cells) is successful. The transfer of previously cultured (frozen) embryos forms part of the IVF attempt during which the embryos were cultured.
Fertility treatment: IVF stages.
In vitro fertilisation (IVF) has four consecutive stages:
 - stage 1: hormone treatment to stimulate egg cell maturation;
 - stage 2: follicular aspiration (retrieval of mature egg cells);
 - stage 3: fertilisation of the egg cells and embryo culture in the laboratory;
 - stage 4: one or more implants of 1 or 2 embryos into the uterus.

Who to get a referral from

- General practitioner.
- Medical specialist.
- Nursing specialist.
- Physician assistant.

Where to go for this healthcare

- Gynaecologist in a licensed facility.
A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee ('Registratiecommissie Geneeskundig Specialisten', RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks.

What is not reimbursed

- Treatment for the egg cell donor and donation of the egg cell in the case of egg cell donation. National criteria apply to the reimbursement of egg cell donation.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Speech and language therapy and stammer therapy

What you are insured for under your general insurance policy

Speech and language therapy (clause B.10.)

Insured healthcare

- Speech and language therapy.
The speech and language therapy is provided on medical grounds, and is aimed at improving or restoring the ability to speak. This also includes stammering therapy.

Your reimbursement

- Reimbursement of 100 % for speech and language therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Terms and conditions

- The treatment can be provided at your home if this is medically necessary.

Who to get a referral from

- You will need a referral if the treatment will be provided by a non-contracted healthcare provider. The referral needs to be provided by a general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, company doctor, dentist, medical specialist, clinical physicist in audiology at an audiology centre, or clinical nurse specialist.

Do you need approval?

- You need approval from us if you need to have more than one treatment on the same day.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Speech and language therapist.
Your healthcare provider is a speech and language therapist with the status of 'kwaliteitsgeregistreerd' (quality registered) on the Quality Register for Allied Health Professionals ('Kwaliteitsregister Paramedici').
- Speech and language therapist affiliated with ParkinsonNet.
The speech and language therapist must have this affiliation if you are receiving care because you have been diagnosed with Parkinson's disease.

What is not reimbursed

- Stammer therapy using the Del Ferro, BOMA or Hausdörfer Institute for Natural Speech ('Hausdörfer Instituut voor Natuurlijk Spreken') methodologies.
- Treatment that has an educational aim.
- Treatment or research related to dyslexia.
- Treatment of language development disorder and/or articulation problems related to dialect and/or being a non-native speaker.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Transport

What you are insured for under your general insurance policy

Transport by ambulance (clause B.18.1.)

Insured healthcare

- Transport by ambulance.
This concerns the following healthcare:
 - non-urgent ambulance transport, as referred to in Article 1, Paragraph 1, of the Dutch Ambulance Facilities and Services Act ('Wet ambulancevoorzieningen'), over a maximum distance of 200 kilometres for a one-way journey;
 - urgent ambulance transport;
 - patient transport by other means of transport if transport by ambulance is not possible;
 - cost of usage for an Automated External Defibrillator (AED) that are charged to the ambulance service (electrode pads).

Your reimbursement

- Reimbursement of 100 % for transport by ambulance.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

The amount you pay yourself

- Deductible applies from the age of 18.

Eligibility for this healthcare

- The medical indication or situation below applies to you:
 - There is a medical necessity, which means that any other type of patient transport (car, public transport or taxi) would not be responsible for medical reasons.

Terms and conditions

- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree ('Besluit Langdurige zorg').
- An ambulance to another residence is only possible if, within reason, you will not be able to receive the care you need at your own home.

Who to get a treatment proposal from

- A doctor requests ambulance transport from the emergency centre of the regional ambulance service. The emergency centre assesses whether transport by ambulance is required.
- You do not need a treatment proposal for urgent ambulance transport.

Do you need approval?

- You need approval from us if you will be travelling further than 200km one way or if you want to use a different type of transport because transport by ambulance is not possible.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- The ambulance service with a recognised permit.

What is not reimbursed

- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Transport by car (clause B.18.2.), transport by taxi (clause B.18.2.), transport by public transport (2nd class) (clause B.18.2.), transport by other means of transport (clause B.18.2.), accommodation costs (clause B.18.2.)

Insured healthcare

- Patient transport by car.
This type of healthcare includes:
 - patient transport by car over a distance of no more than 200 kilometres for a one-way journey;
 - transport of an escort (in exceptional cases 2 escorts) or a guide/assistance dog.
- Patient transport by taxi.
This type of healthcare includes:
 - patient transport by car over a distance of no more than 200 kilometres for a one-way journey;
 - transport of an escort (in exceptional cases 2 escorts) or a guide/assistance dog.
- Patient transport by public transport.
This type of healthcare includes:

- patient transport by public transport (2nd class) over a distance of no more than 200 kilometres for a one-way journey;
- transport of an escort, in exceptional cases 2 escorts, or a guide/assistance dog.
- Patient transport by another means of transport.
Patient transport by another means of transport over a maximum distance of 200 kilometres for a one-way journey if transport by car, public transport (in the lowest class) or taxi is not possible.
- Overnight stay instead of transport.

Your reimbursement

- You can choose from one of the following reimbursements:
 1. From 0 euros: reimbursement of 38 euros, maximum, per kilometre for transport by car and from 0 euros: reimbursement of 100 % for transport by taxi and from 0 euros: reimbursement of 100 % for transport by public transport (2nd class) and from 0 euros: reimbursement of 100 % for transport by other means of transport.
 2. Reimbursement of 89 euros, maximum, per night for accommodation costs.

We use a variety of rates. See the attached General terms and conditions, section [Rates](#).

Terms and conditions for transport by car (clause B.18.2.)

The amount you pay yourself

- Statutory personal contribution of €118 per calendar year for all patient transport combined.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are undergoing kidney dialysis.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are completely dependent on a wheelchair for mobility and so are not able to use public transport or specially adapted transport.
The healthcare you receive must be covered by your health insurance.
 - Your sight is impaired to such an extent that you are unable to travel without an escort.
The healthcare you receive must be covered by your health insurance.
 - You need geriatric rehabilitation.
The healthcare you receive must be covered by your health insurance.
 - You receive day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
The day treatment is provided in a group in accordance with the 'Medical care for specific patient groups' clause.
 - You are younger than 18 and require nursing care and other care.
Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
 - The hardship clause applies.
This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.
 - to be eligible for this, an application must be submitted together with a statement from your attending doctor;
 - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);

- the following calculation applies for this: number of months' treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor);
- if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is a trip to:
 - a healthcare provider; or
 - a facility where you are treated and/or nursed; or
 - the guest house address if you have opted for an overnight stay instead of transport;
 - and a return trip to your legal home address or to another residence if you will not be able to, within reason, receive the care you need at your own legal home address. This also applies to patient transport during a temporary stay in a foreign country to receive treatment.
- If you are undergoing kidney dialysis or being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy, you are only insured for patient transport to and from the location you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy.
- We will assess whether you can use public transport, your own transport or taxi transport because the healthcare to be provided must be effective.
- In the event of the patient being escorted, transport of the escort must be required, or the insured person being escorted must be younger than 16 years of age.
- We use Routenet for calculating the distance of the journey if you travel by car. We use the most recent version of this route planner. We calculate the fastest route from postcode to postcode. We use the usual method of rounding off.
- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree ('Besluit Langdurige zorg').
- In each of these situations, the statutory personal contribution for transport does not apply:
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility to receive inpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical care;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility or healthcare provider to receive outpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical healthcare. Transport back to the facility where you have been admitted is also not subject to a personal contribution;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and you need transport to another facility or healthcare provider to receive dental care provided under the provisions of the Wlz. Transport back to the facility where you have been admitted is also not subject to a personal contribution.

Do you need approval?

- You need approval from us.

If you will be travelling further than 200km one way or if you want to use a different type of transport because transport by car, public transport or taxi is not possible.

For the approval, see the attached General terms and conditions, section [Approval](#).

What is not reimbursed

- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Costs of patient transport in connection with healthcare under an additional insurance package.
- Hire costs for a hire car.

- Costs of transport if we reimburse the accommodation costs.
This relates to transport from your guest house address to the place where you are being treated or cared for and back to your guest house address.
- Transport between your guest house address and the place of treatment.
If you opt for an overnight stay instead of transport, you are not entitled to claim reimbursement for transport from your guest house address to the place of treatment and back to your guest house address.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for transport by taxi (clause B.18.2.)

The amount you pay yourself

- Statutory personal contribution of €118 per calendar year for all patient transport combined.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are undergoing kidney dialysis.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are completely dependent on a wheelchair for mobility and so are not able to use public transport or specially adapted transport.
The healthcare you receive must be covered by your health insurance.
 - Your sight is impaired to such an extent that you are unable to travel without an escort.
The healthcare you receive must be covered by your health insurance.
 - You need geriatric rehabilitation.
The healthcare you receive must be covered by your health insurance.
 - You receive day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
The day treatment is provided in a group in accordance with the 'Medical care for specific patient groups' clause.
 - You are younger than 18 and require nursing care and other care.
Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
 - The hardship clause applies.
This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.
 - to be eligible for this, an application must be submitted together with a statement from your attending doctor;
 - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);
 - the following calculation applies for this: number of months' treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor);
 - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is a trip to:
 - a healthcare provider; or
 - a facility where you are treated and/or nursed; or
 - the guest house address if you have opted for an overnight stay instead of transport;

- and a return trip to your legal home address or to another residence if you will not be able to, within reason, receive the care you need at your own legal home address. This also applies to patient transport during a temporary stay in a foreign country to receive treatment.
- If you are undergoing kidney dialysis or being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy, you are only insured for patient transport to and from the location you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy.
- We will assess whether you can use public transport, your own transport or taxi transport because the healthcare to be provided must be effective.
- In case of transport by taxi, you may have to travel with several insured persons for efficiency reasons.
- In the event of the patient being escorted, transport of the escort must be required, or the insured person being escorted must be younger than 16 years of age.
- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree ('Besluit Langdurige zorg').
- In each of these situations, the statutory personal contribution for transport does not apply:
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility to receive inpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical care;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility or healthcare provider to receive outpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical healthcare. Transport back to the facility where you have been admitted is also not subject to a personal contribution;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and you need transport to another facility or healthcare provider to receive dental care provided under the provisions of the Wlz. Transport back to the facility where you have been admitted is also not subject to a personal contribution.

Do you need approval?

- You need approval from us.
If you will be travelling further than 200km one way or if you want to use a different type of transport because transport by car, public transport or taxi is not possible.

For the approval, see the attached General terms and conditions, section [Approval](#).

Where to go for this healthcare

- Recognised taxi operator with TX quality mark and with the appropriate licence.

What is not reimbursed

- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Costs of patient transport in connection with healthcare under an additional insurance package.
- Costs of transport if we reimburse the accommodation costs.
This relates to transport from your guest house address to the place where you are being treated or cared for and back to your guest house address.
- Transport between your guest house address and the place of treatment.
If you opt for an overnight stay instead of transport, you are not entitled to claim reimbursement for transport from your guest house address to the place of treatment and back to your guest house address.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for transport by public transport (2nd class) (clause B.18.2.)

The amount you pay yourself

- Statutory personal contribution of €118 per calendar year for all patient transport combined.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are undergoing kidney dialysis.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are completely dependent on a wheelchair for mobility and so are not able to use public transport or specially adapted transport.
The healthcare you receive must be covered by your health insurance.
 - Your sight is impaired to such an extent that you are unable to travel without an escort.
The healthcare you receive must be covered by your health insurance.
 - You need geriatric rehabilitation.
The healthcare you receive must be covered by your health insurance.
 - You receive day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
The day treatment is provided in a group in accordance with the 'Medical care for specific patient groups' clause.
 - You are younger than 18 and require nursing care and other care.
Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
 - The hardship clause applies.
This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.
 - to be eligible for this, an application must be submitted together with a statement from your attending doctor;
 - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);
 - the following calculation applies for this: number of months' treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor);
 - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is a trip to:
 - a healthcare provider; or
 - a facility where you are treated and/or nursed; or
 - the guest house address if you have opted for an overnight stay instead of transport;
 - and a return trip to your legal home address or to another residence if you will not be able to, within reason, receive the care you need at your own legal home address. This also applies to patient transport during a temporary stay in a foreign country to receive treatment.
- If you are undergoing kidney dialysis or being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy, you are only insured for patient transport to and from the location you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy.
- We will assess whether you can use public transport, your own transport or taxi transport because the healthcare to be provided must be effective.
- In the event of the patient being escorted, transport of the escort must be required, or the insured person being escorted must be younger than 16 years of age.
- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree ('Besluit Langdurige zorg').
- In each of these situations, the statutory personal contribution for transport does not apply:

- you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility to receive inpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical care;
- you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility or healthcare provider to receive outpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical healthcare. Transport back to the facility where you have been admitted is also not subject to a personal contribution;
- you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and you need transport to another facility or healthcare provider to receive dental care provided under the provisions of the Wlz. Transport back to the facility where you have been admitted is also not subject to a personal contribution.

Do you need approval?

- You need approval from us.

If you will be travelling further than 200km one way or if you want to use a different type of transport because transport by car, public transport or taxi is not possible.

For the approval, see the attached General terms and conditions, section [Approval](#).

What is not reimbursed

- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Costs of patient transport in connection with healthcare under an additional insurance package.
- Costs of transport if we reimburse the accommodation costs.
This relates to transport from your guest house address to the place where you are being treated or cared for and back to your guest house address.
- Transport between your guest house address and the place of treatment.
If you opt for an overnight stay instead of transport, you are not entitled to claim reimbursement for transport from your guest house address to the place of treatment and back to your guest house address.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for transport by other means of transport (clause B.18.2.)

The amount you pay yourself

- Statutory personal contribution of €118 per calendar year for all patient transport combined.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are undergoing kidney dialysis.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are completely dependent on a wheelchair for mobility and so are not able to use public transport or specially adapted transport.
The healthcare you receive must be covered by your health insurance.
 - Your sight is impaired to such an extent that you are unable to travel without an escort.
The healthcare you receive must be covered by your health insurance.
 - You need geriatric rehabilitation.
The healthcare you receive must be covered by your health insurance.

- You receive day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
The day treatment is provided in a group in accordance with the 'Medical care for specific patient groups' clause.
- You are younger than 18 and require nursing care and other care.
Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
- The hardship clause applies.
This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.
- to be eligible for this, an application must be submitted together with a statement from your attending doctor;
- the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);
- the following calculation applies for this: number of months' treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor);
- if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is a trip to:
 - a healthcare provider; or
 - a facility where you are treated and/or nursed; or
 - the guest house address if you have opted for an overnight stay instead of transport;
 - and a return trip to your legal home address or to another residence if you will not be able to, within reason, receive the care you need at your own legal home address. This also applies to patient transport during a temporary stay in a foreign country to receive treatment.
- If you are undergoing kidney dialysis or being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy, you are only insured for patient transport to and from the location you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy.
- We will assess whether you can use public transport, your own transport or taxi transport because the healthcare to be provided must be effective.
- In the event of the patient being escorted, transport of the escort must be required, or the insured person being escorted must be younger than 16 years of age.
- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree ('Besluit Langdurige zorg').
- In each of these situations, the statutory personal contribution for transport does not apply:
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility to receive inpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical care;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) and you need transport to another Wlz or Zvw facility or healthcare provider to receive outpatient specialist medical healthcare. This is necessary because the facility where you have been admitted cannot provide the specialist medical healthcare. Transport back to the facility where you have been admitted is also not subject to a personal contribution;
 - you have been admitted to a facility under the provisions of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and you need transport to another facility or healthcare provider to receive dental care provided under the provisions of the Wlz. Transport back to the facility where you have been admitted is also not subject to a personal contribution.

Do you need approval?

- Approval from us is necessary.

For the approval, see the attached General terms and conditions, section [Approval](#).

What is not reimbursed

- Transport that can be reimbursed under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) or Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).
- Costs of patient transport in connection with healthcare under an additional insurance package.
- Hire costs for a hire car.
- Costs of transport if we reimburse the accommodation costs.
This relates to transport from your guest house address to the place where you are being treated or cared for and back to your guest house address.
- Transport between your guest house address and the place of treatment.
If you opt for an overnight stay instead of transport, you are not entitled to claim reimbursement for transport from your guest house address to the place of treatment and back to your guest house address.

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Terms and conditions for accommodation costs (clause B.18.2.)

The amount you pay yourself

- No statutory personal contribution.
- Deductible applies from the age of 18.

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
 - You are undergoing kidney dialysis.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
This also includes consultations, tests and check-ups that are a necessary part of the treatment.
 - You are completely dependent on a wheelchair for mobility and so are not able to use public transport or specially adapted transport.
The healthcare you receive must be covered by your health insurance.
 - Your sight is impaired to such an extent that you are unable to travel without an escort.
The healthcare you receive must be covered by your health insurance.
 - You are younger than 18 and require nursing care and other care.
Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
 - The hardship clause applies.
This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above.
 - to be eligible for this, an application must be submitted together with a statement from your attending doctor;
 - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);
 - the following calculation applies for this: number of months' treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor);
 - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- You want to stay the night instead of travelling.
 - you are entitled to patient transport based on one of the above medical grounds or situations; and

- you would require the patient transport on at least three consecutive days.

Do you need approval?

- You need to submit an application to have your costs of accommodation reimbursed instead of being provided patient transport or being reimbursed for the costs of such.
You also need approval if you travel further than 200 kilometres one way or if you want to use a different type of transport because transport by car, public transport or taxi is not possible.

For the approval, see the attached General terms and conditions, section [Approval](#).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions](#).

Appendix Definitions

Additional insurance package

An agreement that you can take out in addition to your general insurance policy for the reimbursement of healthcare and healthcare costs. The content and scope of your additional insurance package is set by us. We have it laid down in your terms and conditions of insurance.

Agreed rate

The (average) rate we agree in contracts with healthcare providers for certain types of healthcare. These rates are available on our website.

AGB code

This code is a unique administrative code assigned to healthcare providers in the Netherlands, identifying each one individually in Vektis. Vektis is a national register containing all information necessary to submit claims for the healthcare, to purchase and contract the healthcare and to help guide insured persons to the right healthcare.

Treatment

Contact, physical or online, with one or more healthcare providers, involving the provision of healthcare and/or advice. Treatment does not include courses or training.

Treatment proposal (or prescription)

This proposal states which healthcare (examination, treatment or therapy) you need. You are given a prescription for medicine.

Abroad

Any country other than the country where you live.

CAK

The Dutch Central Administration Office ('Centraal Administratie Kantoor', CAK), as defined in Article 6.1.1, first paragraph, of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

Consultation

Contact with a healthcare provider. This can involve advice, a referral, a discussion of a patient's medical history, a physical examination, diagnosis and/or additional tests where such is deemed medically necessary.

Day treatment

Healthcare in a department set up for day nursing in a facility for specialist medical healthcare (such as a hospital or independent treatment centre). This may also involve a medical examination or treatment in a rehabilitation facility. The healthcare is generally foreseeable and lasts for a number of hours. The patient is not admitted.

DBC healthcare product

A Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC healthcare product or DBC) is a code that describes the entire process of treatment under specialist medical healthcare. A DBC includes all the costs incurred by the healthcare provider to give you the right healthcare. So it also includes costs not directly related to your treatment. The rate for a DBC is based on an average of the costs incurred for a particular course of treatment. The start date of a DBC is the date of first contact with the healthcare provider and determines the reimbursement. The bill is settled on the DBC start date. If the commencement date for a DBC is outside of the term of your insurance, none of the costs associated with that DBC are covered. In addition to a DBC, a hospital may charge for treatments categorised as other healthcare products ('overige zorgproducten', OZP). These are often single treatments that are not associated with a course of treatment. For example, diagnostics requested by the general practitioner, such as an ultrasound or X-ray, or diagnostics for dental surgery. Specific expensive healthcare is also claimed under other healthcare products. Examples here include intensive care, expensive medicines and blood products.

Diagnostics

Determination of the medical cause of the patient's problem, illness or condition.

EU/EEA member state

The EU (European Union) member states are: Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek part), Czech Republic, Denmark, Estonia, Finland, France (including French Guyana, Guadeloupe, Martinique, Réunion, Saint Barthélemy and Saint Martin), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal (including the Azores and Madeira), Romania, Slovakia, Slovenia, Spain (including the Canary Islands, Ceuta and Melilla) and Sweden. Under international treaties, Switzerland is considered to be on a par with the above. The following are not part of the EU (this list is not exhaustive): Andorra, the Channel Islands, the Isle of Man, Monaco, San Marino and Vatican City. The EEA (European Economic Area) states are: the aforementioned EU states, Iceland, Liechtenstein and Norway. Explanation: On 31 January 2020, the United Kingdom, including Gibraltar, left the European Union.

Claimed rate

The amount stated on the invoice. Reimbursement will never exceed the costs of healthcare that you have actually incurred, and that you were invoiced for.

Medical aids on loan

These are medical aids that you may use as long as you are insured for them with us. We or the healthcare provider will enter into a loan agreement with you for this purpose. This agreement specifies your rights and obligations in respect of the medical aid you have on loan. You must return the medical aid upon termination of your insurance policy. We pay the reimbursement directly to the healthcare provider if you receive the medical aid on loan from a contracted healthcare provider. If you purchase a medical aid from a non-contracted healthcare provider and that aid would usually be provided on loan, you will not automatically be reimbursed for the full purchase value. We will reimburse you the costs involved in using the medical aid for an entire year in the same way as we reimburse these costs with a contracted healthcare provider. You do not need to pay any costs for medical aids on loan, so you do not pay a deductible for them. The deductible does apply, however, to the costs of consumables and usage associated with the medical aid that we lend you.

Owned medical aids

These are medical aids that transfer to your possession under your terms and conditions of insurance. You will acquire ownership of them. The purchase costs will be set off against your deductible.

If a medical aid transfers to your possession, it is strictly for your own use. You may not sell it to anyone.

Year

A calendar year. However, when referring to someone's age, we do not mean a calendar year. We simply mean a year in the person's life.

Month

A calendar month.

Market rate applicable in the Netherlands

This is the rate that is reasonable and appropriate in the Dutch market for a given treatment. To determine this rate, we look at what amounts healthcare providers charge on average for that treatment. This means that we will not reimburse unreasonably high costs of treatment in full. See also Article 2.2., clause 2, paragraph b, of the Dutch Health Insurance Decree ('Besluit zorgverzekering').

(Medical) adviser

The doctor, pharmacist, dentist, physiotherapist or other expert who advises us. This includes advice on medical, pharmacotherapy-related, dental or physiotherapy-related healthcare or any other field of healthcare expertise.

Medical indication/grounds

The medical condition or illness that a doctor suspects or has diagnosed so that you can access certain healthcare.

Accident

A sudden, unexpected, involuntary and external event. This event results directly in bodily injury that can be detected objectively by a medical professional. This applies even if you did not and could not reasonably foresee the event. We consider an acute, serious illness to be equivalent to an accident when: - medical care is required immediately on medical grounds and cannot be postponed, or an illness or condition is life-threatening; and - the healthcare required is covered by the general insurance policy; and - based on objective medical standards, no recovery can be expected within the next six months.

Example of an accident.

- an infected wound or blood poisoning; - sprains, dislocations and tears of the muscles and ligaments; - involuntary ingestion of or poisoning with gases, vapours, liquid or solid substances or objects, unless this is through the conscious use of alcohol, medicine or drugs; - infection by exposure to pathogens or due to poisoning during an involuntary fall into water or any other substance (liquid or otherwise), or if you enter it yourself to save a person, animal or object; - drowning, suffocation, frostbite, hypothermia, sunstroke, burning (except as the result of sunbathing), lightning strike or other electrical discharge, or coming into contact with a corrosive substance; - natural violence such as an earthquake, flood, tsunami (tidal wave), hurricane, or volcanic eruption; - starvation, dehydration and exhaustion; - complications or aggravation of injuries as the result of medically required treatment after an accident; - becoming infected with HIV through a blood transfusion or injection with a contaminated needle while being treated in a hospital.

Admission

A period of nursing and treatment with an overnight stay in a department set up for nursing in a specialist medical care facility (such as a hospital). The admission must be a medical necessity in terms of medical healthcare. However, this does not include a stay in an outpatient clinic, nor day care or urgent medical care, nor a stay in a facility for rehabilitation. Your general insurance policy covers admissions of up to 1095 (3 x 365) consecutive days. The following rules apply here: - if your admission is interrupted for less than 31 days, the number of days of the interruption do not count, but we will continue to count after the interruption to determine the total; - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning to determine the total; - if your admission is interrupted for weekend/holiday leave, the number of days of interruption counts towards the total number of days.

Policy (document)

Proof of insurance.

Written

A physical or electronic means of conveying information, whereby the information can be understood, stored and reproduced. An electronic means of conveying information includes the internet and emails. Written communication includes by letter, email and through the 'Mijn' environment on our website.

Urgent medical care

Healthcare that is a medical necessity and that cannot reasonably be postponed. The healthcare can reasonably be described as urgent in the general opinion of the group of relevant professional practitioners.

Rate

The amount of money for healthcare or the resources provided, which we take as the basis for reimbursement of that healthcare or those resources. We have different types of rates.

Treaty country

The Netherlands has a treaty for social security, including arrangements for the provision of medical healthcare, with the following states: Australia, Bosnia and Herzegovina, Cape Verde, Macedonia, Montenegro, Morocco, Serbia, Tunisia and Turkey.

The following are also treaty countries:

- all European Union (EU) member states other than the Netherlands;
- all states that are party to the Agreement on the European Economic Area (EEA);
- Switzerland;
- the United Kingdom.

Referral

For certain types of healthcare, you must have a referral before a consultation or before the start of the healthcare. This referral is the advice from one healthcare provider to go to another healthcare provider for a consultation or for healthcare. In the terms and conditions, we list which healthcare provider must provide this referral under 'referral'.

Insured person

The individual entitled to insured healthcare (and reimbursement thereof) in accordance with our terms and conditions of insurance. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using 'you' and 'your'. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to 'he', 'him' and 'his', this also means 'she' and 'her' and 'her' respectively.

Insurance policy

An insurance agreement may consist of a general insurance policy with one or more additional insurance packages.

If the insurance consists of a combination of 2 or more insurance agreements, the combination can contain no more than one general insurance policy.

Policyholder

The person who takes out insurance with us, must pay the premium and costs and is the only person who can change and cancel the insurance. The policy is in the name of the policyholder. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using 'you' and 'your'. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to 'he', 'him' and 'his', this also means 'she' and 'her' and 'her' respectively.

Statutory personal contribution

Healthcare that is covered under your general insurance policy and in relation to which you must pay the costs in full or in part yourself. Personal contributions are set by law. A statutory personal contribution may be a fixed amount per treatment or a set percentage of the costs. A statutory personal contribution is not the same as a deductible. Statutory personal contributions and deductibles may apply side by side for the same insured healthcare. This may mean you will be charged both a statutory personal contribution and a deductible.

Statutory maximum rate

The maximum rate set by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg). The rate used by a healthcare provider may be lower, but never higher.

Statutory fixed rate

The fixed rate set by the Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg). The rate used by a healthcare provider must be exactly the same as this rate. These rates are also known as set-point rates.

Appendix General terms and conditions

A.1A. Additional definitions

General insurance policy

Your general insurance policy is health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw). The Dutch government determines the content and scope of your general insurance policy.

Family members

Family members living at the same address and who make up a shared household. By this we mean:

- adults who are each other's sole life partner;
- children up to the age of 18 (including adopted children and foster children);
- children aged 18 to 30 (inclusive) who are students (they do not have to be living at the same address as the policyholder);
- a company or facility that has entered into a group agreement with us may also designate someone as a family member.

A family member has their own policy or is co-insured on the policy of another family member.

Health insurer

Your health insurer is OHRA Zorgverzekeringen N.V., registered in the Trade Register of the Chamber of Commerce under number 09067645. This is a health insurer in accordance with the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw) that offers and/or administers health insurance. In these terms and conditions of insurance, 'we' or 'us' means OHRA.

A.2. Insurance fundamentals

Policy document

The details of your insurance are stated on your policy document. We will send you a new policy document every year. You will also receive a new policy document following any changes to the details on your policy.

See also:

[Policy \(document\)](#) (definitions)

General basis of your insurance

We base your insurance on the following:

- your registration form with the details that you have entered or that someone else has entered on your behalf;
- information and statements provided by you or someone else on your behalf;
- the insurance policies you have selected, which are specified on your policy document;
- the terms and conditions of insurance for your insurance policy or policies;
- protocols, regulations and appendices;
- any associated or group agreements.

Fundamentals of your general insurance policy

Your general insurance policy is also based on: - the Dutch Health Insurance Act ('Zorgverzekeringswet'); - the Dutch Health Insurance Decree ('Besluit zorgverzekering'); - the Dutch Health Insurance Regulations ('Regeling zorgverzekering'); - the explanatory notes to the above Acts and Regulations; - the health insurance regulations issued by competent supervisory bodies; - the interpretations of 'Zorginstituut Nederland' (known in Dutch as 'standpunten').

'Combinatie' general insurance policy

Your general insurance policy is a 'combinatie' policy. For one part of your policy, we reimburse costs incurred for certain healthcare covered under the policy (refund), while for the other part, you are insured for healthcare (in kind).

If healthcare is covered on an in-kind basis, this will be stated in the reimbursement details. All other healthcare is covered on a refund basis.

Verification of your policy document

Please verify the details on your policy document.

If any details are incorrect or missing, please let us know. You must do so within 30 days of receiving your policy document. If you do not contact us about this within this time, we will assume that these details are complete and accurate.

Your insurance card

We will send you an insurance card as soon as your policy has taken effect. This card gives you access to the healthcare for which you are insured. If you would also like a European Health Insurance Card (EHIC) that is valid in all EU countries, you can request one in the 'Mijn' environment or by contacting our customer services team. You can read more about the EHIC on our website.

Applicable terms and conditions of insurance

Your policy document lists the insurance policies you have selected. You can view, download and save the terms and conditions of insurance for your policies on the secure 'Mijn' environment.

As and when new terms and conditions of insurance are adopted, the old terms and conditions of insurance will cease to apply.

Translation of the terms and conditions of insurance

The terms and conditions of insurance are in Dutch, but we do have translations. In the event of differences between the content and interpretation of the Dutch-language terms and conditions of insurance and a translation, the Dutch-language terms and conditions of insurance will apply.

If terms and conditions of insurance deviate from the law

The terms and conditions of insurance and appendices for your policy comply with current legislation.

If the legislation changes or an act is repealed or new legislation is passed and this results in a discrepancy between the terms and conditions of insurance and the laws and regulations, the most recent statutory provisions, explanatory memoranda or the interpretation thereof will always apply instead of the terms and conditions of insurance.

Membership

When taking out your general insurance policy, you automatically also request membership of the mutual insurance company 'Onderlinge Waarborg Maatschappij CZ Groep U.A.' for each insured person. The board always accepts this request.

All insured persons are members of this mutual insurance company from the commencement date of your general insurance policy.

A.3. Content and scope of your insurance

General and specific requirements

The healthcare you receive has to meet certain general requirements. Specific requirements that do not apply to all types of healthcare are specified with the healthcare in question.

The following general requirements apply to all types of healthcare:

- it is healthcare that healthcare providers in the relevant profession provide in accordance with their standards and norms and deem accepted. What does this mean?
- healthcare providers within a profession provide the same healthcare for certain complaints and diseases. The healthcare then falls within that profession's area of expertise.
- it is insured healthcare specified in the terms and conditions of insurance for your policy.

- the content and scope of healthcare is determined by the latest practical and theoretical standards, or by what is deemed to constitute responsible and adequate healthcare and services in the field in question. What does this mean?
- there must be sufficient evidence that the healthcare you receive is effective and safe, also in the long term. The evidence must be objective scientific medical evidence. Where necessary, we will also look at the specific situation.
Objective scientific medical evidence will not be required for healthcare provided under your additional insurance package.
- the scope of the healthcare is specified in these terms and conditions of insurance. Exactly how much you will get reimbursed is also detailed in other communications. The maximum amount, number, or period covered is specified with the healthcare in question. We never reimburse more than the amount stated on the bill.
- based on your medical indication, there are reasonable medical grounds for you being provided with the healthcare in question. And the healthcare must be effective and appropriate to your individual situation. What does this mean?
- the healthcare in question must be a logical option given your complaints or disease, meaning that there have to be medical grounds for the healthcare you receive.
- the healthcare must not be unnecessarily costly and not be unnecessarily extensive or involve an unnecessarily large number of treatments. If the healthcare is too expensive or too extensive, it will not be effective healthcare in your situation and is therefore not covered by your general insurance policy, not even if you pay for part of it yourself.

Healthcare mediation

If you cannot get the healthcare you medically need to the required standard or not in time, or good-quality, safe healthcare is available only far away from where you live (or stay on a permanent basis), you will be entitled to healthcare recommendations and mediation. We will look for a provider where you can get the healthcare you need within an acceptable time span. For more information about healthcare recommendations and mediation, please visit our website.

Worldwide cover

Your insurance has worldwide cover.

A.4. Commencement and term of your insurance

Commencement of your insurance and address

You can register with us for a general insurance policy and one or more additional insurance packages. Your insurance will take effect on the date on which we receive your request, or on a later date if you ask for this. Your request must include your address as it is recorded in the Persons Database ('Basisregistratie Personen', BRP). If your address is not recorded in the Persons Database or the address recorded there is incorrect, your insurance will only take effect if there is nothing you can do about the fact that the address recorded in the Persons Database is not the address where you actually live. You will, however, be asked to provide a good explanation and reason that we can accept.

Different address

If the address you submit to us in your request differs from the address recorded in the Persons Database ('Basisregistratie Personen'), you need to send us:

- a statement from your employer or payslip, no more than one month old, that:
- show the commencement date of your employment;
- prove that income tax has been deducted because you work in the Netherlands or on the continental shelf (as defined in Article 1.1.1 of the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz)).
- or a statement from the 'Sociale Verzekeringsbank' confirming that you are insured under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz).

Commencement date and changes

Your insurance will take effect on the date we receive your registration. If you are still insured with another insurer, you can choose to have your policy take effect later. The commencement date must, however, be immediately after the end date of your previous policy. The commencement date of your insurance is stated on your policy document. You can request that your policy be changed. We will then cancel the policy you have at the time, because you cannot have two policies at the same time. Your new policy will, therefore, take the place of your old policy.

General insurance policy commencement date with retrospective effect

You can have your general insurance policy take effect on the day that your insurance obligation commences, provided that we have received your request within 4 months of this commencement date.

If you are wrongly not insured

If you are you required to take out general health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet') but do not have insurance (yet), you can still take out insurance with us. We will then, however, need to receive all the required documents from you in time:

- within 4 months of your insurance obligation commencing; or
- within 1 month of your previous general insurance policy being terminated.

General insurance policy insurance term

The term of your general insurance policy is one full year. If your general insurance policy takes effect part-way through the year, it will run until 1 January of the next year.

Annual renewal

We will renew your insurance for one year on 1 January each year. We will send you a reminder of that along with the changes for the new insurance year. You then have the opportunity to change or cancel your policy.

A.5. You want to terminate your insurance

Withdrawal

Soon after you take out a new insurance policy you have the right to withdraw from the policy without incurring any charges. Withdrawing means that your insurance policy will be nullified and it will be as if it never existed, and this can also be with retrospective effect. There is no need to specify a reason for withdrawing.

Withdrawal is subject to the following conditions:

- you are the policyholder;
- you inform us in writing that you wish to withdraw from the policy;
- the insurance policy from which you are withdrawing is one you took out recently;
- you withdraw from the insurance policy within 14 days of the commencement date or within 14 days of receiving the policy from us.

If you have already paid the premium and costs, these will be refunded within 30 days. If you already received reimbursements under the insurance, you must pay these back within 30 days of receiving notice from us to this effect.

Cancelling or making changes

You may cancel your insurance every year effective from 1 January. What do you (the policyholder) have to do for that?

- you must cancel in writing;
- we must have received the cancellation no later than 31 December.

You may change your insurance every year effective from 1 January. What do you (the policyholder) have to do for that?

- you must submit the change in writing;
- we must have received your request for a change no later than 31 December.

If we approve the change, your old insurance will then end at the same time on 1 January.

See also:

[Policyholder](#) (definitions)

Cancelling on account of insurance with another health insurer

If we receive notice that you have registered for health insurance with another health insurer, we will assume that you are terminating your insurance policy or policies with us. Your insurance with us will end on 1 January after we have received the notice.

Change to the terms and conditions for your general insurance policy

If we change the terms and conditions for your general insurance, and this is to your disadvantage, we will notify you of what will change and what your options are. You will then be able to cancel your insurance or change it to another general insurance policy as of that same date.

What do you (the policyholder) have to do for that?

- you must submit your cancellation or change in writing;
- you must submit your cancellation or change within 30 days of receiving our notice.

If you want to change your insurance, we will send you new insurance documents and new terms and conditions of insurance.

If the change we are making to your general insurance is prompted by a change in the law, you will not be able to cancel or change your insurance.

Change to the premium base for your general insurance policy

If we increase the premium base for your insurance, we will notify you at least 7 weeks in advance. You will then be able to cancel your insurance or change it to another general insurance policy. What do you (the policyholder) have to do for that?

- you must submit your cancellation or change in writing;
- you must submit your cancellation or change before the new premium base takes effect.

Your insurance will end or change on the date that the new premium base takes effect. If you want to change your insurance, we will send you new insurance documents and new terms and conditions of insurance.

See also:

[Premium and costs for your general insurance policy](#) ()

Different employer group scheme

If you (the policyholder) are insured under a group insurance policy through your employer, and you switch jobs to work for another employer with a different group insurance policy, you (the policyholder) will be entitled to cancel your group insurance with your old employer part-way through the year. Please let us know in writing. Be sure to do so within 30 days of joining your new employer. Possible situations - you have group insurance with us and can join a group insurance policy with a different health insurer through your new employer. You are therefore cancelling your old group insurance with us. This group insurance with us will then be terminated as of the day that you leave your former employer; or - you have group insurance with another health insurer and can join a group insurance policy with us through your new employer. This means you are cancelling your old group insurance with the other health insurer and taking out a new group insurance policy with us. If your new jobs starts on the 1st of the month, your new group insurance will take effect on that day. If not, your new group insurance will take effect on the 1st of the next month. Your old group insurance policy will also end on that day; or - you have group insurance with us and can join a different group insurance policy with us through your new employer. In this case, you need to ask us to switch from the old to the new group insurance policy. If your new jobs starts on the 1st of the month, your new group insurance will take effect on that day. If not, your new group insurance will take effect on the 1st of the next month. Your old group insurance policy will also end on that day.

Insurance for someone else

If you (the policyholder) previously took out insurance for someone else and this insured person has now taken out their own insurance, you (the policyholder) are entitled to cancel this initial insurance part-way through the year.

End of the cancelled insurance end

- if we receive your notice of cancellation no later than the day before the commencement date of the new insurance, the cancelled insurance will end on the commencement date of the new insurance.
- if we receive your notice of cancellation on the commencement date of the new insurance or later, the cancelled insurance will end on the last day of the month when we receive the notice of cancellation.

See also:

- [Insured person](#) (definitions)
- [Policyholder](#) (definitions)

Cancelling or making changes to your general insurance through the Dutch Central Administration Office (CAK)

CAK may have taken out general insurance with us for you if you do not have general insurance but are required to under the Dutch Health Insurance Act ('Zorgverzekeringswet'). Cancelling this insurance You can cancel it if you can prove to us and CAK that you have already taken out general insurance elsewhere yourself. You had to take out this insurance within 3 months of receiving notice from CAK saying that you were wrongly not insured. When to cancel this insurance Within 2 weeks of having received notice from CAK informing you that they have taken out general insurance for you with us. The policy will then end on the commencement date of the other policy, and it will be as if it never existed. In all other cases, you cannot cancel your general insurance policy taken out by CAK during the first 12 months.

See also:

- [CAK](#) (definitions)

Instances when you cannot cancel or make changes

You will not be able to cancel or change your insurance: - if you have not paid the premium or costs to us on time; and - if we have sent you a reminder about this, requesting that you pay us within 14 days; and - if we have not (yet) suspended (temporarily stopped) the insurance cover; and - if we have not agreed to the cancellation within 14 days. This means that you will not be able to cancel or change your insurance: - at the end of a contract year; - following a change to the premium or premium base; - when switching between group insurance policies; - if you had taken out insurance for someone else and this person has taken out another policy for themselves. As soon as you have paid all the premiums and costs to us in full, you can make changes to your insurance again or cancel it as of 1 January of the next calendar year.

A.6. Cancellation of your insurance by us

Legally required cancellation

In the following situations, we will terminate your insurance: - if we are no longer allowed to offer or administer insurance policies. This would be the case if our licence as a non-life insurance company were to be modified or revoked. If that happens, we will notify you 2 months in advance; - if you die. We must be informed of this within 30 days of the date of death.

Cancellation of your general insurance policy if required by law

There are two possible situations where we are required by law to terminate your general insurance: - if we have changed our operating area and you now live outside our new operating area. We will give you at least 2 months' notice of this. Your insurance will end as of the date on which our operating area has changed. - if your insurance obligation under the Dutch Health Insurance Act ('Zorgverzekeringswet') ends. You must let us know as soon as possible. Your insurance will end as of the date on which your insurance obligation has expired.

You are unlawfully insured under your general insurance policy

If you have a general insurance policy while you are not under an obligation to have insurance, we will terminate your general insurance policy from the commencement date. This will mean that the general insurance policy never existed.

In the event of a criminal offence or violation

If you were involved in a criminal offence or violation (or attempts at such) in respect of us or a contracted healthcare provider, which includes deception, fraud, coercion, or threats, we will be authorised to: - terminate your insurance policy or policies with us with immediate effect; - suspend your claim for healthcare or reimbursement of the costs of healthcare; - claim back reimbursements you have received; - charge you for the costs of the investigation; - report this to the police; - record your details, or have your details recorded, in the usual warning system used by financial institutions.

If we no longer offer or administer the insurance

Given that we may stop offering and administering a certain type of insurance that you have taken out, we may terminate the relevant policy or replace it with a different policy. We will notify you of this change.

From group scheme to personal additional insurance package

If your group scheme membership ends, we will convert your group additional insurance package into a personal additional insurance package. You will get the insurance that most closely resembles the group insurance you had. If you do not want that, please let us know within 30 days and we will not activate the new additional insurance package.

Policy cancellation document

If your insurance has been cancelled, we will send you a 'policy cancellation document' (statement of cancellation). This document lists the insured persons, what was covered under the policy, what the premium was, and when the policy expired.

A.7. Amount of the premium and costs

Premium and costs for your general insurance policy

You will pay the premium for all persons insured on your policy. The premium base is the gross premium without discounts. You can get a discount on your premium: - if you opt for a voluntary deductible, i.e. an additional deductible on top of the compulsory deductible; - if you pay more than one month in advance (payment term discount). You will also pay costs. These include: - invoices we have paid in advance to your healthcare provider for you; - compulsory deductible and personal contributions that the law requires you to pay; - surcharges or additional costs when you, for example, do not pay by direct debit. This does not include statutory interest, default interest or collection fees incurred in the event that you fail to pay or fail to pay on time. The premium base and discounts for a voluntary deductible are stated in euros on your premium appendix.

See also:

[Policy \(document\)](#) (definitions)

Premium for general insurance up to the age of 18

The premium for children up to the age of 18 is €0. When the insured person turns 18, you will start paying a premium for them from the 1st day of the month after their 18th birthday.

Custody or imprisonment

If you are in custody in a detention centre or in prison, we will suspend your insurance and you will not be charged the premium and costs. As soon as you are no longer in custody or imprisoned, you must let us know. Your insurance will then be reactivated and you will be liable to pay the premium and costs again.

Start, change or end of your insurance

If your insurance changes at the end of a payment period, we will recalculate the premium and deductible for the next payment period. If your insurance starts, changes or ends during a payment period, or an insured person is added or removed, we will also recalculate the premium and deductible for the next payment period, taking into account the moment when the insurance started, changed or ended. You may then get money back or have to pay extra, or we will settle the difference.

A.8. Payment of premium and costs

Paying in full and on time

As the policyholder, you have to pay all premiums and costs. These are payable for each 'payment period'. A payment period can be one month, a quarter, six months or a year.

You are required to pay in full. This means:

- you pay for the payment periods that have passed;
- you pay for the current payment period;
- and you pay for the next payment period. This means that you always pay in advance.

You are also required to pay on time. This means:

- the total amount due must be in our account no later than on the date stated on your premium invoice;
- if you pay by direct debit, we will debit the amount due in the first 7 days of the payment period;
- you will first receive a notification from us before we debit the amount due from your account;
- you make sure you have sufficient funds in your bank account;
- if the total amount cannot be debited in the first 7 days of the payment period, you are free to agree a different direct debit payment date with us.
- if you opt to use a payment method other than premium invoices or direct debit, the full amount due must be in our account before the agreed payment period.

If we have received all these premiums and costs, you have fulfilled your payment obligation.

See also:

[Policyholder](#) (definitions)

Payment method

You have agreed a payment method with us for the premium and costs due. This could be through a premium invoice, by direct debit, or by means of electronic or online payment. If you have agreed with us that we will communicate electronically, you can only pay by direct debit or electronic or online payment.

Off-setting

What is and is not possible: - if you have payment arrears with us, you cannot set off your arrears against any money we owe you. - we can, however, set off your arrears against money to which you are still entitled under your insurance policy or policies. - we will not set off your arrears against any money you are still entitled to under a Personal Care Budget ('Persoonsgebonden Budget', PGB).

A.9. Payment arrears

What we will do if you fail to pay your premium and costs on time

If you fail to pay on time and in full, we will proceed as follows: - we will send you a reminder; - if you fail to pay within 14 days of receiving the reminder, we will send you a second reminder; - we will set off your arrears against money to which you are still entitled under your insurance policy or policies; - if there is any debt left after that, you will be required to pay it. We will engage a bailiff to collect this debt. If you are in arrears with us, you will also pay statutory interest, default interest and collection costs on the due and payable debt.

Registration of your general insurance policy with CAK

If you still have payment arrears on your general insurance policy after 6 months, we will report this to the Dutch Central Administration Office (CAK). You will then have to pay the premium for general insurance to CAK instead of to us. This is the 'administrative premium' that is laid down in the law. The government sets the amount of this premium.

The administrative premium stops and you have to pay the premium to us again:

- once your full general insurance policy debt has been paid;
- if a court declares that you are subject to the debt management scheme for natural persons set out in the Dutch Bankruptcy Act ('Faillissementswet');
- if you decide to participate in a debt/debt management scheme in which we also participate. This must, however, be arranged through a professional debt counsellor;
- if you have agreed a payment arrangement with us or one of our collection partners.

The administrative premium will then be switched back to a premium payable to us as of the first day of the next month.

You have to pay the premium to CAK again instead of to us:

- if the debt/debt management scheme did not work out and has been discontinued;
- if we receive notice from CAK saying that you have dropped out of the agreed scheme early or that you never even entered.

The premium payable to us will then be switched back to an administrative premium as of the first day of the next month.

Since we want to prevent you from incurring more debt, we will notify your municipal authority if you have premium arrears of 2 or more months. We will do that before registering your case with CAK. The municipality may then work with us in devising arrangements for your payment arrears. If you comply with the terms and conditions, your debt will be cleared.

See also:

[CAK](#) (definitions)

Payment term discount ceases to apply

If you pay over a month in advance and run up payment arrears, we will switch you to a one-month payment period. This means you lose the discount you were entitled to for paying further in advance. This payment term discount will cease to apply for all policies for which you are the policyholder. Losing the discount will not be accepted as grounds to cancel the insurance.

See also:

[Policyholder](#) (definitions)

Repaying your debt

Every amount that we receive from you will go towards repaying your debt. The interest and collection fees are always paid first.

Repaying your debt on your general insurance policy

Subsequent payments will go towards repaying your debt on your general insurance policy. These will first go towards the part of the debt that has been outstanding the longest.

Debt for multiple payment periods

If you have not paid for a long time and, consequently, run up a debt spanning multiple periods, your payments will first go towards repaying the period that is the furthest back in time. You must first repay the debt on all your insurance policies for a specific period before you can move on to repaying the debt for the next period. This means the debt on both the general insurance policy and on the additional insurance package(s) for that period. This means you cannot split your debt

Example.

You cannot opt to first pay only the premiums due, followed by any other debts, nor can you opt to pay the premiums and costs for the general insurance policy first and then those for the additional insurance package(s).

A.10 Premium and costs upon termination

Outstanding premium and costs

If you have cancelled your insurance policy with us and still have outstanding premium and costs, we will settle this when you take out a different or a new policy with us. We will set off the outstanding debt on your old policy against reimbursements under your new insurance policy.

If you still have outstanding premium and costs, we will postpone any reimbursements until you have paid everything.

Excess payment during a payment period

If you cancel or change your insurance after you have already paid the premium, we will recalculate your premium and deductible. If this shows that you have overpaid, we will refund the excess, or we will set it off against the new premium. You will receive a notification from us explaining which of these options we have selected.

Unlawful general insurance policy

If you have taken out a general insurance policy but you do not have a legal obligation to take out this insurance, we will end it as of the commencement date. The premium and costs you have already paid will be set off against our reimbursements. The difference will either be refunded to you or payable to us.

Overpaid after we have cancelled your insurance

We may cancel your insurance on account of a criminal offence, violation, deception, fraud, coercion or threat (or attempts at such), in which case premium and costs will not be refunded.

A.12. Compulsory deductible

Deductible for your general insurance policy

The deductible is the amount you have to pay yourself for healthcare under the general insurance policy. This applies to everyone from the age of 18.

Compulsory deductible

For the general insurance policy, there is always a compulsory deductible of €385 for a whole year. The Dutch government sets the amount of the compulsory deductible on an annual basis.

See also:

[Year](#) (definitions)

Voluntary deductible

For your general insurance policy, we can opt to add a voluntary deductible on top of the compulsory deductible. This will entitle you to a discount on the premium. For details of the various deductible options and associated discounts on the premium can be found in the premium appendix.

The year for which you pay the deductible

We will set off costs against your deductible for the year in which you receive the healthcare, but only if we have received the invoice no later than in the following year.

Example.

A treatment you have in 2022 can no longer be set off against the deductible if we receive the invoice in 2024.

The costs will be set off against the deductible for 2022 if you personally forget to submit the invoice and we only receive it in 2024.

The year for which you pay the deductible in case of a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC)

If you receive specialist medical healthcare that goes on beyond the end of the year, and you are sent an invoice with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC) healthcare product code,

the start date of the DBC will determine the reimbursement. The costs will then be set off against the deductible for the year of the start date.

The invoice may also include costs for Other Healthcare Products ('Overige Zorg Producten', OZPs). These costs are set off against the outstanding deductible for the year in which the healthcare is provided.

See also:

- [DBC healthcare product](#) (definitions)
- [Year](#) (definitions)

Deductible-exempt healthcare

There is healthcare that is covered under your general insurance policy that the government has exempted from the deductible. As the health insurer, we may also exempt certain healthcare from the deductible.

This could be for a programme designated by us for diabetes, depression, cardiovascular disease, COPD, being overweight, dementia, thrombosis care, incontinence care or a quit smoking course.

If healthcare costs are exempted from the deductible, this will be stated for the healthcare in question.

For healthcare that is not subject to a deductible, a deductible may still apply for additional care, like when your general practitioner refers you for a blood test.

See also:

[Rate](#) (definitions)

Personal contribution is not same as the deductible

We will not set off any costs that you have to pay out of your own pocket against the deductible. These include, for example, personal contributions, statutory or otherwise.

Payment to the healthcare provider or to you

We pay the reimbursement to a contracted healthcare provider or a healthcare provider with a payment agreement when that party sends the invoice for your healthcare directly to us. If you still have part or all of your deductible or personal contribution outstanding, we will ask you to pay these costs to us, or otherwise settle them with you. We will reimburse you if you claim costs incurred at a non-contracted healthcare provider or a healthcare provider without a payment agreement with us. If you still have part or all of your deductible or personal contribution outstanding, we will deduct this amount from the reimbursement. It will then be your responsibility to pay the healthcare provider's invoice in full and on time. If you send us the invoice, we will pay the reimbursement to you.

If your general insurance policy does not run for a whole year

There may be situations where your general insurance policy runs for only part of a year. The deductible will then be prorated to the part of the year during which your policy was in effect. We prorate the deductible as follows: - we first calculate your daily deductible by dividing the deductible for the whole year by 365 days (or 366 in a leap year). - we multiply the outcome by the number of days during which you are insured. - we round the result off to the nearest whole euro. Please note! You may have various general insurance policies with us within a year. And you may have opted for different voluntary deductible amounts for these policies. We will add up the prorated parts of the compulsory and voluntary deductibles for that year.

Example.

Example of compulsory deductible:

Your general insurance policy with us takes effect on 23 September 2024 and runs through to 31 December 2022.

This is a period of 100 days. There are 365 days in this year and the compulsory deductible for the whole year is €385. Your deductible for this part of the year will then be:

- $€385 / 365 = €1.0547$ deductible per day
- $€1.0547 \times 100 \text{ days} = €105.47$. Rounded to the nearest whole euro, this makes a compulsory deductible of €105 for 2024.

Order in which we set off costs against the deductible

Costs incurred for healthcare covered by your general insurance will be set off against the deductible. We do this in the following order: 1. We first set off the costs of healthcare against the compulsory deductible until it is €0; 2. After that, we set off the costs of healthcare against a voluntary deductible (where applicable) until it is €0. 3. If there is no more deductible outstanding, we will reimburse you for the healthcare, provided you are insured for it.

Payment of compulsory deductible in instalments

You have the option of paying the compulsory deductible in advance instalments. This will mean paying the deductible up front in 10 equal instalments from the 1st quarter. You can use this option if: - you are 18 years old or above; - you have a general insurance policy with us on 1 January without a voluntary deductible, i.e. your general insurance policy is subject only to the compulsory deductible; - you submit your request for payment in instalments to us before 1 February; - you state for which insured persons you want to pay the deductible up front. What we do after the year in which you have paid your deductible up front: - you will receive the final account in the first quarter. - it may be that you have paid more up front than you incurred in terms of healthcare costs. We will refund any compulsory deductible amount that you have overpaid in the first quarter. - it may be that we receive invoices after the 1st quarter that we have to set off against your deductible for the previous year. We will then claim that whole amount from you, without the option of paying it in instalments. Cancellation of participation - If you want to cancel your participation, you must let us know before 1 February. If we do not hear from you, we will renew your participation for another year. - We can cancel your participation if: -- you no longer meet the above conditions; -- you fail to pay on time; -- your insurance situation changes, such as a change of policyholder. - If payment in instalments ends part-way through the year, we will send you a final account immediately. If you have paid too much in advance at that time, we will refund you. If we subsequently receive invoices that we have to set off against your deductible, we will claim that whole amount from you, without the option of paying it in instalments.

A.13. Voluntary deductible**Voluntary deductible from the age of 18**

From age 18, you can opt for a €100, €200, €300, €400 or €500 voluntary deductible for your general insurance policy. Prior to the month when you turn 18, we will ask you if you want a voluntary deductible. If you do, you can then also let us know the amount of your voluntary deductible.

If you do not respond or do not respond in time, we will assume that you are opting for a general insurance policy with only the compulsory deductible. We will calculate the premium for your general insurance policy on this basis.

A.14. General obligations**If you fail to comply with your general obligations**

What we can do if you fail to comply with your general obligations and you harm our interests as a result:

- you will no longer be entitled to reimbursement for healthcare.
- we can possibly claim any previously paid reimbursements back from you.

If someone else is liable for the healthcare you need

Someone else may be liable for the events, circumstances or accidents that led you to need healthcare. In such cases:

- you must notify us as soon as possible.
- you must help us when we start proceedings to recover the costs. If you do not help us, we may hold you liable for all losses and costs incurred.
- you transfer current and future receivables from third parties to us upon commencement of your insurance.
- you are not allowed to make any arrangements with the persons we may hold liable for healthcare (or healthcare costs). Nor are you allowed to enter into an agreement with parties such as another insurer. Only with our prior written consent may you make arrangements or enter into an agreement.

Your general obligations

You have a number of general obligations: - you must be able to show valid proof of identity when you need healthcare at a hospital or an independent treatment centre (ZBC). - you must provide us, our medical adviser, consultant dentist, or contracted healthcare providers with the information that is necessary, or help us or these other parties obtain the necessary information. - you must ask your doctor or medical specialist in attendance to tell our medical adviser about the reason for admission, if requested. - you must inform us within 30 days if you are taken into custody, put in prison or given a prison sentence. - you must inform us within 30 days of leaving custody or prison. - you must let us know within 30 days who will be the new policyholder if the current policyholder has lost the entitlement to dispose of his/her assets independently. - you must let us know within 30 days of the policyholder's death who will be the new policyholder.

See also:

- [\(Medical\) adviser](#) (definitions)
- [Policyholder](#) (definitions)

A.15. Provision of information**If you provide wrong information**

You must provide us with correct information and help us get all the necessary information. If you fail to do that or someone else acting on your behalf fails to do that, or you misrepresent a situation, submit false or misleading documents, make false statements, or fail to cooperate with us, we can: - cancel your insurance policy or policies, which will leave you without cover for healthcare (costs); - claim back all reimbursements paid to you from the date when you misled us or refused to cooperate; - recover from you the costs of investigating the intentional deceit; - list you on our incident register; - register you in the warning systems used by insurers; - report the matter to the police; - deny you new insurance for a period of 5 years.

Significant events

Occurrences we need to know about for the proper execution of your insurance must be reported to us within 30 days. If you notify us within the specified timescale, any changes to your insurance will apply from the date of the significant event. Otherwise, the change will take effect at a moment of our choosing. Significant events include: - moving house or a change of address as registered in the Persons Database ('Basisregistratie Personen', BRP); - a change of postal address or email address; - birth or adoption; - death; - divorce; - start and end of a period of custody or prison sentence; - start and end of participation in a group agreement; - change to the family composition.

Your current address

You must submit your correct postal address and/or email address. We will assume that our correspondence reaches you when it is delivered to the most recent address you have submitted to us. Failure to provide us with your correct postal or email address may result in losses, for which we cannot be held liable.

A.16. Privacy and checks**Privacy**

We process only data that we need to implement your insurance policy or policies. We do this as per the terms and conditions we have agreed on with you. We store this data in our records.

Our processing of personal data on you complies with:

- the Dutch legislation implementing the EU General Data Protection Regulation and
- the EU General Data Protection Regulation (Regulation EU 2016/679).

Please refer to the 'Privacy Statement' on our website for more information about privacy and your rights and obligations with respect to the (personal) data on you that we store and process. In the event of questions or requests for further information for the attention of the Data Protection Officer, send a letter to:

CZ Customer Services
Postbus 90152
5000 LD Tilburg,
Netherlands

Information that we share

We only share information when it is necessary for the adequate implementation of your insurance policy or policies. Information that we may share includes the package composition, premium, discount and personal data. We may do this to: - verify the group scheme in which you participate; - recover the costs we have paid out from third parties, such as from a travel insurance policy if you received insured healthcare outside the Netherlands.

Verification of details

We are authorised to verify details and screen for fraud in the implementation of your insurance policy. We will always do so in accordance with: - the terms and conditions and (personal) data agreed on with you, - the Dutch Health Insurance Act ('Zorgverzekeringswet'); - the national Protocol on Substantive Checks ('Protocol materiële controle') and the national Protocol on Incident Warning Systems for Financial Institutions ('Protocol Incidentenwaarschuwingssystemen Financiële Instellingen'). You must cooperate with us fully in this respect.

A.17. Healthcare providers

Definition of healthcare provider

The Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) defines a healthcare provider as: - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that provides healthcare as a professional or an organisation; - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that charges for healthcare. They do this on behalf of a (different) accredited healthcare provider who provides healthcare. - the natural person who provides insured healthcare not as a professional or an organisation. This concerns district nursing that you procure yourself using a Personal Care Budget ('Persoonsgebonden Budget', PGB). A healthcare provider provides healthcare or provides medicines or medical aids and possible associated services.

Definition of principal contractor

A principal contractor: - is a healthcare provider such as a healthcare group, health centre or podiatrist; - provides services as a legal entity in a partnership with several healthcare providers of different disciplines; - provides various forms of healthcare such as general practitioner care, dietetics and/or foot care; - is responsible for: -- upholding and monitoring quality requirements with respect to the services of the affiliated healthcare providers and -- providing healthcare in accordance with healthcare standards. Healthcare standards specify what requirements healthcare must meet to be considered good-quality healthcare from the patient's perspective. This relates to the content of the healthcare, how it is organised, and support for self-management. A healthcare standard therefore acts as an aid to the healthcare provider, insurer and patient alike.

Requirements for healthcare and healthcare providers

The healthcare and the healthcare provider must meet various general terms and conditions: - for each type of healthcare, we designate the type of healthcare provider that can provide the healthcare. We will not reimburse healthcare provided by another type of healthcare provider, even if this healthcare provider is authorised to provide the healthcare in question. - The aforementioned healthcare provider supplies the care themselves and has an AGB code. Another type of healthcare provider may also provide the healthcare as long as it is done under the responsibility of the healthcare provider specified, except when we have stated otherwise for a type of healthcare. - the healthcare provider specified claims the healthcare under their own name. A facility, another healthcare provider, or another party may also claim the healthcare, provided that the name of the attending, responsible healthcare provider is stated on the invoice. - the healthcare provider must be authorised to provide the healthcare. This means that they must comply with the requirements and rules governing their profession, company, and the exercise thereof. - healthcare providers based in the Netherlands must comply with the requirements laid down in the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) and the Dutch Healthcare Quality, Complaints and Disputes Act ('Wet kwaliteit, klachten en geschillen zorg', Wkkgz). -- the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg') also governs doctors, dentists, pharmacists, healthcare psychologists, psychotherapists, physiotherapists, obstetricians and nurses. They have to be registered in the national BIG registers or another register that we consider to be equivalent. -- we will only reimburse healthcare provided by other healthcare providers if they have gained a designated qualification under Section 34 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg'). They must then lawfully use the title and/or designation conferred upon them by that qualification. - as a means to assure quality, we have imposed additional terms and conditions on healthcare providers with respect to certain types of healthcare. This will be specified for the healthcare providers in question. Some examples are: A podiatrist, for example, must be a member of the Dutch Association of Podiatrists ('Nederlandse Vereniging van Podotherapeuten', NVvP). A provider of alternative healthcare, for example, must be a registered member of one of the professional associations for alternative treatment methods. The list of professional associations is available on our website. - A healthcare provider in a foreign country complies with the requirements, laws and regulations set out for their profession in the country concerned. If such requirements, laws and regulations are lacking, the rules that apply will be those that are customarily imposed on healthcare providers in that country.

See also:

- [Abroad](#) (definitions)
- [AGB code](#) (definitions)

Contracted healthcare providers

We have entered into contracts with healthcare providers on the healthcare and/or resources they provide. These contracts contain agreements on the price, quality and efficacy of the healthcare. They also contain the terms and conditions governing the provision of healthcare and the way costs are claimed. On our website you can find a list of all contracted healthcare providers. The fact that we have contracted a healthcare provider does not mean we always cover all the healthcare they provide. This can mean that: - while a healthcare provider is authorised to provide certain healthcare, you are not insured for it. We have then deliberately not contracted this healthcare provider for part of their healthcare or resources. - you are dealing with a healthcare provider we have contracted up to a certain budget (revenue ceiling). Or we have volume agreements in place with this healthcare provider. This may mean that a healthcare provider will not accept you for treatment. If we have such agreements with a healthcare provider, this will be stated on our website.

Going to another healthcare provider for healthcare under your general insurance policy

For healthcare insured in kind, our Healthcare Team ('Zorgteam') can help you find another healthcare provider.

For healthcare insured on a refund basis, our Healthcare Team ('Zorgteam') can contact the healthcare provider on your behalf to see whether you can be accepted for treatment all the same. For this healthcare, too, our Healthcare Team ('Zorgteam') can help you find another healthcare provider if you prefer.

Ongoing treatment

If you are already being treated by a healthcare provider with a revenue ceiling or a volume agreement, you are free to complete the course of treatment.

See also:

[Treatment](#) (definitions)

Non-contracted healthcare providers under your general insurance policy

If you go to a non-contracted healthcare provider, chances are that we will not cover all the costs. For more information, please refer to clause A.20. Rates

Healthcare provider with a healthcare contract or payment agreement

All contracted healthcare providers have a payment agreement with us. Other healthcare providers may also have a payment agreement with us. The reverse does not apply. Healthcare providers who have a payment agreement with us do not necessarily have a contract with us for the provision of particular healthcare or resources.

End of contract with healthcare provider during treatment

In the following cases, your treatments are insured for a maximum of one year as if they were provided by a contracted healthcare provider:

- you are being treated by a contracted healthcare provider. During the treatment, the contract between your healthcare provider and us ends.
- you switch to us from a different insurer part-way through your ongoing treatment. Your healthcare provider was contracted to your former insurer, but does not (yet) have a contract with us.

Location where the healthcare is provided

Your healthcare provider provides the healthcare at a location that is fit for purpose and medically appropriate. This can be a location about which we have made agreements with the healthcare provider or with you. Or a location designated by law or the Dutch Health and Youth Care Inspectorate ('Inspectie Gezondheidszorg en Jeugd') as a location where healthcare can be provided. In special situations or for special healthcare, we specify the location. If possible, the healthcare may also be provided online.

A.18. Approval

When approval is required

By 'approval' we mean a written statement from our 'Medische Beoordelingen' (Medical assessments) department. Certain healthcare is subject to our prior permission. That you have to seek approval will then be specifically stated with the healthcare. You must seek approval before starting the treatment. We will assess whether you meet the conditions for the healthcare you are seeking approval for. We will also assess whether the healthcare is appropriate and effective in your case. This may mean that we need additional information from you. If we approve the healthcare, the approval will state what we will cover and on what terms and conditions.

See also:

[Written](#) (definitions)

Approval for healthcare from a contracted healthcare provider

If you use a contracted healthcare provider, the healthcare provider can assess on our behalf whether or not to approve the healthcare. This is because we have made arrangements to this effect with contracted healthcare providers. The contracted healthcare provider will do the following: - assess whether you meet the terms and conditions for reimbursement of the costs of the healthcare; - assess what healthcare you need; - issue an approval. If the healthcare provider is not sure, they will forward the request for approval for us to assess. You will then not have to provide us with any information yourself.

Approval for healthcare from a non-contracted healthcare provider

If you go to a non-contracted healthcare provider, you must personally request approval from us. This will be required only if we have stipulated that the healthcare in question is subject to approval. You can ask the healthcare provider to help you with that.

We will need the following information from you:

- a formal request stating the reason why you need the healthcare;
- if possible, a statement of the treatment costs and a treatment plan.

If we need any further information, we will let you know what information is missing.

Please send the information to our 'Medische Beoordelingen' (Medical assessments) department.

What language to use for the request for approval

Requests and additional information must be in Dutch, English, German, French or Spanish. If your request is in another language, we will ask that you include a translation. You can also have us arrange a translation. We will then claim the fee charged by the translation agency back from you.

Approval for medical aids

To purchase a medical aid, get one on loan, or have one replaced, adjusted or repaired, you can go directly to a contracted healthcare provider. A contracted healthcare provider will assess whether you meet the conditions for provision of a medical aid and which medical aid would be the most appropriate in your situation. If you meet the conditions for provision, the healthcare provider will claim the costs back from us directly. If you do not meet the conditions, you can choose:

- to pay for the medical aid yourself; or
- to request approval from us yourself. In the latter case, please make sure you state that the healthcare provider has rejected your request for the medical aid in question. Requests for approval must be submitted in writing to our 'Medische Beoordelingen' (Medical Assessments) department. To do so, please send us a healthcare request.

If we need additional information for the assessment of the healthcare request, we will request it from you. If you are using a contracted healthcare provider, he or she will generally submit the healthcare request to us on your behalf. If you opt to go to a non-contracted healthcare provider, you will have to submit the healthcare request to us yourself. For a number of medical aids, we have a standard application form available, which you can download from our website. You can also call our 'Medische Beoordelingen' (Medical Assessments) department to ask them to send you an application form.

When you send us the healthcare request, you must include a written, substantiated explanation by the prescriber, stating the medical grounds, possibly supplemented by a recommendation or report if we request one. The healthcare request also specifies:

- your customer number;
- your name, address and place of residence;
- your date of birth;
- the name of the healthcare provider supplying the medical aid;
- a description of the medical aid in question;
- the item number from the 'Z-Index' (the Dutch national database of medicines) or the 'GPH-code' (Generic Product Code for Medical Aids): you can obtain these details from the healthcare provider;
- an indication of how long you expect to need the medical aid;
- and, if you are obtaining the medical aid from a non-contracted healthcare provider, a quote or cost estimate for the medical aid in question.

For a general insurance policy when you change health insurers

If you switch to us during your treatment, the approval, referral, or prescription from your previous health insurer will remain valid.

Statements and promises

The approval is valid only with our prior written permission. We will then send a letter to the postal or email address you have submitted. We cannot be held liable for losses arising due to not receiving our correspondence or receiving our correspondence too late. This could happen if you have given us the wrong address, for instance.

Period of validity

Approval issued by us is valid: - in accordance with the generally applicable legislation, regulations and terms and conditions of insurance; - for a maximum of 365 days, unless we state otherwise. If we change the specific terms and conditions for your healthcare within this period, you can complete the treatment as per the approval. Approval issued by us is no longer valid if: - the relevant laws and/or regulations change; or - your insurance policy has changed or stops, unless the commencement date of a treatment with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC) healthcare product code lies within the term of your insurance policy.

See also:

[DBC healthcare product](#) (definitions)

A.19. Invoices

Reimbursement in general

Your reimbursement will never exceed the actual costs of the healthcare specified on the invoice.

Invoices in general

If you are entitled to reimbursement, it will be paid into the bank account (IBAN) we have on record for you. Claims and reimbursements for invoices can be processed in various ways: - a contracted healthcare provider will generally claim the costs directly from us. We will then pay these directly to that healthcare provider. - a non-contracted healthcare provider issues or sends you an invoice. You can then submit this invoice to us to claim a reimbursement. We will subsequently pay you a reimbursement, provided you are entitled to it. - the following actions or arrangements are excluded: -- you may not transfer your claim or another right in respect of us to a non-contracted healthcare provider or any other third party; -- you may not provide a security interest, such as a pledge, to a non-contracted healthcare provider or any other parties with whom we do not have a contract; -- you may not give permission, an order, instruction or similar to claim on your behalf to a non-contracted healthcare provider or any other third party. Such parties are not allowed either to receive a payment for you, or to accept a payment that fulfils an obligation of yours to that third party, not even if you have given permission or an order to that effect.

Requirements for invoices

Requirements that an invoice must meet

- the healthcare must actually have been provided;
- we must have received the invoice within 36 months of you receiving the healthcare. You will cease to be entitled to reimbursement if after 36 months we do not have the invoice.
- the invoice must be in one of the following languages: Dutch, English, German, French or Spanish. The same applies to your treatment reports. If the invoice is not in one of these languages, we will ask that you include a translation. Alternatively, you can have us arrange to have the invoice translated. If you choose this option, you will be required to compensate us for the fee charged by the translation agency;
- you must have submitted the invoice or a contracted healthcare provider must have done so on your behalf;
- we must be able to process the invoice without further enquiries, processing, or investigation. We go by the same requirements for invoices as those used by the Dutch tax authorities. The invoice must always at least state the following:
 - name and address of the healthcare provider;
 - your name and date of birth;
 - specifics of the healthcare provided;
 - the date on which, or the period over which, the healthcare was provided;

- the costs of the healthcare provided;
- the right Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC) healthcare product code, if it concerned specialist medical care;
- the healthcare provider's BIG register number, if the healthcare provider is required to be registered in the BIG register;
- the AGB code (administrative code assigned to healthcare professionals in the Netherlands), if applicable;
- the requirements set by the Dutch tax authorities regarding VAT on invoices.

For reimbursement of healthcare, we need the date of treatment or supply. The invoice date or the order date for a medical aid or other resource is not relevant.

This is what we will not do:

- we will not reimburse costs on the basis of quotes, advance invoices, reminders or final demands;
- we will not return invoices or documents enclosed with the invoice, not even if only part or nothing at all of the invoice has been reimbursed. You can, however, request a certified copy from us, i.e. a copy of the invoice with an original certification stamp.

See also:

- [AGB code](#) (definitions)
- [DBC healthcare product](#) (definitions)

Foreign invoices that have not been reimbursed in full

If you do not live in the Netherlands and have received healthcare in your country of residence that was not reimbursed in full after you submitted the original invoice for this healthcare, you may be entitled to full or partial reimbursement under your general insurance policy.

What you need to do

Please send us a copy of the invoice along with a statement from the social security authority or statutory insurance provider in your country of residence. This statement must specify:

- that some or all of the costs were not reimbursed; and
- the amount that was not reimbursed.

Claiming healthcare costs

How to claim your healthcare costs - use our app on your smartphone to submit invoices electronically; - use the online 'Mijn' environment to submit invoices electronically; - send us the original hard copies of invoices in the post; in some cases we will accept copies, provided that you have arranged this with us first. This is an exception. Your contracted healthcare provider will send the invoices directly to us.

If we pay the healthcare provider directly

If we have made arrangements with a healthcare provider for them to send invoices directly to us, we will also pay them directly. You must cooperate with us in this respect. This means that our obligation to reimburse you for these costs ceases to exist. We may also set off an invoice from a healthcare provider against an advance that the healthcare provider has already received.

If we pay more to the healthcare provider than you are entitled to

We always pay contracted healthcare providers' invoices in full. This may mean, however, that we pay more than the reimbursement to which you are entitled, because you may still have a deductible outstanding or because the treatment is subject to a statutory personal contribution. You will then be required to pay that part back to us. When you took out your insurance with us, you gave us a mandate for collection, meaning that you authorised us to debit both the premium from your account and the amount we have overpaid to the healthcare provider.

See also:

- [Deductible for your general insurance policy](#) ()

- [Statutory personal contribution](#) (definitions)

Retention of original invoices

When submitting invoices by email, online, in the app, or on the 'Mijn' environment, you have to retain the original hard copies for at least 2 years, as we may ask to see them during a check.

Reimbursement for invoices during the insured period

We only pay reimbursements for invoices for healthcare during your insured period. If you have submitted a claim for treatment with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC healthcare product) code, the start date of the DBC must fall within your insured period. If the start date is before the commencement date of your insurance with us, the entire DBC will be considered not to fall within your insured period. This includes if the treatment continues partly during your insurance term with us. You will then have to submit the invoice for the DBC to your former insurer.

See also:

[DBC healthcare product](#) (definitions)

Priority of reimbursement

When it comes to processing invoices, we adhere to a certain sequence. This is how we determine whether you will receive a reimbursement, and if so, how much. We first look at whether an invoice has to be covered under another kind of insurance, such as a national insurance scheme or social security, such as the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz), the Dutch Youth Act ('Jeugdwet'), or the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo).

Sequence for the reimbursement of healthcare under the general insurance policy

After that, we process the invoice as per your general insurance policy.

Insurance for only part of the year

Certain reimbursements are subject to a maximum amount or a maximum number of treatments per year. If your insurance policy stops part-way through the year, your reimbursement will not be lower. We will not reduce the maximum amount or maximum number of treatments for that year.

A.20. Rates

Here you can read everything about

our rates

Amount of the rates: You need healthcare covered on a refund basis

For healthcare insured on a refund basis, we will reimburse 100% of the insured healthcare provided, but not more than:

- the statutory rate, or if there is no statutory rate;
- the statutory maximum rate, or if there is no statutory maximum rate;
- the market rate applicable in the Netherlands.

We never reimburse more than the claimed rate or the maximum stated for the insured healthcare.

Tip:

If you go to a contracted healthcare provider, we will reimburse 100% of the agreed rate. With contracted healthcare providers, we have generally agreed rates that are lower than the rate charged by a non-contracted healthcare provider. So in most cases, you will pay less deductible when you go to a contracted healthcare provider.

See also:

- [Claimed rate](#) (definitions)
- [Market rate applicable in the Netherlands](#) (definitions)
- [Rate](#) (definitions)
- [Statutory fixed rate](#) (definitions)

- [Statutory maximum rate](#) (definitions)

Amount of the rates: You need healthcare covered under an ‘in-kind’ policy

Choice of healthcare provider for healthcare covered under an ‘in-kind’ policy:

- a. You use a contracted healthcare provider; or
- b. You want to go to a contracted healthcare provider, but are not able to:
 - the healthcare is urgently needed; or
 - because a contracted healthcare provider is not available; or
 - because the contracted healthcare provider will not be able to provide timely healthcare. Timely healthcare is subject to a medically appropriate waiting period. This waiting period is also generally accepted by society.

We will reimburse 100% of the insured healthcare provided by this healthcare provider, but not more than:

- the statutory rate, or if there is no statutory rate:
- in situation a.: the agreed rate or
- in situation b.: the average agreed rate (but never more than the statutory maximum rate or the market rate applicable in the Netherlands).

We never reimburse more than the claimed rate or the maximum stated for the insured healthcare.

- c. You can go to a contracted healthcare provider, but you opt to go to a non-contracted healthcare provider.

We will reimburse the lower percentage* (as shown below) of:

- the statutory rate, or if there is no statutory rate;
- the average agreed rate (but never more than the statutory maximum rate or the market rate applicable in the Netherlands); or
- the claimed rate if that is lower.

We never reimburse more than the maximum stated for the insured healthcare.

See also:

- [Agreed rate](#) (definitions)
- [Claimed rate](#) (definitions)
- [Market rate applicable in the Netherlands](#) (definitions)
- [Statutory fixed rate](#) (definitions)
- [Statutory maximum rate](#) (definitions)

*** The reimbursement is lower if you choose to go to a non-contracted healthcare provider**

The reimbursement for all types of in-kind healthcare under your general insurance policy is 75% of the applicable rate.

Hardship clause in your general insurance policy

Your general insurance policy includes a hardship clause. You can invoke this clause if the lower reimbursement impedes your choice when trying to find a healthcare provider that suits your situation.

If this applies to you, you must inform us in writing why this lower reimbursement impedes your choice and ask us to reimburse a higher, reasonable percentage of the agreed rate under your policy. We will let you know our decision within four weeks.

Rates for a Personal Care Budget (‘Persoonsgebonden Budget’, PGB) under your general insurance policy

The provisions about rates apply to district nursing paid from a Personal Care Budget (‘Persoonsgebonden Budget’, PGB). For more information, see the ‘District nursing’ clause and the Regulations on Personal Care Budgets for Nursing and Other Care (‘Reglement Verpleging & Verzorging PGB’).

VAT

A healthcare provider may be under an obligation to levy VAT on the amount they charge for the healthcare, or to levy a similar tax outside the Netherlands. If the healthcare provider charges you VAT, you will be reimbursed for that as well.

A.21. General exclusions

Here you can read everything about our general exclusions

General exclusions

There are some costs of healthcare that we do not reimburse:

- if you fail to comply with an agreement with a healthcare provider;
- the costs of urgent treatment outside the Netherlands that a travel insurance provider or insurer claims from us:
 - this travel insurance provider or insurer has not signed the covenant on overlap of insurance policies ('Convenant Samenloop');
- if you were not insured with us, these costs would be covered by your travel or other insurance policy. Your travel insurance provider or insurer has, therefore, excluded the costs if you have an insurance policy with us;
- this may also concern costs other than those paid or advanced by that travel insurance provider or insurer.

Explanation:

This travel insurance provider or insurer has not signed the covenant on overlap of insurance policies ('Convenant Samenloop'). This covenant regulates the division of costs reimbursed to the insured persons. This is irrespective of whether the travel or other insurance took effect before or after your insurance with us. Our insurance serves as a 'top-up', i.e. we only reimburse costs that exceed the cover provided by this separate travel or other insurance policy;

- healthcare that would also be covered under another insurance policy or scheme and you have not informed us of the name of that insurer;
- costs of money transfers, administration, billing or shipping costs;
- a treatment that is not deemed to constitute responsible and adequate healthcare or services. We assess this based on the latest medical practical and theoretical standards. Or if the healthcare is not recognised as per the medical standards that apply in the Netherlands;
- a treatment that, in our view, is still at a scientific or experimental stage;
- a treatment that, in our view, does not address the illness or conditions, or that does not prevent an illness or condition;
- healthcare with a treatment date outside your insured period, i.e. before your insurance started or after your insurance ended. In case of a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC), only the start date has to fall within your insured period;
- healthcare provided over the telephone, online, or remotely that, in our view, is not logical and not appropriate. This means that we do not expect the healthcare to produce the desired result. For example: a dentist cannot fix a cavity over the telephone. Mental healthcare, on the other hand, can be provided over the telephone;
- self-administered healthcare;
- healthcare costs exceeding the maximum amount or maximum number, regardless of whether you used the full coverage for that healthcare in the previous year;
- healthcare that you receive from a healthcare provider who is your partner or a first or second-degree family member and/or relative;
- treatments that are necessary as a result of nuclear reactions. However, healthcare required because of nuclear material outside a nuclear plant will be reimbursed, but only on the following conditions:
 - there is a permit from the Dutch government for the installation of the nuclides;
 - the location of this material does not contravene the Dutch Nuclear Incidents (Third Party Liability) Act ('Wet aansprakelijkheid kernongevallen');
 - a third party is not liable for the losses, under Dutch law or that of a foreign country;
- healthcare you receive while in custody or prison, regardless of whether that is in the Netherlands or another country. In that case, you will receive healthcare arranged by the facility. In the Netherlands, this is the responsibility of the Dutch Ministry of Justice ('Ministerie van Justitie');
- a new medical aid because your old medical aid no longer works properly;

- because you deliberately did not follow the instructions or explanation of use;
- as a result of your improper use of the medical aid;
- (statutory) personal contributions payable in accordance with the Dutch Youth Act ('Jeugdwet'), the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) and the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo) or the Dutch Health Insurance Act ('Zorgverzekeringswet', Zvw); A personal contribution may be reimbursed under an additional insurance package;
- costs exceeding the maximum rate for which you are insured.

See also:

- [Abroad](#) (definitions)
- [DBC healthcare product](#) (definitions)
- [Rate](#) (definitions)
- [Treatment](#) (definitions)
- [Year](#) (definitions)

No reimbursement in case of acts of war and/or terrorism

We will not reimburse the following costs:

- damage or losses in connection with acts of war. These are costs resulting from armed conflict, civil war, insurrection, domestic civil commotion, riots and mutiny taking place in the Netherlands. This is specified in Article 3:38 of the Dutch Financial Supervision Act ('Wet op het financieel toezicht'). We go by the definitions drawn up by the Dutch Association of Insurers ('Verbond van Verzekeraars');
- terrorism risk. These are costs resulting from terrorism, malicious contamination, preventive measures or preparatory actions and behaviour, both in the Netherlands and abroad. We will reimburse these costs only insofar as we are able to pay them from the amount we receive under reinsurance from the Dutch Terrorism Claims Reinsurance Company ('Nederlandse Herverzekeringsmaatschappij voor Terrorisemeschaden N.V.', NHT) in Amsterdam.

Reinsurance provided by the NHT covers the costs of terrorism risk up to a maximum of 1 billion euros per year. This amount is subject to change on an annual basis. The amount is for all NHT-affiliated insurers combined. After a terrorist act as specified in Article 33 of the Dutch Health Insurance Act ('Zorgverzekeringswet'), an additional contribution may be made available. You will then be insured for additional reimbursement. The level of this reimbursement is set based on the aforementioned Article 33.

If you do not live in the Netherlands, you are not covered by this reinsurance scheme and will, therefore, not receive a reimbursement. For more about terrorism, please visit the NHT website.

A national terrorism clause sheet ('Clausuleblad Terrorisme' published by the NHT) has been published. You can find out more about this at nht.vereende.nl/en/.

A.22 Disputes

Reconsideration and dispute

If you do not agree with a decision we have made in the implementation of your general insurance policy, you can ask that we reconsider our decision. This means that we will take another look at our decision to assess whether we should change it. Such a reconsideration must always be requested in writing. Our contact details are available on our website.

If you disagree with our reconsideration, you have various options as to what to do next:

- you can go to the competent court if we:
- have not responded to your reconsideration request within 4 weeks;
- or if we have reconsidered the decision and let you know that we stand by our initial decision;

- you can refer the dispute to the 'Geschillencommissie Zorgverzekeringen' (Health Insurance Disputes Committee) of the 'Stichting Klachten en Geschillen Zorgverzekeringen' (SKGZ, the Health insurance Complaints and Disputes Committee). You must do so in writing to Postbus 291, 3700 AG Zeist (www.skgz.nl). The Dutch Health Insurance Ombudsman ('Ombudsman Zorgverzekeringen') works for SKGZ. The ombudsman will try to resolve the complaint through a process of mediation. If this proves unsuccessful, the SKGZ can issue a final and binding recommendation.

Once you have chosen one of the above possibilities, you cannot go back later and choose another one.

A.23. Complaints

Complaints about standard forms

If you think our forms are overly complicated or unnecessary, or your healthcare provider or another health insurer thinks that, you or the person with the complaint can take the complaint to Dutch Healthcare Authority ('Nederlandse Zorgautoriteit', NZa): Postbus 3017, 3502 GA Utrecht, Netherlands. The NZa will issue a binding decision on the complaint.

A.24. Dutch law

Dutch law

Your insurance is subject to Dutch law.

A.25. Situations not covered

Situations not covered

Our Executive Board and/or management will decide how to proceed in situations that are not covered in these terms and conditions of insurance.

Appendix Other

Our website contains a number of appendices that are part of your general insurance policy.

These are:

- - National Indication Protocol for Obstetric Care ('Landelijk Indicatieprotocol Kraamzorg')
- Restrictive list of authorisations for dental surgery ('Limitatieve lijst machtigingen Kaakchirurgie')
- 'Zorgautoriteit Nederland' restrictive list of authorisations for specialist medical healthcare ('Limitatieve lijst machtigingen medisch specialistische zorg ZN')
- List of preferred medicines ('Lijst Voorkeursgeneesmiddelen')
- National mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ')
- Dutch Dental Association dental trauma guidelines ('KNMT praktijkrichtlijn tandletsel')
- Regulations on Personal Care Budgets for Nursing and Other Care ('Reglement persoonsgebonden budget: verpleging en verzorging')