Reimbursements and terms and conditions for 2027

General insurance policy

‘Nationale-Nederlanden Zorg Voordelig’ (‘Natura Basis’ health insurance policy)

Product number: 6310002
Valid from 01-01-2027 to 31-12-2027 (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The previous terms and conditions of insurance are hereby superseded.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 in a treaty country (clause B.2.1.), healthcare abroad (clause B.2.2.)

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 in a treaty country: 18, the statutory regulation in the treaty country for healthcare in a treaty country.
  2. For healthcare abroad: 18, the healthcare provided abroad has the same level and scope for which the healthcare is insured in the Netherlands for healthcare abroad.

- 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: 70% of your invoice up to 70% 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]({0}).

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

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
- In the event of urgent medical care, you can request assistance through the ANWB Alarmcentrale emergency assistance centre. You can read more information on our website

Do you need approval?

- You need permission from us for all non-urgent medical care that can be scheduled in advance for which permission is also required in the Netherlands.
  You can see whether approval is required in the clause relating to that particular healthcare.
- You need permission from us for all non-urgent medical care that can be scheduled in advance and is on the list of healthcare abroad that requires permission (‘Lijst aanvragen zorg buitenland’) (outpatient treatment)
  This list is available on our website.
- You need permission 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 come under specialist medical healthcare. This list is available on our website.
- You need permission 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]({0}).

Where to go for this healthcare
- The healthcare provider abroad complies with the requirements, laws and regulations of that country.

What is not reimbursed
- Healthcare not covered under 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]({0}).

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

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
- In the event of urgent medical care, you can request assistance through the ANWB Alarmcentrale emergency assistance centre. You can read more information on our website

Do you need approval?
- You need permission from us for all non-urgent medical care that can be scheduled in advance for which permission is also required in the Netherlands.
  You can see whether approval is required in the clause relating to that particular healthcare.
- You need permission from us for all non-urgent medical care that can be scheduled in advance and is on the list of healthcare abroad that requires permission (‘Lijst aanvragen zorg buitenland’) (outpatient treatment)
  This list is available on our website.
- You need permission 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 come under specialist medical healthcare. This list is available on our website.
- You need permission 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]({0}).

Where to go for this healthcare
- The healthcare provider abroad complies with the requirements, laws and regulations of that country.

What is not reimbursed
- Healthcare not covered under 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]({0}).

Dietary preparations

What you are insured for under your general insurance policy

Dietary preparations (clause B.16.)

Insured healthcare
- Polymer, oligomer, monomer and modular dietary preparations for liquid nutrition and/or tube feeding

Your reimbursement
- Reimbursement of 100 percent 18 for dietary preparations.

- 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: 70% of your invoice up to 70% 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]({0}).

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 (overheid.nl) under 'Wet- en regelgeving' (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.
- We reimburse the costs of the dietary preparations that you receive due to having an allergy from the moment that the allergy is diagnosed by the correct prescriber in accordance with the applicable guidelines.
  When it is suspected, for example, that you have a cow's milk protein allergy a food challenge is conducted. We do not reimburse the testing period prior to the final diagnosis.

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. Permission from us will then not be required
  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]({0}).

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]({0}).

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 maximum, per year, 18 for dietetics.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Your healthcare provider is affiliated with ParkinsonNet if you have Parkinson's disease
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- If you will be treated by a non-contracted healthcare provider, you will need a referral before the treatment can start
  The referral needs 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.
- You always need a referral if it is necessary for you to receive treatment at home

- These healthcare providers may make the referral:
  A general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, dentist, company doctor, clinical nurse specialist or medical specialist.

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').

What is not reimbursed
- Dietetics outside multidisciplinary care if you are already receiving dietetics as part of multidisciplinary care prescribed on the same medical grounds
  Also see the 'Dietetics as part of multidisciplinary care' clause.
- Dietetics in combination with combined lifestyle intervention. Unless this relates to a different healthcare need based on a different indication
  Also see the 'General practitioner care with a focus on combined lifestyle intervention' clause.
- Dietary advice for weight loss or sports, for example

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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

Insured healthcare
- Dietetics as part of multidisciplinary care

Your reimbursement
- Reimbursement of 100 percent 0 for dietetics as part of multidisciplinary care.

- 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: 70% of your invoice up to 70% 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]({0}).

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 cardiovascular risk (CVRM).
  - COPD (Chronic Obstructive Pulmonary Disease).
  - You have asthma.

Terms and conditions
- Your healthcare provider is affiliated with ParkinsonNet if you have Parkinson's disease
- Your healthcare provider is affiliated with a contracted principal contractor if you have asthma
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- If you will be treated by a non-contracted healthcare provider, you will need a referral before the treatment can start
  The referral needs 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.
- You always need a referral if it is necessary for you to receive treatment at home

- These healthcare providers may make the referral:
  A general practitioner, doctor for the mentally disabled, geriatric specialist, youth healthcare doctor, dentist, company doctor, clinical nurse specialist or medical specialist.

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').

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.
- Dietetics in combination with combined lifestyle intervention. Unless this relates to a different healthcare need based on a different indication
  Also see the 'General practitioner care with a focus on combined lifestyle intervention' clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Occupational therapy

What you are insured for under your general insurance policy

Occupational therapy (clause B.9.)

Insured healthcare
- Occupational therapy
  This concerns the provision of advice, instruction, training or treatment to help you achieve, or regain, independence and the ability to look after yourself.

Your reimbursement
- Reimbursement of 10 hours of treatment maximum, per year, 18 for occupational therapy.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Your healthcare provider is affiliated with ParkinsonNet if you have Parkinson's disease
- Group sessions are an option as long as the group does not have more than 10 participants

Who to get a referral from
- If you will be treated by a non-contracted healthcare provider, you will need a referral before the treatment can start
  The referral needs 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.

- These healthcare providers may make the referral:
  A general practitioner, level-5 district nurse, doctor for the mentally disabled, geriatric specialist, company doctor, clinical nurse specialist, physician assistant, youth healthcare doctor or 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').

Where the treatment takes place
- The treatment can be provided at your home if this is necessary

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are younger than 18, from the first session: reimbursement of 9 sessions maximum, per condition, per year, and if necessary 9 additional treatments for the same condition, 0 for physiotherapy and exercise therapy up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a (temporary) complaint or injury.
    This generally 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 or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may 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
  Before you receive physiotherapy or exercise therapy at home, you need a referral stating why you need to receive this therapy at home. These healthcare providers may make the referral: general practitioner, doctor for the mentally disabled, youth healthcare doctor, dentist, physician assistant, clinical nurse specialist, company doctor or medical specialist.

Do you need approval?

- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 18, from the first session: reimbursement of 100 percent 0 for physiotherapy and exercise therapy according to the list of conditions up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

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

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy according to the list of conditions from the age of 18 (clause B.8.1.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are 18 years old or above, from the 21st session: reimbursement of 100 percent 18 for physiotherapy and exercise therapy according to the list of conditions 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: 70% of your invoice up to 70% 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]({0}).

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

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website.
- Our permission is required, however, if you are treated by a non-contracted healthcare provider
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 17, from the first session: reimbursement of 100 percent 0 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.

- 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: 70% of your invoice up to 70% 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]({0}).

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

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from

- Medical specialist

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

- A Cesar/Mensendieck exercise therapist provides the 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').
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register ('Individueel Register Fysiotherapie', IRF) or the individual register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children 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]({0}).

Physiotherapy and exercise therapy for radicular syndrome with loss of motor function or pelvic instability after childbirth from the age of 18 (clause B.8.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are 18 years old or above, from the 21st session: reimbursement of 100 percent during a maximum of 3 months, 18 for physiotherapy and exercise therapy for radicular syndrome with loss of motor function or pelvic instability after childbirth 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have a radicular syndrome with loss of motor function.
  - You have pelvic instability after childbirth (postpartum).

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for radicular syndrome with loss of motor function or pelvic instability after childbirth up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 18, from the first session: reimbursement of 100 percent during a maximum of 3 months, 0 for physiotherapy and exercise therapy for radicular syndrome with loss of motor function or pelvic instability after childbirth up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
  - You have a radicular syndrome with loss of motor function.
  - You have pelvic instability after childbirth (postpartum).

Terms and conditions

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for fractures after conservative treatment from the age of 18 (clause B.8.1.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are 18 years old or above, from the 21st session: reimbursement of 100 percent during a maximum of 6 months, 18 for physiotherapy and exercise therapy for fractures after conservative treatment 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have had a fracture that has been treated conservatively.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet

- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for fractures after conservative treatment up to and including the age of 17 (clause B.8.3.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are younger than 18, from the first session: reimbursement of 100 percent during a maximum of 6 months, 0 for physiotherapy and exercise therapy for fractures after conservative treatment up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have had a fracture that has been treated conservatively.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants

- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register ('Individueel Register Fysiotherapie', IRF) or the individual register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register ('Individueel Register Fysiotherapie', IRF) or the individual register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for frozen shoulder (adhesive capsulitis) or peripheral artery disease at Fontaine stage 3 from the age of 18 (clause B.8.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are 18 years old or above, from the 21st session: reimbursement of 100 percent during a maximum of 12 months, 18 for physiotherapy and exercise therapy for frozen shoulder (adhesive capsulitis) or peripheral artery disease at Fontaine stage 3 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have a frozen shoulder (adhesive capsulitis).
  - You have Fontaine stage 3 peripheral artery disease.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for frozen shoulder (adhesive capsulitis) or peripheral artery disease at Fontaine stage 3 up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 18, from the first session: reimbursement of 100 percent during a maximum of 12 months, 0 for physiotherapy and exercise therapy for frozen shoulder (adhesive capsulitis) or peripheral artery disease at Fontaine stage 3 up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
  - You have a frozen shoulder (adhesive capsulitis).
  - You have Fontaine stage 3 peripheral artery disease.

Terms and conditions

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy after discharge and return home or termination of day treatment from the age of 18 (clause B.8.1.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are 18 years old or above, from the 21st session: reimbursement of 100 percent during a maximum of 12 months following discharge or termination of treatment at the facility, 18 for physiotherapy and exercise therapy after discharge and return home or termination of day treatment 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You were admitted to a hospital, a nursing facility, a rehabilitation facility or after undergoing day treatment at a rehabilitation centre.
    The healthcare is intended to speed up recovery after discharge and return home or termination of day treatment.

Terms and conditions

- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet

- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy after discharge and return home or termination of day treatment up to and including the age of 17 (clause B.8.3.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are younger than 18, from the first session: reimbursement of 100 percent during a maximum of 12 months following discharge or termination of treatment at the facility, 0 for physiotherapy and exercise therapy after discharge and return home or termination of day treatment up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:

- You were admitted to a hospital, a nursing facility, a rehabilitation facility or after undergoing day treatment at a rehabilitation centre.
  The healthcare is intended to speed up recovery after discharge and return home or termination of day treatment.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for a soft tissue tumour from the age of 18 (clause B.8.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are 18 years old or above, from the 21st session: reimbursement of 100 percent for up to 2 years after radiotherapy, 18 for physiotherapy and exercise therapy for a soft tissue tumour 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a soft tissue tumour.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for a soft tissue tumour up to and including the age of 17 (clause B.8.3.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are younger than 18, from the first session: reimbursement of 100 percent for up to 2 years after radiotherapy, 0 for physiotherapy and exercise therapy for a soft tissue tumour up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a soft tissue tumour.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- In the case of Parkinson’s disease, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
- A skin therapist or oedema physiotherapist provides oedema physiotherapy
  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) at the start of the treatment. The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Physiotherapy and exercise therapy for juvenile osteochondrosis up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 18, from the first session: reimbursement of 100 percent 0 for physiotherapy and exercise therapy for juvenile osteochondrosis up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
    - You have juvenile osteochondrosis.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Youth healthcare doctor
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children 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]({0}).

Physiotherapy and exercise therapy for juvenile osteochondrosis from 18 to 21 years of age inclusive (clause B.8.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement
- You are 18 years old or above but younger than 22, from the 21st session: reimbursement of 100 percent 18 for physiotherapy and exercise therapy for juvenile osteochondrosis from 18 to 21 years of age inclusive.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have juvenile osteochondrosis.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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
- Youth healthcare doctor
- Company doctor
- Clinical nurse 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 from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website.
- Our permission is required, however, if you are treated by a non-contracted healthcare provider
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children 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]({0}).

Physiotherapy and exercise therapy for whiplash up to and including the age of 17 (clause B.8.3.)

Insured healthcare

- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are younger than 18, from the first session: reimbursement of 100 percent during a maximum of 3 months, and, if necessary, extension for a maximum period of 6 months, 0 for physiotherapy and exercise therapy for whiplash up to and including the age of 17.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You have whiplash.

Terms and conditions

- Start of treatment must be within 3 months from the date of whiplash being diagnosed
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- This period can only be extended if loss of motor function, exercise intolerance and cognitive disorders (all three) continue after 3 months
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may 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
- Youth healthcare doctor
- Clinical nurse specialist
- Medical specialist
- Medical specialist if it concerns an extension after 3 months
  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.

Do you need approval?
- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist specialising in children provides the exercise therapy for children
  Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children 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]({0}).

Physiotherapy and/or exercise therapy for whiplash from the age of 18 (clause B.8.1.)

Insured healthcare
- Physiotherapy and exercise therapy
  By this we mean physiotherapy, exercise therapy or recognised specialist physiotherapy or exercise therapy.

Your reimbursement

- You are 18 years old or above, from the 21st session: reimbursement of 100 percent during a maximum of 3 months, and, if necessary, extension for a maximum period of 6 months, 18 for physiotherapy and/or exercise therapy for whiplash 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You have whiplash.

Terms and conditions

- Start of treatment must be within 3 months from the date of whiplash being diagnosed
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- This period can only be extended if loss of motor function, exercise intolerance and cognitive disorders (all three) continue after 3 months
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may 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
- Clinical nurse specialist
- Medical specialist
- Medical specialist if it concerns an extension after 3 months
  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.

Do you need approval?

- The contracted healthcare provider will assess on our behalf whether your condition appears on the list of conditions from Appendix 1 of Dutch Health Insurance Decree (‘Besluit zorgverzekering’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare

- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

- A Cesar/Mensendieck exercise therapist provides the 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').
- A manual therapist provides the manual therapy
  This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register ('Individueel Register Fysiotherapie', IRF) or the individual register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', KFIR).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register ('Individueel Register Fysiotherapie', IRF) or the individual register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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
- You are 18 years old or above: reimbursement of 9 sessions maximum, during a maximum of 12 months, 18 for pelvic physiotherapy for urinary incontinence 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have urinary incontinence.

Terms and conditions
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may 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
- Clinical nurse specialist
- Medical specialist

Do you need approval?
- A contracted healthcare provider assesses whether pelvic physiotherapy is required to help treat urinary incontinence. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

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 Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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
- You are 18 years old or above: reimbursement of 37 sessions maximum, during a maximum of 12 months, 18 for physiotherapy (supervised walking therapy) for intermittent claudication 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: 70% of your invoice up to 70% 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]({0}).

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
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- General practitioner

- Clinical nurse specialist
- Medical specialist

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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if the healthcare is provided by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- Physiotherapist or exercise therapist
  If you want to go to a specialist healthcare provider for this, go to a physiotherapist affiliated with Chronisch ZorgNet specialising in peripheral arterial disease.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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
- You are 18 years old or above: reimbursement of 12 sessions maximum, during a maximum of 12 months, 18 for physiotherapy (supervised exercise therapy) for osteoarthritis in the hip or knee joint 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: 70% of your invoice up to 70% 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]({0}).

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
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- General practitioner
- Clinical nurse specialist

- Medical specialist

Do you need approval?
- A contracted healthcare provider assesses whether you have osteoarthritis in the hip or knee joint. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if you are treated by a non-contracted healthcare provider.
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).
- A Cesar/Mensendieck exercise therapist provides the 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’).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Exercise therapy for COPD stage II or higher (clause B.8.6.)

Insured healthcare
- Physiotherapy or exercise therapy in the form of supervised exercise therapy
  This concerns supervised exercise therapy. This is a form of physiotherapy.

Your reimbursement
- You are 18 years old or above, from the first session: reimbursement of 100 percent 18 for exercise therapy for COPD stage II or higher.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have chronic obstructive pulmonary disease (COPD) stage II or higher as classified by the GOLD system for grading COPD symptoms.
    This is COPD stage II or higher of the GOLD classification of COPD severity by spirometry with GOLD classification Group A for symptoms.

Terms and conditions
- Group sessions are an option as long as the group does not have more than 10 participants
- The number of sessions or the period specified is a maximum. You and your physiotherapist or exercise therapist will jointly agree the number of sessions required
- The treatment may 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 contracted healthcare provider will assess whether you meet the conditions and whether the healthcare is covered under your insured healthcare. Permission from us will then not be required
  A list of these healthcare providers is available on our website.
- Our permission is required, however, if you are treated by a non-contracted healthcare provider
- You need permission from us for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need permission 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]({0}).

Where to go for this healthcare
- Physiotherapist or exercise therapist
  If you want to go to a specialist healthcare provider for this, physiotherapist affiliated with Chronisch ZorgNet specialising in lung disease.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Fall prevention exercise intervention (clause B.8.7.)

Insured healthcare
- A fall prevention training programme to improve your muscle strength and balance and ease your mobility problems

Your reimbursement
- Reimbursement of 100 percent once per year, 18 for fall prevention exercise intervention.

- 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: 70% of your invoice up to 70% 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]({0}).

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
- A fall risk check has indicated that you have a high risk of falling.
  It is then seen in a fall risk assessment that you require guidance at the level of a physiotherapist due to physical or psychological problems.
- 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 training programme through your municipality

Who to get a referral from
- General practitioner or general practitioner's practice assistant
  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.

Who to get a treatment proposal from
- The general practitioner, general practitioner's practice assistant or physician assistant carries out a fall risk assessment to determine whether the training programme is medically necessary

Where to go for this healthcare
- A certified physiotherapist or exercise therapist who provides healthcare in accordance with one of the healthcare programmes recognised nationally in the Netherlands
  Check the 'Vergoedingen' section or 'Zorgvinder' tool on our website to find out which healthcare providers you can visit for this healthcare.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Long-term exercise therapy for rheumatoid arthritis (clause B.8.8.)

Insured healthcare
- Long-term supervised exercise therapy
  This concerns personal, active exercise therapy to prevent serious deterioration.

Your reimbursement
- You are 18 years old or above: reimbursement of 100 percent 18 for long-term exercise therapy for rheumatoid arthritis.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have rheumatoid arthritis with severe functional limitations.

Terms and conditions
- Your healthcare provider has received specific training aimed at developing the ability to provide long-term person-oriented active exercise therapy

- You, your physiotherapist or exercise therapist and, where applicable, the person who referred you will agree the number of sessions required, at which time you will also receive an individual treatment plan that meets the applicable guidelines.
  With your additional insurance package, you can have sessions you did not use in one year roll over to the next year. You need to be insured for this 'rollover service' for at least one year before you can start using it.
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- Rheumatologist
  For a chair adapted to a functional limitation if there are obvious medical grounds when you are being treated there.

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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if the healthcare is provided by a non-contracted healthcare provider.
- You need permission from us from the 40th session for each year of treatment

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Physiotherapist
- Cesar or Mensendieck exercise therapy

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Long-term exercise therapy for axial spondyloarthritis (axSpA) (clause B.8.9.)

Insured healthcare
- Long-term supervised exercise therapy
  This concerns personal, active exercise therapy to prevent serious deterioration.

Your reimbursement
- You are 18 years old or above: reimbursement of 100 percent 18 for long-term exercise therapy for axial spondyloarthritis (axSpA).

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have axial spondyloarthritis (axSpA) with severe functional limitations.

Terms and conditions
- Your healthcare provider has received specific training aimed at developing the ability to provide long-term person-oriented active exercise therapy

- You, your physiotherapist or exercise therapist and, where applicable, the person who referred you will agree the number of sessions required, at which time you will also receive an individual treatment plan that meets the applicable guidelines.
  With your additional insurance package, you can have sessions you did not use in one year roll over to the next year. You need to be insured for this 'rollover service' for at least one year before you can start using it.
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- Rheumatologist
  For a chair adapted to a functional limitation if there are obvious medical grounds when you are being treated there.

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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if the healthcare is provided by a non-contracted healthcare provider.
- You need our permission from the 42nd session for each year of treatment

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Physiotherapist
- Cesar or Mensendieck exercise therapy

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Medical mental healthcare

What you are insured for under your general insurance policy

Mental healthcare (clause B.19.1.), admission for mental healthcare (clause B.19.3.)

Insured healthcare
- Medical mental healthcare: psychological, psychotherapeutic and psychiatric healthcare
  This involves: - diagnostics: 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, in a group setting or online under the responsibility of a coordinating practitioner.
- Admission for medical mental healthcare
  - admission in the lowest nursing care category of a hospital or a facility for specialist medical healthcare; - associated allied healthcare (e.g. physiotherapy or occupational therapy), daytime activities, and professional therapy (e.g. music therapy or psychomotor therapy); - nursing and other care, and the associated medicines, medical aids and dressings.

Your reimbursement
- You are 18 years old or above: for mental healthcare: 100 percent 18; and
- You are 18 years old or above, from the 1st day of admission: for admission for mental healthcare: 100 percent maximum of 3 years (1095 days), 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions for mental healthcare (clause B.19.1.)

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: Diagnostic and Statistical Manual of Mental Disorders, 5th version. This is a manual that describes how psychologists and psychiatrists identify and classify mental disorders. - The current national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). This states what mental healthcare providers must arrange in terms of, for example, quality and accountability. This ensures that you get the right healthcare in the right place from the right mental healthcare provider. You can find these regulations on the 'Zorginzicht' website of 'Zorginstituut Nederland' (ZiNl).
- Your healthcare provider has approved mental healthcare quality 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, for example, quality and accountability. This ensures that you get the right healthcare in the right place from the right mental healthcare provider. - If you have any questions, you can also contact your healthcare provider. They know the rules for reimbursements, what we do not cover and the positions of the Dutch National Healthcare Institute ('Zorginstituut Nederland'). - The national mental healthcare quality regulations are included in the Register for Quality Standards and Measuring Instruments ('Register voor kwaliteitsstandaarden en Meetinstrumenten') of the Dutch National Healthcare Institute ('Zorginstituut Nederland', ZiNl). The healthcare providers are listed on ZiNl's 'Zorginzicht' website. - If you receive the healthcare at a facility, the facility must arrange their own mental healthcare quality regulations. These must specify the members of staff who are cleared to provide the healthcare, such as psychologists.
- The coordinating practitioner drawing up the care needs assessment has ultimate responsibility for the diagnosis and the healthcare as per the treatment plan
- The coordinating practitioner drawing up the care needs assessment handles a significant share of the treatment and healthcare process

Who to get a referral from

- General practitioner, company doctor, emergency care doctor, medical specialist, doctor for the homeless or a referral from your coordinating practitioner
  - The referral must be valid for 9 months. - The referral complies with the national referral arrangements for mental healthcare ('Verwijsafspraken GGZ') and the NHG ('Nederlands Huisartsen Genootschap', Dutch College of General Practitioners) guideline on information exchange between general practitioner and mental healthcare ('Informatie uitwisseling huisarts GGZ').

Who to get a treatment proposal from

- The coordinating practitioner determines that the healthcare is medically necessary
  This healthcare provider has a central and responsible role. They will draw up, discuss and evaluate the treatment plan with you.

Do you need approval?
- You need permission 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]({0}).

Where to go for this healthcare
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare
- In case of an independently established healthcare provider, the coordinating practitioner is a healthcare psychologist, a psychotherapist, a clinical psychologist, clinical neuropsychologist, or a psychiatrist
- You will receive highly specialised mental healthcare only from a healthcare provider who has been contracted for this healthcare
  It is highly specialised healthcare that you receive at a facility.
- Has treatment started under the Dutch Youth Act (‘Jeugdwet’) and will it continue after you turned 18?
  If so, you can continue the treatment with the same coordinating practitioner for a maximum of 365 days from your 18th birthday. This coordinating practitioner is included in the transitional arrangement under the applicable national mental healthcare quality regulations (‘Landelijk Kwaliteitsstatuut GGZ’).

Where the treatment takes place
- At the practice of the attending healthcare provider
- In the Netherlands in a facility under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)

What is not reimbursed
- See ‘Vergoedingen GGZ’ (Mental healthcare reimbursements) on our website for the main exclusions
- Mental healthcare provided by your general practitioner or practice assistant for mental healthcare (‘POH-GGZ’). For details, see the ‘General practitioner care with a focus on medical mental healthcare’ clause
  - psychosocial healthcare; - neurofeedback; - an 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; - diagnostics only, without the intention of mental healthcare being provided; - treatment of obesity (overweight) 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 the costs of mental healthcare provided by your general practitioner or practice assistant for mental healthcare (‘POH-GGZ’) under this clause but rather 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]({0}).

Terms and conditions for admission for mental healthcare (clause B.19.3.)

Eligibility for this healthcare
- The medical indication or situation below applies to you:

- You have a diagnosed psychiatric DSM-5 disorder (see clause B.19.1. Medical mental healthcare) for which admission is medically necessary.
  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

- For inpatient addiction treatment (‘rehab’), a trial leave for therapeutic purposes must be tailored to your individual needs
  This also means that you receive individual aftercare and help in the next steps after admission.
- 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, they will complete a questionnaire that will be 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.

Where to go for this healthcare

- If you choose to be admitted abroad, the coordinating practitioner/practitioner drawing up the care needs assessment must be a psychiatrist

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Medical care for specific patient groups

What you are insured for under your general insurance policy

Medical care for specific patient groups (clause B.28.)

Insured healthcare

- Medical care for specific patient groups
  You receive general medical care (diagnostics and treatment). This ensures that you can keep functioning in a stable manner. It prevents your condition, disorder or impairments from getting worse. You learn skills and behaviour to better manage the symptoms of your condition, disorder or impairment.

Your reimbursement

- Reimbursement of 100 percent 18 for medical care for specific patient groups.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:

- The healthcare is intended for vulnerable people who still live at home.
  You qualify if you: - are an elderly person and have a complex condition, or - have a chronic progressive degenerative condition, such as Parkinson's disease, Huntington's disease or multiple sclerosis, or - have an acquired brain injury, or - have a mild intellectual disability.

Terms and conditions

- The healthcare provided must adhere to the principles drawn up by various healthcare providers, professional organisations and 'Zorgverzekeraars Nederland', the umbrella organisation of ten health insurers in the Netherlands
  You will find these principles in the following publications on the 'Zorgverzekeraars Nederland' website: - Principles for 'Group-based healthcare' medical care for specific patient groups and - Principles for 'Individual performance' medical care for specific patient groups.
- A multidisciplinary team can provide the healthcare and is coordinated by the coordinating practitioner for medical care for specific patient groups
  The coordinating practitioner: - is a doctor for the mentally disabled or a geriatric specialist. - is responsible for carrying out the healthcare and treatment plan in collaboration with other healthcare providers. This multidisciplinary healthcare can be provided on an individual or a group level. - can in the case of a nationally recognised multidisciplinary care programme also be a behavioural scientist registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG) (healthcare psychologist, remedial education generalist or clinical psychologist). - records treatments and treatment goals in the treatment plan.

Who to get a referral from

- General practitioner
- Medical specialist

Where to go for this healthcare

- For monodisciplinary medical care for specific patient groups:
  - geriatric specialist - doctor for the mentally disabled.
- For multidisciplinary medical care for specific patient groups:
  - a facility for the mentally disabled - a nursing/personal care and day treatment facility that complies with the Dutch Healthcare Providers (Accreditation) Act ('Wet toetreding zorgaanbieders', Wtza).

What is not reimbursed

- It does not concern medical care for specific patient groups if:
  - clinical admission is required. - 24-hour care/observation is required. - you are unable to organise your own life. - the treatment goals have been achieved or there are no more treatment goals. - you have a medical indication that places you 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]({0}).

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: - joint or collaborative consultation; - health advice and preventive healthcare in areas such as quitting smoking (see the 'Quit smoking course' 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 aged 18 or above; - cardiovascular/vascular risk management to manage cardiovascular disease for insured persons aged 18 or above; - chronic obstructive pulmonary disease (COPD); - asthma suffered by insured persons aged 16 or above.

Your reimbursement

- Reimbursement of 100 percent 0, 385, 385 for general practitioner care for advice, examination, supervision and multidisciplinary care.

- 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: 70% of your invoice up to 70% 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]({0}).

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).
- 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). You can also receive the healthcare under the responsibility of a general practitioner.
- Healthcare provider within a healthcare group

- 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]({0}).

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); and - pulmonary function test (spirometry).

Your reimbursement
- Reimbursement of 100 percent 0 for general practitioner care for medical care.

- 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: 70% of your invoice up to 70% 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]({0}).

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). You can also receive the healthcare 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]({0}).

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 percent 0, 385 for general practitioner care for implanting or removing an IUD or contraceptive implant (e.g. Implanon).

- 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: 70% of your invoice up to 70% 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]({0}).

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). You can also receive the healthcare 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]({0}).

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 percent 0 for general practitioner care for cow’s milk allergy and the cow’s milk allergy test.

- 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: 70% of your invoice up to 70% 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]({0}).

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 Healthcare 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. Permission from us will then not be required
  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 the 'ZN formulieren' website (in Dutch). Go to 'Farmacie' (pharmacy) and then to 'Dieetpreparaten' (dietary preparations).

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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]({0}).

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
  This may involve referral, diagnosis, treatment and supervision. You can also have a Mantoux test performed.

Your reimbursement
- Reimbursement of 100 percent 0, 385, 385 for general practitioner care with a focus on tuberculosis and infectious diseases.

- 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: 70% of your invoice up to 70% 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]({0}).

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
- 'GGD' regional healthcare authority 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]({0}).

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

Insured healthcare
- General practitioner care for mental healthcare
    - request for an initial mental healthcare consultation; - healthcare to treat minor psychological complaints if you do not have (or do not 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 percent 0 for general practitioner care for mental healthcare.

- 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: 70% of your invoice up to 70% 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]({0}).

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’).
  You receive the healthcare from 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.
  Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out where you can go for this healthcare.

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]({0}).

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 health and exercise, i.e. encouraging physical activity and keeping you motivated, monitoring progress and pointing out exercise opportunities in the social sphere; - advice and guidance concerning establishing permanent behavioural change to acquire and maintain a healthy lifestyle; - feedback to the referring healthcare provider about the nature and progress of the healthcare; - an evaluation, with a review of your wishes for a possible maintenance phase.

Your reimbursement

- You are 18 years old or above; by way of exception, 16 or 17 years if the general practitioner believes this type of healthcare is suitable.: reimbursement of 100 percent 0 for general practitioner care and combined lifestyle intervention 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:

- You have a moderately increased weight-related health risk according to the multidisciplinary guideline: Overweight and obesity in adults and children.
  One of the following situations applies to you. You have: - a BMI between 25 and 35 in combination with a large waist circumference. For women, this is 88cm or more. For men, it is 102cm or more. - a BMI between 25 and 35 and one or several diseases associated with overweight (comorbidity). - a BMI of over 35.

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

Who to get a referral from
- General practitioner, company doctor or medical specialist

Do you need approval?
- You only need permission from us 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]({0}).

Where to go for this healthcare
- Lifestyle coach
  The healthcare is provided by a healthcare provider listed as a lifestyle coach on the Quality Register and Accreditation of Healthcare Practitioners (‘Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg’, KABIZ), the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF)/Individual Register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR) or the Dutch Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’, KP). 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
- Dietetics at the same time as a combined lifestyle intervention programme for the same indication

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Integrated care approach to childhood overweight and obesity (clause B.3.5.)

Insured healthcare
- Integrated care approach to childhood overweight and obesity
  This healthcare and support consists of: - an extensive intake interview to gain an understanding of the factors contributing to overweight. - a coordinating role by the central healthcare provider and drawing up an action plan. - combined lifestyle intervention programme of a maximum of 24 months. This programme is aimed at bringing about a change in behaviour in order to achieve and maintain a healthy lifestyle. You will get advice on a healthy diet, healthy eating habits and exercise.

Your reimbursement
- You are younger than 18: reimbursement of 100 percent maximum of 3.5 years, 0 for integrated care approach to childhood overweight and obesity.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You are overweight or obese.
    It involves at least a moderately increased weight-related health risk based on the multidisciplinary guideline: Overweight and obesity in adults and children. If your case involves a slightly increased weight-related health risk, the municipality will reimburse the healthcare.

Terms and conditions

- There must be an action plan that includes a combined lifestyle intervention programme
- If you turn 18 while in the programme, you may complete the programme.
- In the event of no entitlement to reimbursement of the costs of this healthcare, you 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 need permission from us if the healthcare is suspended and restarted later

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare

- Central healthcare provider for the intake interview, coordination, guidance and follow-up care
  This is a youth healthcare nurse with a degree from a university of applied sciences, who is registered in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG), and who is trained as a central healthcare provider. The training has been provided through the Netherlands School of Public & Occupational Health (NSPOH) or the Your Coach Next Door (YCND) Foundation. 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
  This coach is registered with the professional association of lifestyle coaches in the Netherlands (‘Beroepsvereniging Leefstijlcoaches Nederland’, BLCN) and has completed additional training as a child lifestyle coach provided by the Your Coach Next Door (YCND) foundation. Our website tells you which healthcare providers you can visit. You can also contact us for this information.
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed

- The switch to a combined lifestyle intervention programme for adults if you turn 18 during the combined lifestyle intervention programme
- A follow-up combined lifestyle intervention programme for adults after the combined lifestyle intervention programme for children
- Exercise or sport (or guidance during this)

- Dietetics at the same time as a combined lifestyle intervention programme for the same indication

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Hulpmiddelen

What you are insured for under your general insurance policy

Medical aids (clause B.17.)

Insured healthcare
- Medical aids

Your reimbursement
- For medical aids: the medical aids and reimbursement conditions are specified in our Medical aid regulations. These regulations are part of your insurance policy and are available on our website or on request from us. for medical aids.

- 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: 70% of your invoice up to 70% 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]({0}).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 stays in a facility
  - to promote recovery and facilitate a return home. It does not concern specialist medical healthcare but primary medical healthcare under the responsibility of a general practitioner, geriatric specialist or doctor for the mentally disabled, or - can be called palliative care in the final stage of your life. You can use this care if your attending doctor has established that your life expectancy is three months or under. Short-term stays in a facility consist of: - round-the-clock nursing and other care; - medical care; - psychological healthcare relating to the medical grounds for this short-term stay; - physiotherapy, Mensendieck/Cesar exercise therapy, speech and language therapy, dietetics and occupational therapy relating to the medical grounds for this short-term stay.

Your reimbursement
- You are 18 years old or above: reimbursement of 3 months maximum, 18, extension is possible if the goal is justified in a care plan for short-term stays in a facility.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - A stay in a facility is medically necessary and healthcare at home is not safe or not a responsible option.
    This may be because your condition is not stable or because observation is needed before the diagnosis is clear.

Terms and conditions

- We reimburse medicines and dietary preparations during this stay in accordance with the 'Medicines' and 'Dietary preparations' clauses
- We reimburse medical care (including diagnostics) provided by the general practitioner as per the 'General practitioner' clause

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). You can also receive the healthcare under the responsibility of a general practitioner.
- Geriatric specialist.

Where the treatment takes place

- A facility offering nursing and personal care that complies with 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)
  - If you receive healthcare at home based on a medical indication for care under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) through a full home care package (VPT), a modular home care package (MPT) or a Personal Care Budget ('Persoonsgebonden Budget', PGB), or if you receive your care in a form of clustered accommodation. In these cases, the stay is paid for under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz) - If it concerns respite care. Respite care is temporary and full substitute care to allow the regular carer to take a break. This is paid for under the Dutch Social Support Act ('Wet maatschappelijke ondersteuning', Wmo); - If you are younger than 18 years and need mental healthcare. This comes under the Dutch Youth Act ('Jeugdwet'). For more information on medicines linked to sensitive personal information, please contact your municipal authority.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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
  There are medical grounds for the speech and language therapy and it helps with speech or voice problems. This concerns restoring or improving the function of your voice or speech.

Your reimbursement

- Reimbursement of 100 percent 18 for speech and language therapy.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- Your healthcare provider is affiliated with ParkinsonNet if you have Parkinson's disease
- Group sessions are an option as long as the group does not have more than 10 participants
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from

- If you will be treated by a non-contracted healthcare provider, you will need a referral before the treatment can start
  The referral needs 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.
- You always need a referral if it is necessary for you to receive treatment at home
- These healthcare providers may make the referral:
  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 permission 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]({0}).

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').

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

- Screening, intake or diagnosis without the intention to treat
  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.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Medicines

What you are insured for under your general insurance policy

Medicines (clause B.15.)

Insured healthcare

- Medicines included under the Medicines Reimbursement System (GVS)
  The Medicines Reimbursement System (GVS) is the statutory list of medicines that health insurers must adhere to. The Medicines Reimbursement System (GVS) specifies: - whether your medicine is reimbursed - what conditions apply - whether you will be charged a personal contribution. You can find the Medicines Reimbursement System (GVS) in appendices 1 and 2 of the Dutch Health Insurance Regulations (‘Regeling zorgverzekering’). Preferred medicines Appendix 1A of the Dutch Health Insurance Regulations (‘Regeling zorgverzekering’) lists multiple medicines with the same active ingredient, dosage and effect. From these medicines, we select one as the preferred medicine. Go to our website to check whether your medicine is a preferred medicine. If your medicine has been designated as the preferred medicine, the pharmacy will dispense this medicine to you and you will be reimbursed for only the preferred medicine. You will only be given a different medicine with the same active ingredient if: - the preferred medicine is temporarily not available. The pharmacy will then dispense an equivalent medicine. - the preferred medicine is not medically suitable for you. Your doctor specifies the medical necessity and this is verified by the pharmacist.
- Medicines prepared by the pharmacy (pharmaceutical compounding)
  In some cases, the pharmacy will prepare a medicine for you. You will receive reimbursement for such a medicine if: - the medicine is medically necessary for you; - there is no suitable registered medicine; - the treatment has been proven to be effective, suitable and the most economical option (rational pharmacotherapy). You can read more about this in Article 2.8, clause 1, paragraph b of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’).
- Medicines from foreign countries
  In highly exceptional cases, you will be reimbursed for a medicine that the pharmacist has imported. You will receive reimbursement for this if: - the medicine is needed for a rare condition and - the condition cannot be treated using a medicine registered in the Netherlands or a compounded medicine. You cannot collect medicines abroad yourself.
- Pharmacy services and guidance
  The pharmacy will help make sure you take your medicines safely. You will be reimbursed for the following, among other things: - preparing, checking and dispensing your medicine - guidance on your medicines - instructions on how to take your medicines - additional guidance in case of, for example, asthma, COPD or complex medication.

Your reimbursement

- Reimbursement of 100 percent 250 for medicines.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- If you are aged 18 or older, you will be charged the deductible for:
  - medicines; - compounded medicines; - imported medicines; - pharmacy services. Your deductible does not apply to the following: - preferred medicines; -quit smoking aids.
- The quantity of medicines you will receive each time depends on the kind of medicine:
  - 15 days: start of new medication or antibiotics - 30 days: sleeping pills and certain strong painkillers - 3 months: chronic medication - 12 months: contraceptive pill and insulin In some cases, the pharmacy may decide otherwise, such as in case of medical necessity, medicines dispensed in a medicine pouch roll, or for medicines costing more than € 1000,- per month.

Who to get a referral from
- Doctor
- Medical specialist
- Clinical nurse specialist
- Obstetrician
- Physician assistant

Do you need approval?
- You will first need a doctor's statement or permission for the following:
  - imported medicines - some medicines listed in Appendix 2 to the Medicines Reimbursement System (GVS) - some medicines prepared by a pharmacy.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- You can go to any pharmacy. Use our 'Zorgvinder' tool to see if your pharmacy has a contract with us, because this affects your reimbursement

What is not reimbursed
- You will not be reimbursed for the following:
  - medicines not or no longer included in the Medicines Reimbursement System (GVS) - over-the-counter medicine - cosmetic products - additional costs, e.g. administrative, import and/or delivery costs.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 a digital application that we have designated. We have selected 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 this reveals a high risk, you will receive medical advice.

Your reimbursement
- You are 18 years old or above: reimbursement of 100 percent 0 for skinVision.

- 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: 70% of your invoice up to 70% 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]({0}).

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]({0}).

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 and of the DBC healthcare product; - laboratory tests; - nursing; - second opinion.
- Admission for specialist medical healthcare
  This concerns the following healthcare: - admission in the lowest nursing care category of a hospital or a facility for specialist medical healthcare.

Your reimbursement
- For specialist medical healthcare: 100 percent 18; and
- For admission for specialist medical healthcare: 100 percent 18, maximum of 3 years (1095 days).

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions for specialist medical healthcare (clause B.4.3.)

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
- Clinical nurse specialist
- Physician assistant
- Sports doctor
- Youth healthcare doctor

- Company doctor
- 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.
- Forensic doctor

Do you need approval?
- In certain situations, your medical specialist must request our prior permission for add-on medicines and coagulation factors.
  Add-on medicines are expensive medicines that the hospital may bill separately from the treatment (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]({0}).

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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]({0}).

Terms and conditions for admission for specialist medical healthcare (clause B.4.2.)

Terms and conditions
- In determining the number of days of admission, the following applies:
  - 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. - admission is interrupted for more than 30 days: we start counting again from the beginning and you are again entitled to healthcare (or reimbursement of the costs of such) for the total number of days of admission. - 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 country outside the Netherlands
  A facility for specialist medical healthcare in a country outside the Netherlands can have two or more categories of nursing care or other 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 certain situations, your medical specialist must request our prior permission for add-on medicines and coagulation factors.
  Add-on medicines are expensive medicines that the hospital may bill separately from the treatment (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]({0}).

Where to go for this healthcare
- Hospital or independent treatment centre (ZBC).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Plastic surgery (clause B.4.5.)

Insured healthcare
- Plastic surgery
  This is specialist medical healthcare involving treatment of a cosmetic surgery nature. Plus laboratory tests, medicines, medical aids and dressings that are part of the treatment.

Your reimbursement
- Reimbursement of 100 percent 18 for plastic surgery.

- 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: 70% of your invoice up to 70% 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]({0}).

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.
    -- For example: Your abdominal skin covers at least a quarter of the length of your upper leg or causes untreatable intertrigo. -- For example: You need a breast reduction. This applies in case of you having cup size D and being under 1.60m in height. Or in case of cup size DD/E or larger. You have demonstrable physical problems that other treatments have not resolved. Your weight is stable and your BMI is under 30.
  - You have a severe disfigurement. This was caused by a disease, accident or medical treatment.
    -- For example: There is disfigurement resulting from burns, or amputated legs, arms or breasts. -- For example: Your breast prosthesis has to be removed due to demonstrable leakage (we will then only reimburse the removal, not the insertion of a new prosthesis). -- For example: Agenesis/aplasia of the breasts (failure of the breasts to develop) in women. In a similar situation, this also applies to transgender women. The healthcare includes surgical insertion or replacement of breast prostheses.
  - 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 been diagnosed with gender incongruence and require correction of primary sexual characteristics as a result.
  - A healthcare provider who participates in a transgender network establishes the gender incongruence.
  - You have a congenital disfigurement of the facial bones, such as cleft lip, jaw or palate. Or you have uncontrolled growth of blood vessels, lymphatic vessels or connective tissue, birthmarks, or disfigurement of the urinary tract and genitalia.
    -- For example: You need laser treatment of the skin because of a visible disfigurement or a demonstrable disorder of physical function. Most disfigurements do not meet these criteria. -- For example: You need an internal nasal valve correction because the passage in your nose is very limited and this cannot be resolved in any other way.

Terms and conditions
- The healthcare provider goes by the ‘VAV Werkwijzer’ (Manual published by the Dutch Association of Public Health Doctors (‘Vereniging Artsen Volksgezondheid’)) for all plastic surgery procedures
  You can find the manual under ‘Werkwijzers VAGZ/VAV’ on the website of the Dutch Association of Public Health Doctors (‘Vereniging Artsen Volksgezondheid’).
- Insurance eligibility
  For all plastic surgery procedures, we assess insurance eligibility based on the ‘VAV Werkwijzer’ (Manual published by the Dutch Association of Public Health Doctors [‘Vereniging Artsen Volksgezondheid’, VAV]). For a clear patient version, see under ‘Werkwijzers VAGZ/VAV’ on the website of the Dutch Association of Public Health Doctors (‘Vereniging Artsen Volksgezondheid’). Note: we will assess insurance eligibility based on your general insurance policy. This is because not all treatments deemed necessary by a doctor are covered under the general insurance policy. Mental health issues due to your condition, for example, do not make you eligible for insurance coverage for plastic surgery.

Who to get a referral from
- General practitioner
- Doctor for the mentally disabled
- Geriatric specialist
- Medical specialist
- Clinical nurse specialist
- Physician assistant
- Youth healthcare doctor
- Company doctor

Do you need approval?
- You need permission from us for any treatment that appears on the latest national list of procedures requiring prior permission (‘Limitatieve lijst machtigingen medisch specialistische zorg ZN’). See our website for details.
- The contracted healthcare provider will determine whether or not your indication satisfies the provisions of the Dutch Health Insurance Act (‘Zorgverzekeringswet’). Permission from us will then not be required
  A list of these healthcare providers is available on our website. Permission from us is required for non-contracted healthcare providers.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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.
- Photos for the permission request

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Specialist medical rehabilitation (clause B.4.6.1.)

Insured healthcare

- Specialist medical rehabilitation
  Specialist medical rehabilitation ('rehabilitation') is intended to ensure that you are able to function as normally as possible with your impairments. Rehabilitation prevents problems in activities of daily living. It improves your ability to participate in society. When it comes to rehabilitation, we distinguish between: - general rehabilitation: a rehabilitation doctor examines you and gives advice as to what would be the most appropriate course of treatment. - interdisciplinary rehabilitation: a team of different healthcare providers works closely together to achieve your treatment goals. This kind of rehabilitation consists of healthcare of a specialist medical, allied health and behavioural science nature. Rehabilitation is provided in the form of: - part-time treatment or outpatient treatment or - admission if there is proof that this will deliver better results than treatment without admission or if you cannot stay at your home (yet) due to your complex health situation.

Your reimbursement

- Reimbursement of 100 percent 18 for specialist medical rehabilitation.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You have complex, interrelated problems with mobility (movement), feeling, intellectual capacity, speech, language and/or behaviour.
    Your impairments are the result of an accident, operation or serious disease and are caused by: - a disorder of the musculoskeletal system, such as after an amputation, causing you mobility problems; - a neurological disorder, such as after a stroke, causing you mobility problems. If the neurological disorder developed at an older age, it may also be a cognitive impairment involving symptoms such as difficulty thinking and remembering things, or problems with speaking or swallowing; - another condition, problem or disorder causing you mobility problems, such as after severe burns.

Terms and conditions

- The rehabilitation doctor determines whether specialist medical rehabilitation is the right healthcare for you
  This is subject to criteria based on which medical grounds are determined and the stepped care approach, which are specified in Sections 2 and 3 of the Position Document 'Specialist medical rehabilitation: healthcare that rehabilitation doctors usually provide' published by 'Zorginstituut Nederland' in 2023.
- Simple forms of healthcare, such as physiotherapy, do not suffice for you

Who to get a referral from

- General practitioner
- Doctor for the mentally disabled
- Geriatric specialist
- Medical specialist
- Clinical nurse specialist
- Physician assistant
- Sports doctor
- Company doctor

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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if the healthcare is provided by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare

- For general rehabilitation: healthcare provided by a rehabilitation doctor at a hospital or a rehabilitation centre
  Rehabilitation centre: a facility for specialist medical healthcare that specialises in interdisciplinary specialist medical rehabilitation, where at least two rehabilitation doctors work and that is permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza).
- For interdisciplinary rehabilitation: healthcare provided by an interdisciplinarily collaborating team working under the ultimate responsibility of the rehabilitation doctor at a hospital or rehabilitation centre
  Rehabilitation centre: a facility for specialist medical healthcare that specialises in interdisciplinary specialist medical rehabilitation, where at least two rehabilitation doctors work and that is permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Geriatric rehabilitation (clause B.4.6.2.)

Insured healthcare

- Geriatric rehabilitation
  Geriatric rehabilitation comprises integrated, multidisciplinary rehabilitation healthcare This healthcare helps you function better. This way, you can participate in society again.

Your reimbursement

- Reimbursement of 100 percent 18 for geriatric rehabilitation.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
  - You are vulnerable and have several chronic illnesses that lead to complex health problems.
  - Your health changes suddenly.
    You are, for example, suddenly unable to function properly independently or unable to move properly due to a medical problem.

Terms and conditions

- You were not immediately admitted for the geriatric rehabilitation and you were being treated at a facility providing care under the Dutch Long-Term Care Act (‘Wet langdurige Zorg’, Wlz)
  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).

- You have had a geriatric assessment by a geriatric specialist, geriatric internist, or a clinical geriatrician.
  This assessment must establish that you are part of the target group for geriatric rehabilitation
  The assessment is carried out by a geriatric specialist, geriatric internist, or a clinical geriatrician.
- After the assessment, the geriatric specialist at the geriatric facility will assess whether you are eligible for geriatric rehabilitation
  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
- General practitioner
- Physician assistant
- Clinical nurse specialist

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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission is required, however, if the healthcare is provided by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare
- Facility for geriatric rehabilitation permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)
  In this facility, an interdisciplinary team works intensively together on your rehabilitation goals under the responsibility of the geriatric specialist.

What is not reimbursed
- Geriatric rehabilitation in case of a chronic progressive degenerative condition. This comes with a gradual deterioration of your functioning. The aim is to maintain your functioning
  This healthcare comes under the ‘Medical care for specific patient groups’ clause.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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; and - testing, removal, storage and transport of the organ(s)/tissue to be transplanted in connection with the transplant.

Your reimbursement
- Reimbursement of 100 percent 18 for organ transplant, healthcare for the recipient.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- The indication is for the form of transplant in question, in accordance with the latest practical and theoretical standards
- The organ and tissue transplants may be performed in:
  - a European Union member state; or - a state that is party to the Agreement on the European Economic Area (EEA). - If your donor is your spouse, registered partner or a 1st, 2nd or 3rd degree blood relative and does not live in the EU or EEA, the transplant may also be performed in your donor's country of residence.

Who to get a referral from
- Medical specialist
- Nurse
- Physician assistant

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

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]({0}).

Healthcare for the donor in a liver transplant (clause B.4.7.2.)

Insured healthcare
- Healthcare for the donor in a liver transplant
  Healthcare for the liver donor (i.e. the person donating a liver to the recipient) concerns all the following: - admission and specialist medical healthcare in relation to the selection or removal of the liver to be transplanted; - transport (lowest class of public transport) within the Netherlands in relation to the selection and the admission and discharge; - 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 and the transplant is for an insured person who lives in the Netherlands; - costs incurred in relation to the fact that the screening and selection of donors takes place outside the Netherlands. For example, travel costs to and from a facility in the country outside the Netherlands where the screening takes place, costs associated with the selection and transport of blood samples, etc.

Your reimbursement
- Reimbursement of 6 months maximum, after admission, charged to the recipient, 0 for healthcare for the donor in a liver transplant.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Healthcare during the initial period after the donor is admitted is charged to the recipient
  Healthcare for the donor is covered by the organ recipient's insurance. This concerns healthcare that is required as a result of being admitted for the transplant. During the period that this healthcare is being provided, we regard the donor as an insured person under the recipient's insurance. If the donor has their 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.
- After the reimbursement period, the costs will be charged to the person receiving the healthcare
- The indication is for the form of transplant in question, in accordance with the latest practical and theoretical standards
- The organ and tissue transplants may be performed in:
  - a European Union member state; or - a state that is party to the Agreement on the European Economic Area (EEA). - If you, as donor, are the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative of the recipient and you do not live in the EU or EEA, the transplant may also be carried out in your country of residence.

Who to get a referral from
- Medical specialist
- Nurse
- Physician assistant

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

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]({0}).

Healthcare for the donor in the case of other organ transplants (clause B.4.7.2.)

Insured healthcare
- Healthcare for the donor in the case of a transplant other than a liver transplant
  Healthcare for the organ donor (i.e. the person who donates an organ or tissue to the recipient) concerns all the following: - admission and specialist medical healthcare in relation to the selection or removal of the organ or tissue to be transplanted; - transport (lowest class of public transport) within the Netherlands in relation to the selection and the admission and discharge; - 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 and the transplant is a kidney or bone marrow transplant for an insured person who lives in the Netherlands; - costs incurred in relation to the fact that the screening and selection of donors takes place outside the Netherlands. For example, travel costs to and from a facility in the country outside the Netherlands where the screening takes place, costs associated with the selection and transport of blood samples, etc.

Your reimbursement
- Reimbursement of 13 weeks maximum, after admission, charged to the recipient, 0 for healthcare for the donor in the case of other organ transplants.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Healthcare during the initial period after the donor is admitted is charged to the recipient
  Healthcare for the donor is covered by the organ recipient's insurance. This concerns healthcare that is required as a result of being admitted for the transplant. During the period that this healthcare is being provided, we regard the donor as an insured person under the recipient's insurance. If the donor has their 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.
- After the reimbursement period, the costs will be charged to the person receiving the healthcare
- The indication is for the form of transplant in question, in accordance with the latest practical and theoretical standards
- The organ and tissue transplants may be performed in:
  - a European Union member state; or - a state that is party to the Agreement on the European Economic Area (EEA). - If you, as donor, are the spouse, registered partner or a 1st, 2nd or 3rd degree blood relative of the recipient and you do not live in the EU or EEA, the transplant may also be carried out in your country of residence.

Who to get a referral from
- Medical specialist
- Nurse
- Physician assistant

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

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]({0}).

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 maximum, per quarter, 18 for the costs of electricity for mechanical ventilation when this is provided in your home.

- 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: 70% of your invoice up to 70% 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]({0}).

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]({0}).

Fertility treatment IVF and ICSI (clause B.4.14.)

Insured healthcare
- IVF/ISCI 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
- You are younger than 43: reimbursement of 3 attempts maximum, 18 for fertility treatment IVF and ICSI.

- 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: 70% of your invoice up to 70% 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]({0}).

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 the 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 the 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 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.
- Fertility treatments other than IVF and ICSI up to and including the age of 42 come under specialist medical healthcare

Who to get a referral from
- General practitioner
- Medical specialist
- Clinical nurse 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide.

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]({0}).

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 performed under general anaesthesia or sedation (e.g. with nitrous oxide).

Your reimbursement

- Reimbursement of 100 percent 18 for oral care in exceptional circumstances.

- 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: 70% of your invoice up to 70% 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]({0}).

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 you receive the healthcare 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 permission from us
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist. We can withdraw our permission 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 given by the healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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’).
- Healthcare provider who is affiliated with a centre for oral care
- Healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
- For treatment performed under general anaesthetic or sedation (e.g. with nitrous oxide): a 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 (e.g. with nitrous oxide): a 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]({0}).

Implant insertion in toothless jaw (clause B.12.2.)

Insured healthcare
- Insertion of a dental implant

Your reimbursement
- Reimbursement of 100 percent 18, A statutory personal contribution applies to the full denture attached to a dental implant for implant insertion in toothless jaw.

- 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: 70% of your invoice up to 70% 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]({0}).

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 you receive the healthcare 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 permission from us for the placement of one or more implants in your upper jaw
  The request for permission 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. Permission from us will then not be required
  Our permission is always required, however, if the treatment is provided by a non-contracted healthcare provider. The request for permission 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]({0}).

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]({0}).

Orthodontic care in exceptional circumstances (clause B.12.3.)

Insured healthcare
- Orthodontic care in exceptional circumstances

Your reimbursement
- Reimbursement of 100 percent 18 for orthodontic care in exceptional circumstances.

- 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: 70% of your invoice up to 70% 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]({0}).

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 where the diagnosis or treatment also requires the involvement of a dental surgeon or other disciplines besides dental care.

Who to get a treatment proposal from
- If you receive the healthcare 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, all of the healthcare providers involved must devise a multidisciplinary treatment plan beforehand.

Do you need approval?
- You need permission from us
  Your request for permission 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]({0}).

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 ('Vereniging Tandartsen voor Orthodontie', VTvO)
- Healthcare provider who is affiliated with 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*, F811B* or F811C*)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Regular oral care up to the age of 18 such as check-ups, tartar removal and fillings (clause B.13.)

Insured healthcare
- Regular check-up
- Incidental dental consultation
- Teeth cleaning: removal of tartar
- Sealing: application of protective enamel to the crests of molars
- Periodontal care: treatment of the teeth's supporting tissue, e.g. the gums
- Fillings: restoration of tooth or molar with plastic material
- New patient intake

Your reimbursement

- You are younger than 18: reimbursement of 100 percent 0 for regular oral care up to the age of 18 such as check-ups, tartar removal and fillings.

- 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: 70% of your invoice up to 70% 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]({0}).

Who to get a treatment proposal from

- If you receive the healthcare 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 permission from us for the types of oral care listed below:
  - for sealing more than 4 elements per year (treatment codes V30, V35); - repeat sealing treatment of the same element within 3 years; - for more than 6 fillings per year (treatment codes V71 to V74, V81 to V84, V91 to V95); - for more than 1 hour of preventive instruction per year (treatment codes M01/M02); and - for more than 30 minutes of dental cleaning per year (treatment code M03).
- You need permission from us for certain oral care
  - If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you need permission 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. - Permission is always required for oral care in a centre for dental care in exceptional circumstances. - Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist. - We can withdraw our permission if one of the following situations occurs: -- if the oral care is no longer necessary; -- if you fail to follow the advice given by the healthcare provider; -- if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with a centre for oral care
- 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.
- Healthcare provider affiliated with a facility for youth dental care
- Healthcare provider working at a particular 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), meaning: - 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, we do reimburse these costs. See clause B.14.e. for the terms and conditions. Implant with crown to replace an incisor or canine.
- Orthodontic care and associated X-ray
  For oral care in exceptional circumstances, we do reimburse this healthcare.
- Gum shields (code M61)
  Except in the case of oral care in exceptional circumstances.
- External whitening (code E97)
- 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]({0}).

Regular and specialist oral care up to the age of 18 (clause B.13.)

Insured healthcare

- Anaesthesia (local anaesthetic)
- Endodontic care: root canal treatment
- Gnathology care: treatment of the temporomandibular joint
- 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

- You are younger than 18: reimbursement of 100 percent 0 for regular and specialist oral care up to 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: 70% of your invoice up to 70% 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]({0}).

Who to get a referral from

- You need a referral from the paediatrician for the cutting or removal of a tongue tie or lip tie (treatment code H41)

Who to get a treatment proposal from

- If you receive the healthcare 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 permission from us for certain oral care
  - If it concerns one of these treatments: -- replacing and/or filling teeth with non-plastic materials; -- inserting 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; -- inserting dental implants for teeth that have not developed in the case of oligodontia, for the purpose of re-establishing the dental function; -- making a panoramic dental X-ray (OPT, indicated by code X21); -- inserting autografts (autologous implants; codes H36, H37*, H38* and H39). The head of the treatment team submits a request for this treatment using the special request form. - If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you also need permission from us if this concerns one of the following treatments: -- extraction of teeth under general anaesthetic or sedation (e.g. nitrous oxide); -- jaw surgery (osteotomy); -- insertion of a dental implant. You can find more information about 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. - Permission is always required for oral care in a centre for dental care in exceptional circumstances. - Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist. We can withdraw our permission if one of the following situations occurs: - if the oral care is no longer necessary; - if you fail to follow the advice given by the healthcare provider; - if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with a centre for oral care
- 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.
- Healthcare provider affiliated with a facility for youth dental care
- Healthcare provider working at a particular 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), meaning: - 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.
- For insertion of autografts (autologous implants), code H36, H37, H38 and H39: a healthcare provider who has followed the specific training programme and has demonstrable specific expertise

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, we do reimburse these costs. See clause B.14.e. for the terms and conditions. Implant with crown to replace an incisor or canine.
- Gum shields (code M61)
  Except in the case of oral care in exceptional circumstances.
- External whitening (code E97)

- 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, we do reimburse this healthcare.
- 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]({0}).

Dentures up to the age of 18 (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
- You are younger than 18: reimbursement of 100 percent 0 for dentures up to 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: 70% of your invoice up to 70% 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]({0}).

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 and need dentures.

Who to get a treatment proposal from
- If you receive the healthcare 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 permission 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 permission from us if this concerns extraction of teeth under general anaesthetic or sedation (e.g. using nitrous oxide); - permission is always required for oral care in a centre for dental care in exceptional circumstances. Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist. We can withdraw the permission if one of the following situations occurs: - if the oral care is no longer necessary; - if you fail to follow the advice given by the healthcare provider; - if you seriously neglect your oral hygiene.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with a centre for oral care
- 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.
- Healthcare provider affiliated with a facility for youth dental care
- Healthcare provider working at a particular 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), meaning: - 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.
  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]({0}).

Dental surgery (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

- You are 18 years old or above: reimbursement of 100 percent 18 for dental surgery.

- 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: 70% of your invoice up to 70% 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]({0}).

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 permission 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 (e.g. nitrous oxide); - jaw surgery (osteotomy);.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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]({0}).

Full dentures for upper and/or lower jaw without implants (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; - 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

- You are 18 years old or above, from 0 euros: reimbursement of 75 percent 18, 25 for full dentures for upper and/or lower jaw without implants.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- In the case of treatment for which you need permission, the entitlement is not higher than the amount for which we have granted permission
- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Repairing and rebasing full dentures (clause B.14.b.)

Insured healthcare

- Repair and filling (rebasing) of full dentures (removable full implant overdentures)

Your reimbursement

- You are 18 years old or above, from 0 euros: reimbursement of 90 percent 18, 10 for repairing and rebasing full dentures.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- This healthcare is subject to a statutory personal contribution that we reimburse 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).
- Healthcare provider who is affiliated with 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]({0}).

Implant-retained lower denture (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

- You are 18 years old or above, from 0 euros: reimbursement of 90 percent 18, 10 for implant-retained lower denture.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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 permission from us for treatment by a non-contracted healthcare provider
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Implant-retained upper denture (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
- You are 18 years old or above, from 0 euros: reimbursement of 92 percent 18, 8 for implant-retained upper denture.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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 permission from us for treatment by a non-contracted healthcare provider
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

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
- You are 18 years old or above, from 0 euros: reimbursement of 90 percent 18, 10 for repair or rebasing of a removable, implant-retained denture.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- This healthcare is subject to a statutory personal contribution that we reimburse under the ‘Statutory personal contribution for dentures’ clause if you have additional insurance cover for this

Who to get a referral from
- Dentist or centre for dental care in exceptional circumstances if a prosthodontist makes the request

Do you need approval?
- You need permission from us in case of treatment by a non-contracted healthcare provider
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Implant with crown to replace an incisor or canine (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
- You are younger than 23: reimbursement of 100 percent 18 for implant with crown to replace an incisor or canine.

- 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: 70% of your invoice up to 70% 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]({0}).

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.
    The need for the treatment was established before you turned 18.
  - 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 permission 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]({0}).

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, we do reimburse this healthcare.
- 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]({0}).

Full dentures for one jaw combined with full implant-retained dentures for the other jaw (clause B.14.d.), associated mesostructure for implant-retained dentures in the lower jaw (clause B.14.d.), associated mesostructure for implant-retained dentures in the upper jaw (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. The healthcare provider claims these costs 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
- You are 18 years old or above, from 0 euros: for full dentures for one jaw combined with full implant-retained dentures for the other jaw: 83 percent 18, 17; and
- You are 18 years old or above, from 0 euros: for associated mesostructure for implant-retained dentures in the lower jaw: 90 percent 18, 10; and
- You are 18 years old or above, from 0 euros: for associated mesostructure for implant-retained dentures in the upper jaw: 92 percent 18, 8.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions for full dentures for one jaw combined with full implant-retained dentures for the other jaw (clause B.14.d.)

Terms and conditions
- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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 permission from us for treatment by a non-contracted healthcare provider
- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Terms and conditions for associated mesostructure for implant-retained dentures in the lower jaw (clause B.14.d.)

Terms and conditions
- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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 permission from us for treatment by a non-contracted healthcare provider
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist.
- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Terms and conditions for associated mesostructure for implant-retained dentures in the upper jaw (clause B.14.d.)

Terms and conditions
- This healthcare is subject to a statutory personal contribution that we reimburse 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 permission from us for a replacement within 5 years
  If the full upper and/or lower denture are replaced within 5 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 permission from us for treatment by a non-contracted healthcare provider
  Your request for permission must be supported by a treatment plan and a written statement of the reasons from your dentist.

- A contracted healthcare provider will request our permission if that is required

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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).
- Healthcare provider who is affiliated with 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]({0}).

Prevention

What you are insured for under your general insurance policy

Quit smoking programme (clause B.21.2.)

Insured healthcare
- Quit smoking programme
  A quit smoking programme 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 3 programmes maximum, per year, 0, 0 for quit smoking programme.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- If medicines or nicotine substitutes (pharmacotherapy) are required, the healthcare provider must use them 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.
- We do not reimburse medicines that are listed in the Medicines Reimbursement System (GVS) 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 your general practitioner prescribes the pharmacotherapy for the quit smoking coaching, 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.
  A general practitioner will provide the healthcare or take on responsibility for it. 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 the medical specialist has delegated tasks relating to their own 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.
- Contracted quit smoking supplier for the provision of medicines or nicotine substitutes.
  It is likely that your local pharmacy is not contracted for the quit smoking pharmacotherapy. Please see our website to find out which suppliers we have contracted. Simply enter ‘Stoppen met roken’ in the search box.
- Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport

What you are insured for under your general insurance policy

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 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases) or a guide/assistance dog.

- Patient transport by taxi
  This type of healthcare includes: - patient transport by taxi over a distance of no more than 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases), 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 200km for a one-way journey; - transport of an escort (2 escorts in exceptional cases), 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 0,43 euros maximum, per kilometre, 140, 18 for transport by car and From 0 euros: reimbursement of 100 percent 140, 18 for transport by taxi and From 0 euros: reimbursement of 100 percent 140, 18 for transport by public transport (2nd class) and From 0 euros: reimbursement of 100 percent 140, 18 for transport by other means of transport.
  2. Reimbursement of 97 euros maximum, per night, 18 for accommodation costs.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions for transport by car (clause B.18.2.)

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You receive kidney dialysis.
    This also includes all the required consultations, tests and check-ups.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes all the required consultations, tests and check-ups.
  - You are only able to get around in a wheelchair.
    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 receive geriatric rehabilitation healthcare.
    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.
    You receive the day treatment 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 the hardship clause: 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 an outbound and return journey to and from:
    - a healthcare provider or a facility where you receive treatment or nursing care; - your officially registered home address or another residence if you will not be able to receive the care you need at your officially registered home address. This also applies to patient transport during a temporary stay in a country outside the Netherlands 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 where 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 medically necessary, or the insured person who needs to be escorted must be younger than 16
- We use Routenet for calculating the distance of the journey
  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 healthcare; - 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 Zvw facility or healthcare provider in order to receive specialist medical care on an outpatient basis. 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 not subject to a personal contribution either; - you have been admitted to a facility providing care under the Dutch Long-Term Care Act (‘Wet langdurige Zorg, Wlz) and you need transport to another facility or healthcare provider for dental treatment under 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 permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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 concerns transport from your place of accommodation to the place where you are being treated or cared for and back to your place of accommodation.
- 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. We do reimburse the costs of the first trip to the healthcare facility from home and the return trip home, however.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for transport by taxi (clause B.18.2.)

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You receive kidney dialysis.
    This also includes all the required consultations, tests and check-ups.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes all the required consultations, tests and check-ups.
  - You are only able to get around in a wheelchair.
    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 receive geriatric rehabilitation healthcare.
    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.
    You receive the day treatment 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 the hardship clause: 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 an outbound and return journey to and from:
  - a healthcare provider or a facility where you receive treatment or nursing care; - your officially registered home address or another residence if you will not be able to receive the care you need at your officially registered home address. This also applies to patient transport during a temporary stay in a country outside the Netherlands 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 where 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
- For reasons of efficiency, the taxi may transport several insured persons at the same time.

- In the event of the patient being escorted, transport of the escort must be medically necessary, or the insured person who needs to be escorted must be younger than 16
- 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 healthcare; - 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 Zvw facility or healthcare provider in order to receive specialist medical care on an outpatient basis. 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 not subject to a personal contribution either; - you have been admitted to a facility providing care under the Dutch Long-Term Care Act (‘Wet langdurige Zorg, Wlz) and you need transport to another facility or healthcare provider for dental treatment under 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 permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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 concerns transport from your place of accommodation to the place where you are being treated or cared for and back to your place of accommodation.
- 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. We do reimburse the costs of the first trip to the healthcare facility from home and the return trip home, however.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for transport by public transport (2nd class) (clause B.18.2.)

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You receive kidney dialysis.
    This also includes all the required consultations, tests and check-ups.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes all the required consultations, tests and check-ups.
  - You are only able to get around in a wheelchair.
    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 receive geriatric rehabilitation healthcare.
  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.
  You receive the day treatment 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 the hardship clause: 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 an outbound and return journey to and from:
  - a healthcare provider or a facility where you receive treatment or nursing care; - your officially registered home address or another residence if you will not be able to receive the care you need at your officially registered home address. This also applies to patient transport during a temporary stay in a country outside the Netherlands 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 where 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 medically necessary, or the insured person who needs to be escorted must be younger than 16
- 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 healthcare; - 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 Zvw facility or healthcare provider in order to receive specialist medical care on an outpatient basis. 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 not subject to a personal contribution either; - you have been admitted to a facility providing care under the Dutch Long-Term Care Act (‘Wet langdurige Zorg, Wlz) and you need transport to another facility or healthcare provider for dental treatment under 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 permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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 concerns transport from your place of accommodation to the place where you are being treated or cared for and back to your place of accommodation.
- 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. We do reimburse the costs of the first trip to the healthcare facility from home and the return trip home, however.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for transport by other means of transport (clause B.18.2.)

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
  - You receive kidney dialysis.
    This also includes all the required consultations, tests and check-ups.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes all the required consultations, tests and check-ups.
  - You are only able to get around in a wheelchair.
    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 receive geriatric rehabilitation healthcare.
    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.
    You receive the day treatment 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 the hardship clause: 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 an outbound and return journey to and from:
  - a healthcare provider or a facility where you receive treatment or nursing care; - your officially registered home address or another residence if you will not be able to receive the care you need at your officially registered home address. This also applies to patient transport during a temporary stay in a country outside the Netherlands 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 where 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 medically necessary, or the insured person who needs to be escorted must be younger than 16
- 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 healthcare; - 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 Zvw facility or healthcare provider in order to receive specialist medical care on an outpatient basis. 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 not subject to a personal contribution either; - you have been admitted to a facility providing care under the Dutch Long-Term Care Act (‘Wet langdurige Zorg, Wlz) and you need transport to another facility or healthcare provider for dental treatment under 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 permission from us

For the approval, see the attached General terms and conditions, section [Approval]({0}).

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 concerns transport from your place of accommodation to the place where you are being treated or cared for and back to your place of accommodation.
- 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. We do reimburse the costs of the first trip to the healthcare facility from home and the return trip home, however.

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Terms and conditions for accommodation costs (clause B.18.2.)

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You receive kidney dialysis.
    This also includes all the required consultations, tests and check-ups.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes all the required consultations, tests and check-ups.
  - You are only able to get around in a wheelchair.
    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 receive geriatric rehabilitation healthcare.
  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.
- ○ You receive day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
  You receive the day treatment in a group in accordance with the 'Medical care for specific patient groups' clause.
- ○ 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 the hardship clause: 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 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]({0}).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Transport by ambulance (clause B.18.1.)

Insured healthcare

- Transport by ambulance
  This concerns the following healthcare: - ambulance transport, as referred to in Article 1(1) of the Dutch Ambulance Facilities and Services Act ('Wet ambulancevoorzieningen'), over a maximum distance of 200km for a one-way journey; - 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 percent 18 for transport by ambulance.

- 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: 70% of your invoice up to 70% 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]({0}).

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 (‘Regionale Ambulancevoorziening’, RAV)
  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 permission from us if you travel 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]({0}).

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]({0}).

Foot care

What you are insured for under your general insurance policy

Preventive foot care (clause B.23.)

Insured healthcare
- Preventive foot care
  This applies to: - an annual foot examination to see if you have reduced sensation, reduced blood circulation, a fragile skin or increased pressure on the skin; - periodic, targeted foot examination that includes care for your skin, nails and pressure sores that may lead to ulcers (wounds); - checking the correct fit of shoes, for example, and of other things that may pose a risk; - follow-up appointment and information to improve self-care and wearing the right footwear.

Your reimbursement
- Reimbursement of 100 percent 0, 385 for preventive foot care.

- 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: 70% of your invoice up to 70% 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]({0}).

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You have an increased risk of foot ulcers (a wound through all layers of the skin) or amputation. This is due to one of the following situations: - reduced sensation in your feet; - reduced blood circulation in your feet; - vulnerable skin and pressure sores. This may be caused by rheumatoid arthritis or neuropathy due to chemotherapy; - a previous foot ulcer (open wound) or a previous amputation; - an inactive Charcot arthropathy (Charcot joint); - end-stage kidney failure or kidney dialysis; - diabetes mellitus.

Terms and conditions

- Your complaints and symptoms are the result of a medical condition or medical treatment Zorginstituut Nederland (ZiNl) has described them in: - position document on foot care for diabetes mellitus patients (‘Standpunt voetzorg bij diabetes mellitus’); and - memo clarifying the position on foot care for diabetes mellitus patients (‘Notitie verduidelijking standpunt voetzorg voor mensen met diabetes mellitus’).
- You can also get preventive foot care for type 2 diabetes in the form of multidisciplinary care

Who to get a referral from

- A general practitioner, medical specialist, physician assistant or nursing specialist if you receive the healthcare from a podiatrist or medical pedicurist specialising in foot care in cases of diabetes mellitus If a podiatrist, medical pedicurist or pedicurist with the DV (diabetes) certificate provides the healthcare.

Where to go for this healthcare

- Podiatrist.
  A podiatrist with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- 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
- 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

What is not reimbursed

- Removing calluses for cosmetic or care purposes
- Non-medical foot care. For example, toenail care or cutting nails to prevent ingrown toenails

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

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 and the conditions that apply to this healthcare, we refer you to article 2.2 of the Dutch Health Insurance Regulations (‘Regeling zorgverzekering’). You can find this article under ‘Wet- en regelgeving’ on the overheid.nl website.

Your reimbursement

- Reimbursement of 100 percent 18 for conditional healthcare.

- 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: 70% of your invoice up to 70% 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]({0}).

Where to go for this healthcare

- Healthcare provider who has been selected 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]({0}).

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 percent 0 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: 70% of your invoice up to 70% 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]({0}).

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
  You will receive the nursing and other care during one and the same visit 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 bachelor’s degree from a university of applied sciences) or clinical nurse specialist (level 6 or higher) 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: Verpleging en Verzorging’).
- The nurse 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 providing 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 6’ or higher who is permanently affiliated with the healthcare provider. Whether more than one level-6 nurse needs to be available depends on the nature of the healthcare you receive. You can ask us whether the healthcare provider meets these conditions.

- For certain types of healthcare, you need a specialist nurse
  This nurse has additional knowledge and experience in areas such as complex wound care, stoma care, intravenous drips, diabetes care or palliative care. This ensures you receive healthcare from a healthcare provider who specialises in the relevant area. 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 ('Wet maatschappelijke ondersteuning', 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 that you receive 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 (‘Reglement Zvw-pgb Verpleging en Verzorging’).
- 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 and over is carried out by a nurse who holds at least a bachelor’s degree from a university of applied sciences or by a clinical nurse specialist (level 6 or higher)
  - The nurse (with a bachelor’s degree from a university of applied sciences) or clinical nurse specialist (level 6 or higher) carrying out the care needs assessment and drawing up the treatment proposal demonstrably meets the current conditions for drawing up care needs assessments at a professional level as set out by the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN). - 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 a nurse with a bachelor’s degree from a university of applied sciences or a clinical nurse specialist (level 6 or higher)
  - The nurse (with a bachelor’s degree from a university of applied sciences) or clinical nurse specialist (level 6 or higher) carrying out the care needs assessment and drawing up the treatment proposal demonstrably meets the current conditions for drawing up care needs assessments at a professional level as set out by the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN). - This clinical nurse specialist must have trained as a paediatric nurse and 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. Permission from us will then not be required
  A list of these healthcare providers is available on our website. Our permission 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 permission from us for a reassessment of your care needs
  You can have your care needs reassessed by another nurse. We will only reimburse the costs of this reassessment if we have given you our prior permission for it. 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 and possible permission in the appendix 'Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care' ('Reglement Zvw-pgb: Verpleging en Verzorging'). 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]({0}).

Where to go for this healthcare

- Nurse, level 4 or higher registered in accordance with the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg', Wet BIG).
- Healthcare provider 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').
- When you use funds from a Personal Care Budget to procure healthcare, you may also procure the healthcare from another healthcare provider. For details, see the Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care ('Reglement Zvw-pgb')

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]({0}).

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 care for sensory impairment
  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 care for sensory impairment 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

- For sensory impairment care: 100 percent 18; and
- For sensory impairment care with a stay or admission: 100 percent 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions for sensory impairment care (clause B.25.)

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.
- Healthcare psychologist (on behalf of the remedial education generalist) is ultimately responsible for audiological and communicative healthcare
- Ophthalmologist, healthcare psychologist or clinical physicist bears ultimate responsibility for the visual healthcare provided

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. You will not need a referral if the healthcare you receive is simple rehabilitation provided 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. You will not need a referral if the healthcare you receive is simple rehabilitation provided 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
  The healthcare providers within the multidisciplinary team provide healthcare as set out in, and within the meaning of Article 2.5a of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’). They also meet the requirements and conditions for healthcare for sensory impairment.

Where the treatment takes place

- The treatment may be provided at your home if this is medically necessary and stated in the referral
- Hospital (facility for specialist medical healthcare)
- Independent treatment centre (ZBC).

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]({0}).

Terms and conditions for sensory impairment care with a stay or admission (clause B.25.)

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 permission from us for a stay lasting longer than one year
  Healthcare facilities offering these stays will know whether you qualify for the stay and when permission is required.

For the approval, see the attached General terms and conditions, section [Approval]({0}).

Where to go for this healthcare

- Multidisciplinary team
  The healthcare providers within the multidisciplinary team provide healthcare as set out in, and within the meaning of Article 2.5a of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’). They also meet the requirements and conditions for healthcare for sensory impairment.

Where the treatment takes place

- Facility for persons with sensory impairments

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({0}).

Zwangerschap en baby

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

- Preconception care, midwifery care and preventive care on non-medical grounds
  This concerns the following healthcare: - insertion or removal of IUD/implants and insertion or removal of an Implanon rod; - pre-conception consultation: advice and information at the request of the insured person 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 percent 0, 385, 385 for preconception care, midwifery care and preventive care on non-medical grounds.

- 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: 70% of your invoice up to 70% 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]({0}).

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). You can also receive the healthcare 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]({0}).

Preconception care, midwifery care and preventive care on medical grounds (clause B.5.2.)

Insured healthcare
- Preconception 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; and - insertion or removal of IUD/implants and insertion or removal of an Implanon rod.

Your reimbursement
- Reimbursement of 100 percent 0, 385 for preconception care, midwifery care and preventive care on medical grounds.

- 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: 70% of your invoice up to 70% 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]({0}).

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
- Clinical nurse 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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]({0}).

General routine ultrasound (clause B.5.3.)

Insured healthcare
- General routine ultrasound

Your reimbursement
- Reimbursement of 100 percent 0 for general routine ultrasound.

- 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: 70% of your invoice up to 70% 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]({0}).

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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). You can also receive the healthcare 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]({0}).

Specific diagnostic ultrasound (clause B.5.4.)

Insured healthcare
- Specific diagnostic ultrasound

Your reimbursement
- Reimbursement of 100 percent 0 for specific diagnostic ultrasound.

- 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: 70% of your invoice up to 70% 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]({0}).

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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). You can also receive the healthcare 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]({0}).

Antenatal screening on medical grounds (clause B.5.5.)

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 percent 0, 385 for antenatal screening on medical grounds.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- Your healthcare provider 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).
- 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

- 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). You can also receive the healthcare under the responsibility of a general practitioner.
- 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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).
- 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]({0}).

Midwifery care during a home birth (clause B.5.6.)

Insured healthcare

- Midwifery care during a 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). You receive this healthcare 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 percent 0, 385 for midwifery care during a home birth.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- Both the maximum reimbursement per day and the statutory personal contribution per day are doubled for the mother and the child(ren)
  These amounts 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). You can also receive the healthcare under the responsibility of a general practitioner.
- 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Obstetric care at a hospital or birth centre during childbirth without medical necessity (clause B.5.7.)

Insured healthcare

- Obstetric care at a hospital or birth centre during childbirth without medical necessity
  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). You receive this healthcare 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 percent 0, 385 for obstetric care at a hospital or birth centre during childbirth without medical necessity.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- Childbirth means the end of pregnancy, at any time after week 16
- Both the maximum reimbursement per day and the statutory personal contribution per day are doubled for the mother and the child(ren)
  These amounts will remain the same, regardless of whether the birth involves one child or several children.
- The hospital or birth centre claims the costs of midwifery care and use of the delivery room in one single amount (treatment)

The personal contribution and maximum reimbursement explained

If you give birth in a facility on non-medical grounds: - the reimbursement is 2 x € 169,- per day, for mother and child, meaning the total reimbursement for this childbirth is € 338,-. - however, from this we will deduct, for mother and child, the statutory personal contribution of € 23,50, i.e. a total of € 47,-. - you will therefore receive € 338 - € 47 = a maximum of € 291,- per day from us.

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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). You can also receive the healthcare 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Use of a delivery room at a hospital or birth centre without medical necessity (clause B.5.7.)

Insured healthcare
- Obstetric care at a hospital or birth centre during childbirth without medical necessity
  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). You receive this healthcare 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 169 euros maximum, 6, 0 for use of a delivery room at a hospital or birth centre without medical necessity.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Childbirth means the end of pregnancy, at any time after week 16
- Both the maximum reimbursement per day and the statutory personal contribution per day are doubled for the mother and the child(ren)
  These amounts will remain the same, regardless of whether the birth involves one child or several children.
- The hospital or birth centre claims the costs of midwifery care and use of the delivery room in one single amount (treatment)

The personal contribution and maximum reimbursement explained
If you give birth in a facility on non-medical grounds: - the reimbursement is 2 x € 169,- per day, for mother and child, meaning the total reimbursement for this childbirth is € 338,-. - however, from this we will deduct, for mother and child, the statutory personal contribution of € 23,50, i.e. a total of € 47,-. - you will therefore receive € 338 - € 47 = a maximum of € 291,- per day from us.

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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). You can also receive the healthcare 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Obstetric care at a hospital or birth centre during childbirth where medically necessary (clause B.5.8.)

Insured healthcare

- Obstetric care at a hospital or birth centre during childbirth where medically necessary
  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). You receive this healthcare 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 percent 0, 385 for obstetric care at a hospital or birth centre during childbirth where medically necessary.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- Childbirth means the end of pregnancy, at any time after week 16
- We will deduct the hours you stay in the facility after childbirth on medical grounds from the total number of hours of obstetric care to which you are 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Registration and initial interview for obstetric care (clause B.6.1.)

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 1 time(s) maximum, per pregnancy, 0 for registration and initial interview for obstetric care.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- You arrange the obstetric care yourself. We recommend that you do so from the 12th week of your pregnancy, but no later than in the 16th week.
  If you have any questions or anything is not clear, feel free to contact us.
- 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 intake 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Obstetric care after a home birth (clause B.6.2.)

Insured healthcare
- Obstetric care following childbirth at your home

Your reimbursement
- From 0 euros: reimbursement of 100 percent of the agreed number of hours distributed over a maximum of 6 weeks, 6, 0, 385 for obstetric care after a home birth.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- You arrange the obstetric care yourself. We recommend that you do so from the 12th week of your pregnancy, but no later than in the 16th week.
  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 obstetric nurse will determine, in consultation with the obstetrician, 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 person providing care (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines who receives this care; - 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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Obstetric care at a hospital or birth centre after childbirth without medical necessity (clause B.6.3.)

Insured healthcare

- 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 169 euros of the agreed number of hours distributed over a maximum of 6 weeks, 6, 0, 385 for obstetric care at a hospital or birth centre after childbirth without medical necessity.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions

- You arrange the obstetric care yourself. We recommend that you do so from the 12th week of your pregnancy, but no later than in the 16th week.
  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 obstetric nurse will determine, in consultation with the obstetrician, 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 person providing care (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines who receives this care; - 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.
- Both the maximum reimbursement per day and the statutory personal contribution per day are doubled for the mother and the child(ren)
  These amounts will remain the same, regardless of whether the birth involves one child or several children.

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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - 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]({0}).

Obstetric care at a hospital or birth centre after childbirth where medically necessary (clause B.6.4.)

Insured healthcare
- Obstetric 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 percent 0, 385 for obstetric care at a hospital or birth centre after childbirth where medically necessary.

- 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: 70% of your invoice up to 70% 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]({0}).

Terms and conditions
- The obstetric care is given immediately after childbirth
  The obstetric care is for: - the (biological) mother; - the person providing care (e.g. in the case of adoption or surrogacy). The obstetrician or medical specialist determines who receives this care; - the newborn(s).
- In case of admission or a stay, obstetric care is included in the admission (nursing and other care)
  These hours of obstetric care are subtracted from the number of hours discussed during the intake.
- 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
- Clinical nurse 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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. 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]({0}).

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. We determine the content and scope of your additional insurance package. 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.

Pharmacy/online pharmacy
This is a pharmacist at a physical or online pharmacy 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. Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit.

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.

AGB code
This code is a unique administrative code assigned to healthcare providers in the Netherlands, based on which Vektis identifies the healthcare provider. 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.

Doctor for a sports medicine-related diving examination
A doctor who is certified as a level 1 Medical Examiner of Divers (MED) with the European College of Baromedicine (ECB). For more information, go to the website of the Dutch Association for Diving Medicine (‘Nederlandse Vereniging voor Duikgeneeskunde’)

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).

Company doctor
A doctor listed as a company doctor on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS).

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.

Pelvic physiotherapist
Pelvic physiotherapy is provided by a pelvic physiotherapist. This is a physiotherapist listed as a pelvic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

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(1) of the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz).

Central healthcare provider for the combined lifestyle intervention programme
This is a youth healthcare nurse with a degree from a university of applied sciences, who is registered in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG), and who is trained as a central healthcare provider. The training has been provided through the Netherlands School of Public & Occupational Health (NSPOH) or the Your Coach Next Door (YCND) Foundation.

Centre for dental care in exceptional circumstances
A centre providing 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.

Centre for oral care
A comprehensive dental practice that not only does routine check-ups and fillings but also offers specialist treatments such as implants, dental surgery, orthodontic care, periodontology and oral hygiene. This kind of dental practice offers comprehensive dental care.

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. 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. We settle the bill 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. A hospital can also charge for treatments that are not part of a DBC but are categorised under other healthcare products (‘overige zorgproducten’, OZP). These are, for example, single treatments that are not associated with a course of treatment, such as: - preliminary examinations, follow-up examinations or laboratory tests; - dental surgery; - certain types of expensive healthcare (e.g. healthcare in intensive care, expensive medicines and blood products).

Diagnostics

Determination of the medical cause of the patient’s problem, illness or condition.

Dietician

Your healthcare provider is a dietician with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Sonographer

An individual listed in 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.

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’).

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.

Forensic doctor

A doctor on the forensic medicine register administered by the Royal Dutch Medical Association.

Fraud

Fraud is when you deliberately do or fail to do something with a view to misleading us, with the intention of causing us a loss or giving yourself or someone else an undue advantage.

Physiotherapist

Your healthcare provider is a physiotherapist or specialist physiotherapist listed on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

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.

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.

Geriatric physiotherapist
This is a physiotherapist listed as a geriatric physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Weight management consultant
Qualified and affiliated with the Dutch association of weight management consultants (‘Beroepsvereniging Gewichtsconsulenten Nederland’, BGN).

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’.

‘GGD’ regional healthcare authority doctor
A doctor listed as a doctor of public health (‘Arts maatschappij en gezondheid’), general infectious disease control (‘Arts infectiebestrijding’) or tuberculosis control (‘Arts tuberculosebestrijding’) in the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS) and working at a ‘GGD’ regional healthcare authority.

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

Principal contractor
A principal contractor can be a healthcare group, health centre or podiatrist. They enter into contracts with several healthcare providers, which allows them to provide different forms of healthcare, such as general practitioner care, dietetics or foot care.

Skin therapist
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) at the start of the treatment.

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). You can also receive the healthcare under the responsibility of a general practitioner.

General practitioner for quit smoking interventions

A general practitioner will provide the healthcare or take on responsibility for it. 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.

Drop-in centre for cancer patients and survivors

Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Facility for geriatric rehabilitation permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)

In this facility, an interdisciplinary team works intensively together on your rehabilitation goals under the responsibility of the geriatric specialist.

Youth dental care facility

A specialist organisation with oral care professionals with specific expertise and skills, and facilities for consultation, diagnosis and treatment for patients under the age of 18.

Post-trauma care facility

The facility specialises in post-trauma psychosocial assistance and has been recognised or contracted by us.

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.

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.

Physiotherapist specialising in children

This is a physiotherapist listed as a physiotherapist specialising in children on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Child lifestyle coach for combined lifestyle intervention

This coach must hold a degree from higher professional education and be registered with the professional association of lifestyle coaches in the Netherlands (‘Beroepsvereniging Leefstijlcoaches Nederland’, BLCN) and have completed additional training as a child lifestyle coach provided by the Your Coach Next Door (YCND) foundation.

Cesar or Mensendieck exercise therapist specialising in children

Your healthcare provider is a Cesar or Mensendieck exercise therapist specialising in children with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

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: - qualified to nursing or obstetric nursing level 3 or equivalent;- listed in the Quality Register of Obstetric Nurses (‘Kwaliteitsregister Kraamverzorgenden’) at the Dutch Knowledge Centre for Obstetric Care (‘Kenniscentrum Kraamzorg’, KCKZ) and; - works in accordance with the National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’).

Multidisciplinary care

Multidisciplinary care is 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. Multidisciplinary care has a total healthcare programme tailored to your personal situation and circumstances.

Lactation consultant

Is a member of a professional group for lactation consultants and uses the Lactation Consultant Referral Protocol (‘Verwijzingsprotocol Lactatiekundige’).

Lifestyle coach

The healthcare is provided by a healthcare provider listed as a lifestyle coach on the Quality Register and Accreditation of Healthcare Practitioners (‘Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg’, KABIZ), the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF)/Individual Register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR) or the Dutch Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’, KP). This lifestyle coach works in consultation with and provides feedback to the referring healthcare provider.

Guest house

A non-commercial establishment affiliated with: - a hospital (facility for specialist medical healthcare) in the Netherlands or your country of residence; or - a hospital (facility for specialist medical healthcare) outside your country of residence with which we have concluded a healthcare agreement.

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’).

Month

A calendar month.

Manual therapist

This is a physiotherapist listed as a manual therapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Informal care organisation
Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

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.(2)(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 pedicurist
A medical pedicurist listed as such on the Quality Register for Pedicurists (‘Kwaliteitsregister Pedicure’) or the Register for Allied Health Professionals for Foot Care (‘Register Paramedische Voetzorg’).

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 may delegate the healthcare to other qualified healthcare providers but still remains responsible for the healthcare these others provide. The healthcare is provided in a hospital or independent treatment centre (ZBC).

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 the medical specialist has delegated tasks relating to their own 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.

Medical indication/grounds
The medical condition or illness that a doctor suspects or has diagnosed so that you can access certain healthcare.

Dental hygienist
The dental hygienist manages the practice at their own expense and on their own responsibility.

Oedema therapist
The oedema physiotherapist is a physiotherapist listed as an oedema physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

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’).

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 healthcare 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.

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’).

Podiatrist

A podiatrist with ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Policy (document)

Proof of insurance.

Psychosomatic physiotherapist

This is a physiotherapist who is listed as a psychosomatic physiotherapist on the Individual Physiotherapy Register (‘Individueel Register Fysiotherapie’, IRF) or the individual register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, KFIR).

Psychosomatic exercise therapist

Your healthcare provider is a psychosomatic exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

Registered chiropodist
The healthcare provider who is listed as a registered chiropodist on the quality register of Kabiz (Quality Registration and Accreditation of Healthcare Professionals) or a register designated by us and who has a practice as a registered chiropodist.

Rehabilitation centre
A facility for specialist medical healthcare that specialises in interdisciplinary specialist medical rehabilitation, where at least two rehabilitation doctors work and that is permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza).

Cosmetologist
is registered in the SKIN register. On our website, under the relevant healthcare you can find any other registers we recognise over the course of the year. Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Written/in Writing
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’ platform.

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.

Geriatric specialist
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.

Urgent medical care
Unexpected and unforeseeable acute medical care that you receive in situations where, without immediate intervention, there is a risk of death or irreversible damage to health.

Sports doctor
A doctor listed as a sports doctor on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS) in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG). The doctor works at a sports medicine-related advice centre or sports medicine-related facility; this facility must have been accredited by the Dutch Association for Diving Medicine (‘Nederlandse Vereniging voor Duikgeneeskunde’, NVD).

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).

Prosthodontist
The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

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.

A therapist or doctor who is a member of a professional association for alternative treatment methods or psychosocial care that we recognise
The therapist or doctor must have completed a recognised basic medical studies course (‘MBK’) that meets the training, educational and organisational requirements of PLATO (‘Platform Opleiding, Onderwijs en Organisatie’). Check the ‘Vergoedingen’ section or ‘Zorgvinder’ tool on our website to find out which healthcare providers you can visit for this healthcare.

Home care organisation
An organisation that is able to provide the nursing and care of an insured person in the insured person’s own home.

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 EU member states except the Netherlands; - all states that are party to the Agreement on the European Economic Area (EEA); - Switzerland; - the United Kingdom.

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

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.

Transplant centre that has been recognised by law

University medical centre authorised and recognised by law to perform organ transplants, operating under the Organ Donation Act (‘Wet op de orgaandonatie’) and governed by the Dutch Transplant Foundation (‘Nederlandse Transplantatie Stichting’, NTS).

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. We sometimes refer to these rates as ‘set-point rates’.

Hospital

A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza), meaning: - 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. We do not mean an independent treatment centre (ZBC) in this case.

Independent treatment centre (ZBC)

A facility for specialist medical healthcare, as defined in the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza), but not a fully fledged hospital.

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.

Healthcare provider within a healthcare group

- 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.

Healthcare provider who offers a professional or commercial childbirth course

- the healthcare provider/organisation is registered with the Chamber of Commerce as a professional or an organisation, respectively, that offers and provides childbirth courses; and the healthcare provider/organisation has articles of association and a website where it can be seen that the courses offered are aimed at childbirth preparation.

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 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 Centrale Zorgverzekeringen NZV NV, registered in the Trade Register of the Chamber of Commerce under number 27118912. 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 NZV.

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:
- Polisblad (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’).

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 a digital insurance card as soon as your policy has taken effect. Show this digital card to receive the healthcare for which you are insured. If you would prefer to have a physical card, we can provide you with one on request. The back of the card shows your European Health Insurance Card (EHIC), which is valid in all EU countries. 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’ platform. 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. New technological developments do not constitute grounds to replace a medical aid before the end of the period of use. - 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: -- shows the commencement date of your employment; -- proves 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).

See also:
- Maand (definitions)

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 state that you wish to change your insurance policy. 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.

See also:
- Maand (definitions)

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.

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.

See also:
- Maand (definitions)

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; - the withdrawal is in writing; - the insurance policy you are withdrawing is one you took out recently; - you are withdrawing the insurance 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:
- Verzekeringnemer (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.

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.

See also:
- Maand (definitions)

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:
- Verzekerde (definitions)
- Verzekeringnemer (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 unjustified reimbursements you and healthcare providers have received; - charge you for the costs of the investigation; - report the matter to the police; for more about fraud, see clause A.26. Fraud

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 individual 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. The premium base and discounts for a voluntary deductible are stated in euros on your premium schedule.

See also:
- Polisblad (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 or one 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 last week before the next payment period; -- you will first receive notification from us before we debit the amount due from your account; -- you must make sure you have sufficient funds in your bank account; -- if we cannot debit the total amount in the last week before the next 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:
- Maand (definitions)
- Verzekeringnemer (definitions)

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.

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.

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.

Repaying your debt
Every amount that we receive from you will go towards repaying your debt.

What we will do if you are in arrears on your payments
If you fail to pay your premium and costs on time, we will be authorised to: - suspend your cover under your additional insurance package(s). We will take this step if we are unable to offset your debt against money to which you are still entitled. On the day that all your debts to us have been paid, you will be entitled to cover under your additional insurance package(s) again. - terminate your additional insurance package(s). You will then not have additional insurance any more.

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)
- Maand (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:
- Maand (definitions)
- Verzekeringnemer (definitions)

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.

Repaying your debt on your additional insurance package
Subsequent payments will go towards repaying your debt on additional insurance package(s). 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.

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.

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.

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 € 400,- for a whole year. The Dutch government sets the amount of the compulsory deductible on an annual basis.

See also:
- Jaar (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. See the premium schedule for details of the various deductible options and the associated premiums.

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 2024 can no longer be set off against the deductible if we receive the invoice in 2026. The costs will be set off against the deductible for 2024 if you personally forget to submit the invoice and we only receive it in 2026.

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 Zorgproduct Diagnose Behandel Combinatie (definitions)
- Jaar (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:
- Tarief (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 15 June 2027 and runs through to 31 December. This is a period of 200 days. There are 365 days in this year and the compulsory deductible for the whole year is € 400,-. Your deductible for this part of the year will then be: - € 400,-/ 365 = € 1,095 deductible per day - € 1,095 x 200 days = € 219,18. Rounded to the nearest whole euro, this makes a compulsory deductible of € 219,- for 2027.

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

General insurance voluntary deductible at the age of 18
From age 18, you can opt for a €200 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 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

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:
- Medisch adviseur (definitions)
- Verzekeringnemer (definitions)

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 prior written permission from us may you make arrangements or enter into an agreement.

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, we can: - decide to not pay reimbursements relating to this; - claim back any related reimbursements we have already paid; - terminate your insurance policy. Which of these measures we choose depends on the specifics and circumstances of the case. If you misrepresent a situation, submit false or misleading documents, or provide incorrect information, you may be committing fraud. For details of the consequences, see clause A.26. Fraud.

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 Implementation Act of the General Data Protection Regulation ('Uitvoeringswet Algemene verordening gegevensbescherming') and the General Data Protection Regulation (EU Regulation 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.

Check-ups
We are authorised to verify details 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'). You must cooperate with us fully in this respect.

A.17. Healthcare providers

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 under which they can provide 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.

Responsibilities of a principal contractor
A principal contractor 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. Claims are submitted through: - the principal contractor (e.g. 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.

See also:
- Hoofdaannemer (definitions)

- Ketenzorg (definitions)

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. For example: 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 country outside the Netherlands 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:
- AGB-code (definitions)
- Zorgverlener (definitions)

Going to another healthcare provider for healthcare under your general insurance policy
Our Healthcare Team ('Zorgteam') can help you find another healthcare provider.

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:
- Behandeling (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, i.e. at the practice of the healthcare provider or, if this is indicated for this healthcare, at your home or at your temporary place of residence (where you are temporarily living or staying). This can also be a location concerning 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 permission is required
By ‘permission’ we mean a written statement of permission from our ‘Medische Beoordelingen’ (Medical assessments) department. Certain healthcare is subject to prior permission from us. If so, there will be a notice with the healthcare saying that you have to request permission for it. You must request permission before starting the treatment. We will assess whether you meet the conditions. 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 grant permission, the statement of permission will specify what we will cover and on what terms and conditions.

See also:
- Schriftelijk (definitions)

Permission for healthcare from a contracted healthcare provider
If you use a contracted healthcare provider, the healthcare provider can assess whether or not you will be granted permission for 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. If the healthcare provider is not sure, they will forward the request to us and we will then assess whether or not to grant you permission. You will then not have to provide us with any information yourself.

Statements and promises
Permission is valid only if we have granted it beforehand in writing. 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.

Permission for healthcare from a non-contracted healthcare provider
If you go to a non-contracted healthcare provider, you must personally request prior permission from us in writing. This will be required only if we have stipulated that the healthcare in question is subject to prior permission. 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 cost statement for the treatment and a treatment plan. If we need any further information, we will let you know what information is missing. Please send it 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.

Permission 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. We have selected specific healthcare providers for certain medical aids; you can only go to them in that case. The 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 permission 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 permission 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 or selected healthcare provider, that provider will generally take care of submitting the healthcare request to us for you. 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 permission, referral, or prescription from your previous health insurer will remain valid.

Period of validity of permission
The statement of permission 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 statement of permission. Our statement of permission will cease to be 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 Zorgproduct Diagnose Behandel Combinatie (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 repay the fee charged to us 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 the Dutch tax authorities and, if applicable, by the Generic Claiming Standard (‘Generieke Declaratiestandaard’, GDS). 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 healthcare; -- 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 Zorgproduct Diagnose Behandel Combinatie (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 ‘Mijn’ platform 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:
- Eigen bijdrage (definitions)

Retention of original invoices
When submitting invoices online, in the app, or on the ‘Mijn’ platform, 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 Zorgproduct Diagnose Behandel Combinatie (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 about:
on our rates

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: -- because you need the healthcare urgently; 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.: in case of urgent medical care or after healthcare mediation (see clause A.3.) by us: the bill, but never more than the statutory maximum rate (Rate under the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg' (Wmg) or the market rate applicable in the Netherlands). We will 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:
- Afgesproken tarief (definitions)
- Gedeclareerde tarief (definitions)
- Marktconform tarief (definitions)
- Wettelijk maximum tarief (definitions)
- Wettelijk vast tarief (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 70% 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 4 weeks.

Rates for a Personal Care Budget ('Persoonsgebonden Budget', PGB) under your general insurance policy
The provisions about rates do not apply to district nursing care you receive under 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, we will reimburse you for that as well.

A.21. General exclusions

Here you can read about:
on our general exceptions

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 condition, 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. This is regardless of whether or not you used everything that is included in that healthcare; - 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:
- Behandeling (definitions)

- Buitenland (definitions)
- DBC Zorgproduct Diagnose Behandel Combinatie (definitions)
- Jaar (definitions)
- Spoedeisende zorg (definitions)
- Tarief (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 Terrorismeschaden 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. For more information, see the NHT clause sheet under NHT documents on the NHT website.

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 (or on the SKGZ website). 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.

A.26. Fraude

Fraud and fraud screening
Fraud is when you deliberately do or fail to do something with a view to misleading us, with the intention of causing us a loss or giving yourself or someone else an undue advantage. Fraud may include (attempted) deception, falsification, misleading, concealment, a criminal offence, coercion, threats or infringement against us or a healthcare provider. We are authorised to 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 Incident Warning Systems for Financial Institutions (‘Protocol Incidentenwaarschuwingssystemen Financiële Instellingen’). You are under an obligation to cooperate in a fraud screening. This means, among other things, that you must provide us with correct and complete information when we ask for it. You must also help us obtain all the information we need. If you notice any (potential) irregularities at or fraud committed by a healthcare provider, for example in claims, you must report this to us

See also:
- Fraude (definitions)

Consequences of fraud
Fraud committed by you
If we suspect fraud, we will not pay any invoices relating to the suspected fraud while we investigate. If we find that you have indeed committed fraud, we may take one or several of the following measures: - terminate your insurance policy or policies. You will not receive a refund of the premiums you have paid or any costs, such as debt collection costs and interest; - terminate your entitlement to healthcare or reimbursement for healthcare costs. Any invoices that we had put on hold during the investigation will not be paid after the investigation; - claim back all reimbursements you have received from us that relate to the fraud. This applies to payments we made to you and to healthcare providers; - charge you for the costs of the fraud investigation; - record your details in our internal registration systems and incident register; - record your details in the recognised warning system used by insurers (the External Reference Index (EVR) of the Dutch Central Information System Foundation (‘Stichting CIS’); - report the fraud to the police; - refuse to insure you under any new policy for five years. Fraud committed by a healthcare provider
If a healthcare provider commits fraud, we will record the healthcare provider’s details in our internal registration systems and incident register. We may also register the healthcare provider in the recognised warning system used by insurers. If we decide that we will no longer reimburse healthcare provided by this healthcare provider in the future, we will inform the healthcare provider of our decision. The healthcare provider must inform you of this before providing any healthcare

See also:
- Fraude (definitions)

Appendix Other

Our website contains a number of appendices that are part of your general insurance policy.

These are:
- Medical aid regulations - National Indication Protocol for Obstetric Care (‘Landelijk Indicatieprotocol Kraamzorg’) - Restrictive list of authorisations for dental surgery (‘Limitatieve lijst machtigingen kaakchirurgie’) - Dutch Healthcare Authority’s restrictive list of authorisations for specialist medical healthcare (‘Limitatieve lijst machtigingen medisch specialistische zorg ZN’) - list of preferred medicines (‘Lijst voorkeursgeneesmiddelen’) - Dutch Dental Association’s emergency care guidelines (‘KNMT praktijkrichtlijn opvang spoedgevallen’) - Regulations on personal care budgets