Reimbursements and terms and conditions for 2025

General insurance policy

‘Nationale-Nederlanden Zorgpolis’

Product number: 6400102
Valid from 01-01-2025 to 31-12-2025 (inclusive)
The previous terms and conditions of insurance are hereby superseded.

Inhoudsopgave

Abroad

What you are insured for under your general insurance policy

Healthcare abroad (clause B.2.2.)

Insured healthcare
- Healthcare abroad
  You are insured for the same healthcare and scope as you are insured for in the Netherlands (or the country where you live).

Your reimbursement
- For healthcare abroad: the healthcare provided abroad has the same level and scope for which the healthcare is insured in the Netherlands or your country of residence for healthcare abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- If you opt for reimbursement under the general insurance policy, the healthcare must meet the conditions that apply to healthcare in the Netherlands

Do you need approval?
- You need our approval for all non-urgent medical care that can be scheduled in advance for which approval is also required in the Netherlands.
  You can see whether approval is required in the clause relating to that particular healthcare.
- You need our approval for all non-urgent medical care that can be scheduled in advance and is on the list of healthcare abroad that requires approval (‘Lijst aanvragen zorg buitenland’) (outpatient treatment)
  This list is available on our website.
- You need our approval 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 our approval 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 must comply 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 for dietary preparations.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

Who to get a treatment proposal from
- Medical specialist
- Geriatric specialist
- Doctor for the mentally disabled
- Dietician
- Clinical nurse specialist

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

For the approval, see the attached General terms and conditions, section [Approval]({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 for dietetics.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Who to get a referral from
- If the treatment will be provided by a non-contracted healthcare provider you will need a referral before the treatments starts
  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’).
- Dietician affiliated with ParkinsonNet
  The dietician must have this affiliation if you are receiving care because you have been diagnosed with Parkinson’s disease.

What is not reimbursed
- Dietetics outside multidisciplinary care if you 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 at the same time as a combined lifestyle intervention programme for the same indication
- Dietetics on non-medical grounds, such as dietary advice for weight loss or sports

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

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

Insured healthcare
- Dietetics as part of multidisciplinary care

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Terms and conditions
- The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances
  The healthcare comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre) all working together to provide the required care.
- The treatment may be provided at your home if this is medically necessary and stated in the referral

Who to get a referral from
- If the treatment will be provided by a non-contracted healthcare provider you will need a referral before the treatments starts
  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 who is affiliated with or contracted by a principal contractor.
  The dietician has ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- Dietician who is affiliated with a contracted principal contractor in the case of asthma.
  The dietician has ‘kwaliteitsgeregistreerd’ (quality registered) status on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
- Dietetics as part of multidisciplinary care if you are already receiving dietetics outside multidisciplinary care prescribed on the same medical grounds.
  Also see the ‘Dietetics’ clause.
- 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}).

Occupational therapy

What you are insured for under your general insurance policy

Occupational therapy (clause B.9.)

Insured healthcare
- Occupational therapy
  Occupational therapy includes advice, instruction, training and/or treatment, aimed at helping you achieve, or regain, your independence and ability to look after yourself.

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Who to get a referral from
- If the treatment will be provided by a non-contracted healthcare provider you will need a referral before the treatments starts
  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’).

- Occupational therapist affiliated with ParkinsonNet
  The occupational therapist must have this affiliation if you are receiving care because you have been diagnosed with Parkinson's disease.

Where the treatment takes place
- The 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 for physiotherapy and exercise therapy up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a (temporary) complaint or injury.
    In most cases, physiotherapy relates to a short-term, acute complaint. If you have any doubts, please ask your physiotherapist or exercise therapist or attending doctor.

Terms and conditions
- The number of sessions or the period specified is a maximum. You, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.

- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for whiplash up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- 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 for physiotherapy and/or exercise therapy for whiplash from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for juvenile osteochondrosis up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 for physiotherapy and exercise therapy for juvenile osteochondrosis from 18 to 21 years of age inclusive.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- Deductible applies from the age of 18

Eligibility for this healthcare

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

Terms and conditions

- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- 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 Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- 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 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 for physiotherapy and exercise therapy according to the list of conditions from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy according to the list of conditions up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have had a CVA (cerebrovascular accident).
  - You have a spinal cord condition as a result of a disorder in the nervous system.
  - You have MS (multiple sclerosis).
  - You have peripheral neuropathy with loss of motor function.
  - You have an extrapyramidal condition.
  - You have a congenital defect of the central nervous system.
  - You have a cerebellar condition.
  - You have neurological paralysis symptoms as a result of brain damage or a tumour in the brain or spinal cord.
  - You have a neuromuscular disease as a result of a disorder in the nervous system.
  - You have myasthenia gravis.
  - You have a congenital defect of the musculoskeletal system.
  - You have progressive scoliosis.
  - You have reflex dystrophy.
  - You have a fracture due to bone metastases, Kahler’s disease, or Paget’s disease.

- ○ You have Forestier's disease (hyperostotic spondylosis).
- ○ You have a collagen disease.
- ○ You have had an amputation.
- ○ You have a congenital defect of the respiratory tract.
- ○ You have lymphedema.
- ○ You have scar tissue of the skin after a trauma or otherwise.
- ○ You have diffuse interstitial lung disease with ventilatory defect or diffusion disorder.

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy ('Lijst met aandoeningen voor fysiotherapie en/of oefentherapie'). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for motor retardation or a developmental disorder of the central nervous system up to and including the age of 16.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have motor retardation or a developmental disorder of the central nervous system and are younger than 17 years of age.

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 for physiotherapy and exercise therapy for radicular syndrome with loss of motor function or pelvic instability after childbirth from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have a 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for fractures after conservative treatment from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have had 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for fractures after conservative treatment up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- 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 Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy ('Kwaliteitsregister Fysiotherapie Nederland', KRF) and/or the register of the Dutch Certified Physiotherapy Foundation ('Stichting Keurmerk Fysiotherapie', SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for frozen shoulder (adhesive capsulitis) or peripheral artery disease at Fontaine stage 3 from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - ○ You have a 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy after discharge and return home or termination of day treatment from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You were admitted to a hospital, a nursing facility, a rehabilitation facility or for day treatment at a rehabilitation facility.
    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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

- You need our approval for treatment by 2 or more different healthcare providers for the same indication The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy after discharge and return home or termination of day treatment up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- This healthcare is not subject to the deductible

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - You were admitted to a hospital, a nursing facility, a rehabilitation facility or for day treatment at a rehabilitation facility.
    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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for a soft tissue tumour from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy and exercise therapy for a soft tissue tumour up to and including the age of 17.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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 for physiotherapy and/or exercise therapy (‘Lijst met aandoeningen voor fysiotherapie en/of oefentherapie’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 being diagnosed, physiotherapy is provided by a Cesar/Mensendieck exercise therapist affiliated with ParkinsonNet
  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. This is a physiotherapist listed as a oedema physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A physiotherapist specialising in children provides the physiotherapy for children
  This is a physiotherapist listed as a physiotherapist specialising in children on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- A geriatric physiotherapist provides the geriatric physiotherapy
  This is a physiotherapist listed as a geriatric physiotherapist on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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, once per insured person for pelvic physiotherapy for urinary incontinence from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- The number of sessions or the period specified is a maximum. You, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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. Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy (supervised walking therapy) for intermittent claudication from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  ○ You have intermittent claudication with peripheral artery disease at Fontaine stage 2.

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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. Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the healthcare is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 affiliated with Chronisch Zorgnet and specialising in peripheral arterial disease
  Your physiotherapist is listed as a specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for physiotherapy (supervised exercise therapy) for osteoarthritis in the hip or knee joint from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have osteoarthritis in the hip or knee joint.

Terms and conditions
- 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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. Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.
- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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 Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for exercise therapy for COPD stage II or higher.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have 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, your physiotherapist or exercise therapist and, where applicable, the person who referred you, will 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. Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the healthcare is provided by a non-contracted healthcare provider.

- You need our approval for treatment by 2 or more different healthcare providers for the same indication
  The request must state why this is medically necessary.
- You need our approval 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 affiliated with Chronisch Zorgnet and specialising in lung disease
  Your physiotherapist is listed as a specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- Cesar/Mensendieck exercise therapist who is affiliated with Chronisch Zorgnet and specialises in lung disease
  Your healthcare provider is a Cesar or Mensendieck exercise therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for fall prevention exercise intervention.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a high risk of falling in combination with underlying or additional physical or psychological problems.
    As a result, you need support from a physiotherapist or exercise therapist.

Terms and conditions
- 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 exercise 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
  You will find these programmes and healthcare providers listed on our website; you can also ask us for more information.

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 for long-term exercise therapy for rheumatoid arthritis.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- 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?
- You need our approval from the 40th session in the 1st year and from the 21st session in the following years.

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

Where to go for this healthcare
- Physiotherapist or exercise therapist with training specifically aimed at developing the ability to provide long-term person-oriented active exercise therapy
  Our website tells you which healthcare provider you can go to for this healthcare.

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

Medical mental healthcare

What you are insured for under your general insurance policy

Outpatient mental healthcare (clause B.19.1.)

Insured healthcare
- Medical mental healthcare: psychological, psychotherapeutic and psychiatric healthcare (also in the form of eHealth) on an outpatient basis
  Mental healthcare is medical care and is focused on recovery from or prevention of worsening of a psychological disorder or psychiatric condition. The healthcare provider will determine which mental healthcare you need based on the diagnosed or suspected DSM-5-listed disorder, the severity and problems, the risk, the complexity and the course of the complaints. This concerns the following healthcare: - diagnostics (i.e. identification of a suspected condition) with the intention of starting treatment; - the treatment of a DSM-5-listed disorder. This can be done on an individual basis or in a group setting and can also be provided in the form of eHealth. eHealth is a complete programme of treatment initiated and completed under the responsibility of a healthcare provider.

Your reimbursement
- Reimbursement of 100 percent for outpatient mental healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- Mental healthcare is based on DSM-5, the list of mental healthcare interventions, and the applicable national mental healthcare quality regulations:
  - a psychological disorder is categorised based on DSM-5, a classification system using a common language and standard criteria for specific psychological disorders; - list of mental healthcare interventions (‘Lijst interventies binnen de GGZ’; see our website); - the currently valid national mental healthcare quality regulations (see www.zorginzicht.nl). You will find the positions regarding the insured healthcare (in Dutch) at www.zorginstituutnederland.nl. Go to ‘Zvw Kompas’ and click the link for medical mental healthcare, ‘Geneeskundige Geestelijke Gezondheidszorg (geneeskundige GGZ)’.

- Your healthcare provider has approved, valid mental healthcare quality regulations and acts in accordance with these regulations.
  Your healthcare provider's quality regulations have been assessed against the most recent national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). This states what your mental healthcare provider must have arranged in terms of quality and accountability, this way providing assurance that the right support will be provided at the right place and by the right healthcare provider within a professional, high-quality network. If you have any questions, you can also talk to your healthcare provider; they know about the exclusions, the regulations on mental health reimbursement under the Dutch Health Insurance Act ('Zorgverzekeringswet'), and the positions of the Dutch National Healthcare Institute ('Zorginstituut Nederland'). 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. You can find the healthcare providers at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.
- This must be a mental health facility where 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 (preferably supported by the practice assistant specifically trained for mental healthcare), company doctor, emergency care doctor, medical specialist, coordinating practitioner (if it concerns a referral within the scope of mental healthcare), or a doctor for the homeless
  - you have a referral before the start of treatment. This referral may not be older than 9 months at the start of the treatment. - the referring doctor will ensure an objective and substantiated referral. The referral will therefore specify that the case concerns a diagnosed or suspected DSM-5-listed disorder for which treatment is needed as part of mental healthcare. The following is required for this: -- a diagnostic consultation; and -- preferably also a reliable and valid system (digital resource) that supports the decision. - The objective outcome produced by the decision support system must indicate which level of healthcare is appropriate for your specific healthcare needs. - the objective outcome produced by the decision support system is part of the referral and must be available from both the general practitioner or other referring doctor and the mental healthcare provider. - the referral, the outcome produced by the decision support system, the formulated treatment plan (treatment proposal) and any amendments will all be recorded in your medical file.

Who to get a treatment proposal from

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

Do you need approval?

- You need our approval 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

- The coordinating practitioner (responsible for drawing up the care needs assessment and coordinating) has ultimate responsibility for the healthcare
  The coordinating practitioner (as designated and appointed under the applicable national mental healthcare quality regulations ['Landelijk Kwaliteitsstatuut GGZ']) has ultimate responsibility for making the diagnosis and for the drafting and implementation of the treatment plan. In addition, we endorse the field agreements for mental healthcare that apply at that time. This means that with an independently established healthcare provider, the coordinating practitioner may only be a healthcare psychologist, a psychotherapist, a clinical psychologist, clinical neuropsychologist, or a psychiatrist.
- A treatment started under the Dutch Youth Act ('Jeugdwet') that continues after the age of 18 can continue under the current coordinating practitioner
  This coordinating practitioner is included in the transitional arrangement under the applicable national mental healthcare quality regulations ('Landelijk Kwaliteitsstatuut GGZ'). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.
- Highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare.
  This concerns very serious or uncommon problems or a combination of complaints that are difficult to treat. This healthcare is very specialised and provided in a facility.

Where the treatment takes place

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

What is not reimbursed

- Under no circumstances does mental healthcare include:
  - psychosocial healthcare; - neurofeedback; - 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}).

Inpatient mental healthcare (clause B.19.3.)

Insured healthcare

- Medical mental healthcare: psychological, psychotherapeutic and psychiatric healthcare on a medically necessary inpatient basis
  Mental healthcare is medical care and is focused on recovery from or prevention of worsening of a psychological disorder or psychiatric condition. The healthcare provider will determine which mental healthcare you need based on the diagnosed or suspected DSM-listed disorder, the severity and problems, the risk, the complexity and the course of the complaints. This concerns the following healthcare: - diagnostics (i.e. identification of a suspected condition) with the intention of starting treatment; - the treatment of a DSM-5-listed disorder. This can be done on an individual basis or in a group setting. The healthcare includes psychiatric treatment, associated allied healthcare (such as physiotherapy or occupational therapy), daytime activities, and professional therapy (e.g. music therapy or psychomotor therapy); - nursing and other care, associated medicines, medical aids and dressings.

Your reimbursement
- From the 1st day of admission: reimbursement of 100 percent maximum of 365 days for inpatient mental healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- Mental healthcare is based on DSM-5, the list of mental healthcare interventions, and the applicable national mental healthcare quality regulations:
  - a psychological disorder is categorised based on DSM-5, a classification system using a common language and standard criteria for specific psychological disorders; - list of mental healthcare interventions (‘Lijst interventies binnen de GGZ’; see our website); - the currently valid national mental healthcare quality regulations (see www.zorginzicht.nl). You will find the positions regarding the insured healthcare (in Dutch) at www.zorginstituutnederland.nl. Go to ‘Zvw Kompas’ and click the link for medical mental healthcare, ‘Geneeskundige Geestelijke Gezondheidszorg (geneeskundige GGZ)’.
- Your healthcare provider has approved, valid mental healthcare quality regulations and acts in accordance with these regulations.
  Your healthcare provider’s quality regulations have been assessed against the most recent national mental healthcare quality regulations (‘Landelijk Kwaliteitsstatuut GGZ’). This states what your mental healthcare provider must have arranged in terms of quality and accountability, this way providing assurance that the right support will be provided at the right place and by the right healthcare provider within a professional, high-quality network. If you have any questions, you can also talk to your healthcare provider; they know about the exclusions, the regulations on mental health reimbursement under the Dutch Health Insurance Act (‘Zorgverzekeringswet’), and the positions of the Dutch National Healthcare Institute (‘Zorginstituut Nederland’). 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. You can find the healthcare providers at www.zorginzicht.nl. For salaried qualified staff, like psychologists for example, the facility is responsible for drawing up these quality regulations.
- This must be a mental health facility where the coordinating practitioner drawing up the care needs assessment handles a significant share of the treatment and healthcare process
- For inpatient addiction treatment (‘rehab’), a trial leave for therapeutic purposes must be tailored to your individual needs

Who to get a referral from
- General practitioner (preferably supported by the practice assistant specifically trained for mental healthcare), company doctor, emergency care doctor, medical specialist, coordinating practitioner (if it concerns a referral within the scope of mental healthcare), or a doctor for the homeless

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

Who to get a treatment proposal from

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

Do you need approval?

- A contracted healthcare provider will assess whether your condition is covered under your insured healthcare. Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. However, if the treatment is provided by a non-contracted healthcare provider our approval is required prior to admission.
- You need our approval 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

- The coordinating practitioner (responsible for drawing up the care needs assessment and coordinating) has ultimate responsibility for the healthcare
  The coordinating practitioner (as designated and appointed under the applicable national mental healthcare quality regulations [‘Landelijk Kwaliteitsstatuut GGZ’]) has ultimate responsibility for making the diagnosis and for the drafting and implementation of the treatment plan. In addition, we endorse the field agreements for mental healthcare that apply at that time. This means that with an independently established healthcare provider, the coordinating practitioner may only be a healthcare psychologist, a psychotherapist, a clinical psychologist, clinical neuropsychologist, or a psychiatrist.
- A treatment started under the Dutch Youth Act (‘Jeugdwet’) that continues after the age of 18 can continue under the current coordinating practitioner
  This coordinating practitioner is included in the transitional arrangement under the applicable national mental healthcare quality regulations (‘Landelijk Kwaliteitsstatuut GGZ’). The coordinating practitioner can continue in this role for a maximum of 365 days from the day the insured person turns 18.
- Highly specialised mental healthcare may only be provided by a healthcare provider who has a contract with us for this healthcare.
  This concerns very serious or uncommon problems or a combination of complaints that are difficult to treat. This healthcare is very specialised and provided in a facility.

Where the treatment takes place
- A facility permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)
  This can be a psychiatric ward of a hospital (institution for specialist medical healthcare) if it concerns healthcare under the Dutch Health Insurance Act (‘Zorgverzekeringswet’, Zvw) or it can be a facility for specialist mental healthcare if this concerns healthcare covered by the Dutch Health Insurance Act (Zvw) and/or the Dutch Long-Term Care Act (Wlz).

What is not reimbursed
- Under no circumstances does mental healthcare include:
  - psychosocial healthcare; - neurofeedback; - 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}).

Medical care for specific patient groups

What you are insured for under your general insurance policy

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

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

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

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

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

What is not reimbursed
- Healthcare that comes under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz)

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

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

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

Your reimbursement
- Reimbursement of 100 percent for medical care for specific patient groups by behavioural scientist.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have confirmed or suspected dementia, multiple sclerosis, Parkinson’s disease, intellectual disability, an acquired brain injury.
    or another chronic or complex disease or condition that has an impact on your psychological and cognitive functioning.
  - Your multiple morbidities are often degenerative and progressive in nature.
    You are at a very advanced age with an accumulation of somatic symptoms and, for example, a lack of meaning and purpose.

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

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

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

What is not reimbursed
- Healthcare that comes under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz)

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

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

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

Your reimbursement
- Reimbursement of 100 percent for first-line allied healthcare for specific patient groups.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

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

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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’).
- Occupational therapist.
  Your healthcare provider is an occupational therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- Speech and language therapist.
  Your healthcare provider is a speech and language therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

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

What is not reimbursed
- Healthcare that comes under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz)

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

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

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

Your reimbursement
- Reimbursement of 100 percent for medical care in a group setting for vulnerable patients.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

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

Where to go for this healthcare
- A physiotherapist provides physiotherapy
  Your healthcare provider is a physiotherapist or specialist physiotherapist registered on the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF) and/or the register of the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF).
- 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’).

- Occupational therapist.
  Your healthcare provider is an occupational therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- Speech and language therapist.
  Your healthcare provider is a speech and language therapist with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).
- Dietician.
  Your healthcare provider is a dietician with the status of ‘kwaliteitsgeregistreerd’ (quality registered) on the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’).

What is not reimbursed
- Healthcare that comes under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz)

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

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

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

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

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

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

What is not reimbursed
- Healthcare that comes under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz)

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

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

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

Your reimbursement
- Reimbursement of 100 percent for medical care in a group setting for people with Huntington’s disease.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- All of the following medical indications or situations apply to you:
  - You have Huntington’s disease.
  - You are vulnerable in your home and have complex or highly complex problems.
    You are reasonably dependent on this healthcare because you are increasingly unable to cope and handle matters on your own.

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

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

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

What is not reimbursed

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

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

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

Insured healthcare

- Primary medical healthcare for patients with severely disturbed behaviour and mild intellectual disabilities
  The stepped care approach is used for the provision of this healthcare and comprises:
  - integrated, multidisciplinary diagnosis of behavioural problems;
  - multidisciplinary treatment of the behavioural problems.
    The healthcare is aimed at increasing your competencies, your support system and your professional network with regard to you learning to deal with your impairments in intellectual and adaptive functioning.

Your reimbursement

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- Deductible applies from the age of 18

Eligibility for this healthcare

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

Terms and conditions

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

Who to get a referral from

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

Where to go for this healthcare

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

What is not reimbursed

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

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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: - health advice and preventive healthcare in areas such as quitting smoking (see the ‘Quitting smoking’ clause), problematic alcohol use, depression and being overweight; - treatment; - diagnostic tests carried out by and at the general practice; - request for MRI for indications specified in NHG (‘Nederlands Huisartsen Genootschap’, Dutch College of General Practitioners) guidelines and standards; - pre-conception care to start a pregnancy as healthily as possible; - multidisciplinary care if this relates to: - diabetes mellitus type II (DM Type II) in insured persons 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 for general practitioner care for advice, examination, supervision and multidisciplinary care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

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

Terms and conditions

- In the case of multidisciplinary care, the principal contractor submits the claim
  In accordance with the policy rule of the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) on general practitioner care and multidisciplinary care (‘Huisartsenzorg en multidisciplinaire zorg’) defined on the basis of the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg).
  Definition of multidisciplinary care
  Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances. Consultations may also be provided online if the healthcare programme has made arrangements for such.
- The integrated care is provided in accordance with the healthcare standards that apply for these conditions
  Also see the general ‘Healthcare providers’ clause and the definition of ‘principal contractor’.

Where to go for this healthcare

- General practitioner.
  A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Healthcare provider within the general practice, out-of-hours general practitioner surgery or healthcare group.
  The healthcare provider (such as a practice assistant, nurse, physician assistant) works under the ultimate responsibility of the general practitioner. The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home).
- General practitioner or other healthcare provider in multidisciplinary care.
  - for healthcare in the case of asthma or cardiovascular risk management for increased vascular risk, the healthcare provider is affiliated with a contracted principal contractor; - for healthcare in the case of COPD, DM type II or cardiovascular risk management for cardiovascular disease, the healthcare provider must meet the standards set out in the policy rule of the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) on general practitioner care and multidisciplinary care (‘Huisartsenzorg en multidisciplinaire zorg’). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). Or at the location where the healthcare provider (affiliated with a principal contractor or working in a regional partnership with several healthcare providers of different disciplines) works.

What is not reimbursed

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

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for general practitioner care for medical care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- Consultations and treatments are not subject to the deductible

Where to go for this healthcare

- General practitioner.
  A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for general practitioner care for implanting or removing an IUD or contraceptive implant (e.g. Implanon).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

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

Who to get a referral from

- General practitioner

- Medical specialist

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

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for general practitioner care for cow’s milk allergy and the cow’s milk allergy test.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Consultations and treatments are not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You are suspected to have an allergy to cow’s milk.

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

Who to get a referral from
- General practitioner
- Medical specialist

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

For the approval, see the attached General terms and conditions, section [Approval]({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 (e.g. a Mantoux test)
  This may involve referral, diagnosis, treatment and supervision. A Mantoux test may also be done.

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

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

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

Who to get a referral from
- General practitioner
- Medical specialist

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

What is not reimbursed
- Mantoux test as part of prevention before a trip to a foreign country
  This healthcare is described in the ‘Prevention for travel abroad’ clause.

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

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

Insured healthcare
- General practitioner care for mental healthcare
  - healthcare to treat minor psychological complaints if you do not have (or 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 for general practitioner care for mental healthcare.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

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

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

What is not reimbursed
- Consultations and treatment for a psychological or psychiatric disorder that requires treatment under medical mental healthcare on either an inpatient or outpatient basis
  This healthcare is described in the ‘Medical mental healthcare’ clause; your general practitioner can refer you.
- Treatments for medical pedagogical issues
- Treatment that has an educational aim
- Intelligence test

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for general practitioner care and combined lifestyle intervention from the age of 18.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- This healthcare is not subject to the deductible

Eligibility for this healthcare

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

Terms and conditions

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

Who to get a referral from

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

Do you need approval?

- You only need our permission 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 registered as a lifestyle coach with the professional association of lifestyle coaches in the Netherlands (‘Beroepsvereniging Leefstijl Coaches Nederland’, BLCN), the Dutch Quality Register for Physiotherapy (‘Kwaliteitsregister Fysiotherapie Nederland’, KRF), the Dutch Certified Physiotherapy Foundation (‘Stichting Keurmerk Fysiotherapie’, SKF) or the Dutch Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’). This lifestyle coach works in consultation with and provides feedback to the referring healthcare provider.

What is not reimbursed

- Exercise or sport (or guidance during this)
- Day treatment and/or admission
- 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}).

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

Insured healthcare

- Healthcare and support for overweight and obese children
  The healthcare consists of: - a central healthcare provider taking a general anamnesis, i.e. a medical history compiled by asking the patient or their family members questions to gain insight into various factors that may play a role in becoming or remaining overweight; - following this, if, based on an action plan, a combined lifestyle intervention programme is part of the treatment: -- guidance and coordination under the responsibility of a healthcare provider; -- the central healthcare provider organising a cross-domain multidisciplinary consultation to discuss the goals of the healthcare plan; -- combined lifestyle intervention programme from the age of 2, i.e. a programme with advice and guidance on health and nutrition, healthy eating habits, and health and exercise. The combined lifestyle intervention programme is aimed at bringing about a change in behaviour in order to achieve and maintain a healthy lifestyle.

Your reimbursement

- You are younger than 18: reimbursement of 100 percent maximum of 3.5 years for healthcare and support for overweight and obese children.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- This healthcare is not subject to the deductible

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - This concerns being overweight or obese with at least a moderately increased weight-related health risk according to the guidelines on overweight and obesity in adults and children of the ’Partnerschap Overgewicht Nederland’ (Partnership for overweight Netherlands) network.
    This can be:
  - a BMI of 30kg/m2; or
  - a BMI of 25kg/m2 with an increased risk of cardiovascular conditions and type 2 diabetes mellitus based on the cardiovascular risk, obesity and diabetes healthcare standards; or
  - a BMI of 25kg/m2 and osteoarthritis or sleep apnea.

Terms and conditions

- There must be an action plan that includes a combined lifestyle intervention programme
- If your child turns 18 while in the programme, your child may complete the programme.

- In the event of no entitlement to reimbursement of the costs of this healthcare, your child may possibly be able to turn to your municipality for care and support
- The healthcare forms part of the integrated care approach to childhood overweight and obesity (‘Ketenaanpak voor kinderen met overgewicht en obesitas’)
  The healthcare providers involved make demonstrable collaboration agreements with parties in the social sphere.

Who to get a referral from
- General practitioner
- Paediatrician
- Youth healthcare doctor
- Youth healthcare nurse

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

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

Where to go for this healthcare
- Central healthcare provider for anamnesis, 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 with a higher professional education degree
  This lifestyle coach is registered with the Beroepsvereniging Leefstijlcoaches Nederland (BLCN) (Professional association of lifestyle coaches in the Netherlands) 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.

What is not reimbursed
- If your child turns 18 in the course of the combined lifestyle intervention (CLI) programme, switching to a CLI programme for adults
- A follow-up combined lifestyle intervention programme for adults in continuance of the 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}).

Medical aids

What you are insured for under your general insurance policy

Hairpieces/wigs (clause B.17.6.)

Insured healthcare
- Hairpieces/wigs

Your reimbursement
- From 0 euros: reimbursement of 48.250 euros maximum for hairpieces/wigs.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.
- You are entitled to a functioning medical aid
  'Functioning' is taken to mean that the medical aid is ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have an adequate, functioning medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner

Who to get a referral from
- Attending doctor

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

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

What is not reimbursed
- Hairpieces for normal male hair loss (alopecia androgenetica)

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

See also:
- Hulpmiddelen in eigendom (definitions)

Hearing aids (clause B.17.8.)

Insured healthcare
- Hearing aids

Your reimbursement
- You are younger than 18: reimbursement of 100 percent for hearing aids.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Terms and conditions
- The audiogram is not over 12 months old
- The medical aid must be fitted as per the most recent version of the Hearing Protocol
- The hearing aid is included in the national hearing aids database
  You may qualify for a hearing aid that is not included in the national hearing aids database if: - you have tried at least two different hearing aids from the database first; and - the hearing care professional or audiologist has provided adequate justification for such, showing that there are no hearing aids in the database that are appropriate in your case.
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.
- You are entitled to a functioning medical aid
  A medical aid is considered to be a functioning medical aid if it is ready for use when delivered. Upon the first purchase, the medical aid must come with instructions for use, batteries or charging equipment, and the accessories needed to make the medical aid work properly. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed.
- You can normally keep using your hearing aid for at least 5 years.
  If your hearing aid needs any adjustments or repairs before the end of this 5-year period, contact the contracted medical aid supplier that provided the hearing aid. We have an agreement with the healthcare provider about the costs of repairs or adjustments that are needed during the first 5 years. If you go to a non-contracted medical aid supplier You are responsible for any adjustments and/or repairs during this period.
- You acquire this medical aid; you are the owner

Who to get a referral from
- Up to age 18: Audiology centre
- From age 18 to 67 for hearing aid wearers: triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals

- For insured persons aged between 18 and 67 who do not wear a hearing aid: ENT specialist or audiology centre
- Contracted triage hearing care professional if you wear a hearing aid and are older than 18 years of age but younger than 67

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You need our permission for a hearing aid that is not included in the national hearing aids database
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
  This can even be a retail shop selling housewares.
- A non-contracted medical aid supplier is a triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals
  This medical aid supplier works according to the most recent version of the Hearing Protocol.

What is not reimbursed
- Replacement of
  - batteries; - accessories, with the exception of those needed for the device to operate.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Hearing aids (clause B.17.8.)

Insured healthcare
- Hearing aids

Your reimbursement
- You are 18 years old or above, from 0 euros: reimbursement of 75 percent for hearing aids.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- A statutory personal contribution of 25%
- Deductible applies from the age of 18

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

Terms and conditions
- The audiogram is not over 12 months old
- The medical aid must be fitted as per the most recent version of the Hearing Protocol

- The hearing aid is included in the national hearing aids database
  You may qualify for a hearing aid that is not included in the national hearing aids database if: - you have tried at least two different hearing aids from the database first; and - the hearing care professional or audiologist has provided adequate justification for such, showing that there are no hearing aids in the database that are appropriate in your case.
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.
- You are entitled to a functioning medical aid
  A medical aid is considered to be a functioning medical aid if it is ready for use when delivered. Upon the first purchase, the medical aid must come with instructions for use, batteries or charging equipment, and the accessories needed to make the medical aid work properly. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed.
- You can normally keep using your hearing aid for at least 5 years.
  If your hearing aid needs any adjustments or repairs before the end of this 5-year period, contact the contracted medical aid supplier that provided the hearing aid. We have an agreement with the healthcare provider about the costs of repairs or adjustments that are needed during the first 5 years. If you go to a non-contracted medical aid supplier You are responsible for any adjustments and/or repairs during this period.
- You acquire this medical aid; you are the owner

Who to get a referral from
- Up to age 18: Audiology centre
- From age 18 to 67 for hearing aid wearers: triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals
- For insured persons aged between 18 and 67 who do not wear a hearing aid: ENT specialist or audiology centre
- Contracted triage hearing care professional if you wear a hearing aid and are older than 18 years of age but younger than 67

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You need our permission for a hearing aid that is not included in the national hearing aids database
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
  This can even be a retail shop selling housewares.
- A non-contracted medical aid supplier is a triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals
  This medical aid supplier works according to the most recent version of the Hearing Protocol.

What is not reimbursed
- Replacement of
  - batteries; - accessories, with the exception of those needed for the device to operate.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Other medical aids: Hearing loops, infrared system, FM device and streamers (clause B.17.8.)

Insured healthcare
- Hearing loops, infrared system, FM device and streamers

Your reimbursement
- Reimbursement of 100 percent for other medical aids: Hearing loops, infrared system, FM device and streamers.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

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

Who to get a referral from
- Up to age 18: Audiology centre
- From age 18 to 67 for hearing aid wearers: triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals
- For insured persons aged between 18 and 67 who do not wear a hearing aid: ENT specialist or audiology centre
- Contracted triage hearing care professional if you wear a hearing aid and are older than 18 years of age but younger than 67

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You need our permission if you need an additional medical aid/provision
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier is a triage hearing care professional registered with the StAr quality assurance organisation for hearing care professionals and/or in the CvC register of hearing care professionals
  This medical aid supplier works according to the most recent version of the Hearing Protocol.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Absorbent incontinence products (clause B.17.9.)

Insured healthcare
- Absorbent incontinence products

Your reimbursement
- Reimbursement of 100 percent for absorbent incontinence products.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.
- You are entitled to a functioning medical aid
  ‘Functioning’ is taken to mean that the medical aid is ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have an adequate, functioning medical aid at your disposal; the healthcare provider will determine whether this is the case.

- If pelvic floor therapy could help with your form of incontinence, reimbursement is only possible once you start this therapy
  Depending on the nature of the incontinence, pelvic floor therapy may help relieve your symptoms. We can approve absorbent incontinence products that you wear on your body if you are actually prepared to follow this therapy, but only in situations where you can in all reasonableness be required to take this therapy. If you are not prepared to follow the therapy, we will assume that you do not need incontinence products given that these will not be a form of effective healthcare.
- You acquire this medical aid; you are the owner

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

Do you need approval?
- You need our permission for the initial provision for children between the ages of 3 and 5
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

What is not reimbursed
- Cleaning and odour products
- Skin protection products
- Clothing (except for net pants)
- Bedwetting alarm for treatment of nocturnal enuresis (nocturnal bedwetting)
- Mattress protectors (except in the case of a personal special healthcare need)
- Incontinence products for nocturnal enureses (night-time bedwetting)
- Incontinence products for short-term incontinence
  For example, after an operation, pregnancy or bladder infection.
- Children under the age of 3 are never entitled to reimbursement

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

See also:
- Hulpmiddelen in eigendom (definitions)

Ostomy supplies (clause B.17.9.)

Insured healthcare
- Ostomy supplies

Your reimbursement
- Reimbursement of 100 percent for ostomy supplies.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- You acquire this medical aid; you are the owner

Who to get a referral from
- Medical specialist
- Stoma nurse

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted healthcare provider must at least hold an SEMH certificate with the DISW-s specialism.

What is not reimbursed
- Cleaning and odour products
- Clothing
- Mattress protectors (except in the case of a personal special healthcare need)

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

See also:
- Hulpmiddelen in eigendom (definitions)

Stoma products (clause B.17.9.)

Insured healthcare
- Catheters and accessories
  Catheters inserted at a hospital are covered by the hospital's funding.

Your reimbursement
- Reimbursement of 100 percent for stoma products.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner
- Medical specialist
- Physician assistant
- Clinical nurse specialist (Master's degree level 6)
- UCS nurse (degree from higher professional education; level 6)
  This healthcare provider may write a letter of referral, but cannot determine the nature of the treatment.

- Continence nurse (intermediate professional education qualification; level 4)
  This healthcare provider may write a letter of referral, but cannot determine the nature of the treatment.

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

What is not reimbursed
- Cleaning and odour products
- Skin protection products
- Clothing (except for net pants)
- Mattress protectors (except in the case of a personal special healthcare need)
- Incontinence products for short-term incontinence
  For example, after an operation, pregnancy or bladder infection.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Foot-propelled ‘trippelstoel’ chair (clause B.17.10.2.)

Insured healthcare
- Foot-propelled ‘trippelstoel’ chair

Your reimbursement
- Reimbursement of 100 percent for foot-propelled ‘trippelstoel’ chair.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Medical aids on loan are not subject to the deductible. The costs of usage and consumables associated with the medical aid are subject to a deductible, however.

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You are only mobile while seated and you have impaired hand or arm function that makes the use of other mobility aids impossible.
  - You are unable remain standing without support from your hands.

Terms and conditions
- A ‘trippelstoel’ chair can be for long-term use or for use for a for a short or uncertain period of time
- Only for use indoors
- You are given this medical aid on loan

Who to get a referral from
- ‘Trippelstoel’ chair for a short or uncertain period of time:

  - attending doctor (specialist/general practitioner) - (district/transfer) nurse - clinical nurse specialist - physician assistant - occupational therapist A report from an occupational therapist is not required.
- 'Trippelstoel' chair for long-term use:
  - Attending doctor with advisory report from occupational therapist - Physician assistant with advisory report from occupational therapist - Clinical nurse specialist for geriatric healthcare with advisory report from occupational therapist - Occupational therapist with advisory report from occupational therapist.

Do you need approval?
- You need our permission for a 'trippelstoel' chair for long-term use
- For short-term use, the contracted medical aid supplier determines whether the conditions have been met
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

What is not reimbursed
- Use in the event of standing problems only

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

See also:
- Hulpmiddelen in bruikleen (definitions)

Orthopaedic shoes (clause B.17.10.1.)

Insured healthcare
- Orthopaedic shoes

Your reimbursement
- You are younger than 16, from 0 euros: reimbursement of 100 percent for orthopaedic shoes.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €67 per pair
- This healthcare is not subject to the deductible

Terms and conditions
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.

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

Who to get a referral from
- For low-complexity care: general practitioner or podiatrist
- For highly complex care: orthopaedic surgeon, rehabilitation doctor, rheumatologist, geriatric specialist, physician assistant or clinical nurse specialist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You need our permission for early replacement of your medical aid
- You need our permission for temporary orthopaedic shoes
- You need our permission for other orthopaedic modifications to (commercially available) shoes when such modifications will cost more than €400
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- Non-contracted medical aid supplier must be accredited under the 'Erkenningsregeling Orthopedische Schoentechnische Bedrijven (OSB)' (Accreditation scheme for orthopaedic shoemakers)

What is not reimbursed
- Work footwear
- Medical aids used exclusively while playing sports.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Orthopaedic shoes (clause B.17.10.1.)

Insured healthcare
- Orthopaedic shoes

Your reimbursement
- You are 16 years old or above, from 0 euros: reimbursement of 100 percent for orthopaedic shoes.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €134 per pair
- Deductible applies from the age of 18

Terms and conditions
- The medical aid is effective and appropriate to your personal situation
  There must be medical grounds for the healthcare. The healthcare must be neither unnecessarily expensive nor unnecessarily extensive, because it will then not be effective healthcare in your situation. The medical aid supplier looks at the appropriateness of the medical aids that have been selected and maintains a care plan to demonstrate their effectiveness. Ineffective healthcare is not covered by your general insurance policy, not even if you pay for part of it yourself.
- You are entitled to a functioning medical aid
  'Functioning' is taken to mean that the medical aid is ready for use on delivery. Instructions for use must be given upon the first purchase and accessories may be required for operation. For a medical aid to be considered (or continue to be considered) a functioning and adequate medical aid, repairs, replacement or adjustments may be needed. A spare medical aid may also be reimbursed or provided if having a spare can in all reasonableness be considered necessary. The idea is for you to always have an adequate, functioning medical aid at your disposal; the healthcare provider will determine whether this is the case.
- You acquire this medical aid; you are the owner

Who to get a referral from
- For low-complexity care: general practitioner or podiatrist
- For highly complex care: orthopaedic surgeon, rehabilitation doctor, rheumatologist, geriatric specialist, physician assistant or clinical nurse specialist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You need our permission for early replacement of your medical aid
- You need our permission for temporary orthopaedic shoes
- You need our permission for other orthopaedic modifications to (commercially available) shoes when such modifications will cost more than €400
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- Non-contracted medical aid supplier must be accredited under the 'Erkenningsregeling Orthopedische Schoentechnische Bedrijven (OSB)' (Accreditation scheme for orthopaedic shoemakers)

What is not reimbursed
- Work footwear
- Medical aids used exclusively while playing sports.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Lenses for glasses and filter lenses (clause B.17.11.)

Insured healthcare
- Lenses for glasses

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

Your reimbursement
- You are younger than 18, from 0 euros: reimbursement of 100 percent for lenses for glasses and filter lenses.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €64 per calendar year in the case of a new lens on one side
- Statutory personal contribution of €128 per calendar year in the case of a new lens on both sides
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have medical grounds for contact lenses, but wearing lenses is not desirable, for example due to:.
  - a high refractive error (more than 10 dioptres); - large differences in strength between the left and right eye (more than 4 dioptres); - strong cylinder formation (more than 4 dioptres); - keratoconus and corneal transplantation.
  - You have pathological myopia with a refractive error of at least –6 dioptres.
  - You have had surgery on one or both eyes due to a refractive error.
  - You have pure accommodative esotropia.

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

Who to get a referral from
- You need a referral with medical diagnosis from an ophthalmologist

Do you need approval?
- You need our permission for the initial provision
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must be an optician who is a qualified orthoptist or optometrist

What is not reimbursed
- Frame
- Transition lenses, sunglasses lenses
- Anti-glare treatment and other coatings of the glasses
- Preventive use in the treatment of pathological myopia with a refractive error of under -6 dioptres

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

See also:
- Hulpmiddelen in eigendom (definitions)

Contact lenses (with vision correction) (clause B.17.11.)

Insured healthcare
- Contact lenses with vision correction
- Scleral contact lenses with vision correction
  A scleral contact lens is a hard, larger than usual lens shaped a bit like a bucket hat. The rim of the lens rests on the white of the eye (sclera) and, unlike with regular lenses, the vaulted centre part does not make contact with the cornea. You need a medical indication for this.
- Bandage contact lenses with vision correction
  These are special lenses used to protect the eye. Unless otherwise specified, the lenses will remain in your eye for a certain period of time, day and night. You need a medical indication for this.
- Coloured contact lenses
  These are special hand-coloured, custom-made contact lenses. You need a medical indication for this. Coloured lenses for cosmetic purposes are not included.
- Daily contact lenses
  But only if another type of contact lenses is not an option for medical reasons.

Your reimbursement
- From 0 euros: reimbursement of 100 percent for contact lenses (with vision correction).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €64 per calendar year in the case of a new lens on one side
- Statutory personal contribution of €128 per calendar year in the case of a new lens on both sides
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a medical condition or trauma where contact lenses can provide greater improvement than glasses would. This concerns improvement of visual acuity or quality, for example by:.
  - a high refractive error (more than 10 dioptres); - large differences in strength between the left and right eye (more than 4 dioptres); - strong cylinder formation (more than 4 dioptres); - keratoconus and corneal transplantation.

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

Who to get a referral from
- You need a referral with medical diagnosis from an ophthalmologist

Do you need approval?
- You need our permission for the initial provision of bandage contact lenses or contact lenses for certain indications
  Your medical aid supplier will provide further details about this.
- For the initial provision of scleral contact lenses or coloured contact lenses, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

- A non-contracted medical aid supplier must be an optician who is a qualified contact lens specialist or optometrist

What is not reimbursed
- Preventive use in the treatment of pathological myopia with a refractive error of under -6 dioptres

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

See also:
- Hulpmiddelen in eigendom (definitions)

Contact lenses (with vision correction) (clause B.17.11.)

Insured healthcare
- Contact lenses with vision correction
- Scleral contact lenses with vision correction
  A scleral contact lens is a hard, larger than usual lens shaped a bit like a bucket hat. The rim of the lens rests on the white of the eye (sclera) and, unlike with regular lenses, the vaulted centre part does not make contact with the cornea. You need a medical indication for this.
- Bandage contact lenses with vision correction
  These are special lenses used to protect the eye. Unless otherwise specified, the lenses will remain in your eye for a certain period of time, day and night. You need a medical indication for this.
- Coloured contact lenses
  These are special hand-coloured, custom-made contact lenses. You need a medical indication for this. Coloured lenses for cosmetic purposes are not included.
- Daily contact lenses
  But only if another type of contact lenses is not an option for medical reasons.

Your reimbursement
- You are younger than 18, from 0 euros: reimbursement of 100 percent for contact lenses (with vision correction).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €64 per calendar year in the case of a new lens on one side
- Statutory personal contribution of €128 per calendar year in the case of a new lens on both sides
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have a medical condition or trauma where contact lenses can provide greater improvement than glasses would. This concerns improvement of visual acuity or quality, for example by:.
  - a high refractive error (more than 10 dioptres); - large differences in strength between the left and right eye (more than 4 dioptres); - strong cylinder formation (more than 4 dioptres); - keratoconus and corneal transplantation.
  - You have pathological myopia with a refractive error of at least –6 dioptres.

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

Who to get a referral from
- You need a referral with medical diagnosis from an ophthalmologist

Do you need approval?
- You need our permission for the initial provision of bandage contact lenses or contact lenses for certain indications
  Your medical aid supplier will provide further details about this.
- For the initial provision of scleral contact lenses or coloured contact lenses, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must be an optician who is a qualified contact lens specialist or optometrist

What is not reimbursed
- Preventive use in the treatment of pathological myopia with a refractive error of under -6 dioptres

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

See also:
- Hulpmiddelen in eigendom (definitions)

Diaphragm (clause B.17.13.)

Insured healthcare
- Diaphragm

Your reimbursement
- You are younger than 21: reimbursement of 100 percent for diaphragm.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- Your general practitioner fits the contraceptive device
  If the medical aid is inserted by a medical specialist, the medical aid comes under the ‘Specialist medical healthcare’ clause.
- You acquire this medical aid; you are the owner

Who to get a referral from
- Attending doctor

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

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

See also:
- Hulpmiddelen in eigendom (definitions)

IUD (clause B.17.13.)

Insured healthcare
- IUD
  This concerns a copper IUD.

Your reimbursement
- You are younger than 21: reimbursement of 100 percent for IUD.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- Your general practitioner fits the contraceptive device
  If the medical aid is inserted by a medical specialist, the medical aid comes under the ‘Specialist medical healthcare’ clause.
- You acquire this medical aid; you are the owner

Who to get a referral from
- Attending doctor

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care

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

See also:
- Hulpmiddelen in eigendom (definitions)

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

Insured healthcare
- Blood glucose meter
  - equipment for self-blood collection and associated lancets;

  - ○ blood glucose meter and associated test strips;
  - ○ lancing device;
  - ○ a modified version.

Your reimbursement
- Reimbursement of 100 percent for real-Time Continuous Glucose Monitoring.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- Blood glucose meter must meet the requirements of the consensus document on quality criteria for optimum and efficient use of diabetes aids
  A blood glucose meter from a non-contracted medical aid supplier must meet the requirements of the ISO 15197: 2013 standard.
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner
- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Insulin pump and accessories (clause B.17.19.)

Insured healthcare
- Insulin pump and accessories

Your reimbursement
- Reimbursement of 100 percent for insulin pump and accessories.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- Depending on the medical aid, you can either borrow it or own it

Who to get a referral from
- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

What is not reimbursed
- Replacement of
  - batteries; - accessories, with the exception of those needed for the device to operate.
- Pump holder, pump bag or protective cover
  You will receive this on the initial provision; afterwards, you are responsible for the costs or this is part of the service provided by the product supplier.
- A new medical aid before the end of its service life because of new technological developments
  - consumer batteries
  - special purpose batteries
  - accessories, with the exception of those needed for the device to operate.

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

See also:
- Hulpmiddelen in bruikleen (definitions)
- Hulpmiddelen in eigendom (definitions)

Finger-prick blood test self-sampling device (clause B.17.19.)

Insured healthcare
- Finger-prick blood test self-sampling device

Your reimbursement
- Reimbursement of 100 percent for finger-prick blood test self-sampling device.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner
- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Test strips (clause B.17.19.)

Insured healthcare
- Test strips

Your reimbursement
- Reimbursement of 100 percent for test strips.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner
- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Injection materials to administer insulin (clause B.17.19.)

Insured healthcare
- Injection materials to administer insulin

Your reimbursement
- Reimbursement of 100 percent for injection materials to administer insulin.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner
- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.
- Our website tells you which medical aid supplier you can go to for this care

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

See also:
- Hulpmiddelen in eigendom (definitions)

Glucose monitor: flash glucose monitoring (FGM) (clause B.17.19.)

Insured healthcare
- Glucose monitor: flash glucose monitoring (FGM)

Your reimbursement
- Reimbursement of 100 percent for glucose monitor: flash glucose monitoring (FGM).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- The conditions specified on the most recent ‘Zorginstituut Nederland’ form are the starting point
- If you can demonstrate that you do not have a suitable phone, reimbursement for a reader is possible
- You acquire this medical aid; you are the owner

Who to get a referral from
- General practitioner

- Paediatrician
- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Glucose monitor: Real-time continuous glucose monitoring (rtCGM) (clause B.17.19.)

Insured healthcare
- Glucose monitor: real-time continuous glucose monitoring (rtCGM)

Your reimbursement
- Reimbursement of 100 percent for glucose monitor: Real-time continuous glucose monitoring (rtCGM).

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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

Terms and conditions
- The conditions specified on the most recent ‘Zorginstituut Nederland’ form are the starting point
- If you can demonstrate that you do not have a suitable phone, reimbursement for a reader is possible
- You acquire this medical aid; you are the owner

Who to get a referral from
- Paediatrician

- Internist
- Endocrinologist
- Diabetologist

Do you need approval?
- For the initial provision, the contracted medical aid supplier will assess whether you meet the conditions. Our permission is not required in this case
- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

Where to go for this healthcare
- Our website tells you which medical aid supplier you can go to for this care
- A non-contracted medical aid supplier must at least hold an SEMH certificate with the DISW-d specialism.

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

See also:
- Hulpmiddelen in eigendom (definitions)

Personal alarms (clause B.17.23.)

Insured healthcare
- Personal alarms

Your reimbursement
- Reimbursement of 100 percent for personal alarms.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Medical aids on loan are not subject to the deductible. The costs of usage and consumables associated with the medical aid are subject to a deductible, however.

Eligibility for this healthcare
- All of the following medical indications or situations apply to you:
  - You have a physical disability and a medical need for immediate medical or technical help from an outside party in the event of an emergency.
  - You have to care for yourself for a lengthy period of time.
  - You are unable to independently operate the telephone in an emergency.

Terms and conditions
- You are given this medical aid on loan

Who to get a referral from
- Attending doctor

Do you need approval?
- You need our permission for the initial provision

- You always need our prior permission if you want to see a non-contracted medical aid supplier
  This also applies to the repair, replacement or repeat provision of your medical aid by a non-contracted medical aid supplier.

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

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

What is not reimbursed
- Subscription costs for (professional) alarm response from the emergency resolution centre
- Personal alarm equipment if you have a medical indication that places you under the Dutch Long-Term Care Act (Wlz)

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

See also:
- Hulpmiddelen in bruikleen (definitions)

Short-term stays in a facility

What you are insured for under your general insurance policy

Short-term stays in a facility (clause B.27.)

Insured healthcare
- Short-term stay and primary healthcare in a facility
  The stay is medically necessary. This concerns the following healthcare: - nursing and other care; - medical healthcare including first-line diagnostics; - physiotherapy, Mensendieck/Cesar exercise therapy, speech and language therapy, dietetics and occupational therapy relating to the indication for this short-term stay. This healthcare is aimed at recovery and a return home (except in the case of palliative care).

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have an immediate and demonstrable risk of a deterioration in health and you are temporarily unable to stay at home.

Terms and conditions
- We reimburse medicines and dietary preparations during this stay in accordance with the ‘Medicines’ and ‘Dietary preparations’ clauses

Who to get a referral from
- General practitioner

Who to get a treatment proposal from
- The general practitioner carries out the care needs assessment together with the district nurse
  And they consult with the geriatric specialist, doctor for the mentally disabled or medical specialist.

Where to go for this healthcare
- General practitioner.
  A doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in the practice of the general practitioner, an after-hours general practice, the general practitioner’s laboratory, or your home or temporary place of residence (though not at a hospital or independent treatment centre (ZBC) or nursing home). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Geriatric specialist.
  The healthcare is provided by or under the ultimate responsibility of a geriatric specialist. This is a doctor listed as a geriatric specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare takes place in a hospital, independent treatment centre (ZBC), or at the medical specialist’s practice.
- Doctor for the mentally disabled.
  This is a doctor listed as a doctor for the mentally disabled on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Professional carer or nurse.
  In consultation with the general practitioner and the geriatric specialist or doctor for the mentally disabled.
- Allied health professional provides allied healthcare.
  Allied health professionals can be: physiotherapist, manual therapist, pelvic physiotherapist, physiotherapist specialising in children, geriatric physiotherapist, oedema therapist, remedial therapist, occupational therapist, speech and language therapist, dietician.

Where the treatment takes place
- A facility for nursing and personal care permitted to operate in the Netherlands under the Dutch Healthcare Providers (Accreditation) Act (‘Wet toetreding zorgaanbieders’, Wtza)
  This facility has at least one staff member with a ‘Nursing level 4 or 5’ AGB code (administrative code assigned to healthcare professionals in the Netherlands).

What is not reimbursed
- Care under the Dutch Youth Act (‘Jeugdwet’), Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) and/or Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo)
  For example, if it concerns respite care or if you receive your care in a form of clustered accommodation under the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz).

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

Your reimbursement
- Reimbursement of 100 percent for speech and language therapy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- This concerns restoring, improving or maintaining the function of your hearing, voice or speech.
  Or it concerns the regulation of your breathing necessary for voice production.
- 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 the treatment will be provided by a non-contracted healthcare provider you will need a referral before the treatments starts
  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 our approval 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’).
- Speech and language therapist affiliated with ParkinsonNet
  The speech and language therapist must have this affiliation if you are receiving care because you have been diagnosed with Parkinson’s disease.

What is not reimbursed
- Stammer therapy using the Del Ferro, BOMA or Hausdörfer Institute for Natural Speech (‘Hausdörfer Instituut voor Natuurlijk Spreken’) methodologies
- Treatment that has an educational aim
- Treatment or research related to dyslexia

- Treatment of language development disorder and/or articulation problems related to dialect and/or being a non-native speaker
- 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 under the Medicines Reimbursement System (GVS) (clause B.15.1.)

Insured healthcare

- Medicines included under the Medicines Reimbursement System (GVS)
  In the Medicines Reimbursement System (GVS) the Dutch Ministry of Health, Welfare and Sport determines: - which pharmaceutical healthcare and medicines are eligible for full reimbursement; and - for which healthcare a statutory personal contribution applies (you must then pay part yourself); and - which conditions apply to this. The Medicines Reimbursement System (GVS) comprises several appendixes, which you can find (in Dutch) by entering wetten.overheid.nl and “Regeling zorgverzekering” in your browser. The appendices follow ‘Hoofdstuk 8’. Your policy covers medicines listed in: - Appendix 1A: these are registered medicines that are interchangeable. Interchangeable medicines are administered in the same way, used for similar medical indications, and are generally for people in the same age group. - Appendix 1B: these are registered medicines that are not interchangeable because they have different properties; for example, the effect of the medicine and the indication for which you use the medicine are different. - Appendix 2: these are registered medicines with specific conditions for reimbursement (concerning the indication, for example). The Minister of Health, Welfare and Sport regularly changes this list of medicines and the conditions for each. All the latest information on assessing medicines and preparations is available (in Dutch) at www.znformulieren.nl. - Appendix 3: these are compounded medicines and are described in the clause ‘Medicines prepared by the pharmacy’.

Your reimbursement

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- Statutory personal contribution maximum of €250
- Deductible applies from the age of 18
- You do not pay a deductible for a preferred medicine for which the active ingredient, brand and Z-index code are on our list of preferred medicines (‘Lijst voorkeursgeneesmiddelen’)
- If a preferred medicine is not available, you will receive another medicine with the same active ingredient. You will have to pay a deductible for that medicine.
- You always have to pay a deductible for the pharmacy’s services, even when they dispense a preferred medicine
- You do not pay a deductible for products associated with a quit smoking course; see the ‘Quitting smoking’ course clause

Terms and conditions

- Advice and guidance is included as part of the supply of your medicine
  This applies to: - dispensing: gathering and checking your medicine when you collect it or have it delivered; - guidance: explaining the use of your medicine when you are given a new medicine or if you have not used the medicine over the last 12 months; - instruction in relation to a medicine that also requires the use of a medical aid; - pharmacological support during visits to an outpatient clinic, during hospitalisation and/or discharge from a hospital. - additional costs, for example if the pharmacist has to prepare your medicine personally or if it concerns partial delivery or weekend or evening rates.
- A maximum reimbursement applies to the medicines included in a group of interchangeable medicines (Appendix 1A)
  For each group of interchangeable medicines, the government has set a maximum reimbursement. If the price of the medicine prescribed for you from that group is higher, you will have to pay the excess yourself as a ‘personal contribution’.
- Within the group of interchangeable medicines (Appendix 1A), you are only insured for the preferred medicines
  The active ingredient determines the medicine’s effect. There are often multiple medicines with the same active ingredient and effect but for a different price. Within this group of interchangeable medicines, we designate one or more medicines as preferred medicines on the basis of the lowest price. Within this group, you are only insured for the preferred medicine. There will always be at least one medicine available to you containing the prescribed active ingredient. The preferred medicine policy also applies if you live in the Netherlands but prefer to buy your medicines abroad, because you live close to the border, for example.
- Medicine other than the preferred medicine is only possible where medically necessary
  You may experience different side effects or have an intolerance to the medicine from a certain manufacturer. You must contact your pharmacist if unacceptably unpleasant side effects have not disappeared after 15 days of use. Your pharmacist will assess (possibly in consultation with your doctor) whether you should switch to a medicine from the Medicines Reimbursement System (‘GVS’) other than the preferred medicine. The other medicine may not be unnecessarily expensive and will generally not be the original branded medicine. If your doctor believes that treatment with a medicine designated by us (from the list of preferred medicines [‘Lijst Voorkeursgeneesmiddelen’]) is not medically responsible, your doctor can indicate this by including ‘Medische Noodzaak’ (medically necessary) on the prescription. Under Article 2.8(4) of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’), you are then entitled to reimbursement of the costs of the medicine prescribed by your doctor.
- You may only receive medicines on prescription (treatment proposal) for a specified period
  These supply periods apply per prescription (if a medicine comes under several of these categories, the shortest period applies): - 15 days or the smallest package for a medicine that you are taking for the first time; - 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy; - 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics); - a maximum of 30 days for medicines listed in the Dutch Opium Act (‘Opiumwet’), with the exception of medicines for the treatment of ADHD, for which a maximum of 3 months applies; - 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy; - 12 months for ‘the pill’ (oral contraceptives) and insulin; - 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.
- The medicine may only be supplied to the insured person for whom it is intended, or to their carer, or to the healthcare provider responsible for administering the medicine
- Partial delivery or medicine pouch rolls are only an option where medically necessary
  This is referred to as ‘personalised medication management’ and comprises the supply of individual pill pouches on a roll, with each pouch containing one or more medicines that must be taken at a certain time of day. This form of dispensing is possible per two, three or four weeks if a medicine has been prescribed for an extended period and no one is able to manage the medicine on your behalf.

- Medicines from foreign countries
  If you need to buy prescription medicines abroad, all the following conditions apply: - the active ingredient, dosage and method of administration of the medicine are listed in the Dutch Medicines Reimbursement System (GVS); - reimbursement will be in line with the Dutch reimbursement limit; - invoices for medicines must be legible and complete and specify the name, quantity, strength and method of administration of the medicine. If any information is missing, you must send us the patient information leaflet, box or labels (or a photo of these) along with your invoice.

Who to get a treatment proposal from
- General practitioner
- Medical specialist
- Geriatric specialist
- ‘GGD’ regional healthcare authority doctor specialising in infectious diseases
- Dental surgeon
- Dentist
- Doctor for the mentally disabled
- Physician assistant
  For the additional conditions relating to the authority of a physician assistant in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions (‘Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants’) produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).
- Nursing specialist with additional terms and conditions regarding authority in relation to writing prescriptions
  For the additional conditions relating to the authority of a specialist nurse in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions (‘Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants’) produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).
- Obstetrician, taking into account authority in relation to writing prescriptions and field of expertise
  All the information relating to this is provided in Article 36 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, ‘Wet BIG’), which you will find (in Dutch) at wetten.overheid.nl.
- One of the healthcare providers abroad stated above
  This healthcare provider complies with the requirements, laws and regulations that apply to their profession in the country concerned.
- You do not need a repeat prescription for contraceptive medicines or insulin
  A new prescription will be required if the medicine, dosage and/or the use of the medicine changes.

Do you need approval?
- You need our approval for certain medicines listed in Appendix 2
  - For medicines listed in Appendix 2 your attending doctor can complete a doctor’s statement; your pharmacy will then assess whether you are entitled to reimbursement of the costs. To find out more, your doctor can consult our site for healthcare providers. - Certain medicines (active ingredients) from Appendix 2 must be assessed by us. You will find a list of these medicines on our website.
- Objection to your pharmacy's assessment
  If you do not want your pharmacist or supplier to make the assessment, you can send the statement completed by your prescriber to our ‘Medische Beoordelingen’ (Medical Assessments) department directly, stating your objection.
- If we do give our approval, costs can be reimbursed only from the date we received the request for approval
  So it is important that you request approval before you start taking the medicine. Submitting an application for reimbursement does not guarantee that we will issue approval.

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

Where to go for this healthcare

- Pharmacy.
  This is a pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet'). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Dispensing doctor or general practitioner.
  This is a doctor or general practitioner with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet'). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Pharmacist, dispensing general practitioner or dispensing doctor abroad
  This healthcare provider has a licence to supply medicines in the country concerned and complies with the requirements, laws and regulations set out for their profession in the country concerned.

What is not reimbursed

- Medicines for research or experimental use
  Or medicines that are part of specialist medical healthcare. These come under 'Specialist medical healthcare'.
- A medicine that is equivalent or almost equivalent to a registered medicine that is not included in the Medicines Reimbursement System (GVS), except where stipulated otherwise in a ministerial regulation. See the 'Medicines prepared by the pharmacy' clause.
- Medicines, information and advice aimed at preventing illness during trips abroad
- Over-the-counter medicines and medicines used in a hospital that, in accordance with Dutch Health Insurance Regulations ('Regeling zorgverzekering'), are not covered by your health insurance. Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described in the 'Other optical aids' section of the regulations on medical aids ('Reglement Hulpmiddelen').
- Medicines for which, following the determination of an issue with the medicine, a claim can be made under a compensation scheme or the medicine is recalled
  - This might concern, for example, a method of administration related to a medical aid or consumer item with a manufacturer's warranty or other compensation scheme. - A recall concerns a medicine having to be returned to the pharmacy, because the medicine is defective, for example.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under 'treatment proposal'.
- Personal care products and cosmetic products, or products of a similar nature
  Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs of submitting prescriptions and collecting medicines outside normal opening hours, except in an urgent situation
  This will be reimbursed in urgent situations.
- Provision of and instruction in the use of medical aids, where the associated medicines are paid for by the hospital
- Instruction in the use of medical aids that are required for medicines if the medical aids have not been supplied by a pharmacist or dispensing general practitioner
- Additional costs, e.g. administrative, import and/or postage costs
- Medicines, as referred to in Article 40, clause 3, paragraph f of the Dutch Medicines Act ('Geneesmiddelenwet')
- Alternative medicines
  For example, homoeopathic and anthroposophic medicines. The clause on 'Alternative and psychosocial healthcare' applies to these medicines.
- Esketamine nasal spray (Spravato)
  This healthcare is described in the 'Medical mental healthcare' clause.

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

Medication assessment (clause B.15.2.)

Insured healthcare
- Medication assessment (periodic assessment)
- Pharmaceutical self-management information for a patient group
  Depending on the agreements we have made with your pharmacy, this pharmaceutical self-management information for a patient group (‘Voorlichting farmaceutisch zelfmanagement voor patiëntengroep’) and the conditional pharmaceutical support services (‘facultatieve prestaties farmaceutische zorg’) as described in the policy rule of the ‘Nederlandse Zorgautoriteit’ (Dutch Healthcare Authority, Nza) facilitate: - improved medication adherence of patients with asthma/COPD; - medication optimisation and support for patients receiving complex pharmaceutical healthcare; - guidance for chronic use of prescription only medicines (POMs); - guidance for asthma and/or COPD medicines.

Your reimbursement
- Reimbursement of 1 once every 12 months (or more often if needed) for medication assessment.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You use several medicines on a chronic basis and there is a medical and pharmaceutical need.

Terms and conditions
- The healthcare provider drawing up the treatment proposal has established the medical and pharmaceutical necessity.
  The conditions for this can be found in the Medication Assessment guideline (‘richtlijn 'Medicatiebeoordeling’) of the Royal Dutch Pharmacists Association (KNMP) at www.knmp.nl.
- This concerns medicines that meet the conditions for medicines set out in the Medicines Reimbursement System (GVS).
  If you also use medicines that do not meet these conditions, these will still be included in the medication assessment.
- The medication assessment is conducted in consultation with you, your attending doctor, and the other healthcare providers involved
- The healthcare provider must follow the current performance description of the Dutch Healthcare Authority (‘NZa Prestatiebeschrijving’) and the multidisciplinary guideline for geriatric polypharmacy (‘Multidisciplinaire Richtlijn Polyfarmacie bij ouderen’)

Who to get a treatment proposal from
- Pharmacist
- Dispensing general practitioner
- Medical specialist
- Doctor for the mentally disabled
- Geriatric specialist

Do you need approval?
- You need our approval for a medication assessment if the conditions of the KNMP’s Medication Assessment guideline are not met but you still require this medication assessment for other medical or pharmaceutical reasons

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

Where to go for this healthcare
- Pharmacist or dispensing general practitioner with medication assessment training.
  We must deem the additional training taken satisfactory for the purpose, and the pharmacist or dispensing general practitioner must have successfully completed the course.

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

Medicines prepared by the pharmacy (clause B.15.4.)

Insured healthcare
- Medicines prepared by the pharmacy
  These are: - non-registered medicines that a pharmacist prepares specifically for you for a specific prescription (a ‘compounded medicine’); or - a non-registered medicine that your pharmacist instructs a different pharmacy to prepare (a ‘third-party compound’). Appendix 3A lists the medicines in a pharmacy preparation (compounded medicine or third-party compound) for which the costs can be reimbursed, and Appendix 3B lists the medicines for which the costs are not reimbursed.

Your reimbursement
- Reimbursement of 100 percent for medicines prepared by the pharmacy.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- A statutory personal contribution of a maximum of €250 applies to compounded medicines that include an active ingredient for which a statutory personal contribution applies

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - An existing medicine is not suitable for you, because of its strength or form, for example.

Terms and conditions
- Advice and guidance is included as part of the supply of your medicine
  This applies to: - dispensing: gathering and checking your medicine when you collect it or have it delivered; - guidance: explaining the use of your medicine when you are given a new medicine or if you have not used the medicine over the last 12 months; - instruction in relation to a medicine that also requires the use of a medical aid; - pharmacological support during visits to an outpatient clinic, during hospitalisation and/or discharge from a hospital. - additional costs, for example if the pharmacist has to prepare your medicine personally or if it concerns partial delivery or weekend or evening rates.
- We only reimburse the costs of a compounded medicine that is equivalent or almost equivalent to a registered medicine not included in the Medicines Reimbursement System (GVS) if stipulated in a ministerial regulation
  This concerns Appendix 3A: - a compound for use during a ‘bridging period’, i.e. an application for the medicine to be included in the Medicines Reimbursement System (GVS) has been submitted, but a decision has not yet been made; - a medicine that is not included in the Medicines Reimbursement System (GVS) because it is too expensive, while the price of the compounded medicine would be acceptable.

- This must involve rational pharmacotherapy.
  This means that the medicine must meet all these conditions: - it is in a form that is suitable for the recipient, for example, a liquid solution for a child who cannot swallow tablets yet; - it has been proven to be efficient and effective, meaning that adequate medical research has been conducted into the medicine showing that it is effective in treating your symptoms or illness; - it must be the most economical for the health insurer. It must, for example, not be more expensive than comparable medicines that are equally or more effective. For certain preparations, we will need additional information in order to assess whether they qualify as rational pharmacotherapy.
- You may only receive medicines on prescription (treatment proposal) for a specified period (with the exception of 'the pill')
  A prescription is valid for a certain period, which can be different for each type of medicine or medicine category. If a medicine comes under several of these categories, the shortest period applies. The following supply periods apply to prescriptions (treatment proposal): - 15 days or the smallest package for a medicine that you are taking for the first time; - 15 days for a medicine intended for treating acute conditions with antibiotics or chemotherapy; - 30 days for sleeping pills (hypnotics) and for medicines aimed at reducing anxiety and agitation (anxiolytics); - a maximum of 30 days for medicines listed in the Dutch Opium Act ('Opiumwet'), with the exception of medicines for the treatment of ADHD, for which up to a 3-month supply may be provided; - 3 months for medicines for the treatment of a chronic illness, or up to 12 months if we have made agreements for this with the pharmacy; - 12 months for insulin; - 1 month for medicines that cost more than €1000 per month. If, after an uninterrupted period of 6 months, the effective dosage has been established and your health has stabilised, a 3-month supply of this expensive medicine can be provided.
- The medicine may only be supplied to the insured person for whom it is intended, or to their carer, or to the healthcare provider responsible for administering the medicine
- Partial delivery or medicine pouch rolls are only an option where medically necessary
  This is referred to as 'personalised medication management' and comprises the supply of individual pill pouches on a roll, with each pouch containing one or more medicines that must be taken at a certain time of day. This form of dispensing is possible per two, three or four weeks if a medicine has been prescribed for an extended period and no one is able to manage the medicine on your behalf.

Who to get a treatment proposal from

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

Where to go for this healthcare

- Pharmacy.
  This is a pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet'). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.
- Dispensing doctor or general practitioner.
  This is a doctor or general practitioner with a permit to dispense medicines under the terms of the Dutch Medicines Act ('Geneesmiddelenwet'). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.

What is not reimbursed

- Compounds aimed at preventing illness during trips abroad

- Over-the-counter medicines and medicines used in a hospital that, in accordance with Dutch Health Insurance Regulations (‘Regeling zorgverzekering’), are not covered by your health insurance.
  Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described in the ‘Other optical aids’ section of the regulations on medical aids (‘Reglement Hulpmiddelen’).
- Medicines for which, following the determination of an issue with the medicine, a claim can be made under a compensation scheme or the medicine is recalled
  - This might concern, for example, a method of administration related to a medical aid or consumer item with a manufacturer’s warranty or other compensation scheme. - A recall concerns a medicine having to be returned to the pharmacy, because the medicine is defective, for example.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under ‘treatment proposal’.
- Personal care products and cosmetic products, or products of a similar nature
  Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs of submitting prescriptions and collecting medicines outside normal opening hours, except in an urgent situation
  This will be reimbursed in urgent situations.
- Additional costs, e.g. administrative, import and/or postage costs

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

Medicines imported from abroad (clause B.15.5.)

Insured healthcare
- Medicines your pharmacy imports from abroad and which are not registered in the Netherlands

Your reimbursement
- Reimbursement of 100 percent for medicines imported from abroad.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- You have an illness that does not occur more frequently in the Netherlands than in 1 in 150,000 inhabitants
- No treatment is possible with a medicine registered in the Netherlands or one prepared in the Netherlands through pharmaceutical compounding
- The treatment, prevention or diagnostics are provided in a form that is suitable for you
- The efficacy and effectiveness has been proven in scientific literature
- The treatment is the most economical for you and the health insurance
- All the conditions listed above are the rules according to Article 2.8(1)(b) of the Dutch Health Insurance Decree (‘Besluit zorgverzekering’)

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

Who to get a treatment proposal from
- General practitioner
- Medical specialist
- Geriatric specialist
- ‘GGD’ regional healthcare authority doctor specialising in infectious diseases
- Dental surgeon
- Dentist
- Doctor for the mentally disabled
- Physician assistant
- Nursing specialist with additional terms and conditions regarding authority in relation to writing prescriptions
  For the additional conditions relating to the authority of a specialist nurse in relation to writing prescriptions, please refer to the Guidance on the Authority of Specialist Nurses and Physician Assistants in relation to Writing Prescriptions (‘Handreiking voorschrijfbevoegdheid verpleegkundig specialisten en physician assistants’) produced by the Dutch Association of Hospital Pharmacists (NVZA) and the Royal Dutch Society for the Promotion of Pharmacy (KNMP).
- Obstetrician, taking into account authority in relation to writing prescriptions and field of expertise
  All the information relating to this is provided in Article 36 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, ‘Wet BIG’), which you will find (in Dutch) at wetten.overheid.nl.

Do you need approval?
- The prescriber must request our approval in advance. Approval will only be given if all the conditions have been met.

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

Where to go for this healthcare
- A pharmacist or a dispensing doctor/dispensing general practitioner with a dispensation from the Dutch Health and Youth Care Inspectorate (‘Inspectie Gezondheidszorg en Jeugd’) for the import of the medicine
  This is a pharmacist or a dispensing doctor/dispensing general practitioner under the terms of the Dutch Medicines Act (‘Geneesmiddelenwet’). You receive this healthcare at home, in the practice of a dispensing doctor or general practitioner or a government-recognised pharmacy, or at your temporary place of residence.

What is not reimbursed
- Medicines for research or experimental use
  Or medicines that are part of specialist medical healthcare. These come under ‘Specialist medical healthcare’.

- A pharmacy preparation (compounded medicine): these are described in the ‘Medicines prepared by the pharmacy’ clause
  For example, a pharmacy preparation (compounded medicine): these medicines are described in the ‘Medicines prepared by the pharmacy’ clause, or a medicine imported from abroad: these are described in the ‘Medicines from foreign countries’ clause.
- Medicines, information and advice aimed at preventing illness during trips abroad
- Over-the-counter medicines and medicines used in a hospital that, in accordance with Dutch Health Insurance Regulations (‘Regeling zorgverzekering’), are not covered by your health insurance.
  Moisturising eye drops (artificial tears with hyaluronic acid) not listed in the Medicines Reimbursement System (GVS) are described in the ‘Other optical aids’ section of the regulations on medical aids (‘Reglement Hulpmiddelen’).
- Medicines for which, following the determination of an issue with the medicine, a claim can be made under a compensation scheme or the medicine is recalled
  - This might concern, for example, a method of administration related to a medical aid or consumer item with a manufacturer’s warranty or other compensation scheme. - A recall concerns a medicine having to be returned to the pharmacy, because the medicine is defective, for example.
- Medicines prescribed by an alternative healthcare provider or by another healthcare provider that we do not specify under ‘treatment proposal’.
- Personal care products and cosmetic products, or products of a similar nature
  Such as toothpastes, soaps, disinfectants, shampoos, bath oils, balsams, lotions, hair growth preparations, mouth rinses and sun-care products.
- Additional costs of submitting prescriptions and collecting medicines outside normal opening hours, except in an urgent situation
  This will be reimbursed in urgent situations.
- Provision of and instruction in the use of medical aids, where the associated medicines are paid for by the hospital
- Instruction in the use of medical aids that are required for medicines if the medical aids have not been supplied by a pharmacist or dispensing general practitioner
- Additional costs, e.g. administrative, import and/or postage costs

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

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; and
- For admission for specialist medical healthcare: 100 percent maximum of 365 days.

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.)

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- Plastic surgery, organ transplants and fertility treatment 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
- Optometrist of orthoptist
  This healthcare provider may refer you to an ophthalmologist in the case of eye conditions.
- 'GGD' regional healthcare authority doctor in the case of general infectious disease control or an STD
- Triage hearing care professional
  A triage hearing care professional may refer to an ENT specialist or audiology centre in the case of a hearing disorder.
- Clinical physicist in audiology
  A clinical physicist in audiology may provide the referral for audiology care.

Do you need approval?
- In certain situations, your medical specialist must request our prior approval for add-on medicines and coagulation factors.
  Add-on medicines are expensive medicines that the hospital may bill separately from the treatment (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
- Periodontal surgical healthcare as part of dental surgery
- Sterilisation treatments and treatments to reverse sterilisation
- Healthcare and/or aids required after treatment (or associated with continued treatment)
- Laboratory tests at the request of an alternative healthcare provider
- Correction of the position of the ears (protruding ears)

- Geriatric rehabilitation
  Integrated and multidisciplinary rehabilitation care as provided by geriatric specialists.
- Conditional healthcare
  All conditional healthcare relating to specialist medical healthcare, medicines and medical aids.
- 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.)

The amount you pay yourself
- Deductible applies from the age of 18

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 approval 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).
  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.

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

Skinvision (clause B.4.3.)

Insured healthcare
- Digital specialist medical healthcare (Skinvision)
  Specialist medical healthcare is also available using digital applications that we have designated. One of these is the SkinVision app, which you can use to take a photo of a spot on your skin and have this assessed to see whether it presents a risk of skin cancer. If a high risk is detected, you will receive medical advice.

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a 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}).

Plastic surgery (clause B.4.5.)

Insured healthcare
- Plastic surgery
  This concerns treatment of a cosmetic surgery nature. In addition, the medicines, medical aids and dressings that are part of the treatment and laboratory tests. If admission is required, the healthcare also includes admission in the lowest nursing care category of a facility for specialist medical healthcare, admission, nursing and other care.

Your reimbursement
- Reimbursement of 100 percent for plastic surgery.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have an abnormality in your appearance with demonstrable disorders of physical function.
    This relates to physical complaints, which objective tests have shown to be caused by the physical abnormality to be corrected. An example of this is untreatable, constantly-present blemishes in the folds of skin associated with a severely overhanging abdomen.
  - You have a disfigurement that has arisen as the result of illness, an accident or a medical procedure.
    This is the case where a severe disfigurement is immediately obvious in daily life, for example: disfigurement resulting from burns, or amputated legs, arms or breasts.
  - You have paralysed or drooping upper eyelids.
    The paralysis or drooping has led to severe limitations to the field of vision, or is the result of a congenital defect or the existence of a chronic condition at birth.
  - You have agenesis/aplasia of the breasts (failure of the breasts to develop) in women and in man-to-woman transgender people.
    The procedure consists of the surgical insertion or replacement of a breast prosthesis in women and a comparable situation in transgender women. In the case of transgender women, the person's gender dysphoria must be established by a healthcare provider who participates in a transgender network.
  - You have been diagnosed with gender dysphoria (transsexuality) and require correction of primary sexual characteristics as a result.

- You have a congenital disfigurement.
  such as cleft lip, jaw or palate, disfigurement of the facial bones, uncontrolled growth of blood vessels, lymphatic vessels or connective tissue, birthmarks, or disfigurement of the urinary tract and genitalia.
- You need a breast reduction.
  This applies in the case of you having a cup size that is DD/E or greater (or cup size D if you are less than 1.60m in height) and you suffer from a demonstrable physical complaint. The complaint is the consequence of the weight of your breasts and causes severe restriction. Other treatments and therapies must have been unsuccessful in relieving your complaint. Your weight is stable and not excessive.
- You need laser treatment of the skin.
  This applies is the case of (immediately noticeable) disfigurement or demonstrable disorders of physical function. Most disfigurements do not meet these criteria.
- You need nose correction surgery.
  This applies in a situation where the function of the nose is significantly limited and this cannot be treated in any other way. Corrective surgery in connection with deformity or congenital disfigurement is rare.

Terms and conditions

- If you need to be admitted, your health insurance covers the admission up to a maximum of 1095 days
  Days are counted using the following rules:
  - if your admission is interrupted for a period of time less than 31 days, the number of days of the interruption does not count towards the total number of days. The count will resume after the interruption.
  - if your admission is interrupted for a period of more than 30 days, we start counting again from the beginning and you are again entitled to healthcare and reimbursement of such for the total number of days.
  - if your admission is interrupted for weekend/holiday leave, the number of days of interruption counts towards the total number of days.
- For admission, this must be medically necessary in terms of medical healthcare
- The ‘VAV Werkwijzer’ (Manual published by the Dutch Association of Public Health Doctors [‘Vereniging Artsen Volksgezondheid’]) will be used for all plastic surgery procedures
  The ‘Werkwijzer’ is available at vavolksgezondheid.nl under ‘Werkwijzers VAGZ/VAV’.

Who to get a referral from

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

Do you need approval?

- You need our approval for any treatment that appears on the latest national list of procedures requiring prior approval (‘Limitatieve lijst machtigingen medisch specialistische zorg ZN’). This list (in Dutch) can be found on our website.
- The contracted healthcare provider will determine whether or not your indication satisfies the provisions of the Dutch Health Insurance Act (‘Zorgverzekeringswet’). Our prior approval is not required in this case
  A list of these healthcare providers is available on our website. Our approval is required, however, if the treatment is provided by a non-contracted healthcare provider.

For the approval, see the attached General terms and conditions, section [Approval]({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.
- The costs of photos we may require as part of the request for approval

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

Rehabilitation (clause B.4.6.1.)

Insured healthcare
- Rehabilitation
  Specialist medical rehabilitation involves the most suitable healthcare for preventing, mitigating and/or overcoming your handicap. This healthcare is provided in the form of: - part-time or day treatment; or - admission when it is expected that this will achieve better results than outpatient rehabilitation. Rehabilitation consists of tests, advice and treatment of a specialist medical, allied health, behavioural science, psychological and rehabilitation nature. Rehabilitation doctors have ultimate medical responsibility for the content and quality of specialist medical rehabilitation. Rehabilitation healthcare is provided by a cohesive, interdisciplinary team, in which all members cooperate closely in working towards the same treatment goal for the patient. The team is associated with a facility for rehabilitation.

Your reimbursement
- Reimbursement of 100 percent for rehabilitation.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have complex, interrelated problems with mobility (movement), feeling, intellectual capacity, speech, language and/or behaviour. These problems are caused by:.
  - a disorder of the musculoskeletal system, such as in muscles or bones, causing you mobility problems; - a neurological disorder, such as in the brain, causing you mobility problems. If the neurological disorder was not present at birth but developed later, it can also involve problems with speaking or swallowing; - another condition, complaint or disorder that causes you mobility problems, such as chronic pain.

Terms and conditions
- You strive to function as independently as possible given your limitations
  Rehabilitation focuses on improving and/or preventing problems in daily life and social functioning that arise as a result of an accident, operation or serious illness.

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

Do you need approval?
- You need our approval for outpatient rehabilitation

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

Where to go for this healthcare
- Rehabilitation doctor with interdisciplinary team.
  A cohesive, interdisciplinary team under the ultimate responsibility of the rehabilitation doctor.
  The healthcare takes place in a rehabilitation centre.

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for organ transplant, healthcare for the recipient.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

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 carried out 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 who complies with the statutory requirements for organ and tissue transplants and is affiliated with a transplant centre that has been authorised and recognised by law
  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.

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}).

Liver transplant: healthcare for the donor (clause B.4.7.2.)

Insured healthcare
- Liver transplant: healthcare for the donor
  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 for liver transplant: healthcare for the donor.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare and the transport are not subject to the deductible

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 cover is for a maximum of 6 months from the date of the donor's discharge from hospital. This concerns healthcare that is required as a result of being admitted for the transplant. Accordingly, during the period that this healthcare is being provided the donor is regarded 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 who complies with the statutory requirements for organ and tissue transplants and is affiliated with a transplant centre that has been authorised and recognised by law
  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.

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 organs (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 week maximum, after admission, charged to the recipient for healthcare for the donor in the case of other organs.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare and the transport are not subject to the deductible

Terms and conditions
- Healthcare during the initial period after the donor is admitted is charged to the recipient
  The healthcare provided to the donor required specifically in relation to the donor’s admission for the organ transplant, up to a maximum of 13 weeks after the donor’s discharge from hospital, is covered under the organ recipient’s insurance policy. Accordingly, during the period that this healthcare is being provided the donor is regarded 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 who complies with the statutory requirements for organ and tissue transplants and is affiliated with a transplant centre that has been authorised and recognised by law
  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.

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 for the costs of electricity for mechanical ventilation when this is provided in your home.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- You can claim costs on a quarterly basis

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for fertility treatment IVF and ICSI.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- Deductible applies from the age of 18

Eligibility for this healthcare

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

Terms and conditions

- Terms and conditions under which IVF and ICSI are covered under the healthcare
  - if you are younger than 38, and no more than one embryo is transferred in each of the 1st and 2nd IVF attempts (up to 2 embryos in the 3rd attempt); - if you are between 38 and 42 years old, and a maximum of 2 embryos are transferred in each attempt; - if you are 43 or older but were younger than 43 when the treatment commenced, you will be entitled to conclude the current attempt.
    Fertility treatment: IVF examples
  - you are undergoing your 3rd attempt. Although the follicular aspiration is successful, it does not result in pregnancy. A subsequent (4th) attempt is not covered by your health insurance. - you are undergoing your 3rd attempt. You did not become pregnant as a result of embryo transfer, but a few frozen embryos remain. All of the remaining frozen embryos can be transferred, up to a maximum of two at a time. This applies even if you have reached the age of 43: this is still considered to be part of the 3rd attempt which started when you were not yet 43. If it were the 1st or 2nd attempt, and you were younger than 38, only one embryo at a time could be transferred. - you are undergoing your 3rd attempt. An embryo is transferred, but the pregnancy ends 14 weeks after the date of follicular aspiration. You will again be entitled to three attempts (if you are younger than 43), since you had a successful pregnancy. - you have had three attempts without success. After a period of time you become pregnant naturally. Assuming you are younger than 43, you are then entitled to three more attempts.
- Following a successful pregnancy, you will be entitled to this healthcare again
  A successful pregnancy means: - a term of pregnancy of at least 9 weeks and 3 days, calculated from the date of implantation in the case of transfer of cryopreserved (frozen) embryos; or - a term of pregnancy of at least 10 weeks, calculated from the date of follicular aspiration; or - a term of pregnancy of at least 12 weeks, calculated from the first day of the last period, in the case of a spontaneous (physiological) pregnancy.
- An IVF attempt is deemed to have been made if follicular aspiration is successful
  In vitro fertilisation (one IVF attempt) is deemed to have occurred if stage 2, follicular aspiration (retrieval of mature egg cells) is successful. The transfer of previously cultured (frozen) embryos forms part of the IVF attempt during which the embryos were cultured.
  Fertility treatment: IVF stages
  In vitro fertilisation (IVF) has four consecutive stages:
  - stage 1: hormone treatment to stimulate egg cell maturation;
  - stage 2: follicular aspiration (retrieval of mature egg cells);
  - stage 3: fertilisation of the egg cells and embryo culture in the laboratory;
  - stage 4: one or more implants of 1 or 2 embryos into the uterus.

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

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You have a severe developmental or growth disorder of the teeth/jaw/mouth.
  - You have an acquired disorder of the teeth/jaw/mouth.
  - You suffer from a non-dental physical or mental condition.
  - You receive medical treatment that has demonstrably inadequate results without dental care.
    This generally involves ensuring that the mouth is kept free of infection through, for example, the use of periodontal treatment, the extraction of teeth and/or the administration of antibiotics.

Terms and conditions
- Without special oral care, you would not be able to maintain the function of your teeth
  Or your teeth would not function as they would if you were not to have one of the conditions mentioned.

Who to get a referral from
- Dentist, orthodontist or dental implantologist in the case of fitting dental implants

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this

Do you need approval?
- You need our approval
  Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist. We can withdraw our approval if one of the following situations occurs: - if the oral care is no longer necessary; - if you seriously neglect your oral hygiene;- if you fail to follow the advice 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').
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- For treatment performed under general anaesthetic or sedation (e.g. with nitrous oxide): an authorised healthcare provider in a centre for dental care in exceptional circumstances that is recognised by the Dutch Central Consultative Body for Dental Care in Exceptional Circumstances ('Centraal Overleg Bijzondere Tandheelkunde', COBIJT)
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- For treatment under general anaesthetic or sedation (e.g. with nitrous oxide): an authorised healthcare provider with whom we have made agreements about these treatments

What is not reimbursed
- Mandibular repositioning device (MRD)
  Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the ‘Respiratory aids’ clause.
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001)
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002)
- External whitening per jaw (code K003)
- Incomplete cosmetic dentistry (K004)

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

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

Insured healthcare
- Insertion of a dental implant

Your reimbursement
- Reimbursement of 100 percent for implant insertion in toothless jaw.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- A statutory personal contribution applies to the full denture attached to a dental implant

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a severely shrunken, toothless jaw, to which the removable denture can be attached.

Who to get a referral from
- Dentist
- Dental implantologist
  The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG).

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider’s place of work), you will need a written recommendation from the general practitioner or specialist for this

Do you need approval?
- You need our approval for the placement of one or more implants in your upper jaw
  The request for approval must be supported by a written statement of the reasons from your dentist or dental surgeon, along with a written treatment plan. You can find more information on requesting approval for dental surgery in the ‘Limitatieve lijst machtigingen Kaakchirurgie’ (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.
- For the lower jaw, a contracted healthcare provider will assess whether you meet the conditions. Our prior approval is not required in this case
  Our approval is always required if the treatment is provided by a non-contracted healthcare provider. The request for approval must be supported by a written statement of the reasons from your dentist or dental surgeon, along with a written treatment plan. You can find more information on requesting approval for dental surgery in the ‘Limitatieve lijst machtigingen Kaakchirurgie’ (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request.

For the approval, see the attached General terms and conditions, section [Approval]({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 for orthodontic care in exceptional circumstances.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - You have a severe developmental or growth disorder of the teeth/jaw/mouth.
    This always involves a very severe disorder where the treatment also requires the involvement of a dental surgeon or other disciplines besides dental care.

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider’s place of work), you will need a written recommendation from the general practitioner or specialist for this
- A treatment plan is required for prosthetic follow-up treatment
  If, in the case of combined orthodontic treatment and dental surgery, prosthetic follow-up treatment is required, a multidisciplinary treatment plan will need to be drawn up in advance by all of the healthcare providers involved.

Do you need approval?
- You need our approval
  Your request for approval must be supported by a treatment plan and a written explanation of the reasons from your orthodontist or from your dentist for orthodontics who meets the additional requirements of the Dutch Association of Dentists for Orthodontics (‘VTvO’).

For the approval, see the attached General terms and conditions, section [Approval]({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 (‘VTvO’)
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

What is not reimbursed
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37*, H38* and H39)
- Brace repair or replacement (code F811A*)
- Brace repair or replacement (code F811B*)
- Brace repair or replacement (code F811C*)

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

Regular oral care such as check-ups, tartar removal and fillings (clause B.13.)

Insured healthcare
- Regular examination
- Incidental dental consultation
- Teeth cleaning: removal of tartar
- Fluoride: fluoride treatment once permanent teeth have started to come through
- 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 for regular oral care such as check-ups, tartar removal and fillings.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider’s place of work), you will need a written recommendation from the general practitioner or specialist for this

Do you need approval?
- You need our approval 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 2 fluoride treatments per jaw per year (M30 OR M40); - 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 our approval for certain oral care
  If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you need our approval if this concerns treatment of the teeth's supporting tissue, e.g. the gums (periodontal care). You can find more information on requesting approval for dental surgery in the 'Limitatieve lijst machtigingen Kaakchirurgie' (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request. - approval is always required for oral care in a centre for dental care in exceptional circumstances. - your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist. - We can withdraw our approval if one of the following situations occurs: -- if the oral care is no longer necessary; -- if you fail to follow the advice 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).
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Authorised healthcare provider affiliated with a facility for youth dental care.
- Authorised healthcare provider 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, these costs will be reimbursed.
- Orthodontic care and associated X-ray
  For oral care in exceptional circumstances, this healthcare will be reimbursed.
- Gum shields (code M61)
  Except in the case of oral care in exceptional circumstances.
- External whitening (code E97)
- Shaping and/or treatment of milk teeth (code M05)
- Mandibular repositioning device (MRD)
  Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the 'Respiratory aids' clause.
- Simple bacteriological examination (code M32)
- Treatment of white spots (codes M80* and M81*)
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37*, H38* and H39)
- Extensive examination for the integral treatment plan (code C012)
- Making and discussing a restorative model (code C016*)
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001)
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002)
- External whitening per jaw (code K003)

- Incomplete cosmetic dentistry (K004)

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

Regular and specialist oral care (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 for regular and specialist oral care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider’s place of work), you will need a written recommendation from the general practitioner or specialist for this

Do you need approval?
- You need our approval 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 application is submitted by the head of the treatment team using the special application form for this treatment. If the treatment is performed by a specialist dentist for oral disease or a dental surgeon, you need our approval 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 on requesting approval for dental surgery in the ‘Limitatieve lijst machtigingen Kaakchirurgie’ (restrictive list of authorisations for dental surgery), which you will find on our website, or we can send this to you on request. - approval is always required for oral care in a centre for dental care in exceptional circumstances. - your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist. - We can withdraw our approval if one of the following situations occurs: -- if the oral care is no longer necessary; -- if you fail to follow the advice 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).
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Authorised healthcare provider affiliated with a facility for youth dental care.
- Authorised healthcare provider 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.
- The head of a team who has followed the specific training programme and has demonstrable specific expertise in the case of inserting autografts (autologous implants), codes H36, H37, H38 and H39

What is not reimbursed

- Crown, bridge and implant
  For oral care in exceptional circumstances, or if a front tooth, incisor or canine is missing as a direct result of an accident or because it has not developed, these costs will be reimbursed.
- Gum shields (code M61)
  Except in the case of oral care in exceptional circumstances.
- External whitening (code E97)
- Shaping and/or treatment of milk teeth (code M05)
- Mandibular repositioning device (MRD)
  Including diagnostics and aftercare (codes G71*, G72 and G73*). This is a medical aid for apnea (snoring). Reimbursement for this may be possible under the ‘Respiratory aids’ clause.
- X-ray examination for orthodontic care
- Insertion of skeletal anchorage devices in the context of orthodontic care
  Except in the case of orthodontic care in exceptional circumstances. See the ‘Orthodontic care in exceptional circumstances’ clause.
- Orthodontic care and associated X-ray
  For oral care in exceptional circumstances, this healthcare will be reimbursed.
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37*, H38* and H39)
- Extensive examination for the integral treatment plan (code C012)
- Making and discussing a restorative model (code C016*)
- Cosmetic dentistry, direct veneer (built-up in the mouth) (code K001)
- Cosmetic dentistry, indirect veneer (fabricated in the dental lab) (code K002)
- External whitening per jaw (code K003)
- Incomplete cosmetic dentistry (K004)

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

Dentures (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 for dentures.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

Who to get a referral from
- Dentist in the event of treatment by a prosthodontist if you still have your own teeth and/or dental implants

Who to get a treatment proposal from
- If the healthcare is to be provided at your place of residence (so not your healthcare provider's place of work), you will need a written recommendation from the general practitioner or specialist for this

Do you need approval?
- You need our approval 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 our approval if this concerns extraction of teeth under general anaesthetic or sedation (e.g. using nitrous oxide); - approval is always required for oral care in a centre for dental care in exceptional circumstances. Your request for approval must be supported by a treatment plan and a written statement of the reasons from your dentist. - We can withdraw our approval if one of the following situations occurs: -- if the oral care is no longer necessary; -- if you fail to follow the advice 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).
- Authorised healthcare provider who is affiliated with a centre for oral care.
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled 'de centrumindicatie' and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Authorised healthcare provider affiliated with a facility for youth dental care.
- Authorised healthcare provider 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 insofar as authorised.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists ('Besluit opleidingseisen en deskundigheidsgebied tandprotheticus').

What is not reimbursed
- Extensive examination for the integral treatment plan (code C012)

- Making and discussing a restorative model (code C016*)
- Incomplete cosmetic dentistry (K004)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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. These costs are claimed under code J080. This includes insertion of the fixed part of the suprastructure (the snap-on system).
- Mesostructure for the lower or upper jaw
  This is part of the combination of dentures for one jaw combined with implant-retained dentures for the other jaw.

Your reimbursement
- 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; and
- You are 18 years old or above, from 0 euros: for associated mesostructure for implant-retained dentures in the lower jaw: 90 percent; and
- You are 18 years old or above, from 0 euros: for associated mesostructure for implant-retained dentures in the upper jaw: 92 percent.

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.)

The amount you pay yourself
- Deductible applies from the age of 18
- Personal contribution 17%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

Do you need approval?
- You need our approval 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).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Insertion of a dental implant
- Uncomplicated extraction (extraction of tooth or molar)

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

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

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 10%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

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

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

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Insertion of a dental implant
- Uncomplicated extraction (extraction of tooth or molar)

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

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

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 8%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

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

For the approval, see the attached General terms and conditions, section [Approval]({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).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

- Prosthodontist if you have been referred by the dentist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Insertion of a dental implant
- Uncomplicated extraction (extraction of tooth or molar)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for dental surgery.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Terms and conditions
- In case of admission, it must be medically necessary for specialist surgical oral care

Who to get a referral from
- Dentist
- Orthodontist
- General practitioner

Do you need approval?
- You need our approval 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 for full dentures for upper and/or lower jaw without implants.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 25%

Terms and conditions
- In the case of treatment for which you need approval, the entitlement is not higher than the amount for which we have granted approval
- This healthcare is subject to a statutory personal contribution that can be reimbursed under the ‘Statutory personal contribution for dentures’ clause if you have additional insurance cover for this

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

Do you need approval?
- You need our approval 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 our approval 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).

- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Uncomplicated extraction (extraction of tooth or molar)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for repairing and rebasing full dentures.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 10%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

Where to go for this healthcare
- Dentist.
  The dentist is qualified as a dentist and is registered as a dentist under the terms and conditions of Article 14 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist for dentures (possibly involving dental implants), not on natural elements.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for implant-retained lower denture.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 10%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

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

For the approval, see the attached General terms and conditions, section [Approval]({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).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.
- Prosthodontist if you have been referred by the dentist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Insertion of a dental implant
- Uncomplicated extraction (extraction of tooth or molar)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for implant-retained upper denture.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 8%

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

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

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

For the approval, see the attached General terms and conditions, section [Approval]({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).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

- Prosthodontist if you have been referred by the dentist.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
- Insertion of a dental implant
- Uncomplicated extraction (extraction of tooth or molar)

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for repair or rebasing of a removable, implant-retained denture.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18
- Statutory personal contribution 10%

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

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

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

For the approval, see the attached General terms and conditions, section [Approval]({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).
- Authorised healthcare provider who is affiliated with a centre for dental care in exceptional circumstances.
  The centre for dental care in exceptional circumstances is a centre that provides dental care in exceptional cases. It does this in accordance with the document entitled ‘de centrumindicatie’ and the applicable specifications. Treatment is provided by a team and/or requires special expertise. A centre or facility for oral care is not regarded as the same as a centre for dental care in exceptional circumstances.

- Prosthodontist for dentures (possibly involving dental implants), not on natural elements.
  The prosthodontist holds a valid diploma under the Decree on Training Requirements and Expertise for Prosthodontists (‘Besluit opleidingseisen en deskundigheidsgebied tandprotheticus’).

What is not reimbursed
For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 for implant with crown to replace an incisor or canine.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You are missing one or more permanent incisors or canines because they have not developed.
  - You are missing one or more permanent incisors or canines as a direct result of an accident before the age of 18.
    This also applies to situations in which:
  - as the result of an accident, a tooth has broken to such an extent that only a small part of the root remains. The remaining part of the root needs to be left in place so as not to disrupt the development of the jaw. This will need to be removed later because it will not be able to support a prosthetic device;
  - a tooth that has been knocked out in an accident has been put back in the socket and secured so as not to disrupt the development of the jaw, even though there is little chance that the tooth can ultimately be saved.

Terms and conditions
- The treatment history must show that the accident occurred and was recorded before the age of 18
- The remaining part of the root or the reinserted front tooth needs to be removed before the age of 23, right before the insertion of an implant
- In case of admission, it must be medically necessary for specialist surgical oral care

Who to get a referral from
- Dentist, orthodontist or general practitioner for treatment by a centre for dental care in exceptional circumstances

Do you need approval?
- You need our approval. 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, this healthcare will be reimbursed.
- Orthodontic care required as a result of the insertion of autografts (codes H36, H37*, H38* and H39)

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

Prevention

What you are insured for under your general insurance policy

Support with quitting smoking (clause B.21.2.)

Insured healthcare
- Support with quitting smoking
  Quit smoking coaching consists of interventions aimed at a change in behaviour, if necessary with the help of ‘proven effective’ medicines or nicotine substitutes (pharmacotherapy). The healthcare provider tailors the actual healthcare and guidance under the quit smoking coaching to you personally and, if necessary, gradually adjusts this during the healthcare process.

Your reimbursement
- Reimbursement of 1 attempt to quit maximum, per year for support with quitting smoking.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Coaching and support during a quit smoking course are not subject to the deductible if you go to a healthcare provider that we have contracted for this healthcare
- Medicines or nicotine substitutes are not subject to the deductible if they are prescribed by a contracted quit smoking healthcare provider and are prescribed as part of the quit smoking course

Terms and conditions
- If medicines or nicotine substitutes (pharmacotherapy) are required, they must be used in combination with behavioural support from the quit smoking course
  The pharmacotherapy must therefore be part of the behavioural support in the form of individual coaching and support by telephone, online or through group coaching and support. A quit smoking coach is involved in this, in accordance with a quit smoking course that has proven to be effective.
- Medicines that are listed in the Medicines Reimbursement System (GVS) are not reimbursed under the provisions of this clause, but under the ‘Medicines under the Medicines Reimbursement System’ clause

- If you are being treated for another addiction as part of mental healthcare, the quit smoking course will also come under the mental healthcare programme for the other addiction

Who to get a treatment proposal from

- General practitioner or healthcare provider contracted for quit smoking interventions for a prescription for medicines or for nicotine substitutes (pharmacotherapy)
  - if the pharmacotherapy for the quit smoking coaching is prescribed by your general practitioner, a prescription with the letters SMR (initialisation for the Dutch term for quit smoking) is sufficient. - healthcare providers contracted for quit smoking interventions must prescribe the pharmacotherapy using the quit smoking medicines application form (‘Geneesmiddelen bij het stoppen met roken’). This form, which can be downloaded from our website, includes a description of the prescribed procedure. - healthcare providers who do not have a contract with us for quit smoking interventions will need to refer you to your general practitioner for the pharmacotherapy.
- Not necessary if it only concerns the quit smoking coaching and support

Where to go for this healthcare

- General practitioner for quit smoking interventions.
  The healthcare is provided by or under the responsibility of a general practitioner. This is a doctor listed as a general practitioner on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). Furthermore, the general practitioner must be listed on the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) and have been trained to provide intensive counselling for those trying to quit smoking.
- Quit smoking medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist is responsible for the healthcare provided by other qualified healthcare providers to whom he or she has delegated tasks relating to his or her medical specialism. Furthermore, the specialist must be listed on the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) and have been trained to provide intensive counselling for those trying to quit smoking.
- Quit smoking coach.
  The healthcare provider who provides the programme and is listed in the Quality Register for Quit Smoking Coaches (‘Kwaliteitsregister Stoppen met Roken’) who has been trained to provide intensive counselling for those trying to quit smoking.
- Healthcare psychologist.
  Healthcare psychologist (‘GZ-psycholoog’) is a legally protected title in the Netherlands; this title may only be used by someone registered as such under the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG). This means not every psychologist working in healthcare is a ‘GZ-psycholoog’.
- Pharmacy for dispensing medicines or nicotine substitutes
  A pharmacist with a permit to dispense medicines under the terms of the Dutch Medicines Act (‘Geneesmiddelenwet’).
- Contracted quit smoking supplier for the provision of medicines or nicotine substitutes
  Please see our website to find out which suppliers we have contracted. Simply enter ‘Stoppen met roken’ in the search box.

What is not reimbursed

For the general exclusions, see the attached General terms and conditions, section [General exclusions]({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 40 euros maximum, per kilometre for transport by car and From 0 euros: reimbursement of 100 percent for transport by taxi and From 0 euros: reimbursement of 100 percent for transport by public transport (2nd class) and From 0 euros: reimbursement of 100 percent for transport by other means of transport.
  2. Reimbursement of 91 euros maximum, per night for accommodation costs.

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.)

The amount you pay yourself

- Statutory personal contribution of €126 per calendar year for all patient transport combined
- Deductible applies from the age of 18

Eligibility for this healthcare

- One of the following medical indications or situations applies to you:
  - You are undergoing kidney dialysis.
    This also includes consultations, examinations and check-ups relating to this treatment, from discussing the definitive treatment plan to ending the treatment.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes consultations, tests and check-ups that are a necessary part of the treatment.
  - You are 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 day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
    The day treatment is provided in a group in accordance with the ‘Medical care for specific patient groups’ clause.

- You are younger than 18 and require nursing care and other care.
  Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
- The hardship clause applies.
  This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above. - to be eligible for this, an application must be submitted together with a statement from your attending doctor; - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz); - the following calculation applies for this: number of months’ treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor); - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is an outbound and return journey to and from:
  - a healthcare provider; - a facility where you are treated and/or nursed; or - your officially registered home address or another residence if you will not be able to, within reason, 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 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 being 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 our approval

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.)

The amount you pay yourself
- Statutory personal contribution of €126 per calendar year for all patient transport combined
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You are undergoing kidney dialysis.
    This also includes consultations, examinations and check-ups relating to this treatment, from discussing the definitive treatment plan to ending the treatment.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes consultations, tests and check-ups that are a necessary part of the treatment.
  - You are 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 day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
    The day treatment is provided in a group in accordance with the ‘Medical care for specific patient groups’ clause.
  - You are younger than 18 and require nursing care and other care.
    Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
  - The hardship clause applies.
    This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above. - to be eligible for this, an application must be submitted together with a statement from your attending doctor; - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz); - the following calculation applies for this: number of months’ treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor); - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions
- This is an outbound and return journey to and from:
  - a healthcare provider; - a facility where you are treated and/or nursed; or - your officially registered home address or another residence if you will not be able to, within reason, 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 you are undergoing the kidney dialysis, chemotherapy, radiotherapy or immunotherapy

- We will assess whether you can use public transport, your own transport or taxi transport because the healthcare to be provided must be effective
- In case of transport by taxi, you may have to travel with several insured persons for efficiency reasons
- In the event of the patient being escorted, transport of the escort must be medically necessary, or the insured person being 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 our approval

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.)

The amount you pay yourself
- Statutory personal contribution of €126 per calendar year for all patient transport combined
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:

- You are undergoing kidney dialysis.
  This also includes consultations, examinations and check-ups relating to this treatment, from discussing the definitive treatment plan to ending the treatment.
- You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
  This also includes consultations, tests and check-ups that are a necessary part of the treatment.
- You are 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 day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
  The day treatment is provided in a group in accordance with the ‘Medical care for specific patient groups’ clause.
- You are younger than 18 and require nursing care and other care.
  Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
- The hardship clause applies.
  This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above. - to be eligible for this, an application must be submitted together with a statement from your attending doctor; - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz); - the following calculation applies for this: number of months’ treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor); - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is an outbound and return journey to and from:
  - a healthcare provider; - a facility where you are treated and/or nursed; or - your officially registered home address or another residence if you will not be able to, within reason, 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 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 being 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 our approval

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.)

The amount you pay yourself
- Statutory personal contribution of €126 per calendar year for all patient transport combined
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You are undergoing kidney dialysis.
    This also includes consultations, examinations and check-ups relating to this treatment, from discussing the definitive treatment plan to ending the treatment.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes consultations, tests and check-ups that are a necessary part of the treatment.
  - You are 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 day treatment in connection with a healthcare programme for chronically progressive, degenerative disorders, an acquired brain injury or an intellectual disability.
  The day treatment is provided in a group in accordance with the ‘Medical care for specific patient groups’ clause.
- You are younger than 18 and require nursing care and other care.
  Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
- The hardship clause applies.
  This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above. - to be eligible for this, an application must be submitted together with a statement from your attending doctor; - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz); - the following calculation applies for this: number of months’ treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor); - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions

- This is an outbound and return journey to and from:
  - a healthcare provider; - a facility where you are treated and/or nursed; or - your officially registered home address or another residence if you will not be able to, within reason, 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 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 being 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 our approval

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.)

The amount you pay yourself
- No statutory personal contribution
- Deductible applies from the age of 18

Eligibility for this healthcare
- One of the following medical indications or situations applies to you:
  - You are undergoing kidney dialysis.
    This also includes consultations, examinations and check-ups relating to this treatment, from discussing the definitive treatment plan to ending the treatment.
  - You are being treated for cancer and are undergoing chemotherapy, radiotherapy or immunotherapy.
    This also includes consultations, tests and check-ups that are a necessary part of the treatment.
  - You are 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 are younger than 18 and require nursing care and other care.
    Due to complex physical problems or a physical disability, you require nursing and other care. You require permanent supervision or need to have healthcare available nearby 24 hours a day.
  - The hardship clause applies.
    This applies where it would be very unreasonable for you not to qualify for patient transport for the treatment (or consultations, tests and check-ups that are necessary as part of the treatment) of a prolonged illness or condition other than those described above. - to be eligible for this, an application must be submitted together with a statement from your attending doctor; - the healthcare you receive must be covered by your health insurance or the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz); - the following calculation applies for this: number of months’ treatment x number of treatments per week x 52/12 (number of weeks in a year) x number of kilometres in a one-way journey x 0.25 (weighting factor); - if the result is 250 or higher, you are also insured for patient transport.

Terms and conditions
- You want to stay the night instead of travelling
  - you are entitled to patient transport based on one of the above medical grounds or situations; and - you would require 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: - non-urgent 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; - urgent ambulance transport; - patient transport by other means of transport if transport by ambulance is not possible; - cost of usage for an automated external defibrillator (AED) that are charged to the ambulance service (electrode pads).

Your reimbursement
- Reimbursement of 100 percent for transport by ambulance.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Deductible applies from the age of 18

Eligibility for this healthcare
- The medical indication or situation below applies to you:
  - There is a medical necessity, which means that any other type of patient transport (car, public transport or taxi) would not be responsible for medical reasons.

Terms and conditions
- The healthcare you receive at the place of treatment and nursing is covered by the health insurance or by Article 3.1.1. of the Dutch Long-term Care Decree (‘Besluit Langdurige zorg’)
- An ambulance to another residence is only possible if, within reason, you will not be able to receive the care you need at your own home

Who to get a treatment proposal from
- A doctor requests ambulance transport from the emergency centre of the regional ambulance service The emergency centre assesses whether transport by ambulance is required.
- You do not need a treatment proposal for urgent ambulance transport

Do you need approval?
- You need our approval if you will be travelling further than 200km one way or if you want to use a different type of transport because transport by ambulance is not possible

For the approval, see the attached General terms and conditions, section [Approval]({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: - annual foot check: anamnesis, foot examination and risk inventory; - targeted foot examination and treatment of risk factors such as skin and nail problems; - treatment of foot shape and position deviations with an increased risk of foot ulcers; - information and lifestyle advice; - advice on the correct footwear.

Your reimbursement

- Reimbursement of 100 percent for preventive foot care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

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

Eligibility for this healthcare

- The medical indication or situation below applies to you:
  - Below the ankle, you have an increased risk of a wound through all layers of the skin (foot ulcers). This is due to one of the following situations: - your feet are less sensitive to pressure (loss of protective sensibility); - blood circulation in your feet has decreased; - the pressure on your skin has increased; this may be associated with fragile skin. Or this is due to one of these indications as described in the position document on foot care for diabetes mellitus patients (‘Standpunt voetzorg bij diabetes mellitus’) and the memo clarifying the position on foot care for diabetes mellitus patients (‘Notitie verduidelijking standpunt voetzorg voor mensen met diabetes mellitus’) of ‘Zorginstituut Nederland’ (ZiNl): - a foot ulcer or a previous amputation; - inactive Charcot arthropathy (Charcot joint); - end-stage kidney failure or kidney dialysis.

Terms and conditions

- Your complaints and symptoms are the result of a medical condition or medical treatment. Zorginstituut Nederland (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’).
- There is an individual treatment plan that includes:
  - the number of treatments and check-ups required; and - the diagnostics used to determine the targeted treatment.
- The preventive foot care for type 2 diabetes can also be provided in the form of multidisciplinary care. See clause A.17.3.
- The claim is submitted through

- the principal contractor (possibly a podiatrist) in accordance with the policy rule of the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) on general practitioner care and multidisciplinary care (‘Huisartsenzorg en multidisciplinaire zorg’) defined on the basis of the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg); or - the individual, affiliated healthcare providers with what is known as ‘costs for organisation and infrastructure’, i.e. the overhead costs claimed by the principal contractor.
  Definition of multidisciplinary care
  Multidisciplinary care comprises multidisciplinary, regional healthcare offered by several healthcare providers affiliated with a principal contractor (like a healthcare group or a healthcare centre), all working together to provide the required care. The multidisciplinary care takes the form of a total healthcare programme tailored to your personal situation and circumstances.

Who to get a referral from

- General practitioner, medical specialist, physician assistant or clinical nurse specialist
  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 in the Quality Register for Allied Health Professionals (‘Kwaliteitsregister Paramedici’) who is a member of the Dutch Association of Podiatrists (‘Nederlandse Vereniging van Podotherapeuten’, NVvP).
- 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
- General toenail care such as cutting nails straight to prevent ingrown toenails

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

Healthcare before childbirth

What you are insured for under your general insurance policy

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

Insured healthcare

- Preconception care, midwifery care and preventive care on non-medical grounds
  This concerns the following healthcare: - insertion of IUD/implants and/or removal of an Implanon rod; - pre-conception consultation: advice and information at the request of the insured 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; and - obstetric and preventive care during pregnancy to promote good health for mother and child.

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

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

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

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

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

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.

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise
- From the age of 18, the deductible applies to the fitting of an IUD or implantation or removal of an Implanon rod

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

Who to get a referral from
- General practitioner
- Physician assistant
- Obstetrician
- 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.5.2.)

Insured healthcare
- General routine ultrasound

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Where to go for this healthcare
- Medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist 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). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Obstetrician
  An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians (‘Koninklijke Nederlandse Organisatie van Verloskundigen’, KNOV).
- Sonographer.
  An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians (KNOV) or the register administered by the Dutch Professional Association of Sonographers (‘Beroepsvereniging Echoscopisten Nederland’, BEN).
  The healthcare takes place in an ultrasound centre or antenatal screening centre.

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

Specific diagnostic ultrasound (clause B.5.2.)

Insured healthcare
- Specific diagnostic ultrasound

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

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

Where to go for this healthcare
- Medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist 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). The healthcare can also be provided by or under the responsibility of a general practitioner.
- Obstetrician
  An obstetrician listed on the Quality Register of the Royal Dutch Organisation of Obstetricians (‘Koninklijke Nederlandse Organisatie van Verloskundigen’, KNOV).
- Sonographer.
  An individual with a medical or allied health qualification at a minimum of higher professional (HBO) level who is listed in the sonography register administered by the Royal Dutch Organisation of Obstetricians (KNOV) or the register administered by the Dutch Professional Association of Sonographers (‘Beroepsvereniging Echoscopisten Nederland’, BEN).
  The healthcare takes place in an ultrasound centre or antenatal screening centre.

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

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

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

Your reimbursement
- Reimbursement of 1 time(s) maximum, per pregnancy for registration and initial interview for obstetric care.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- This healthcare is not subject to the deductible

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

Where to go for this healthcare
- Obstetric care facility.
- Obstetric nurse
  The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - 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

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

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

Healthcare during childbirth

What you are insured for under your general insurance policy

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

Insured healthcare

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

Your reimbursement

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

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

Terms and conditions

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

Where to go for this healthcare

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

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

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

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

Your reimbursement
- Reimbursement of 261 euros maximum, per childbirth for midwifery care in a hospital or birth centre.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

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

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

Where to go for this healthcare
- 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). The healthcare can also be provided by or under the responsibility of a general practitioner.

- Nurse.
  The healthcare is provided in a hospital or independent treatment centre (ZBC).
- Obstetric nurse
  The obstetric nurse works independently or is employed by a facility that organises the obstetric care. The obstetric nurse meets all the following conditions: - 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}).

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

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

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

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

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

Who to get a referral from
- General practitioner
- Obstetrician

Where to go for this healthcare
- Medical specialist.
  A doctor listed as a medical specialist on the relevant register administered by the Medical Specialists Registration Committee (‘Registratiecommissie Geneeskundig Specialisten’, RGS). The medical specialist 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}).

Healthcare after childbirth

What you are insured for under your general insurance policy

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

Insured healthcare
- Midwifery care following childbirth at your home
- Obstetric care following childbirth at your home

Your reimbursement
- From 0 euros: reimbursement of 100 percent of the agreed number of hours distributed over a maximum of 6 weeks for obstetric and midwifery care after childbirth at your home.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- The statutory personal contribution for obstetric care is €5.40 per hour
- This healthcare is not subject to the deductible
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise

Terms and conditions
- You arrange the obstetric care yourself. You do so no later than your 20th week of pregnancy
  If you have any questions or anything is not clear, feel free to contact us.
- Registration and the initial interview for obstetric care take place before the birth of the child or the obstetric care
  This may be done at your home or by telephone. During the intake you will discuss the number of days of obstetric care and the number of hours per day.

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

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

Your reimbursement
- From 0 euros: reimbursement of 100 percent of the agreed number of hours distributed over a maximum of 6 weeks, maximum of €152 per person per day for obstetric and midwifery care after childbirth if you choose to give birth in a hospital (midwifery unit) or birth centre.

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself
- Statutory personal contribution of €21.50 per person per day
- This healthcare is not subject to the deductible
- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise

Terms and conditions
- You arrange the obstetric care yourself. You do so no later than your 20th week of pregnancy
  If you have any questions or anything is not clear, feel free to contact us.
- Registration and the initial interview for obstetric care take place before the birth of the child or the obstetric care
  This may be done at your home or by telephone. During the intake you will discuss the number of days of obstetric care and the number of hours per day.

- After childbirth, the 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.

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

Insured healthcare

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

Your reimbursement

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

We use a variety of rates. See the attached General terms and conditions, section [Rates]({0}).

The amount you pay yourself

- This healthcare is not subject to the deductible

- From the age of 18, the deductible applies to additional healthcare, such as medicines or transport by ambulance or otherwise

Terms and conditions
- The obstetric care is given immediately after childbirth
  The obstetric care is for: - the (biological) mother; - the 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)
  The number of days of admission are used to calculate the number of hours/days of obstetric care that remain.
- You have medical grounds for this healthcare
  Medical grounds will be deemed to exist if the pregnancy or childbirth involve an increased risk to the health of you or your baby.

Who to get a referral from
- Obstetrician
- General practitioner
- Medical specialist
- Physician assistant
- 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. The content and scope of your additional insurance package is set by us. We have it laid down in your terms and conditions of insurance.

Agreed rate
The (average) rate we agree in contracts with healthcare providers for certain types of healthcare. These rates are available on our website.

AGB code
This code is a unique administrative code assigned to healthcare providers in the Netherlands, identifying each one individually in Vektis. Vektis is a national register containing all information necessary to submit claims for the healthcare, to purchase and contract the healthcare and to help guide insured persons to the right healthcare.

Treatment
Contact, physical or online, with one or more healthcare providers, involving the provision of healthcare and/or advice. Treatment does not include courses or training.

Treatment proposal (or prescription)
This proposal states which healthcare (examination, treatment or therapy) you need. You are given a prescription for medicine.

Abroad
Any country other than the country where you live.

CAK
The Dutch Central Administration Office (‘Centraal Administratie Kantoor’, CAK), as defined in Article 6.1.1(1) of the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz).

Consultation
Contact with a healthcare provider. This can involve advice, a referral, a discussion of a patient’s medical history, a physical examination, diagnosis and/or additional tests where such is deemed medically necessary.

Day treatment
Healthcare in a department set up for day nursing in a facility for specialist medical healthcare (such as a hospital or independent treatment centre). This may also involve a medical examination or treatment in a rehabilitation facility. The healthcare is generally foreseeable and lasts for a number of hours. The patient is not admitted.

DBC healthcare product

A Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC healthcare product or DBC) is a code that describes the entire process of treatment under specialist medical healthcare. A DBC includes all the costs incurred by the healthcare provider to give you the right healthcare. The rate for a DBC is based on an average of the costs incurred for a particular course of treatment. The start date of a DBC is the date of first contact with the healthcare provider and determines the reimbursement. The bill is settled on the DBC start date. If the commencement date for a DBC is outside of the term of your insurance, none of the costs associated with that DBC are covered. 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.

EU/EEA member state

The EU (European Union) member states are: Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek part), Czech Republic, Denmark, Estonia, Finland, France (including French Guyana, Guadeloupe, Martinique, Réunion, Saint Barthélemy and Saint Martin), Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal (including the Azores and Madeira), Romania, Slovakia, Slovenia, Spain (including the Canary Islands, Ceuta and Melilla) and Sweden. Under international treaties, Switzerland is considered to be on a par with the above. The following are not part of the EU (this list is not exhaustive): Andorra, the Channel Islands, the Isle of Man, Monaco, San Marino and Vatican City. The EEA (European Economic Area) states are: the aforementioned EU states, Iceland, Liechtenstein and Norway. Explanation: On 31 January 2020, the United Kingdom, including Gibraltar, left the European Union.

Claimed rate

The amount stated on the invoice. Reimbursement will never exceed the costs of healthcare that you have actually incurred, and that you were invoiced for.

Medical aids on loan

These are medical aids that you may use as long as you are insured for them with us. We or the healthcare provider will enter into a loan agreement with you for this purpose. This agreement specifies your rights and obligations in respect of the medical aid you have on loan. You must return the medical aid upon termination of your insurance policy. We pay the reimbursement directly to the healthcare provider if you receive the medical aid on loan from a contracted healthcare provider. If you purchase a medical aid from a non-contracted healthcare provider and that aid would usually be provided on loan, you will not automatically be reimbursed for the full purchase value. We will reimburse you the costs involved in using the medical aid for an entire year in the same way as we reimburse these costs with a contracted healthcare provider. You do not need to pay any costs for medical aids on loan, so you do not pay a deductible for them. The deductible does apply, however, to the costs of consumables and usage associated with the medical aid that we lend you.

Owned medical aids

These are medical aids that transfer to your possession under your terms and conditions of insurance. You will acquire ownership of them. The purchase costs will be set off against your deductible. If a medical aid transfers to your possession, it is strictly for your own use. You may not sell it to anyone.

Year

A calendar year. However, when referring to someone’s age, we do not mean a calendar year. We simply mean a year in the person’s life.

Month
A calendar month.

Market rate applicable in the Netherlands
This is the rate that is reasonable and appropriate in the Dutch market for a given treatment. To determine this rate, we look at what amounts healthcare providers charge on average for that treatment. This means that we will not reimburse unreasonably high costs of treatment in full. See also Article 2.2.(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 indication/grounds
The medical condition or illness that a doctor suspects or has diagnosed so that you can access certain healthcare.

Accident
A sudden, unexpected, involuntary and external event. This event results directly in bodily injury that can be detected objectively by a medical professional. This applies even if you did not and could not reasonably foresee the event. We consider an acute, serious illness to be equivalent to an accident when: - medical care is required immediately on medical grounds and cannot be postponed, or an illness or condition is life-threatening; and - the healthcare required is covered by the general insurance policy; and - based on objective medical standards, no recovery can be expected within the next six months.

Example of an accident

- an infected wound or blood poisoning; - sprains, dislocations and tears of the muscles and ligaments; - involuntary ingestion of or poisoning with gases, vapours, liquid or solid substances or objects, unless this is through the conscious use of alcohol, medicine or drugs; - infection by exposure to pathogens or due to poisoning during an involuntary fall into water or any other substance (liquid or otherwise), or if you enter it yourself to save a person, animal or object; - drowning, suffocation, frostbite, hypothermia, sunstroke, burning (except as the result of sunbathing), lightning strike or other electrical discharge, or coming into contact with a corrosive substance; - natural violence such as an earthquake, flood, tsunami (tidal wave), hurricane, or volcanic eruption; - starvation, dehydration and exhaustion; - complications or aggravation of injuries as the result of medically required treatment after an accident; - becoming infected with HIV through a blood transfusion or injection with a contaminated needle while being treated in a hospital.

Admission
A period of nursing and treatment with an overnight stay in a department set up for nursing in a specialist medical 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.

Policy (document)
Proof of insurance.

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’ environment on our website.

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

Rate
The amount of money for healthcare or the resources provided, which we take as the basis for reimbursement of that healthcare or those resources. We have different types of rates.

Treaty country
The Netherlands has a treaty for social security, including arrangements for the provision of medical healthcare, with the following states: Australia, Bosnia and Herzegovina, Cape Verde, Macedonia, Montenegro, Morocco, Serbia, Tunisia and Turkey. The following are also treaty countries: - all EU member states except the Netherlands; - all states that are party to the Agreement on the European Economic Area (EEA); - Switzerland; - the United Kingdom.

Referral
For certain types of healthcare, you must have a referral before a consultation or before the start of the healthcare. This referral is the advice from one healthcare provider to go to another healthcare provider for a consultation or for healthcare. In the terms and conditions, we list which healthcare provider must provide this referral under ‘referral’.

Insured person
The individual entitled to insured healthcare (and reimbursement thereof) in accordance with our terms and conditions of insurance. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using ‘you’ and ‘your’. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to ‘he’, ‘him’ and ‘his’, this also means ‘she’ and ‘her’ and ‘her’ respectively.

Insurance policy
An insurance agreement may consist of a general insurance policy with one or more additional insurance packages. If the insurance consists of a combination of 2 or more insurance agreements, the combination can contain no more than one general insurance policy.

Policyholder
The person who takes out insurance with us, must pay the premium and costs and is the only person who can change and cancel the insurance. The policy is in the name of the policyholder. The policyholder may also be the insured person. In the terms and conditions of insurance, we refer to the insured person and the policyholder using ‘you’ and ‘your’. You can determine from the scope and content of the terms and conditions of insurance whether we mean the insured person or the policyholder. Where we refer to ‘he’, ‘him’ and ‘his’, this also means ‘she’ and ‘her’ and ‘her’ respectively.

Statutory personal contribution

Healthcare that is covered under your general insurance policy and in relation to which you must pay the costs in full or in part yourself. Personal contributions are set by law. A statutory personal contribution may be a fixed amount per treatment or a set percentage of the costs. A statutory personal contribution is not the same as a deductible. Statutory personal contributions and deductibles may apply side by side for the same insured healthcare. This may mean you will be charged both a statutory personal contribution and a deductible.

Statutory maximum rate

The maximum rate set by the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg). The rate used by a healthcare provider may be lower, but never higher.

Statutory fixed rate

The fixed rate set by the Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa) for certain types of healthcare, in accordance with the Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg). The rate used by a healthcare provider must be exactly the same as this rate. These rates are also known as set-point rates.

Appendix General terms and conditions

A.1A. Additional definitions

General insurance policy
Your general insurance policy is non-life insurance as defined in the Dutch Financial Supervision Act (‘Wet op het financieel toezicht’). This general insurance policy reimburses healthcare and healthcare costs. We determine the content and scope of your general insurance policy. Details are given in these terms and conditions of insurance.

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.

Insurer
By insurer we mean an insurance company as defined in the Solvency II Directive that is authorised as a non-life insurer as defined in the Dutch Financial Supervision Act (‘Wet op het financieel toezicht’). The insurance company to which these terms and conditions of insurance apply is the insurance company stated on the policy document in that capacity and is ‘Onderlinge Waarborgmaatschappij CZ groep U.A.’, registered in the Trade Register of the Chamber of Commerce under number 18028752. In these terms and conditions of insurance, we refer to the insurance company as ‘we’ and ‘us’.

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 insurance
When registering for your insurance, you may be asked to provide a health statement and medical reports. We will base your insurance policy or policies on those. We assume that you or someone else on your behalf will fill in these documents and send them to us. We also assume that you are familiar with these documents.

See also:
- Verzekering (definitions)

Deviation from terms and conditions of insurance
If the content of a group agreement differs from the general rules and regulations in these terms and conditions of insurance, the specific rules and regulations from the group agreement will apply. This means that those specific rules and regulations will take precedence over the general rules and regulations.

Refund general insurance policy
Your general insurance policy is a refund policy, which means that we reimburse costs incurred for healthcare that is covered under the policy.

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.

Applicable terms and conditions of insurance
Your policy document lists the insurance policies you have selected. You can view, download and save the terms and conditions of insurance for your policies on the secure ‘Mijn’ environment. As and when new terms and conditions of insurance are adopted, the old terms and conditions of insurance will cease to apply.

Translation of the terms and conditions of insurance
The terms and conditions of insurance are in Dutch, but we do have translations. In the event of differences between the content and interpretation of the Dutch-language terms and conditions of insurance and a translation, the Dutch-language terms and conditions of insurance will apply.

If terms and conditions of insurance deviate from the law
The terms and conditions of insurance and appendices for your policy comply with current legislation. If the legislation changes or an act is repealed or new legislation is passed and this results in a discrepancy between the terms and conditions of insurance and the laws and regulations, the most recent statutory provisions, explanatory memoranda or the interpretation thereof will always apply instead of the terms and conditions of insurance.

Membership
When taking out your general insurance policy, you automatically also request membership of the mutual insurance company ‘Onderlinge Waarborg Maatschappij CZ Groep U.A.’ for each insured person. The board always accepts this request. All insured persons are members of this mutual insurance company from the commencement date of your general insurance policy.

A.3. Content and scope of your insurance

General and specific requirements
The healthcare you receive has to meet certain general requirements. Specific requirements that do not apply to all types of healthcare are specified with the healthcare in question. The following general requirements apply to all types of healthcare: - it is healthcare that healthcare providers in the relevant profession provide in accordance with their standards and norms and deem accepted. What does this mean? Healthcare providers within a profession provide the same healthcare for certain complaints and diseases. The healthcare then falls within that profession's area of expertise. It is insured healthcare specified in the terms and conditions of insurance for your policy. - the content and scope of healthcare is determined by the latest practical and theoretical standards, or by what is deemed to constitute responsible and adequate healthcare and services in the field in question. What does this mean? There must be sufficient evidence that the healthcare you receive is effective and safe, also in the long term. The evidence must be objective scientific medical evidence. Where necessary, we will also look at the specific situation. Objective scientific medical evidence will not be required for healthcare provided under your additional insurance package. The scope of the healthcare is specified in these terms and conditions of insurance. Exactly how much you will get reimbursed is also detailed in other communications. The maximum amount, number, or period covered is specified with the healthcare in question. We never reimburse more than the amount stated on the bill. - based on your medical indication, there are reasonable medical grounds for you being provided with the healthcare in question. And the healthcare must be effective and appropriate to your individual situation. What does this mean? The healthcare in question must be a logical option given your complaints or disease, meaning that there have to be medical grounds for the healthcare you receive. 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.

Other healthcare
You are also insured for healthcare other than the healthcare specified in your general insurance policy. For such 'other healthcare': - the result of the 'other healthcare' must be comparable to the result of healthcare that does appear in the general insurance policy. This must be a generally accepted result; and - the other healthcare is not barred for legal reasons; and - we have given you our prior approval for the 'other healthcare'.

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.

Content and scope of your general insurance policy?
Your general insurance policy is based on health insurance under the Dutch Health Insurance Act ('Zorgverzekeringswet'). For some healthcare, you will have more or less cover.

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.

Commencement date and changes
Your insurance will take effect on the date we receive your registration. If you are still insured with another insurer, you can choose to have your policy take effect later. The commencement date must, however, be immediately after the end date of your previous policy. The commencement date of your insurance is stated on your policy document. You can request that your policy be changed. We will then cancel the policy you have at the time, because you cannot have two policies at the same time. Your new policy will, therefore, take the place of your old policy.

General insurance policy commencement date with retrospective effect
You can have your general insurance policy take effect on the day after your policy with another insurer ends, provided that we have received your request within 1 month of this date.

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, your additional insurance package will run until 1 January and for one full year after that.

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.

Insurance term upon addition of a family member
If you add a family member to your policy part-way through the year, the insurance term for that family member will be the same as yours.

Concealment
If the information you provided to us when you took out the insurance is incorrect or incomplete, this constitutes concealment of the correct or full information. We will then contact you about this and give you 14 days to respond. You can then terminate the insurance for all insured persons with immediate effect. We can terminate your insurance with immediate effect for all insured parties within 60 days of discovering your concealment.

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 or premium for your general insurance policy
If we change the terms and conditions or the premium 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 within 30 days of receiving our notice; - you must submit your cancellation or change in writing. Your change is subject to our approval. If we change your insurance, we will send you new insurance documents and new terms and conditions of insurance. In case of a change necessitated by a change in the law, you will not be able to cancel or change your insurance.

Change to premium for your general insurance policy
When you turn 30, 50 or 60, the premium for your general insurance policy will change. This change will take effect on the 1st day of the month following your birthday. You cannot cancel or change your general insurance policy on account of this change to the premium.

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)

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.

End of the insurance due to compulsory health insurance
Please notify us if you are obliged to take out health insurance under the Dutch Health Insurance Act (‘Zorgverzekeringswet’). Your general insurance policy will end when this obligation takes effect. If you also have an additional insurance package that is incompatible with compulsory statutory general insurance, this additional insurance package will also be terminated.

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.

You are unlawfully insured under your general insurance policy
If you have a general insurance policy while you are not under an obligation to have insurance, we will terminate your general insurance policy from the commencement date. This will mean that the general insurance policy never existed.

In the event of a criminal offence or violation
If you were involved in a criminal offence or violation (or attempts at such) in respect of us or a contracted healthcare provider, which includes deception, fraud, coercion, or threats, we will be authorised to: - terminate your insurance policy or policies with us with immediate effect; - suspend your claim for healthcare or reimbursement of the costs of healthcare; - claim back reimbursements you have received; - charge you for the costs of the investigation; - report this to the police; - record your details, or have your details recorded, in the usual warning system used by financial institutions.

If we no longer offer or administer the insurance
Given that we may stop offering and administering a certain type of insurance that you have taken out, we may terminate the relevant policy or replace it with a different policy. We will notify you of this change.

In the event of payment arrears for your general insurance policy
We can suspend your general insurance policy if you are in arrears of 2 months or more.

Upon the end of family participation in your insurance
If one of the insured persons is no longer a member of your family, or an insured person is no longer staying abroad temporarily but has moved there permanently, you (the policyholder) must let us know within 30 days. We will then terminate the insurance policy or policies for this insured person.

See also:
- Verzekerde (definitions)

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. - any taxes we are required to pay, by law or under a treaty, to particular bodies or authorities. The premium base and discounts for a voluntary deductible are stated in euros on your policy.

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, a quarter, six months or a year. You are required to pay in full. This means: - you pay for the payment periods that have passed; - you pay for the current payment period; - and you pay for the next payment period. This means that you always pay in advance. You are also required to pay on time. This means: - the total amount due must be in our account no later than on the date stated on your premium invoice; - if you pay by direct debit, we will debit the amount due in the 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 the total amount cannot be debited 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:
- 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. - we will not set off your arrears against any money you are still entitled to under a Personal Care Budget (‘Persoonsgebonden Budget’, PGB).

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 general insurance
If you fail to pay your premium and costs for the general insurance on time, we will be authorised to: - suspend your general insurance cover. We will take this step if your debt cannot be set off against money to which you are still entitled. On the day that all your debts to us have been paid, you will once more be entitled to cover under your general insurance. - terminate your general insurance policy. You will then not have general insurance any more.

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:
- 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.

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.

Overpaid after we have cancelled your insurance
We may cancel your insurance on account of a criminal offence, violation, deception, fraud, coercion or threat (or attempts at such), in which case premium and costs will not be refunded.

A.12. Compulsory deductible

Deductible for your general insurance policy
The deductible is the amount you have to pay yourself for healthcare under the general insurance policy. This applies to everyone from the age of 18.

The year for which you pay the deductible
We will set off costs against your deductible for the year in which you receive the healthcare, but only if we have received the invoice no later than in the following year.
Example
A treatment you have in 2022 can no longer be set off against the deductible if we receive the invoice in 2024. The costs will be set off against the deductible for 2022 if you personally forget to submit the invoice and we only receive it in 2024.

The year for which you pay the deductible in case of a Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC)
If you receive specialist medical healthcare that goes on beyond the end of the year, and you are sent an invoice with a Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC) healthcare product code, the start date of the DBC will determine the reimbursement. The costs will then be set off against the deductible for the year of the start date. The invoice may also include costs for Other Healthcare Products (‘Overige Zorg Producten’, OZPs). These costs are set off against the outstanding deductible for the year in which the healthcare is provided.

See also:
- DBC 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 23 September 2024 and runs through to 31 December 2024. This is a period of 100 days. There are 365 days in this year and the compulsory deductible for the whole year is €385. Your deductible for this part of the year will then be: - €385/ 365 = €1.0547 deductible per day - €1.0547 x 100 days = €105.47. Rounded to the nearest whole euro, this makes a compulsory deductible of €105 for 2024.

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 our prior written consent 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, or you misrepresent a situation, submit false or misleading documents, make false statements, or fail to cooperate with us, we can: - cancel your insurance policy or policies, which will leave you without cover for healthcare (costs); - claim back all reimbursements paid to you from the date when you misled us or refused to cooperate; - recover from you the costs of investigating the intentional deceit; - list you on our incident register; - register you in the warning systems used by insurers; - report the matter to the police; - deny you new insurance for a period of 5 years.

Significant events
Occurrences we need to know about for the proper execution of your insurance must be reported to us within 30 days. If you notify us within the specified timescale, any changes to your insurance will apply from the date of the significant event. Otherwise, the change will take effect at a moment of our choosing. Significant events include: - moving house or a change of address as registered in the Persons Database (‘Basisregistratie Personen’, BRP); - a change of postal address or email address; - birth or adoption; - death; - divorce; - start and end of a period of custody or prison sentence; - start and end of participation in a group agreement; - change to the family composition.

Your current address
You must submit your correct postal address and/or email address. We will assume that our correspondence reaches you when it is delivered to the most recent address you have submitted to us. Failure to provide us with your correct postal or email address may result in losses, for which we cannot be held liable.

A.16. Privacy and checks

Privacy
We process only data that we need to implement your insurance policy or policies. We do this as per the terms and conditions we have agreed on with you. We store this data in our records. Our processing of personal data on you complies with: - the 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.

Verification of details
We are authorised to verify details and screen for fraud in the implementation of your insurance policy. We will always do so in accordance with: - the terms and conditions and (personal) data agreed on with you, - the Dutch Health Insurance Act (‘Zorgverzekeringswet’); - the national Protocol on Substantive Checks (‘Protocol materiële controle’) and the national Protocol on Incident Warning Systems for Financial Institutions (‘Protocol Incidentenwaarschuwingssystemen Financiële Instellingen’). You must cooperate with us fully in this respect.

A.17. Healthcare providers

Definition of healthcare provider
The Dutch Healthcare (Market Regulation) Act (‘Wet marktordening gezondheidszorg’, Wmg) defines a healthcare provider as: - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that provides healthcare as a professional or an organisation; - a natural person, a legal entity, a facility for the provision of healthcare, or a healthcare group that charges for healthcare. They do this on behalf of a (different) accredited healthcare provider who provides healthcare. - the natural person who provides insured healthcare not as a professional or an organisation. This concerns district nursing that you procure yourself using a Personal Care Budget (‘Persoonsgebonden Budget’, PGB). A healthcare provider provides healthcare or provides medicines or medical aids and possible associated services.

Contracted healthcare providers
We have entered into contracts with healthcare providers on the healthcare and/or resources they provide. These contracts contain agreements on the price, quality and efficacy of the healthcare. They also contain the terms and conditions governing the provision of healthcare and the way costs are claimed. On our website you can find a list of all contracted healthcare providers. The fact that we have contracted a healthcare provider does not mean we always cover all the healthcare they provide. This can mean that: - while a healthcare provider is authorised to provide certain healthcare, you are not insured for it. We have then deliberately not contracted this healthcare provider for part of their healthcare or resources. - you are dealing with a healthcare provider we have contracted up to a certain budget (revenue ceiling). Or we have volume agreements in place with this healthcare provider. This may mean that a healthcare provider will not accept you for treatment. If we have such agreements with a healthcare provider, this will be stated on our website.

Definition of principal contractor
A principal contractor: - is a healthcare provider such as a healthcare group, health centre or podiatrist; - provides services as a legal entity in a partnership with several healthcare providers of different disciplines; - provides various forms of healthcare such as general practitioner care, dietetics and/or foot care; - is responsible for: -- upholding and monitoring quality requirements with respect to the services of the affiliated healthcare providers and -- providing healthcare in accordance with healthcare standards. Healthcare standards specify what requirements healthcare must meet to be considered good-quality healthcare from the patient’s perspective. This relates to the content of the healthcare, how it is organised, and support for self-management. A healthcare standard therefore acts as an aid to the healthcare provider, insurer and patient alike.

Requirements for healthcare and healthcare providers
The healthcare and the healthcare provider must meet various general terms and conditions: - for each type of healthcare, we designate the type of healthcare provider that can provide the healthcare. We will not reimburse healthcare provided by another type of healthcare provider, even if this healthcare provider is authorised to provide the healthcare in question. - The aforementioned healthcare provider supplies the care themselves and has an AGB code. Another type of healthcare provider may also provide the healthcare as long as it is done under the responsibility of the healthcare provider specified, except when we have stated otherwise for a type of healthcare. - the healthcare provider specified claims the healthcare under their own name. A facility, another healthcare provider, or another party may also claim the healthcare, provided that the name of the attending, responsible healthcare provider is stated on the invoice. - the healthcare provider must be authorised to provide the healthcare. This means that they must comply with the requirements and rules governing their profession, company, and the exercise thereof. - healthcare providers based in the Netherlands must comply with the requirements laid down in the Dutch Healthcare (Market Regulation) Act ('Wet marktordening gezondheidszorg', Wmg) and the Dutch Healthcare Quality, Complaints and Disputes Act ('Wet kwaliteit, klachten en geschillen zorg', Wkkgz). -- the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg') also governs doctors, dentists, pharmacists, healthcare psychologists, psychotherapists, physiotherapists, obstetricians and nurses. They have to be registered in the national BIG registers or another register that we consider to be equivalent. -- we will only reimburse healthcare provided by other healthcare providers if they have gained a designated qualification under Section 34 of the Dutch Individual Healthcare Professions Act ('Wet op de beroepen in de individuele gezondheidszorg'). They must then lawfully use the title and/or designation conferred upon them by that qualification. - as a means to assure quality, we have imposed additional terms and conditions on healthcare providers with respect to certain types of healthcare. This will be specified for the healthcare providers in question. For example: A podiatrist, for example, must be a member of the Dutch Association of Podiatrists ('Nederlandse Vereniging van Podotherapeuten', NVvP). A provider of alternative healthcare, for example, must be a registered member of one of the professional associations for alternative treatment methods. The list of professional associations is available on our website. - A healthcare provider in a 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)
- Buitenland (definitions)

Going to another healthcare provider for healthcare under your general insurance policy
Our Healthcare Team ('Zorgteam') can contact the healthcare provider to see whether you can be accepted for treatment all the same. Our Healthcare Team ('Zorgteam') can also help you find another healthcare provider if you prefer.

Ongoing treatment
If you are already being treated by a healthcare provider with a revenue ceiling or a volume agreement, you are free to complete the course of treatment.

See also:
- 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 approval is required
By ‘approval’ we mean a written statement from our ‘Medische Beoordelingen’ (Medical assessments) department. Certain healthcare is subject to our prior permission. That you have to seek approval will then be specifically stated with the healthcare. You must seek approval before starting the treatment. We will assess whether you meet the conditions for the healthcare you are seeking approval for. We will also assess whether the healthcare is appropriate and effective in your case. This may mean that we need additional information from you. If we approve the healthcare, the approval will state what we will cover and on what terms and conditions.

See also:
- Schriftelijk (definitions)

Approval for healthcare from a contracted healthcare provider
If you use a contracted healthcare provider, the healthcare provider can assess whether or not to approve the healthcare. This is because we have made arrangements to this effect with contracted healthcare providers. The contracted healthcare provider will do the following: - assess whether you meet the terms and conditions for reimbursement of the costs of the healthcare; - assess what healthcare you need. If the healthcare provider is not sure, they will forward the request for approval to us and we will then assess whether or not to approve the request. You will then not have to provide us with any information yourself.

Statements and promises
The approval is valid only with our prior written permission. We will then send a letter to the postal or email address you have submitted. We cannot be held liable for losses arising due to not receiving our correspondence or receiving our correspondence too late. This could happen if you have given us the wrong address, for instance.

Approval for healthcare from a non-contracted healthcare provider
If you go to a non-contracted healthcare provider, you must personally request our approval. This will be required only if we have stipulated that the healthcare in question is subject to approval. You can ask the healthcare provider to help you with that. We will need the following information from you: - a formal request stating the reason why you need the healthcare; - if possible, a 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 the information to our 'Medische Beoordelingen' (Medical assessments) department. What language to use for the request for approval Requests and additional information must be in Dutch, English, German, French or Spanish. If your request is in another language, we will ask that you include a translation. You can also have us arrange a translation. We will then claim the fee charged by the translation agency back from you.

Approval for medical aids
To purchase a medical aid, get one on loan, or have one replaced, adjusted or repaired, you can go directly to a contracted healthcare provider. A contracted healthcare provider will assess whether you meet the conditions for provision of a medical aid and which medical aid would be the most appropriate in your situation. If you meet the conditions for provision, the healthcare provider will claim the costs back from us directly. If you do not meet the conditions, you can choose: - to pay for the medical aid yourself; or - to request our approval yourself. In the latter case, please make sure you state that the healthcare provider has rejected your request for the medical aid in question. Requests for approval must be submitted in writing to our 'Medische Beoordelingen' (Medical Assessments) department. To do so, please send us a healthcare request. If we need additional information for the assessment of the healthcare request, we will request it from you. If you are using a contracted healthcare provider, that provider will generally submit the healthcare request to us on your behalf. If you opt to go to a non-contracted healthcare provider, you will have to submit the healthcare request to us yourself. For a number of medical aids, we have a standard application form available, which you can download from our website. You can also call our 'Medische Beoordelingen' (Medical Assessments) department to ask them to send you an application form. When you send us the healthcare request, you must include a written, substantiated explanation by the prescriber, stating the medical grounds, possibly supplemented by a recommendation or report if we request one. The healthcare request also specifies: - your customer number; - your name, address and place of residence; - your date of birth; - the name of the healthcare provider supplying the medical aid; - a description of the medical aid in question;- the item number from the 'Z-Index' (the Dutch national database of medicines) or the 'GPH-code' (Generic Product Code for Medical Aids): you can obtain these details from the healthcare provider; - an indication of how long you expect to need the medical aid; - and, if you are obtaining the medical aid from a non-contracted healthcare provider, a quote or cost estimate for the medical aid in question.

Period of validity
Approval issued by us is valid: - in accordance with the generally applicable legislation, regulations and terms and conditions of insurance; - for a maximum of 365 days, unless we state otherwise. If we change the specific terms and conditions for your healthcare within this period, you can complete the treatment as per the approval. Approval issued by us is no longer valid if: - the relevant laws and/or regulations change; or - your insurance policy has changed or stops, unless the commencement date of a treatment with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC) healthcare product code lies within the term of your insurance policy.

See also:
- DBC 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 those used by the Dutch tax authorities. The invoice must always at least state the following: -- name and address of the healthcare provider; -- your name and date of birth; -- specifics of the healthcare provided; -- the date on which, or the period over which, the healthcare was provided; -- the costs of the healthcare provided; -- the right Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC) healthcare product code, if it concerned specialist medical 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)

Claiming healthcare costs
How to claim your healthcare costs - use our app on your smartphone to submit invoices electronically; - use the online ‘Mijn’ environment to submit invoices electronically; - send us the original hard copies of invoices in the post; in some cases we will accept copies, provided that you have arranged this with us first. This is an exception. Your contracted healthcare provider will send the invoices directly to us.

If we pay the healthcare provider directly
If we have made arrangements with a healthcare provider for them to send invoices directly to us, we will also pay them directly. You must cooperate with us in this respect. This means that our obligation to reimburse you for these costs ceases to exist. We may also set off an invoice from a healthcare provider against an advance that the healthcare provider has already received.

If we pay more to the healthcare provider than you are entitled to
We always pay contracted healthcare providers' invoices in full. This may mean, however, that we pay more than the reimbursement to which you are entitled, because you may still have a deductible outstanding or because the treatment is subject to a statutory personal contribution. You will then be required to pay that part back to us. When you took out your insurance with us, you gave us a mandate for collection, meaning that you authorised us to debit both the premium from your account and the amount we have overpaid to the healthcare provider.

See also:
- Eigen bijdrage (definitions)

Retention of original invoices
When submitting invoices by email, online, in the app, or on the 'Mijn' environment, you have to retain the original hard copies for at least 2 years, as we may ask to see them during a check.

Reimbursement for invoices during the insured period
We only pay reimbursements for invoices for healthcare during your insured period. If you have submitted a claim for treatment with a Diagnosis-Treatment Combination ('Diagnose Behandel Combinatie', DBC healthcare product) code, the start date of the DBC must fall within your insured period. If the start date is before the commencement date of your insurance with us, the entire DBC will be considered not to fall within your insured period. This includes if the treatment continues partly during your insurance term with us. You will then have to submit the invoice for the DBC to your former insurer.

See also:
- DBC 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.

Medicines under your general insurance policy if you do not live in the Netherlands
Your general insurance policy also reimburses medicines that are recognised in your country of residence and that have been supplied to you. These must be medicines that would be covered by the general insurance policy in the Netherlands but are not included in the Dutch government's Medicines Reimbursement System (GVS). This also includes: - vaccinations under a national immunisation programme and accompanying consultations for children where they would also have had these if they were living in the Netherlands; - vaccinations under a national immunisation programme and accompanying consultations for at-risk groups where they would also have had these if they were living in the Netherlands. One example is the flu jab. Not reimbursed - medicines, preparations and vaccinations that are covered under another general insurance policy or a different additional insurance package; - medicines that are available over the counter in the Netherlands.

A.20. Rates

Here you can read about:
on our rates

Amount of the rates: You need healthcare covered on a refund basis
For healthcare insured on a refund basis, we will reimburse 100% of the insured healthcare provided, but not more than: - the statutory rate, or if there is no statutory rate; - the statutory maximum rate, or if there is no statutory maximum rate; - the market rate applicable in the Netherlands. We never reimburse more than the claimed rate or the maximum stated for the insured healthcare. Tip: If you go to a contracted healthcare provider, we will reimburse 100% of the agreed rate. With contracted healthcare providers, we have generally agreed rates that are lower than the rate charged by a non-contracted healthcare provider. So in most cases, you will pay less deductible when you go to a contracted healthcare provider.

See also:
- Gedeclareerde tarief (definitions)
- Marktconform tarief (definitions)
- Tarief (definitions)
- Wettelijk maximum tarief (definitions)
- Wettelijk vast tarief (definitions)

Reimbursement of healthcare if you do not live in the Netherlands
If you do not live in the Netherlands and you receive healthcare in your country of residence, this insurance provides the following reimbursement: - for healthcare covered under your general insurance, we will reimburse the rates that are reasonable and in line with market rates in your country of residence; - if the rates for that healthcare on your general insurance policy differ from market rates applicable in the Netherlands, we will reimburse the highest of these rates; - if you also have an(other) additional insurance package that reimburses healthcare up to a maximum amount, we will double this maximum amount; - your reimbursement will never exceed the actual costs of the healthcare, i.e. it will never exceed the amount stated on the invoice.
Examples
Example 1 You live in Greece and have physiotherapy there under your general insurance policy and you receive an invoice of €36 for a session there. A similar physiotherapy session would cost €28.50 in the Netherlands. In this case, we reimburse €36. Example 2 You live in Malaysia and have 6 alternative healthcare sessions there. - You have an additional insurance package that covers a maximum of €30 per treatment session up to a maximum of €250 per year. - you receive an invoice amounting to the equivalent of €420, based on €70 per session. - your reimbursement will be doubled for each session, meaning that we will reimburse you €60 (2 x €30) per session. - the maximum reimbursement per year will also be doubled to €500 per year (2 x €250). All in all, you will receive a reimbursement of €360 (6 x €60) for the 6 sessions.

See also:
- Behandeling (definitions)
- Marktconform tarief (definitions)
- Tarief (definitions)

VAT
A healthcare provider may be under an obligation to levy VAT on the amount they charge for the healthcare, or to levy a similar tax outside the Netherlands. If the healthcare provider charges you VAT, you will be reimbursed for that as well.

A.21. General exclusions

Here you can read 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. - more than one treatment of the same type of healthcare in one day. This will be reimbursed only if specifically included in the cover provided by your insurance policy; - 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 for an existing illness when taking out your general insurance policy
When you registered for the general insurance policy, we asked you about pre-existing illnesses, conditions or impairments. If you withheld certain information from us at that point or misrepresented a situation, we will not reimburse any healthcare in relation to an illness, condition or impairment that you already knew about at that time. Nor will we reimburse healthcare that is associated with that and that was already causing you health problems when you took out your general insurance policy.

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. You can find out more about this at nht.vereende.nl/en/.

No reimbursement in case of intentional acts and negligence
Guilt, recklessness or intent If you fall ill, develop a condition, or become injured due to negligence, recklessness, or intentional acts on your part, we will not reimburse the healthcare needed to treat that illness, condition, or injury. Examples include the following: - driving a vehicle, piloting a vessel, or flying an aircraft without meeting statutory requirements. For these purposes, ‘aircraft’ also extends to an aeroplane, helicopter, parachute, hot air balloon, and hang-glider; - taking part in races or speed trials in a vehicle, vessel, or aircraft; - engaging in professional sports; - taking part in a brawl, assault or other violent act; - taking part in armed activities as part of foreign armed forces, navy, or air force, except if you exclusively provide humanitarian aid or care or exclusively perform medical activities as an aid worker working on behalf of a recognised humanitarian aid organisation. In the latter cases, we will cover the healthcare you need; - failing to cooperate in your healing process or undermining the healing process; - travelling to or staying in a country for which the Dutch government had issued negative travel advice before your departure. Negative travel advice is: -- the advice to only travel if absolutely necessary (code orange); - the advice not to travel at all (code red). The negative travel advice was issued on account of: -- current or imminent war, riots or other circumstances where a threatening situation may arise; -- a risk of infectious pathogens, such as viruses, bacteria, fungi or other forms or combinations of these. The treatment or healthcare you receive must have a causal relationship with the negative travel advice. except if you exclusively provide humanitarian aid or care or exclusively perform medical activities as an aid worker working on behalf of a recognised humanitarian aid organisation. In the latter cases, we will cover the healthcare you need. What we do reimburse We do reimburse healthcare needed as a result of: - lawful self-defence; - saving yourself, others or animals; - saving your or others’ property. The rescue, act, or behaviour listed as an exclusion must then be justified in all reasonableness or be part of a statutory duty of care. Criminal offences, violations and fraud If you fall ill, develop a condition, or become injured as a result of a criminal offence, violation, or fraud that you committed, we will not reimburse the healthcare needed to treat that illness, condition, or injury. This also applies if you are only an accessory to an attempted criminal offence, violation, or fraud. If someone else with an interest in the reimbursement or the insurance contract, such as a healthcare provider, commits a criminal offence, violation, or fraud, we will not reimburse the costs of the resulting healthcare either. In case of fraud, we may do the following: - report the matter to the police; - terminate your insurance; - make a record in the warning systems used by insurers; - recover a reimbursement and (investigation) costs from you.

A.23. Complaints

Complaint
If you have a complaint about your insurance, you can file it in writing or by telephone. We will let you know our decision on the complaint. Our contact details are available on our website. If you do not agree with our decision and/or your complaint has not been resolved satisfactorily, you have various options as to what to do next: - you can go to the competent court or - you can refer your complaint to the ‘Geschillencommissie Zorgverzekeringen’ (Health Insurance Disputes Committee) of the ‘Stichting Klachten en Geschillen Zorgverzekeringen’ (SKGZ, the Health insurance Complaints and Disputes Committee). You must do so in writing to Postbus 291, 3700 AG Zeist (www.skgz.nl). The Dutch Health Insurance Ombudsman (‘Ombudsman Zorgverzekeringen’) works for SKGZ. The ombudsman will try to resolve the complaint through a process of mediation. If this proves unsuccessful, the SKGZ can issue a final and binding recommendation. Once you have chosen one of the above possibilities, you cannot go back later and choose another one.

Complaints about standard forms
If you think our forms are overly complicated or unnecessary, or your healthcare provider or another health insurer thinks that, you or the person with the complaint can take the complaint to Dutch Healthcare Authority (‘Nederlandse Zorgautoriteit’, NZa): Postbus 3017, 3502 GA Utrecht, Netherlands. The NZa will issue a binding decision on the complaint.

A.24. Dutch law

Dutch law
Your insurance is subject to Dutch law.

A.25. Situations not covered

Situations not covered
Our Executive Board and/or management will decide how to proceed in situations that are not covered in these terms and conditions of insurance.

Appendix Other

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

These are:
- Medical Aids appendix; - National indication protocol for obstetric care (‘Landelijk Indicatieprotocol Kraamzorg’); - National mental healthcare quality regulations (‘Landelijk Kwaliteitsstatuut GGZ’); - 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 dental trauma guidelines (‘NMT praktijkrichtlijn tandletsel’); and - Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care (‘Reglement Zvw-pgb in het kader van Verpleging en Verzorging’)