Basic and supplementary insurance policy conditions

avéro achmea

ZorgPlan Natura
ZorgPlan Restitutie

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These are the conditions of the basic and supplementary insurance policies offered by Avéro Achmea

As a courtesy we provide you with an English translation of our policy conditions. You can and may not derive any rights, entitlements or obligations from this English translation. Our health insurance policies are regulated by Dutch law and as such, our Dutch conditions and entitlements documents are the only legal documents from which you can derive your rights, entitlements and obligations.

What basic and supplementary insurance policies do we offer?

We offer the following basic insurance policies:

- ZorgPlan Natura (naturaverzekering)
- ZorgPlan Restitutie (restitutieverzekering)

We also offer the following supplementary insurance policies:

- Intro, Start, Royaal and Excellent
- T start, T Extra, T Royaal and T Excellent

These policy conditions apply to all of these policies. Do you want to know what policies you have taken out? Then check your policy certificate.

The government determines the contents of our basic insurance policies.

This is laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the corresponding legislation. Every health insurer must comply strictly with these conditions. This ensures that the care covered by basic insurance is the same for everyone in the Netherlands. Basic insurance policies are 'health insurance policies' in the sense of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

What is the difference between arranged care and reimbursement insurance?

Do you have an arranged care policy or an arranged care policy with selective contracting? In that case, you are entitled to care (arranged by us). What if you have a reimbursement policy? In that case, you are entitled to reimbursement of the costs of care.

How is this difference reflected in the policy conditions?

These policy conditions apply to all forms of basic insurance. No matter what kind of basic insurance you have, in these policy conditions we always refer to 'entitlement to care, medicines or medical devices'. Do you have an arranged care policy? In that case, you should read this as 'entitlement to care, medicines or medical devices (arranged by us)'. What if you have a reimbursement policy? In that case, you should read this as 'entitlement to reimbursement of the costs of care, medicines or medical devices'.

Lower reimbursement if treatment is provided by non-contracted care providers

Whether you have an arranged care policy or a reimbursement policy also affects the level of reimbursement if you use a non-contracted care provider, healthcare institution or supplier. You can find out more about this lower reimbursement and contracted and non-contracted care providers, healthcare institutions and suppliers in article 4 of the 'General conditions of the basic insurance policies'.

Advantages of contracted care

We have contracts with a large number of care providers, healthcare institutions and suppliers. What are the advantages of using a contracted care provider?

- The contracted care provider sends an invoice directly to us. This means that you do not receive a bill from the care provider.
- No matter what kind of policy you have, the invoice is paid in full if, according to the policy conditions, you are entitled to full reimbursement. The mandatory excess, any voluntarily chosen excess and (statutory) personal contributions will be deducted from the reimbursement.
- Our contracted care providers meet our quality criteria.

What applies to contracted and non-contracted care if you have supplementary insurance?

If you have supplementary insurance you are entitled to reimbursement of the costs of care. However, even if you have supplementary insurance a lower reimbursement tariff may apply if you use a non-contracted care provider.
If this is the case, it will say so in the respective article in the section on 'Reimbursements covered by the supplementary insurance policies' The lower reimbursement tariff will also be specified. In some situations we only reimburse the costs of care if the care is provided by our contracted care providers. Even if you have supplementary insurance this may still apply. Should this be the case, you will not receive any reimbursement of the costs of treatment provided by a non-contracted care provider.
These conditions will also say if this applies.

How do you find a contracted care provider?

It is important for you to know whether or not we have a contract with a particular care provider. Do you want to know with which care providers and healthcare institutions we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What information can be found in these conditions?

These conditions tell you what care is and is not reimbursed by our basic and supplementary insurance policies.

The conditions are organised as follows:

- the 'General conditions of the basic insurance policies' (general information about our basic insurance, such as the premium, the excess and rules with which you must comply);
- the 'Care covered by the basic insurance policies' (the care to which you are entitled and the conditions that apply);
- the 'General conditions of the supplementary insurance policies';
- the 'Reimbursements covered by the supplementary insurance policies'.

How do you find the care you are looking for?

Your care may be reimbursed by your basic insurance and/or your supplementary insurance. The care covered by our basic insurance policies can be found on pages 25 to 46. The reimbursements under the supplementary insurance policies can be found on pages 50 to 69.

Please note! Your care may be reimbursed by both your basic insurance and your supplementary insurance. In that case you will have to read several items in these conditions in order to discover the total reimbursement. An example:
You need dietetic therapy and you want to know whether this will be reimbursed.
To find out, you need to go through the following steps:

1 First look for 'Dietetic therapy' under 'D' in the 1st column of the alphabetical overview.
2 In columns 2 and 3 'Basic insurance' you will find the article and page number for reimbursement of 'Dietetic therapy' under the basic insurance. Article 36 of the section on 'Care covered by the basic insurance policies' tells you what you are entitled to. Article 36 also tells you which conditions you must fulfil and what exclusions exist.
3 In columns 4 and 5 you will find the article and page number for reimbursement of 'Dietetic therapy' under the supplementary insurance.

In article 41.1 of the 'Reimbursements covered by the supplementary insurance policies', you can read what you are entitled to, depending on what type of supplementary insurance you have taken out. Please note! The reimbursement under the supplementary insurance applies in addition to the reimbursement under the basic insurance.

Do you need permission?

You will see that for certain reimbursements we must give permission in advance. You can request our permission by phone, post or email. More information about requesting permission can be found on our website. The application forms can also be downloaded from our website.

The mandatory excess

For everyone aged 18 or older basic insurance involves a mandatory excess. The government has set the mandatory excess for 2018 at €385.00. You are not required to pay an excess for:

- care that is reimbursed by any supplementary insurance (policies) you have taken out;
- care provided by a general practitioner or family doctor;
- care provided for children up to the age of 18 years;
- items on loan, excluding maintenance costs and costs of use;
- maternity care and obstetric or midwifery care (excluding medicines, blood pressure tests, chorionic villus sampling and patient transport);
- integrated care;
- after-care for a donor;
- The donor's transport costs if these costs are reimbursed by the donor's own basic insurance;
- the costs of nursing and care in your own surroundings.

You can find out more about the mandatory excess in article 6 of the 'General conditions of the basic insurance policies' (see page 14).

Voluntarily chosen excess

In addition to the mandatory excess, you can also opt for a voluntarily chosen excess. This means that you can increase your excess by €100.00, €200.00, €300.00, €400.00 or €500.00.
The premium for your basic insurance will then be lower.
You can find out more about the voluntarily chosen excess in article 7 of the 'General conditions of the basic insurance policies' (see page 15).

Please note!

- The items in this index are clickable. So you can easily click to the desired chapter or article.
- Your care may be reimbursed by your basic insurance and your supplementary insurance

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General conditions of the basic insurance policies

1 What is the regulatory basis for our basic health insurance policies?

1.1 This insurance contract is based on:

a the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) and the accompanying explanatory notes;
b the Health Insurance Decree (Besluit zorgverzekering) and the accompanying explanatory notes;
c the Health Insurance Regulations (Regeling zorgverzekering) and the accompanying explanatory notes;
d interpretations (so-called 'standpunten') adopted by the Dutch National Health Care Institute (Zorginstituut Nederland (ZINL);
e the application form that you (the policyholder) completed.

If these insurance conditions are inconsistent with one or more legislative provisions, explanatory notes or the interpretation thereof, the legislative provisions, explanatory notes and interpretation take precedence.

1.2 It is also based on current scientific knowledge and practice

The contents of basic insurance are determined by the government and laid down in the legislation and regulations referred to in article 1.1. Among other things these laws and regulations state that, in terms of the nature and extent of care, your entitlement to care is determined by established medical science and medical practice. What if no such criteria exist? In that case, the standard is whatever the professional field involved regards as responsible and adequate care and services.

Temporary entitlement to care that does not comply with established medical science and medical practice

The effectiveness of certain forms of care has not yet been sufficiently proven. Therefore these forms of care do not comply with established medical science and medical practice. However, in some cases you are entitled to receive this care on a temporary basis. The Dutch Minister of Health, Welfare and Sport is entitled to designate treatments as 'conditionally admitted' treatments four times a year. So we cannot give you a current overview of the treatments to which this applies in these conditions. For the most recent overview we refer you to article 2.2 of the Regeling zorgverzekering (Health Insurance Regulations). This article can be found at http://wetten.overheid.nl/BWBR0018715/Hoofdstuk2/1/11/Artikel22/.

1.3 Cooperation with municipal authorities

We have made agreements with municipal authorities in order to ensure that the care services provided in your area are organised as efficiently as possible. Some of these care services (such as nursing and care in your own surroundings for example) are reimbursed by us. Other care services, such as assistance, are reimbursed by the municipality under the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)). Under article 14a of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), we are obliged to make agreements regarding the provision of these services with the municipal authorities. Insofar as these agreements are relevant they are incorporated in the policy conditions. If you receive care services provided both by the municipality and by us, please contact us.

2 What does the basic insurance cover and for whom is it intended?

2.1 This basic insurance entitles you to healthcare. The government decides which care is insured. The insurance can be taken out with or for:

a people living in the Netherlands who are obliged to take out insurance;
b people living in a country other than the Netherlands who are obliged to take out insurance.

The section on 'Care covered by the basic insurance policies' provides details of the care covered by your basic insurance.

2.2 Procedures for taking out insurance

You (the policyholder) apply to us for the basic insurance by completing, signing and returning an application form. Or by completing the application form on our website.

2.3 Application and registration

When you apply to us for insurance, we determine whether you meet the registration conditions stipulated by the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). Do you meet the registration conditions? In that case we issue a policy certificate. The insurance contract is set out in the policy certificate. You (the policyholder) receive this policy certificate from us once a year. We also provide you with a healthcare card. You need to present the policy certificate or the healthcare card to a care provider when obtaining healthcare. You are then entitled to care in accordance with the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

2.4 The nature and extent of the care to which you are entitled is determined by the Dutch Health Insurance Act

The care to which you are entitled is laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), the Health Insurance Decree (Besluit zorgverzekering) and the Health Insurance Regulations (Regeling zorgverzekering). These laws and regulations stipulate the nature and extent of the care to which you are entitled. You are only entitled to care if you are reasonably reliant on care of that nature and to that extent.

3 What is not insured (exclusions)?

3.1 You are not entitled to care if care is required as a consequence of one of the following situations in the Netherlands:

a armed conflict;
b civil war;
c uprising;
d civil disturbances;
e riot and mutiny.

This is stipulated in article 3.38 of the Dutch Financial Supervision Act (Wet op het financieel toezicht (Wft)).

3.2 Check-ups, flu vaccinations, doctors' statements and certain treatments

You are not entitled to:

a check-ups;
b flu vaccinations;
c treatments for snoring (uvulopalatoplasty);
d treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis;
e treatments designed to result in sterilisation;
f treatments designed to reverse sterilisation;
g treatments for circumcision without medical necessity;
h the issuing of doctors' statements.

Please note! In some cases you are entitled to these forms of care. For this to apply, the policy conditions must state that these forms of care are reimbursed.

3.3 Missed appointments and prescribed medicines that are not collected

You are not entitled to care if you:

- fail to turn up for care appointments;
- fail to collect medical devices, medicines and dietary preparations.

In this respect it is irrelevant whether the devices, medicines or dietary preparations are supplied by the care provider or healthcare institution at your request or at the request of the prescriber.

3.4 Laboratory tests requested by a doctor who practices alternative medicine

You are entitled to laboratory tests and/or X-rays requested by a general practitioner, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor specialising in juvenile health care, an obstetrician or midwife, an optometrist or a medical specialist.

You are not entitled to laboratory tests and/or X-rays requested by a care provider in their capacity as a practitioner of alternative or complementary medicine.

3.5 Costs of care that is self-administered or provided by a member of your family

You may not claim the costs of self-administered or self-referred care against your own insurance. You are not entitled to these forms of care. Do you want your partner, a family member and/or a first-degree or second-degree family member to administer your care? And do you want to claim the costs of this treatment? In that case we must give you permission in advance. We only grant permission in exceptional cases. Exceptional circumstances exist if you can prove that it is necessary for care to be administered by a family member rather than another care provider.

Please note! This condition does not apply to care paid for with a personal care allowance (persoonsgebonden budget (Zvw-pgb)).

3.6 Care required as a result of terrorism

3.6.1 Is care needed as a consequence of one or more terrorist acts? In that case you may only be entitled to part of this care. This will apply if a very large number of insured persons submit a health insurance claim as a consequence of one or more terrorist acts. In that case each insured person will only receive a percentage of their claim. In other words: is the total amount claimed in a calendar year from (non-)life insurers or in-kind funeral insurers governed by the Dutch Financial Supervision Act (Wet op het financieel toezicht (Wft)) for damage (resulting from terrorist acts) expected to exceed the maximum sum that the insurance company reinsures per calendar year? In that case you are only entitled to care up to a percentage of the costs or value of the care or other services. This percentage is the same for all forms of insurance and is determined by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT)).

3.6.2 The precise definitions and provisions that apply to the above-mentioned entitlement are set out in the NHT clause sheet on terrorism cover. This clause sheet and the corresponding Claims Settlement Protocol are an integral part of these policy conditions. The protocol can be found at www.terrorismeverzekerd.nl. The clause sheet can be downloaded from our website or obtained from us.

3.6.3 We may receive an additional payment following a terrorist act. This possibility exists under article 33 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). In that case, you are entitled to an additional reimbursement as defined in article 33 of the Dutch Health Insurance Act.

3.7 You are not entitled to forms of care or other services that qualify for reimbursement under the Dutch Long-term Care Act (Wet Langdurige zorg (Wlz)), the Dutch Youth Act (Jeugdwet), the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)) 2015 or any other statutory regulations. If you and we differ in our opinions on this, we reserve the right to discuss the matter with all parties involved (Centrum Indicatiestelling Zorg (CIZ) (Dutch Care Assessment Centre), the municipal authorities, the informal carer(s), you and ourselves) in order to determine the act or provisions under which entitlement to care exists. If this consultation leads to the conclusion that entitlement to care exists under an act or provisions other than the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), you are not entitled to care under your basic insurance.

4 What is reimbursed? And which care providers, healthcare institutions and suppliers can you use?

4.1 This basic insurance entitles you to care. We reimburse the part of this care that is not covered by personal contributions (including your mandatory excess). The extent of the reimbursement will depend on, among other things, which care provider, healthcare institution or supplier you choose. You can choose from:

- care providers, healthcare institutions and suppliers that have a contract with us (contracted care providers, healthcare institutions and suppliers, hereafter referred to as 'contracted care providers');
- care providers, healthcare institutions and suppliers that do not have a contract with us (non-contracted care providers, healthcare institutions and suppliers, hereafter referred to as 'non-contracted care providers');

4.2 Contracted care providers

Do you need care that is covered by the basic insurance? In that case you can choose any care provider in the Netherlands that has a contract with us. The care provider will claim the costs directly from us.

The fact that we have contracted a particular hospital or independent treatment centre does not mean that the hospital or independent treatment centre is contracted to provide all care and/or treatments provided by that facility. The hospital or independent treatment centre may only be contracted to provide certain treatment(s).

Do you want to know with which care providers we have a contract? Or what care and/or treatments hospitals or independent treatment centres are contracted to provide? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Remuneration ceiling

1 We agree a remuneration ceiling with our contracted care providers. This means that, in any one calendar year, these care providers will only be paid up to a predetermined maximum amount for the care they provide. We do this to control the costs of care. This is necessary in order to prevent a significant increase in the premiums paid for care.
2 We do everything we can to minimise the impact of the remuneration ceiling as far as you are concerned. Nevertheless, you may be affected by the remuneration ceiling. For example, a care provider may not be able to schedule an appointment for you until the following year. Or, if you want to receive care without having to wait until the following year, we may ask you to see another contracted care provider. You are not obliged to comply with our request. You can choose to wait until the following year.
3 You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener to find care providers with whom we have agreed a remuneration ceiling.
4 We reserve the right to (temporarily) remove certain care providers from the list of contracted care providers in the Medical Provider Search Tool on our website during the course of the calendar year if the remuneration ceiling has been reached. This means that some of the care providers on the list of contracted care providers on 1 January 2018 may be removed from the list during the course of the year. So you may find that there is more choice on 1 January 2018 than on 1 December 2018 (for example). It is important to bear this in mind.

Please note! Do you have a reimbursement policy? In that case the remuneration ceiling does not affect your entitlement to reimbursement. However, it may mean that at a certain point you have to submit the invoices yourself for example.

4.3 Non-contracted care providers

Do you want to use a non-contracted care provider? In that case it may affect the reimbursement tariff. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. For each form of basic insurance the following list shows the tariffs that apply for services provided by non-contracted care providers.

Please note! This article does not apply to any supplementary insurance policy you have taken out. Article 2.1 of the 'General conditions of the supplementary insurance policies' explains the conditions that apply to the reimbursement of non-contracted care under supplementary insurance.

4.3.1 Arranged care policy (ZorgPlan Natura)
Do you have an arranged care policy and do you use a non-contracted care provider? In that case you are entitled to reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). What if we purchased insufficient care and/or a contracted care provider is unable to supply the care on time? In that case we reimburse the costs of care up to, at the most, the current (maximum) tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). What if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act? In that case we reimburse the costs of care up to a maximum of the prevailing market rate in the Netherlands.

A list of the reimbursement tariffs that apply to services provided by non-contracted care providers can also be found on our website or obtained from us.

4.3.2 The following care can also be received at non-contracted hospitals
The lower reimbursement tariff if you use a non-contracted hospital (referred to in article 4.3.1) does not always apply. The treatments to which it does not apply include:

a urgent medical care;
b obstetric or midwifery care;
c fertility-enhancing treatments;
d dental surgery;
e treatments for which you are referred to another healthcare institution by a specialist treating you (tertiary referral);
f care in accordance with the conditions of the Wet bijzondere medische verrichtingen;
g follow-on treatments to the treatments referred to in (a) to (f) that form part of the same care need.

You can receive this care at any hospital. The reimbursement of this care is limited to the current (maximum) tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). What if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act? In that case we reimburse the costs of care up to a maximum of the prevailing market rate in the Netherlands.

A list that gives an indication of the reimbursement tariffs that apply to services provided by non-contracted care providers can also be found on our website or obtained from us.

Please note! After receiving one of these treatments are you starting a new plannable treatment? Then first check which hospitals have been contracted by Avéro Achmea. Simply use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. That way you can avoid having to pay part of the bill yourself or having to pay the bill and then submit a claim.

4.3.3 Reimbursement policy (ZorgPlan Restitutie)
Do you have a reimbursement policy and do you use a non-contracted care provider? In that case we reimburse the costs of care up to, at the most, the current (maximum) tariff established on the basis of the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). What if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act? In that case we reimburse the costs of care up to a maximum of the prevailing market rate in the Netherlands.

A list that gives an indication of the reimbursement tariffs that apply to services provided by non-contracted care providers can also be found on our website or obtained from us.

4.4 Occasionally you will have to repay an amount
We sometimes pay a care provider or healthcare institution more than the amount to which you are entitled under the insurance contract. This might happen if, for example, you are required to pay part of the amount yourself as a personal contribution or mandatory excess. In that case, you (the policyholder) are required to repay anything over and above the amount to which you are entitled. We will collect the amount in question by direct debit. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

4.5 If you require healthcare mediation services
You are entitled to healthcare mediation services. These services mean that you receive information about treatments, waiting times and differences in quality between care providers or healthcare institutions, for example. Based on this information:

- you can make your own choice, or
- if there is a waiting list, we will mediate with the care provider or healthcare institution on your behalf. And arrange an appointment for you. We call this waiting list mediation.

You are also entitled to healthcare mediation if you are looking for a new care provider or healthcare institution, possibly because you have moved home. In that case we help you find a care provider or healthcare institution. Do you want healthcare mediation and/or waiting list mediation? Then please contact us.

5 What are your obligations?

5.1 Your obligations are listed below. Have you harmed our interests by failing to fulfil these obligations? In that case you are not entitled to care.

5.2 General obligations
You are entitled to care if you fulfil the following obligations:

a Are you obtaining care from a hospital or outpatient clinic? In that case you must hand over one of the following valid documents as proof of identity:
  - driving licence;
  - passport;
  - Dutch identity card;
  - foreign national's document.
b Does our medical advisor want to know why you were admitted? In that case you must ask your doctor or medical specialist to inform our medical adviser.
c You must provide all the information we need and cooperate in our efforts to obtain this information. This is for our medical advisers or for people responsible for monitoring or investigation. Naturally, we always comply with the requirements of privacy legislation.
d You must cooperate if we want to recover costs from an accountable third party.
e You are obliged to inform us of (possible) irregularities or fraud by care providers (in claims for example).
f You are obliged to hand over a referral or statement in cases in which this is required. The referral or statement is only valid if it was issued less than a year prior to the date on which you first contact the specialist to whom you have been referred. As long as you are still being treated by the same care provider for the same care need you do not have to present another referral or statement.

g You are obliged to request our permission in advance in cases in which this is required. If you receive a positive medical assessment we will issue permission in the form of an authorisation document. What happens if you switch to another health insurer while your authorisation document is still valid? In that case your new insurer will take over the authorisation and reimburse the treatment in accordance with the insurance conditions that then apply.

5.3 Obligations if you are detained in custody

a Are you being detained in custody? Inform us, within 30 days after being detained, when the detention started (date of commencement) and how long it will last.
b Have you been released? In that case inform us, within 2 months of being released, of the date on which you were released.

5.4 Obligations if you submit invoices yourself

Do you receive invoices from a care provider, healthcare institution or supplier? In that case send us the original and clearly specified invoices (keep a copy for your own files). You can also scan the original invoices and send them to us electronically. We do not accept copies of invoices, reminders, pro-forma invoices, (cost) estimates or any other such documents. We only issue reimbursement if we receive an original and clearly specified invoice that notes the treatment code. The treatment codes are established by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)).

Do you (the policyholder) submit invoices electronically? Then you (the policyholder) are obliged to keep the original invoices for a period of 1 year after we receive them. We may ask you to submit these original invoices.

The care provider who treats you must issue invoices in their own name. Is the care provider a legal person (such as a foundation, a practice or a limited company)? In that case the name of the doctor or specialist who treated you must be stated on the invoice. Any claim you have on us may not be transferred to a third party. Reimbursements to which you are entitled are always paid to you (the policyholder), via the international bank account number (IBAN) known to us. You cannot authorise a third person to receive the payment on your behalf.

5.5 Obligation: submit claims within a specified period

Be sure to submit your invoices to us as soon as possible. In any event, you must do this within 12 months of the end of the calendar year in which you were treated.

Please note! The date of treatment and/or the supply date noted on an invoice is decisive in determining whether you are entitled to care. In other words, the date on which the invoice was drawn up is not the determining factor.

Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie, (DBC))? In that case the date on which treatment starts is decisive in determining entitlement to care. You must be insured with us on the date on which treatment starts. Do you want to know what applies in your case? Then please contact us.

Are you submitting invoices more than 12 months after the end of the calendar year in which you were treated? In that case you may receive a lower reimbursement than the reimbursement to which you would otherwise be entitled in accordance with the conditions. We do not process invoices submitted more than 3 years after the date of treatment and/or the date on which care was provided. This is pursuant to article 942, Book 7 of the Dutch Civil Code.

5.6 Obligation: inform us about alterations in your situation within 1 month

Has there been a change in your personal situation? Or in the situation of one of the other persons covered by your policy? Then you (the policyholder) must notify us of the change within 1 month. This applies to any occurrence which may be relevant to the proper implementation of the basic insurance Obvious examples include termination of the insurance obligation, a change of address, a change in your international bank account number (IBAN), divorce, death or a prolonged stay abroad. If we write to you (the policyholder) at your last-known address, we are entitled to assume that the letter reached you (the policyholder).

6 What is your mandatory excess?

6.1 If you are 18 years or older and you are liable to pay a premium, you have a mandatory excess for the basic insurance. The government determines what the amount is. In 2018 the mandatory excess is €385.00 per insured person per calendar year.

6.2 You pay the first €385.00 of your healthcare costs yourself

We apply the mandatory excess to your entitlement to care. These are costs that you incur on the basic insurance during the course of the calendar year. For example: you are treated in a hospital, but you receive no invoice. In that case we reimburse the hospital directly. You (the policyholder) subsequently receive an invoice from us for €385.00.

Please note! Physiotherapy treatments for disorders that appear on the list approved by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' (article 3 of the section on 'Care covered by the basic insurance policies') are always deducted from your mandatory excess. Treatments that continue into the following year are deducted from the mandatory excess for the following year.

6.3 There is no mandatory excess for some healthcare costs

We do not deduct mandatory excess from:

a the costs of care or other services incurred in 2018 but for which the invoices are not received until after 31 December 2019;
b the costs of care normally provided by general practitioners. The costs of tests or examinations performed as part of this care, which are performed elsewhere and charged for separately, are an exception in this respect. The person or institution that carries out the examination must be authorised to charge the tariff fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit) for this examination;
c the direct costs of obstetric and/or midwifery care and maternity care;
d the costs of registering with a general practitioner or with an institution that provides general practitioner care. Registration costs are defined as:
    1 the sum that a general practitioner or an institution that provides general practitioner care charges you for registering you as a patient. This will not exceed the tariff stipulated as the availability tariff in the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg));
    2 reimbursements that are related to the way in which medical care is provided by a general practitioner, at a general practice or in an institution that provides general practitioner care. Or to the characteristics of the patient database or the location of the practice or institution. This applies insofar as we have agreed these reimbursements with your general practitioner or the institution that provides general practitioner care and insofar as a general practitioner or institution is allowed to charge us these costs if you register;
e the costs of follow-up examinations of a donor after the period of caring for that donor has expired. This period of care lasts, at the most, 13 weeks, or in the event of a liver transplant, 6 months;
f the donor's transport costs if these costs are reimbursed by the donor's own basic insurance;
g the costs of integrated care that are claimed in accordance with the Policy Regulation on Performance-related funding of the provision of multidisciplinary care for chronic disorders. This policy regulation was established on the basis of the Healthcare Market Regulation Act;
h the costs of nursing and care normally provided by nurses under article 28 of the section on 'Care covered by the basic insurance policies' (Nursing and care in your own surroundings (extramural))'.

6.4 Mandatory excess exemption
The direct costs of a medication review of chronic use of prescription drugs performed by a dispensing general practitioner or pharmacy contracted for this purpose is exempt from the mandatory excess.

6.5 Healthcare costs that we do not reimburse do not count towards the mandatory excess
In some cases you pay for part of the care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. These sums are unrelated to the mandatory excess, which means they do not count towards the €385.00 mandatory excess that we deduct.

6.6 Mandatory excess commences when you reach 18 years of age
Will you be 18 during the course of the calendar year? In that case your mandatory excess commences on the first day of the month that follows the calendar month in which you become 18 years of age. The size of your mandatory excess at that moment will depend on the number of days over which we can deduct mandatory excess.

6.7 Mandatory excess if your basic insurance commences later
Will your basic insurance commence after 1 January? In that case we calculate your mandatory excess based on the number of days you are insured in that calendar year.

6.8 Mandatory excess if your basic insurance ends earlier
Will your basic insurance end during the course of the calendar year? In that case we calculate your mandatory excess based on the number of days you were insured in that calendar year.

6.9 Mandatory excess in relation to a diagnosis-treatment-combination
Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie, (DBC))? In that case the moment at which the treatment started determines the mandatory excess that we have to apply. There is more information about reimbursements in the case of DBCs in article 5.5 of these general conditions.

6.10 Deducting mandatory excess
Are you receiving care from a contracted care provider or a care provider with whom we have a payment agreement? In that case we reimburse the care provider or healthcare institution directly. Is part of your mandatory excess still payable? In that case the amount will count towards your voluntarily chosen excess or you will be invoiced for this amount. It can also be set off against claims made under your personal care allowance (persoonsgebonden budget (Zvw-pgb)). We will collect the sum via direct debit collection. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

If you (the policyholder) do not pay the mandatory excess on time, we can charge you administration costs, debt collection costs and statutory interest.

7 What is a voluntarily chosen excess?

7.1 Each calendar year an insured person aged 18 years or older can opt for a voluntarily chosen excess. In relation to your basic insurance you can opt for no voluntarily chosen excess, or a voluntarily chosen excess of €100.00, €200.00, €300.00, €400.00 or €500.00 per calendar year. Have you opted for a voluntarily chosen excess? In that case you will receive a discount on your premium. The discount for each voluntarily chosen excess is shown in the 2018 Premium Table on our website. The Premium Table is an integral part of this policy.

7.2 Consequence of a voluntarily chosen excess
We deduct the voluntarily chosen excess from your reimbursement. We do this after we have deducted the full amount of the mandatory excess. This applies to costs covered by your basic insurance incurred during the course of the calendar year. If, for example, in addition to the mandatory excess, you (the policyholder) opt for a voluntarily chosen excess of €500.00. This means your total excess is (€385.00 + €500.00 =) €885.00. Is your care provider going to receive €950.00 from us for care that you received? In that case your total excess will be offset against the bill. This €885.00 is automatically deducted from the policyholder's account (see also article 6.10 of these general conditions).

7.3 A voluntarily chosen excess is not offset against certain healthcare costs
We do not deduct a voluntarily chosen excess from:

a the costs of care normally provided by general practitioners. The costs of tests or examinations performed as part of this care, which are performed elsewhere and charged for separately, are an exception in this respect. The person or institution that carries out the examination must be authorised to charge the tariff fixed by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit) for this examination;
b the direct costs of obstetric and/or midwifery care and maternity care;
c the costs of registering with a general practitioner or with an institution that provides general practitioner care. Registration costs are defined as:
    1 the sum that a general practitioner or an institution that provides general practitioner care charges you for registering you as a patient. This will not exceed the tariff stipulated as the availability tariff in the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg));
    2 reimbursements that are related to the way in which medical care is provided by a general practitioner, at a general practice or in an institution that provides general practitioner care. Or to the characteristics of the patient database or the location of the practice or institution. This applies insofar as we have agreed these reimbursements with your general practitioner or the institution that provides general practitioner care and insofar as a general practitioner or institution is allowed to charge us these costs if you register;
d the costs of follow-up examinations of a donor after the period of caring for that donor has expired. This period of care lasts, at the most, 13 weeks, or in the event of a liver transplant, 6 months;
e the donor's transport costs if these costs are reimbursed by the donor's own basic insurance;
f the costs of integrated care that are claimed in accordance with the Performance-related funding of the multidisciplinary provision of care for chronic disorders Policy Regulation. This policy regulation was established on the basis of the Healthcare Market Regulation Act;
g the costs of nursing and care normally provided by nurses under article 28 of the section on 'Care covered by the basic insurance policies' (Nursing and care in your own surroundings (extramural))'.

7.4 Healthcare costs that we do not reimburse do not count towards the voluntarily chosen excess
In some cases you pay for part of the care covered by the basic insurance. This applies in the case of maternity care and certain medicines for example. These sums are unrelated to the voluntarily chosen excess, which means they do not count towards the voluntarily chosen excess that we deduct.

7.5 Voluntarily chosen excess commences when you reach 18 years of age
Will you be 18 during the course of the calendar year? In that case your voluntarily chosen excess commences on the first day of the month that follows the calendar month in which you become 18 years of age. The size of your voluntarily chosen excess at that moment will depend on the number of days over which we can deduct voluntarily chosen excess.

7.6 Voluntarily chosen excess if your basic insurance commences later
Will your basic insurance commence after 1 January? In that case we calculate your voluntarily chosen excess based on the number of days you are insured in that calendar year.

7.7 Voluntarily chosen excess if your basic insurance ends earlier
Will your basic insurance end during the course of the calendar year? In that case we calculate your voluntarily chosen excess based on the number of days you were insured in that calendar year.

7.8 Voluntarily chosen excess in relation to a diagnosis-treatment-combination
Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie, (DBC))? In that case the moment at which the treatment started determines the voluntarily chosen excess that we have to apply. There is more information about reimbursements in the case of DBCs in article 5.5 of these general conditions.

7.9 Deducting voluntarily chosen excess
Are you receiving care from a contracted care provider or a care provider with whom we have a payment agreement? In that case we reimburse the care provider or healthcare institution directly. Is part of your voluntarily chosen excess still payable? In that case the amount will count towards your voluntarily chosen excess or you will be invoiced for this amount. It can also be set off against claims made under your personal care allowance (persoonsgebonden budget (Zvw-pgb)). We will collect the sum via direct debit collection. You (the policyholder) authorise us to collect payment by direct debit when you take out this insurance with us.

If you (the policyholder) do not pay the voluntarily chosen excess on time, we can charge you administration costs, debt collection costs and statutory interest.

7.10 Altering the voluntarily chosen excess
Do you want to alter your voluntarily chosen excess? You can do this as of 1 January of the following calendar year. You should inform us about the altered voluntarily chosen excess at the latest by 31 December. This period for alteration can also be found in article 12.5 of these general conditions.

8 What will you have to pay?

8.1 We determine your premium
8.1.1 We determine the amount of the premium for your basic insurance. The premium you are liable to pay is the basic premium, minus any discount due to the voluntarily chosen excess and/or a group discount. We calculate both discounts according to the basis for the premium calculation.

8.1.2 We charge a premium for insured persons aged 18 years or older. Is an insured person about to become 18 years? Then you (the policyholder) must pay a premium as of the first of the month following the month in which the insured person becomes 18 years of age.

8.1.3 You (the policyholder) are no longer entitled to a group discount from the moment that you no longer participate in a group.

8.2 You (the policyholder) pay the premium
You (the policyholder) must pay the premium in advance. You may not offset the premium that you (the policyholder) have to pay against your reimbursement.

Has your basic insurance been terminated prematurely by you (the policyholder) or by us? Then we will refund any premium overpayment. In this case we assume that a month has 30 days. Have we terminated your insurance due to fraud or deception (see also article 20 of these general conditions)? In that case we may deduct an administration fee from the premium that we have to refund.

8.3 How you (the policyholder) pay the premium and other costs
We prefer you (the policyholder) to pay the following sums by direct debit:
a premium;
b mandatory excess and voluntarily chosen excess;
c statutory personal contributions;
d personal contributions;
e any other amounts you owe us.

What if you (the policyholder) choose to use a different method of payment? In that case you (the policyholder) may have to pay administration costs.

8.4 You will be notified of a direct debit 14 days in advance
We send you (the policyholder) advance notice of collection of payment by direct debit. We endeavour to notify you (the policyholder) 14 days before we collect the payment. This does not apply to notification of the new premium. We announce collection of the premium by direct debit once a year on the policy certificate we send you.

9 What happens if you do not pay on time?

9.1 Rules apply to how you pay the premium
If you are liable to pay the premium, then you must comply with these rules. This also applies to a third party who pays the premium.

9.2 We set off arrears in premium payments against claims submitted to us and any personal care allowance (persoonsgebonden budget (Zvw-pgb))
Do you (the policyholder) still have to pay overdue premium to us and have you submitted claims that we have to pay to you (the policyholder)? In that case we set off the premium against these claims. We set off arrears in premium payments against claims made under your personal care allowance (persoonsgebonden budget (Zvw-pgb)).

If you (the policyholder) do not pay on time, we may charge you (the policyholder) administration fees, payment collection fees (including debt collection costs) and statutory interest.

9.3 If you (the policyholder) do not comply with the terms of payment
Have you (the policyholder) opted to pay the premium per quarter, twice a year or once a year? And have you failed to pay the premium within the period we stipulated? In that case we reserve the right to demand that you (the policyholder) start paying your premium monthly again. The consequence of this is that you no longer have a right to a payment discount.

9.4 You can only cancel the insurance after overdue premiums have been paid
Have we ordered you to pay one or more instalments of the premiums payable? In that case you (the policyholder) may not cancel the basic insurance until you have paid the premium owed and any administration costs, debt collection costs and statutory interest. This does not apply if we suspend the cover provided by your basic insurance.

9.5 Exception to article 9.4
Article 9.4 of these General conditions does not apply if we inform you (the policyholder) within 2 weeks that we confirm the cancellation.

9.6 e-Court
Are there outstanding premiums or other outstanding costs? Then extrajudicial dispute resolution proceedings may be commenced through the e-Court. If we start proceedings, you have one month to file a notice of objection against the proceedings with the e-Court. The matter will then be settled by the subdistrict court, unless you submit the dispute to the SKGZ. e-Court proceedings are subject to statutory regulations and the appropriate rules of procedure, which are listed on the website www.e-court.nl.

10 What will happen if you fall behind with your payments?

10.1 Payment arrangement if you have not paid your premium for 2 months.
Have we established that you have not paid the monthly premium for 2 months? In that case we will send you (the policyholder) a payment arrangement in writing within 10 working days. This payment arrangement means that:
a you (the policyholder) authorise us to collect new monthly premiums from you (the policyholder) or a third party by direct debit;
b you (the policyholder) agree to repay us the overdue premiums and health insurance debts in instalments;
c we will not terminate the basic insurance cover because of the existence of debts as described under b, nor will we suspend the basic insurance cover based on this reason as long as the payment arrangement continues. This does not apply if you (the policyholder) withdraw the authorisation described under a, or if you (the

policyholder) fail to comply with the payment agreements stipulated under b.

The letter will state that you (the policyholder) have 4 weeks to accept the arrangement. It will also inform you (the policyholder) what will happen if you (the policyholder) have not paid the monthly premium for 6 months. Furthermore, the letter offering the payment arrangement will provide you (the policyholder) with information about assistance with debts, how you (the policyholder) can obtain such assistance and what debt assistance is available.

10.2 Payment arrangement if you (the policyholder) insure someone else

Have you (the policyholder) insured someone else? And have you (the policyholder) failed to pay the monthly premium for the basic insurance of that insured person for 2 months? In that case the payment arrangement also means that we offer you (the policyholder) the chance to cancel this insurance on the day that the payment arrangement commences. This offer only applies if:

a the insured person has taken out basic insurance for themselves elsewhere on the date that the payment arrangement enters into effect, and
b the insured person authorises us to collect new monthly premiums by direct debit if they have taken out basic insurance with us.

10.3 Insured person(s) receive(s) copies of information about the payment arrangement

If article 10.2 of these general conditions applies, we send the insured person(s) copies of the documents referred to in articles 10.1, 10.2 and 10.4 that we send you (the policyholder). These documents are sent simultaneously.

10.4 What happens if you (the policyholder) have not paid your monthly premium for 4 months?

Have you (the policyholder) failed to pay the monthly premium for 4 months (excluding administration costs, debt collection costs and statutory interest)? In that case you (the policyholder) and anyone co-insured with you will be informed that we intend to report you (the policyholder) to the Central Administration Office (Centraal Administratie Kantoor (CAK)) the moment you (the policyholder) have failed to pay monthly premiums for 6 months or longer. What happens if we report you (the policyholder) to the Central Administration Office? In that case the Central Administration Office will collect an administrative premium from you (the policyholder).

You (the policyholder) can also ask us if we are willing to enter into a payment arrangement with you (the policyholder). You (the policyholder) can read about what this payment arrangement entails in article 10.1 of these general conditions. If we agree a payment arrangement with you (the policyholder), we will not report you (the policyholder) to the Central Administration Office as long as you (the policyholder) pay the new monthly premiums on time.

10.5 If you (the policyholder) disagree with the payment arrears

Do you (the policyholder) disagree with the payment arrears and/or our plan to report you to the Central Administration Office (Centraal Administratie Kantoor (CAK)) as described in article 10.4? Then you should inform us by sending us a letter of objection. In that case we will not report you (the policyholder) to the Central Administration Office for the time being. We will first investigate whether we calculated your debt correctly. Is our conclusion that we calculated your debt correctly? In that case you (the policyholder) will be informed. If you (the policyholder) disagree with our opinion, then you (the policyholder) can put the matter before the Health Insurance Complaints and Disputes Board (Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ)) or take it to the civil court. You (the policyholder) must do this within 4 weeks of the date on which you (the policyholder) received the letter informing you of our assessment. Also in this case we will not report you (the policyholder) to the Central Administration Office for the time being. See also article 18 of these general conditions regarding complaint handling.

10.6 What happens if you (the policyholder) have not paid your monthly premium for 6 months

Have we established that you (the policyholder) have not paid the monthly premium (excluding administration costs, debt collection costs and statutory interest) for 6 months? Then we will report you (the policyholder) to the Central Administration Office. From this moment on you will no longer pay a flat-rate premium to us. Instead the Central Administration Office will impose an administrative premium on you (the policyholder). We will provide the Central Administration Office with your personal details and those of any person(s) that you (the policyholder) have insured with us for this purpose. We will only provide the Central Administration Office with the personal details it needs to be able to charge you (the policyholder) the administrative premium. You (the policyholder) and the person(s) whom you (the policyholder) have insured will receive notification about this from us.

10.7 Have all the premiums been paid? Then we will terminate your (the policyholder's) registration with the Central Administration Office (Centraal Administratie Kantoor (CAK)).

We will terminate your (the policyholder's) registration with the Central Administration Office, if, following the intervention of the Central Administration Office, you (the policyholder) have paid the following amounts:

a the premiums owed;
b the debt based on invoices for healthcare costs;
c the statutory interest;
d any debt collection costs;
e any costs of proceedings.

Once we have terminated your (the policyholder's) registration with the Central Administration Office, the collection of the administrative premium will cease. Instead you (the policyholder) will start paying us the flat-rate premium again.

10.8 The information we send you (the policyholder) and the Central Administration Office

We inform you (the policyholder and persons covered by the insurance) and the Central Administration Office (Centraal Administratie Kantoor (CAK)) immediately of the date on which:

a the debts accumulated with regard to the basic insurance (will) have been paid or (will) have been annulled;
b the debt management scheme for natural persons, as defined in the Bankruptcy Act, becomes applicable to you (the policyholder);
c an agreement was entered into as defined in article 18c, second paragraph, subclause (d.) of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). This agreement must have been entered into through the mediation of a debt counsellor, as referred to in article 48 of the Dutch Consumer Credit Act (Wet op het consumentenkrediet (Wck)). Or we will inform you (the policyholder) and the Central Administration Office of the date on which a debt repayment plan has been arranged. Apart from yourself (the policyholder), the debt repayment plan must also involve, at least, your health insurer.

10.9 Are you applying to us for insurance after having defaulted? And have we approved your application? In that case you (the policyholder) will have to pay 2 months premium in advance.

11 What if your premium and/or conditions alter?

11.1 We can change the basis for the premium calculation and the conditions of your basic insurance. For example, because the composition of the basic package has altered. We will send you (the policyholder) a new offer, according to the new basis for the premium calculation and the altered conditions.

11.2 If the basis for your premium calculation alters

An alteration in the basis for your premium calculation will not come into force earlier than 6 weeks after the day on which we informed you (the policyholder) about it. You (the policyholder) can cancel the basic insurance as of the day on which the alteration comes into force (usually 1 January).

This means that you (the policyholder) have in any case 1 month to cancel your basic insurance from the moment that we informed you about the alteration.

11.3 If the conditions and/or your entitlement to care alter(s)
What if alterations in the conditions and/or entitlement to care are disadvantageous for the insured person? In that case you (the policyholder) are allowed to cancel the basic insurance. This does not apply if this alteration occurs due to an amendment in a statutory provision. You (the policyholder) can cancel the basic insurance as of the day on which the alteration comes into force. This means that you (the policyholder) have 1 month to cancel your basic insurance from the moment that we informed you (the policyholder) about the alteration.

12 When does your basic insurance commence?

12.1 The date of commencement appears on the policy certificate
The basic insurance commences on the date of commencement that appears on the policy certificate. This date of commencement is the day on which we received the application from you (the policyholder) to take out basic insurance. As of the next 1 January we extend the basic insurance each year automatically. We do this each time for a period of 1 calendar year.

12.2 Already insured? In that case the insurance can commence later
Is the person for whom we provide basic insurance cover already insured on the grounds of a basic insurance on the day on which we receive your application? And have you (the policyholder) indicated that you want the basic insurance to commence later than on the day mentioned in article 12.1 of these general conditions? In that case the basic insurance will commence on the later date that you (the policyholder) have indicated.

12.3 Insurance should be taken out within 4 months after the obligation to take out insurance arises
Will the basic insurance commence within 4 months after the obligation to take out insurance arose? In that case we shall keep to the day on which the obligation to take out insurance arose as date of commencement.

12.4 Insurance can have retrospective effect for up to 1 month
Will the basic insurance commence within 1 month of another basic insurance policy being cancelled as of 1 January? In that case the new insurance will commence retroactively from the day on which the previous basic insurance was cancelled. In this matter we can depart from that which is stipulated in article 925, first paragraph, Book 7 of the Dutch Civil Code. The retrospective effect of the basic insurance will also apply if you cancelled your previous insurance because the conditions became unfavourable to you. This is stipulated in article 940, fourth paragraph, Book 7 of the Dutch Civil Code.

12.5 Altering your basic insurance
Have you taken out basic insurance with us? In that case you (the policyholder) can alter this as of 1 January of the next calendar year. You will receive written confirmation of this. You need to inform us about the alteration by 31 December at the latest.

12.6 Agreements about the date of commencement in the event of a group discount
The group basic insurance also applies to your family. Does the group contract contain limiting agreements about the age at which your children can take advantage of your group discount? In that case we will inform your children about this in writing.

13 When can you cancel your basic insurance?

13.1 Revoking your basic insurance
You (the policyholder) can revoke basic insurance that you have just taken out. This means that you (the policyholder) can cancel the basic insurance within 14 days after you have received your policy certificate. Send us a letter or an email in which you cancel the insurance. You (the policyholder) are not required to state your reasons for this. In this case we will assume that your basic insurance did not commence.

Have you (the policyholder) revoked your basic insurance with us? In that case you (the policyholder) will receive a refund of any premium that has already been paid. If we have already reimbursed healthcare costs under the policy, then you (the policyholder) must repay the amounts in question.

13.2 Cancelling your basic insurance
You (the policyholder) can cancel your basic insurance in one of the following ways:

a You (the policyholder) notify us that you wish to cancel your basic insurance by post or email. We must receive notice of cancellation by 31 December at the latest. In this case the basic insurance will end on 1 January of the following year. Have you (the policyholder) notified us that you wish to cancel your basic insurance with us? In that case the cancellation is irrevocable.
b You (the policyholder) can make use of the cancellation service provided by your new health insurer. Have you (the policyholder) taken out basic insurance for the next calendar year by 31 December of the current calendar year at the latest? In that case the new health insurer will cancel, on your (the policyholder's) behalf, the basic insurance you have with us.
c Have you (the policyholder) insured someone other than yourself and has that insured person taken out other basic insurance? In that case you (the policyholder) can send a letter or email to cancel this insurance for the insured person. Did we receive this cancellation before the date of commencement of the new insurance? In that case the basic insurance will end on the day that the insured person's new basic insurance commences. In other cases the termination date is the first day of the second calendar month following the day on which you (the policyholder) cancelled.
d You (the policyholder) may switch from one group basic insurance scheme to another, because you (the policyholder) have terminated your employment with one employer and/or commenced employment with a new employer. In that case you (the policyholder) have up to 30 days from the date on which the old employment ended to cancel the old basic insurance. The cancellation does not take place retrospectively and commences on the first day of the next month.
e It may also be the case that your participation in group basic insurance scheme via an authority is terminated. The reason for cancellation may be that you (the policyholder) will start participating in a group basic insurance scheme via an authority that pays your allowance in a different municipality, or that you (the policyholder) will start participating in a group basic insurance because you (the policyholder) have new employment. You (the policyholder) have up to 30 days from the date on which your participation in the group basic insurance scheme ended to cancel the old basic insurance. The cancellation does not take place retrospectively and commences on the first day of the next month.

Have you notified us that you wish to cancel your insurance? In that case we will notify you (the policyholder) to this effect. The date on which the insurance terminates will be specified in the confirmation.

14 In what situations will we cancel your basic insurance?

14.1 In some cases we will cancel your basic insurance:

a commencing on the day after the day on which your no longer fulfil the requirements for registering for basic insurance;
b on the date on which you are no longer insured under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz));
c if you are a member of the military in active service;
d in the event of proven fraud as described in article 20 of these 'General conditions of the basic insurance policy';
e in the event of death;
f if we are no longer allowed to offer or implement basic insurance, because our permit to operate as a general insurance company is altered or withdrawn. In that case we will have informed you about this by the latest 2 months in advance.
g if we withdraw our basic insurance from the market for reasons that we consider to be important, we are entitled to terminate your basic insurance unilaterally.

Are we cancelling your insurance? In that case we will notify you (the policyholder) to this effect. The reason for the termination of your insurance and the date on which the insurance terminates will be specified in our letter.

14.2 Basic insurance also lapses in the event of illegal registration
Was an insurance contract issued for you under the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw))? And has it since become apparent that you were not obliged to take out insurance? In that case the insurance contract will lapse with retroactive effect from the date on which you were no longer obliged to take out insurance. Have you (the policyholder) paid premiums while you were no longer obliged to take out insurance? In that case we will set off the premiums against the reimbursement of care costs that you (the policyholder) subsequently received. If the premiums you (the policyholder) paid exceed the reimbursements you (the policyholder) received, we will refund the difference. Did the reimbursements you (the policyholder) received exceed what you (the policyholder) paid in premiums? In that case we shall charge you (the policyholder) the difference. In this case we assume that a month has 30 days.

14.3 Cancelling if you were registered under article 9a to d incl. of the Health Insurance Act
14.3.1 Has the Central Administration Office (Centraal Administratie Kantoor (CAK)) insured you with us under the Dutch Health Insurance (Detection and Insurance of Uninsured) Act (Wet opsporing en verzekering onverzekerden zorgverzekering)? In that case you can have this insurance annulled (nullified). This must be done within 2 weeks of the date on which the Central Administration Office informed you that you were insured with us. To be able to nullify the insurance you must prove to the Central Administration Office and to us that you already had other health insurance during the preceding period. This is the period as referred to in article 9d, paragraph 1 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

14.3.2 We are authorised to nullify – on account of error – an insurance contract entered into with you, if it later emerges that you were not, at that moment, obliged to take out insurance. In this matter we depart from article 931, Book 7 of the Dutch Civil Code.

14.3.3 You cannot cancel the basic insurance as referred to in article 9d, paragraph 1 of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), during the first 12 months of its term of validity. This is a departure for you from article 7 of the Dutch Health Insurance Act, unless the fourth paragraph of that article applies. In that case you are able to cancel.

15 When are you entitled to reimbursement of healthcare received abroad?

15.1 Are you receiving care in a treaty country, EU country or EEA country? In that case you can choose from entitlement to:

a care according to the statutory regulations of that country, on the grounds of provisions of the EU social security regulation, or as stipulated in the relevant treaty;
b reimbursement of the costs of care provided by a contracted care provider or healthcare institution in another country with whom or with which we have a contract;
c reimbursement of the costs of care provided by a non-contracted care provider or healthcare institution. In that case you are entitled to reimbursement as specified in the section on 'Care covered by the basic insurance policies' up to a maximum of:
   - the lower reimbursement if lower reimbursement is specified in the section on 'Care covered by the basic insurance policies';
   - the (maximum) tariff currently set on the basis of the Dutch Healthcare Market Regulation Act (Wet marktverordening gezondheidszorg (Wmg));
   - the prevailing market rate in the Netherlands. This applies if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act.

   The reimbursement is reduced by any personal contribution that you are liable to pay.

Please note! In addition to the provisions of this article, the conditions and exclusions that apply to the healthcare in question in the Netherlands also apply to healthcare received abroad. Do you need a referral for example? In that case, the same will apply abroad.

15.2 Reimbursement of care in a country that is not a treaty country, an EU country or a member of the EEA
Are you receiving care in a country that is not a treaty country, an EU country or a member of the EEA? In that case you are entitled to reimbursement of the costs of care provided by a non-contracted care provider or healthcare institution as specified in the section on 'Care covered by the basic insurance policies' up to a maximum of:

a the lower reimbursement if lower reimbursement is specified in the section on 'Care covered by the basic insurance policies';;
b the (maximum) tariff currently set on the basis of the Dutch Healthcare Market Regulation Act (Wet marktverordening gezondheidszorg (Wmg));
c the prevailing market rate in the Netherlands. This applies if no (maximum) tariff has been established on the basis of the Healthcare Market Regulation Act.

The reimbursement is reduced by any personal contribution that you are liable to pay.

Please note! In addition to the provisions of this article, the conditions and exclusions that apply to the healthcare in question in the Netherlands also apply to healthcare received abroad. Do you need a referral for example? In that case, the same will apply abroad.

15.3 Conversion rate of foreign currencies
Reimbursement of the costs of care given by a non-contracted care provider is issued to you (the policyholder) in euros. We do this according to the daily conversion rates published by the European Central Bank. We use the rate that was applicable on the date of the invoice. Reimbursements to which you are entitled are always paid to you (the policyholder), by bank transfer to the bank account number (IBAN) known to us. This must be an account number (IBAN) of a bank that has its registered office in the Netherlands.

15.4 Invoices from abroad
Healthcare invoices should preferably be written in Dutch, French, German, English or Spanish. If we feel it is necessary, we may ask you to have an invoice translated by a certified translator. We do not reimburse translation costs.

16 Non-liability for damage caused by a care provider or healthcare institution

We are not liable for any damage you suffer as a result of an action or omission by a care provider or healthcare institution. This applies even if the care or assistance provided by the care provider or healthcare institution was covered by the basic insurance.

17 What should you do if (a) third party/parties is/are liable?

17.1 Is a third party liable for costs that are a consequence of your illness, accident or injury? In that case you must provide us, free of charge, with all information that is necessary in order to recover the costs from the person responsible. The right of recovery is based on statutory regulations. This does not apply to liability that results from statutory insurance, health insurance subject to public law or a contract between you and another (legal) person.

17.2 You are obliged to report
Have you become ill, suffered an accident or sustained an injury in some other way? And did this involve a third party, as referred to in article 17.1 of these general conditions? In that case you must report this (or have it reported) to us as soon as possible. You must also report the incident (or have it reported) to the police.

17.3 No arrangement with third parties without permission
You may not enter into an arrangement that is prejudicial to our rights. You may only (instruct another party to) make an arrangement with a third party, or their insurer, or a person acting on their behalf, if you have received written permission from us.

18 Do you have a complaint?

18.1 Do you disagree with a decision we have made? Or are you dissatisfied with our services? In that case you can submit your complaint to our Customer Feedback Management Department (Afdeling Klantsignaalmanagement). You must do this within 6 months of the date on which we informed you of our decision or provided the service. You can notify us of your complaint in a letter or email, by telephone or through our website.

Complaints must be written in Dutch or English. If you submit a complaint in a language other than Dutch or English, you will have to pay any translation costs.

18.2 What will we do with your complaint?
As soon as we receive your complaint, we enter it in our complaint registration system. You will receive confirmation of receipt. We will then send you a detailed response within 10 working days. If we need more time to process your complaint, we will let you know.

18.3 Do you disagree with our response? You can have your complaint reassessed
Do you disagree with how we dealt with your complaint? In that case you can ask us to reassess your complaint. You can contact the Customer Feedback Management Department (Afdeling Centrale Klantsignaalmanagement) to request a reassessment by post, email or telephone, through our website or by fax. You will receive confirmation of receipt. We will then send you a detailed response within 10 working days. We will let you know if more time is necessary in order to reassess your complaint.

18.4 You can also submit your complaint to the Health Insurance Complaints and Disputes Board (SKGZ)
Not interested in having your complaint reassessed? Or did our reassessment fail to meet your expectations? In that case you can submit your complaint to the Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ) (Health Insurance Complaints and Disputes Board), Postbus 291, 3700 AG Zeist, the Netherlands (skgz.nl). SKGZ will be unable to process your request if a judicial authority is already examining your case or has already ruled on it.

18.5 Recourse to a civil court
Instead of approaching SKGZ, you can also take your complaint to the civil court. You can also turn to a civil court after SKGZ has issued a ruling. In that case the court will determine whether the way in which the ruling was reached is acceptable. You can also take the matter to a civil court if we fail to comply with the ruling issued by SKGZ.

18.6 Complaints about forms
Do you find our forms superfluous or too complicated? In that case you can submit your complaint not only to us, but also to the Dutch Healthcare Authority (NZa). If the NZa rules on such a complaint, then this is regarded as binding advice.

18.7 This contract is governed by Dutch law.

More information? Would you like more information about how to submit a complaint to us, how we will deal with it and about the SKGZ procedures? In that case you can download the brochure 'Klachtenbehandeling bij zorgverzekeringen' from our website. You can request a copy of this brochure from us.

19 What do we do with your personal details?

19.1 Avéro Achmea is part of the Achmea Group. Achmea B.V. is responsible for the processing of your data. If you apply for insurance or a financial service, we ask you for personal details. The companies that are part of Achmea B.V. use your details:
a to enter into and execute contracts;
b to inform you about and offer you relevant products and/or services provided by companies owned by Achmea B.V.;
c to improve products and services;
d to guarantee the safety and integrity of the financial services sector;
e to conduct scientific research and perform statistical analysis;
f to assess risks;
g to maintain relationships;
h to comply with statutory obligations.

When using your personal data we are required to comply with the 'Code of Conduct for the Processing of Personal Data by Health Insurers' (Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars). We process your data in accordance with the requirements of the Dutch Personal Data Protection Act (Wet bescherming persoonsgegevens (Wbp)) and the legislative amendments that apply from May 2018. The above-mentioned data processing is registered with the Dutch Data Protection Authority (Autoriteit Persoonsgegevens).

19.2 If you do not want to receive information about our products and services
Would you prefer not to receive information about our products and/or services? Or do you want to withdraw your permission for us to use your email address? In that case you can inform us in one of 3 ways:
a send a letter to Avéro Achmea, Postbus 101, 7300 AC Apeldoorn, The Netherlands;
b by telephone number 071 - 751 00 22;
c via our website.

19.3 We refer to the Central Information System when processing applications
To ensure responsible acceptance policy, Avéro Achmea is permitted to consult the data held on you by the Central Information System (CIS) Foundation in Zeist (a foundation that retains insurance data for companies). Members of the CIS Foundation can also exchange data with one another. The purpose of this process is to manage risks and combat fraud. All exchange of information through the CIS Foundation is governed by CIS privacy regulations. You can find more information at www.stichtingcis.nl.

19.4 We are allowed to pass your details on to third parties
From the moment that your basic insurance commences, we are allowed to ask for and pass on your address, insurance and policy details to third parties (including care providers, healthcare institutions, suppliers, Vecozo (the Healthcare Communication Centre), Vektis (the Health Insurer Information Centre) and the Central Administration Office (Centraal Administratie Kantoor (CAK)). We are allowed to do this insofar as is necessary in order to comply with the obligations based on the basic insurance. Are there urgent reasons why it is imperative that third parties may not have access to your address, insurance and policy details? In that case you can report this to us in writing. Achmea does not sell your data.

19.5 We register your citizen service number
We are under a statutory obligation to enter your citizen service number (burgerservicenummer (BSN)) in our administration. Your care provider or healthcare institution is under a statutory obligation to use your BSN on all forms of communication. Other care providers who provide care within the framework of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) are under the same obligation. This means that we use your BSN when we communicate with these parties.

19.6 Where can you find more information about your rights and about how Achmea uses your data?
You can find more information in the Privacy Statement published on our website. Among other things it explains your rights, the legislative

requirements that apply to the processing of personal data and the new statutory requirements that apply from May 2018.

20 What are the consequences of fraud?

20.1 Fraud is when someone obtains or tries to obtain a reimbursement from an insurer, or an insurance contract with us:

a under false pretences;
b on improper grounds and/or in an improper way.

In this contract fraud is specifically defined as one or more of the following activities. You are committing fraud if you and/or someone else who has an interest in the reimbursement have/has:

a misrepresented the facts;
b submitted false or misleading documents;
c made a false statement regarding a claim that has been submitted;
d have concealed facts that could be important for us in assessing a claim that has been submitted.

20.2 No reimbursement in the event of fraud

In the event of proven fraud, all right to reimbursement of the costs of care covered by the basic insurance ceases to apply. This also applies to situations in which true statements were made and/or the facts were represented correctly.

20.3 Other consequences of fraud

Furthermore, fraud may form a reason for us to:

a report the matter to the police;
b cancel your insurance contract(s), in which case you will only be able to take out another insurance contract with us after 5 years;
c register you in acknowledged signalling systems between insurers (such as CIS);
d reclaim reimbursement(s) that were paid out and (examination) costs that were incurred.

21 Definitions

Terms used in this insurance contract are explained below. What do we mean by the following terms?

Pharmacy

By pharmacy we are referring to dispensing general practitioners, (internet) pharmacies, chain store pharmacies, hospital pharmacies and pharmacies in outpatient clinics.

Doctor

A person who is competent to carry out the profession of medicine on the grounds of Dutch legislation and is registered as such with the competent government authority within the framework of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Basic insurance

Health insurance as laid down in the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)).

Company doctor

A doctor who is listed as a company doctor in the register, set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Medical Specialists Registration Committee), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society) and who acts on behalf of an employer or on behalf of the Occupational Health and Safety Office (arbodienst) with which the employer is affiliated.

Pelvic physiotherapist

A physiotherapist who is registered as such in accordance with the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and who also appears as a pelvic physiotherapist in the register for pelvic physiotherapy of the Centraal Kwaliteitsregister (CKR) (Central Quality Register) of the Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF) (Royal Dutch Association for Physiotherapy) or the Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Youth Care Agency (Bureau Jeugdzorg)

An agency as referred to in article 4 of the Dutch Youth Care Act (Wet op de jeugdzorg (Wjz)).

Centre for Exceptional Dentistry

A university centre, or a centre that we deem the equivalent thereof, that provides dental care in exceptional cases, whereby treatment requires a team approach and/or exceptional expertise.

Centre for genetic research

An institution that has a permit on the grounds of the Dutch Special Medical Procedures Act (Wet op bijzondere medische verrichtingen (Wbmv)) for applying clinical genetic research and providing genetic advice.

Contract with preferential policy

We define this as a contract between us and the pharmacy in which specific agreements are made about preferential policy and/or the supply and payment of pharmaceutical care.

Day treatment

Admission lasting less than 24 hours.

Diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))

A DBC describes, by means of a DBC code established by the Dutch Healthcare Authority (Nederlandse Zorgautoriteit (NZa)) under the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)), a self-contained and validated process of specialist medical and/or mental health care (GGZ). This includes (part of) the entire care process, from the diagnosis made by the care provider to the completion of (any) resulting treatment. The DBC process commences the moment the insured person submits a request for care and is completed when treatment ends, or after 120 days in the case of specialist medical care, or 365 days in the case of specialist mental health care (GGZ).

Dietitian

A dietitian who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Primary care stay

A medically necessary short stay for medical care normally provided by general practitioners, which may also involve nursing and (paramedical) care.

Occupational therapist

An occupational therapist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

EU country and a member of the EEA

This includes, apart from the Netherlands, the following countries of the European Union: Belgium, Bulgaria, Cyprus (Greek), Denmark, Germany, Estonia, Finland, France, (including Guadeloupe, French Guiana, Martinique, Saint Martin and La Réunion), Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal (including Madeira and the Azores), Romania, Slovenia, Slovakia, Spain (including Ceuta, Melilla and the Canary islands), the Czech Republic, the United Kingdom and Sweden. Switzerland is equated with these countries on the grounds of treaty provisions.

Members of the EEA (countries that are party to the contract concerning the European Economic Area) are Lichtenstein, Norway and Iceland.

Pharmaceutical care

Pharmaceutical care is defined as:

a the provision of medicines and dietary preparations designated in this insurance contract, and/or
b advice and guidance as normally provided by pharmacists when performing a medication review and informing you of responsible use of medication, hereby taking into account our Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).

Physiotherapist

A physiotherapist who is registered as such in accordance with the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)). A physiotherapist also includes a physiotherapeutic masseur as referred to in article 108 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Birth centre
A delivery facility in or on the premises of a hospital, possibly combined with a maternity care facility. A birth centre can be equated with a birthing hotel and a delivery centre.

General Basic GGZ
Diagnosis and treatment of mild to moderate non-complex mental health problems or stable chronic problems. The GGZ Quality Charter specifies who is qualified to act as the specialist in charge of this care.

Geriatric physiotherapist
A geriatric physiotherapist who is registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and who is also registered as a geriatric physiotherapist in the Centraal Kwaliteitsregister (CKR) (Central Quality Register) or the Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Specialist mental health care
Diagnosis and specialist treatment of (very) complex mental health disorders. The GGZ Quality Charter specifies who is qualified to act as the specialist in charge of this care.

Family
One adult, or two persons who are married or cohabiting and their unmarried biological, step, foster or adopted children up to the age of 30 years, for whom the entitlement to child benefits maintenance still exists, or an allowance based on the Dutch Fees and Educational Expenses (Allowances) Act (Wet tegemoetkoming onderwijsbijdrage en schoolkosten (WTOS)) or to the deduction of extraordinary expenses based on tax legislation.

Healthcare psychologist
A healthcare psychologist registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

GGZ institution
An institution that provides medical care in connection with a psychiatric disorder and which is authorised as such.

Skin therapist
A skin therapist who has been trained in accordance with the Skin Therapists (Professional Training Requirements and Area of Expertise) Decree (Besluit opleidingseisen en deskundigheidsgebied huidtherapeut (Stb. 2002, nr. 626)). This decree is based on article 34 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

General practitioner
A physician listed as a general practitioner in the register of accredited general practitioners established by the Registratiecommissie Geneeskundig Specialisten (RGS) (Medical Specialists Registration Committee) of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Association) and who practices as a general practitioner in the usual way.

Care in the form of medical devices
Provisions that fulfil the need of functioning medical devices and bandages designated in the Health Insurance Regulations (Regeling zorgverzekering), taking into account the regulations we have stipulated on permission requirements, terms of use and rules pertaining to volume.

IDEA contract
IDEA stands for Integral Cost-effectiveness Contract for Excellent Pharmacies. This is the contract between us and a pharmacy in which specific agreements have been made about pharmaceutical care.

Doctor specialised in juvenile health care
A doctor who is listed as such, with the profile Juvenile health care, in the registers of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society), set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Medical Specialists Registration Committee).

Dental surgeon
A dental specialist listed in the register of specialists in oral diseases and dental surgery of the Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde (KNMT) (Royal Dutch Dental Association).

Calendar year
The period from 1 January up to and including 31 December.

Integrated care
A programme of care that is organised around a given disorder.

Child and youth psychologist
A child and youth psychologist registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and listed in the Register Kinder- en Jeugdpsycholoog (Child and Youth Psychologists' Register) maintained by the Nederlands Instituut van Psychologen (NIP) (Dutch Institute of Psychologists).

Paediatric physiotherapist
A paediatric physiotherapist who is registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and who is also registered as a paediatric physiotherapist in the Centraal Kwaliteitsregister (CKR) (Central Quality Register) or the Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Paediatric remedial therapist
A paediatric remedial therapist who is registered as such in accordance with the requirements of the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and who is also registered in the register designated by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists) and Zorgverzekeraars Nederland (the Association of Dutch Health Insurers).

Clinical psychologist
A healthcare psychologist registered as such in accordance with the conditions referred to in article 14 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Maternity centre
An institution that offers obstetric, midwifery and/or maternity care and which fulfils the requirements stipulated by the law.

Maternity care
Care provided by a qualified maternity carer or by a nurse who works as such.

Laboratory tests
Tests carried out by a legally accredited laboratory.

Speech therapist
A speech therapist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Manual therapist
A manual therapist who is registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and who is also registered as a manual therapist in the Centraal Kwaliteitsregister (CKR) (Central Quality Register) or the Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Medical adviser
A doctor who advises us on medical matters.

Medical specialist
A doctor who appears in the Registratiecommissie Geneeskundig Specialisten (RGS) (Register of Specialists, set up by the Medical Specialists Registration Committee), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society).

Oral hygienist
An oral hygienist who has been trained in accordance with the training requirements for an oral hygienist, as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and the Decree on Functional Independence (Besluit functionele zelfstandigheid (Stb. 1997, 553)).

Multidisciplinary collaboration
An integrated care trajectory that is jointly supplied by numerous care providers with different disciplinary backgrounds and whereby coordination is necessary to provide the care process for the insured person.

Oedema therapist
An oedema therapist who is registered as such in accordance with the conditions referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)) and who is also registered as an oedema therapist in the Centraal Kwaliteitsregister (CKR) (Central Quality Register) or the Stichting Keurmerk Fysiotherapie (Dutch Quality Physiotherapy Certification Foundation).

Cesar or Mensendieck remedial therapist
A remedial therapist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Admission
Admission to a (psychiatric) hospital, a psychiatric department of a hospital, a convalescence institution, a convalescent home or an independent treatment centre, when and as long as nursing, examination and treatment can only be provided, on medical grounds, in a hospital, convalescence institution or convalescent home.

Optometrist
An optometrist trained in accordance with the Decree governing the professional training requirements and area of expertise of optometrists (Besluit opleidingseisen en deskundigheidsgebied optometrist). This decree is based on article 34 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Orthodontist
A dental specialist listed in the Register of Specialists in dentomaxillary orthopaedics of the Koninklijke Nederlandse Maatschappij tot bevordering der Tandheelkunde (KNMT) (Royal Dutch Dental Association).

General remedial educationalist
A general remedial educationalist who appears in the NVO Register of General Remedial Educationalists of the Nederlandse Vereniging van pedagogen en onderwijskundigen (NVO) (Association of Educationalists in the Netherlands).

Podiatrist
A podiatrist who complies with the requirements as stipulated in what is known as the Dietitian, occupational therapist, speech therapist, oral hygienist, remedial therapist, orthoptist and podiatrist Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut).

Policy certificate
The health insurance policy (deed) recording the basic insurance and supplementary insurance that has been entered into between you (the policyholder) and the health insurer.

Preferred medicines
The preferred medicines designated by us within a group of identical, interchangeable medicines.

Private clinic
A private clinic is a treatment centre not accredited in accordance with the Dutch Care Institutions (Accreditation) Act (Wet toelating zorginstellingen (WTZi)).

Psychiatrist
A physician listed as a psychiatrist/neuropathist in the Register of Specialists established by the Medical Specialists Registration Committee (Registratiecommissie Geneeskundig Specialisten (RGS)) of the Royal Dutch Medical Association (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)).

Psychotherapist
A psychotherapist who is registered according to the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Specialist in charge
The care provider who supervises the care process.

Rehabilitation
Examination, advice and treatment that involve the provision of specialist medical, paramedic, behavioural and/or rehabilitation care. This care is provided by a multidisciplinary team of experts, under the guidance of a medical specialist, affiliated with an institution authorised to provide rehabilitation care in accordance with the rules laid down by or pursuant to the law.

Geriatric specialist
A doctor who has followed the specialist training in geriatrics and appears in the Register of Medical Geriatric Specialists, set up by the Registratiecommissie Geneeskundig Specialisten (RGS) (Commission for the Registration of Medical Specialists), of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Society).

Urgent medical care
Urgent medical care is the care required if assessment or treatment of symptoms needs to be performed within a matter of hours, or a day at most, to prevent damage to health or possible death.

Dentist
A dentist who is registered as such according to the conditions in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Clinical dental technician
A clinical dental technician trained in accordance with the Decree governing the professional training requirements and area of expertise of clinical dental technicians (Besluit opleidingseisen en deskundigheidsgebied tandprotheticus).

Tertiary referral
Patient referral to another healthcare institution for their care need by the medical specialist treating the patient.

You/your
The insured person. This person's name appears on the policy certificate. When we say 'you (the policyholder)' we are referring to the person who took out the basic insurance and/or supplementary insurance with us.

Exclusions
Exclusions in the insurance contract stipulate that an insured person is not entitled to, or has no right to, reimbursement of costs.

Stay
Admission lasting 24 hours or longer.

Treaty country
Every country with which the Netherlands has entered into a treaty relating to social security that includes regulations for the provision of medical care. This includes Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Serbia and Montenegro, Tunisia and Turkey.

Obstetrician or midwife
An obstetrician or midwife who is registered as such in accordance with the conditions as referred to in article 3 of the Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg (BIG)).

Referral/Statement
A referral or statement is valid for a maximum of 1 year.

Insured person
All persons named as such in the policy certificate.

Policyholder
The person who entered into the insurance contract with us.

BIG Act
The Dutch Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg). This act describes the expertise and the competencies of the care providers. The corresponding registers list the names of care providers who meet the statutory requirements.

We/us
Avéro Achmea Zorgverzekeringen N.V.

District nurse
A level-5 nurse (article 3a of the Dutch BIG Act, Bachelor's degree) or nursing specialist (article 14 of the Dutch BIG Act, Master's degree).

Long-term Care Act (Wlz)
Dutch Long-term Care Act (Wet langdurige zorg).

Social Support Act (Wmo)
Dutch Social Support Act (Wet maatschappelijke ondersteuning).

Independent treatment centre
A specialist medical care institution (IMSZ) that provides nursing care, examinations and treatment in accordance with the rules stipulated by or pursuant to the law, and is authorised to do so.

Hospital
A specialist medical care institution (IMSZ) that provides nursing care, examinations and treatment of the ill in accordance with the rules stipulated by or pursuant to the law, and is authorised to do so.

Care group
A group of care providers from different disciplines who jointly supply integrated care.

Care provider
A care provider or healthcare institution that provides care.

Health insurer
The insurance company that is authorised as such and offers insurance in the sense of the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)). For implementation of this insurance contract, this is Avéro Achmea Zorgverzekeringen N.V., whose registered office is in Utrecht, Chamber of Commerce number: 30208633 and which is registered with the AFM under number 12001023.

Care need
The symptoms that led the insured person to seek treatment from a specialist (the specialist in charge). The specialist in charge initiates a care process for this care need. All claims that can be traced back to the original care need and/or care process are regarded as a single care need.

Care covered by the basic insurance policies

The care covered by the basic insurance is summarised below. The conditions under which you are entitled to these forms of care are also listed below. Unable to find what you are looking for? Then first refer to the contents page or the alphabetical list at the start of these policy conditions.

Bones, muscles and joints

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

1 Occupational therapy

You are entitled to 10 hours of advice, tuition, training or treatment by an occupational therapist. This means 10 hours per calendar year. The occupational therapy must be intended to promote or improve your ability to cope better by yourself. The nature and extent of the care provided is limited to the care normally provided by occupational therapists.

Conditions for entitlement to occupational therapy

1 You need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to occupational therapy under the basic insurance.
2 Are you receiving treatment at school? In that case, you are only entitled to occupational therapy if we have entered into agreements about this with your care provider.

Sometimes no statement is necessary for contracted occupational therapists

Please note! In some cases no statement is needed for entitlement to occupational therapy. This is because we have entered into agreements with a number of contracted occupational therapists about direct access: These occupational therapists can treat you without a statement from the referring doctor. We call this Direct Access Occupational Therapy (Directe Toegang Ergotherapie (DTE)). You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener to find contracted care providers who offer DTE.

What you are not entitled to (under this article)

We do not reimburse surcharges for:

a appointments outside of regular working hours;
b missed appointments;
c simple, brief reports or more complicated, time-consuming reports.

Lower reimbursement for treatment provided by a non-contracted occupational therapist

Please note! Do you want to use a non-contracted occupational therapist? In that case the reimbursement may be lower than for a contracted occupational therapist. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which occupational therapists we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted occupational therapists can also be found on our website or obtained from us.

2 Foot care for insured persons with diabetes mellitus

Do you have diabetes mellitus? In that case, you are entitled to foot care. The nature of the foot care you receive will depend on your care profile. Your care profile is determined by a general practitioner, an internist or a geriatric specialist. The doctor will base the assessment of your care profile on the Simm's score and any other medical risks that may apply.

Once your care profile has been established, a personal treatment plan will be prepared for you. This will be done by a suitably qualified and competent podiatrist. The number of foot inspections and the use of diagnostics will partly depend on the care profile. The elements of care to which you are entitled are stipulated in the care module Prevention of Diabetic Foot Ulcers 2014 (Preventie Diabetische Voetulcera 2014). This can be found on our website or obtained from us.

Care Profile 1 (Zorgprofiel 1):
one podiatric foot inspection by a podiatrist per calendar year.

Care Profile 2 (Zorgprofiel 2):

- one podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year;
- foot inspection appointments;
- education and encouragement of self-management;
- preventive foot care to prevent ulcers. The podiatrist may delegate the provision of this care to a pedicure qualified to provide it.

Care Profile 3 (Zorgprofiel 3):

- one podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year;
- use of podiatric treatment(s) and a podiatric monitoring consultation with a podiatrist;
- preventive foot care and, if problems are caused by pressure and chafing, instrumental treatment to minimise the risk of an ulcer. The podiatrist may delegate the provision of this care to a pedicure qualified to provide it.

Care Profile 4 (Zorgprofiel 4):

- one podiatric foot inspection and preparation of a treatment plan by a podiatrist per calendar year;
- use of podiatric treatment(s) and a podiatric monitoring consultation with a podiatrist;
- preventive foot care and, if problems are caused by pressure and chafing, instrumental skin and nail treatment to keep the skin structure intact in order to reduce the risk of an ulcer. The podiatrist may delegate the provision of this care to a pedicure qualified to provide it.

The foot care to which you are entitled under this policy is arranged as part of integrated care or through care providers outside the healthcare chain. For foot care arranged as part of integrated care, we refer you to article 38 of 'Care covered by the basic insurance policies'.

Conditions for entitlement to foot care for insured persons with diabetes mellitus

1 We stipulate that the podiatrist must meet the following conditions:
   - The podiatrist must be a member of the Nederlandse Vereniging voor Podotherapeuten (NVvP) (Dutch Association of Podiatrists) and registered in the Kwaliteitsregister Paramedici (Paramedics Quality Register).
   - The podiatrist may delegate the provision of preventive foot care to a pedicure. Pedicures who provide foot care services on behalf of podiatrists must be listed in one of the following registers:
     - the ProCert Kwaliteitsregister voor Pedicures (KRP) (Quality Register for Pedicures) with the designation 'foot care for diabetics' (DV) or as a medical pedicure (MP)
     - the Stipezo Register Paramedische Voetzorg (RPV) (Register for Paramedical Foot Care);
     - the Kwaliteitsregister Medisch Voetzorgverleners (KMV) (Quality Register for Medical Foot Care Providers) maintained by Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ) (Health Professional Registration and Accreditation Agency) in partnership with Nederlandse Maatschappij van/voor Medisch Voetzorgverleners (NMMV) (Dutch Medical Foot Care Provider Association).

The podiatrist is the specialist in charge. The podiatrist will claim the costs directly from us quarterly. This also applies if the treatments are provided by a pedicure.

2 You need a statement from a general practitioner, internist or geriatric specialist. The statement must specify your care profile. This statement enables us to determine whether you are entitled to foot care under the basic insurance.

3 The podiatrist must note the care profile and details of the services provided on the invoice.

What you are not entitled to (under this article)

You are not entitled to:

a foot care and treatment by a podiatrist or pedicure if you have diabetes mellitus and are entitled to the corresponding integrated care, which includes foot care. In that case these foot care treatments fall under integrated care (see article 38 of 'Care covered by the basic insurance policies')

b medical devices for foot care treatment, such as podiatric insoles and orthoses. More information about this can be found in the Medical Devices Regulations (Reglement Hulpmiddelen). These regulations can be found on our website or obtained from us;

c foot care services provided by a pedicure if you have no care profile or Care profile 1 (Zorgprofiel 1). If you have Care profile 1 (Zorgprofiel 1), you may be entitled to reimbursement under your supplementary insurance.

d foot screening by a general practitioner. This foot screening falls under general practitioner care (see article 37 of 'Care covered by the basic insurance policies' (General practitioner care)).

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Physiotherapy and Cesar or Mensendieck remedial therapy

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

3 Physiotherapy and Cesar or Mensendieck remedial therapy

You are entitled to physiotherapy and Cesar or Mensendieck remedial therapy. The following is a summary of the care involved and the conditions that apply for entitlement to these forms of care.

3.1 Physiotherapy and/or Cesar or Mensendieck remedial therapy for insured persons aged 18 or older

Are you 18 or older? In that case you are entitled to the 21st treatment (per condition) and subsequent treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. This must involve a disorder that appears on the list approved by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering'). This list can be found on our website or obtained from us. The list drawn up by the Dutch Minister of Health, Welfare and Sport also specifies a maximum treatment period for a number of disorders.

Do you need manual lymph drainage because you suffer from severe lymphatic oedema? In that case you can also be treated by a skin therapist. The nature and extent of care provided is limited to the care normally provided by physiotherapists, Cesar or Mensendieck remedial therapists, and – when manual lymph drainage is involved – skin therapists.

Conditions for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy

1 Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to physiotherapy and Cesar or Mensendieck remedial therapy under the basic insurance.

2 Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register), with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
   - paediatric physiotherapy
   - pelvic physiotherapy
   - manual therapy
   - oedema therapy
   - geriatric physiotherapy
   - paediatric remedial therapy

   Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

3 Are you receiving treatment at school? In that case, you are only entitled to physiotherapy and Cesar or Mensendieck remedial therapy if we have entered into agreements about this with your care provider.

4 What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day? In that case a specific letter of referral issued by the referring doctor (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

What you are not entitled to (under this article)

You are not entitled to:

a the first 20 treatment sessions per condition. Do treatments for this condition continue into the following calendar year? In that case, the treatment sessions for the condition received the previous year count towards the 20 treatment sessions to which you are not entitled;

b individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;

c pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;

d surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - simple, brief reports or more complicated, time-consuming reports;

e bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

3.2 Physiotherapy and Cesar or Mensendieck remedial therapy for insured persons up to the age of 18

Are you under the age of 18? And do you have a disorder that appears on the list established by the Dutch Minister of Health, Welfare and Sport (VWS), 'Annex 1 relating to article 2.6 of the Health Insurance Decree' ('Bijlage 1 bij artikel 2.6 van het Besluit zorgverzekering')? In that case you are entitled to all treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. The list drawn up by the Dutch Minister of Health, Welfare and Sport specifies a maximum treatment period for a number of disorders. This list can be found on our website or obtained from us.

Do you need manual lymph drainage because you suffer from severe lymphatic oedema? In that case you can also be treated by a skin therapist.

Do you have a disorder that is not included in the list established by the Dutch Minister of Health, Welfare and Sport? In that case you are entitled to 9 treatments by a physiotherapist or Cesar or Mensendieck remedial therapist. This means 9 treatments per disorder, per calendar year. Do you need more treatments after these 9 treatments because you are still suffering from the disorder? In that case you are entitled to a maximum of 9 extra treatments. This only applies if the extra treatments are medically necessary. In other words, in total, you are entitled to a maximum of 18 treatments.

The nature and extent of care provided is limited to the care normally provided by physiotherapists, Cesar or Mensendieck remedial therapists, and – when manual lymph drainage is involved – skin therapists.

Conditions for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy

1 Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to physiotherapy and Cesar or Mensendieck remedial therapy under the basic insurance.
2 Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register), with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
   - paediatric physiotherapy
   - pelvic physiotherapy
   - manual therapy
   - oedema therapy
   - geriatric physiotherapy
   - paediatric remedial therapy

   Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.
3 Are you receiving treatment at school? In that case, you are only entitled to physiotherapy and Cesar or Mensendieck remedial therapy if we have entered into agreements about this with your care provider.
4 What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day? In that case a specific letter of referral issued by the referring doctor (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

Please note! In some cases no statement is needed from the referring doctor for entitlement to physiotherapy and Cesar or Mensendieck remedial therapy. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists: These physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a referral. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Cesar or Mensendieck Remedial Therapy (Directe Toegang Oefentherapie Cesar/Mensendieck (DTO)). You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener to find contracted physiotherapists and Cesar or Mensendieck remedial therapists that offer DTF or DTO. You are also welcome to contact us.

What you are not entitled to (under this article)

You are not entitled to:
a individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;
b pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - simple, brief reports or more complicated, time-consuming reports;

d bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

3.3 Pelvic physiotherapy to treat urinary incontinence for insured persons aged 18 or older

Are you 18 or older and do you suffer from urinary incontinence? And would you like to use pelvic physiotherapy to treat it? In that case you are entitled to the first 9 treatment sessions by a pelvic physiotherapist once per medical indication. The nature and extent of the care provided is limited to the care normally provided by physiotherapists.

Conditions for entitlement to pelvic physiotherapy

1 Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to pelvic physiotherapy under the basic insurance.
2 Are you receiving pelvic physiotherapy to treat urinary incontinence? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register), or with the Stichting Keurmerk Fysiotherapie (Quality Physiotherapy Certification Foundation). Do you want to know which pelvic physiotherapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What you are not entitled to (under this article)
You are not entitled to:
a pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
b surcharges for:
- appointments outside of regular working hours;
- missed appointments;
- simple, brief reports or more complicated, time-consuming reports;

c bandages and medical devices supplied by your pelvic physiotherapist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

3.4 Physiotherapy or remedial therapy to treat leg pain caused by stage II intermittent claudication (restricted blood supply to the legs) for insured persons aged 18 or older
Are you 18 or older and do you suffer from intermittent claudication? And do you want to treat it with remedial therapy supervised by a physiotherapist? In that case you are entitled to a maximum of 37 supervised remedial therapy treatments over a period of up to 12 months. The nature and extent of the care provided is limited to the care normally provided by physiotherapists.

Condition for entitlement to physiotherapy
Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to supervised remedial therapy for stage II intermittent claudication (restricted blood supply to the legs) under the basic insurance.

What you are not entitled to (under this article)
You are not entitled to:
a remedial therapy for restricted blood supply to the legs caused by stage III intermittent claudication. In that case you may be entitled to physiotherapy or remedial therapy under article 3.1;
b pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c surcharges for:
- appointments outside of regular working hours;
- missed appointments;
- simple, brief reports or more complicated, time-consuming reports;

d dressings, bandages and medical devices supplied by your physiotherapist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

3.5 Physiotherapy to treat osteoarthritis of the hip or knee joint for insured persons aged 18 or older
Are you 18 or older and do you have osteoarthritis in your hip or knee joint? And do you want to treat it with remedial therapy supervised by a physiotherapist or remedial therapist? In that case you are entitled to a maximum of 12 supervised remedial therapy treatments over a period of up to 12 months. The nature and extent of the care provided is limited to the care normally provided by physiotherapists and remedial therapists.

Condition for entitlement to physiotherapy
Before starting treatment you need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether you are entitled to supervised remedial therapy treatments for osteoarthritis of the hip or knee joint under the basic insurance.

What you are not entitled to (under this article)
You are not entitled to:
a pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
b surcharges for:
- appointments outside of regular working hours;
- missed appointments;
- simple, brief reports or more complicated, time-consuming reports;

c bandages and medical devices supplied by your physiotherapist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Medical devices

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

4 Medical devices

You are entitled to:
a supply of functioning medical devices and dressings for personal use (not on loan). A statutory personal contribution or a statutory maximum reimbursement sometimes applies for a medical device;
b alteration, replacement or repair of medical devices;
c spare medical devices.

Conditions for entitlement to medical devices
More detailed conditions for reimbursement of medical devices are specified in the Medical Devices Regulations (Reglement Hulpmiddelen). These regulations form an integral part of this policy and can be found on our website or obtained from us.
You do not need prior permission for the supply, customisation, replacement or repair of a large number of medical devices. You can contact a contracted supplier directly. The medical devices to which this applies are listed in article 4 of the Medical Devices Regulations (Reglement Hulpmiddelen). You do need our prior permission for the supply, customisation, replacement or repair of a number of medical devices. We assess whether the medical device is necessary, appropriate and not needlessly expensive or complicated. You always have to ask for our prior permission when non-contracted suppliers are involved.

In some cases medical devices are provided on loan. The devices to which this applies are listed in the Medical Devices Regulations (Reglement Hulpmiddelen). In this case we deviate from that which is stipulated in (a) of this article and article 2.1 of the 'General conditions of the basic insurance policies'.

What you are not entitled to (under this article)
Do you need a medical device that forms part of specialist medical care? In that case you are not entitled to medical devices under this article. These medical devices fall under article 30 of 'Care covered by the basic insurance policies'

Lower reimbursement for a non-contracted supplier

Please note! Do you order your medical devices from a non-contracted supplier? In that case the reimbursement may be lower than for a contracted supplier. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which suppliers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted suppliers can also be found on our website or obtained from us.

Medicines and dietary preparations

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

5 Pharmaceutical care: medicines and dietary preparations

Pharmaceutical care is defined as:

a medicines and dietary preparations designated in your insurance contract and dispensed to you by pharmacists;
b advice and guidance normally provided by pharmacists in terms of doing a medication check and informing you of the responsible use of medicines and dietary preparations as designated in this insurance agreement.

More detailed conditions for pharmaceutical care are specified in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). These regulations form part of this policy and can be found on our website or obtained from us.

You are entitled to the dispensing of and the provision of advice and guidance on:

a all medicines that are included for reimbursement in the GVS by ministerial decision. GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem). The GVS states which medicines can be reimbursed under the basic insurance. The provision of medicines, advice and guidance must be carried out by a pharmacy that has entered into an IDEA contract with us;
b medicines designated for reimbursement by ministerial decree that are included in the GVS insofar these medicines are designated and included in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). The provision of medicines, advice and guidance must be carried out by a pharmacy that has entered into a preferential policy contract with us or a pharmacy that does not have a contract with us;
c other than registered medicines that may be supplied in the Netherlands according to the Medicines Act (Geneesmiddelenwet). These must be based on rational pharmacotherapy. We define rational pharmacotherapy as treatment with a medicine in a form suited to the patient, the efficacy and effectiveness of which has been established by scientific research and which is also most economic for you or for your basic insurance. This definition of rational pharmacotherapy includes:
   - medicines prepared on a small scale by or on the orders of a pharmacy;
   - medicines that, according to article 40, third paragraph, under c, of the Dutch Medicines Act, in response to a request by a doctor as referred to in that provision, are prepared in the Netherlands by a manufacturer, as referred to in article 1, first paragraph, under mm, of the Medicines Act;
   - medicines that, according to article 40, third paragraph under c, of the Dutch Medicines Act, are marketed in a different member state or in a third country and, at the request of a doctor as referred to in that provision, are imported into the territory of the Netherlands. These medicines must be intended for one of that doctor's patients, who suffers from a disorder that is found in no more than 1 in every 150,000 residents in the Netherlands;
d polymer, oligomer, monomer and modular dietary preparations.

Pharmaceutical care includes a number of (partial) provisions. A description of these (partial) provisions can be found in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). On our website you will also find a summary of the maximum reimbursements we have established for (partial) provisions relating to pharmacy, medicines and dietary preparations. You will also find the registered medicines that we have designated as 'preferred medicines'. You can of course also obtain this information from us.

Conditions for entitlement to medicines and dietary preparations

1 The medicines must be prescribed by a general practitioner, a medical specialist, a dentist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, an obstetrician or midwife or a suitably qualified nurse (once this has been regulated via the ministry).
2 The medicines must be dispensed by a pharmacy. Dietary preparations may also be supplied by other specialised medical suppliers.
3 Are there identical interchangeable medicines? In that case you are only entitled to medicines designated by us. You are only entitled a non-designated medicine in the event of a medical emergency. This applies if it would be medically irresponsible to give you the medicine that we have designated. The prescriber (see under 1) must indicate on the prescription – and must be able to substantiate – that this is a case of a medical indication. More information about this can be found in the list of definitions in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).
4 You are only entitled to dietary preparations if:
   a you have a condition that requires the use of these preparations as an essential part of adequate healthcare;
   b your health problems cannot be managed with an adjusted normal diet and/or dietary products;
   c the additional conditions for reimbursement listed in Annex 2 (Bijlage 2) of the Health Insurance Regulations (Regeling zorgverzekering). Annex 2 (Bijlage 2) is amended on a regular basis. Also during the course of the current policy year. You can find the latest version of Annex 2 (Bijlage 2) (with the conditions for reimbursement) online at http://www.wetten.overheid.nl. Type 'Regeling zorgverzekering' (Health Insurance Regulations) in the search box, click on 'Zoeken' (Search). Click on 'Regeling zorgverzekering'. Towards the bottom of the list on the left you will find Bijlage 2 (Annex 2);
   d if they are prescribed by a doctor specialising in juvenile health care, a medical specialist or a dietitian. A general practitioner may only prescribe dietary preparations for allergies diagnosed on the basis of an elimination and provocative re-exposure test.

Additional provisions that apply for entitlement to specific medicines are listed in article 4.4 of the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg). You are only entitled to these medicines if you meet these additional provisions.

Conditions for entitlement to (partial) provisions
We stipulate additional requirements for a number of (partial) provisions relating to the quality of the care provided and/or preconditions regarding which pharmaceutical care you are allowed to declare. You are only entitled to these partial provisions if these additional requirements are met. The (partial) provisions to which these conditions apply are listed in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg).

Please note! Application of the mandatory excess in the case of the fitting of a coil for insured persons between the ages of 18 and 21.
If the coil is fitted by a gynaecologist, both the fitting of the coil and the coil itself are reimbursed by the basic insurance. In that case the costs are deducted from your mandatory excess. If the coil is fitted by a general practitioner, both the fitting of the coil and the coil itself are reimbursed by the basic insurance. In this case the costs of the coil are deducted from your mandatory excess. The costs of the fitting of the coil by the general practitioner are not deducted from your mandatory excess.

What you are not entitled to (under this article)
You are not entitled to the following medicines and/or pharmaceutical (partial) provisions:

a contraceptives for insured persons aged 21 or older, unless there is a medical indication. Within the framework of this article, our definition of a medical indication is endometriosis or menhorragia (severe blood loss);
b medicines and/or advice on preventing an illness within the framework of travelling abroad;
c pharmaceutical care listed in the Health Insurance Regulations (Regeling zorgverzekering) as care to which you are not entitled;
d medicines for research that appear in article 40, third paragraph, under b of the Dutch Medicines Act (Geneesmiddelenwet);
e medicines that appear in article 40, third paragraph, under f of the Dutch Medicines Act;
f medicines that are – or are almost – the therapeutic equivalent of any non-designated, registered medicine;
g non-prescription drugs not listed in the Health Insurance Regulations (Regeling zorgverzekering). Self-care products are medicines that you can purchase without a prescription;
h all pharmaceutical (partial) provisions that are not regarded as insured care. All (partial) pharmacy services are described in the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg);
i homeopathic, anthroposophic and/or other alternative medicines and remedies;
j non-registered allergens, unless treatment with a registered allergen is not possible. You are only entitled to a non-registered allergen on the basis of authorisation issued by us on an individual basis.

Lower reimbursement for a non-contracted pharmacy

Please note! Are you receiving pharmaceutical care from a non-contracted pharmacy? In that case the reimbursement may be lower than for a contracted pharmacy. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which pharmacies we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted pharmacies can also be found on our website or obtained from us.

Oral health care and dentistry

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

You are entitled to necessary dental care as is normally provided by dentists, clinical dental technicians, dental surgeons, oral hygienists and orthodontists. The dental care to which this applies is described in detail in the following articles (articles 6 to 12).

6 Orthodontics (braces) in exceptional cases

Do you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth or an acquired deformity of the teeth, jaw or mouth? And are you unable to retain or attain a dental function equivalent to the dental function you would have had without the disorder or deformity without orthodontic treatment? Then you are entitled to this treatment. Please note! Orthodontic care is not covered by basic insurance in other cases. You can take out supplementary insurance for orthodontic care. Please note! This only applies to insured persons up to the age of 18.

Conditions for entitlement to orthodontic care in exceptional cases

1 The treatment must be carried out by an orthodontist or in a Centre for Exceptional Dentistry.
2 Are you being treated at a Centre for Exceptional Dentistry? In that case you must be referred by your dentist, dental specialist or general practitioner.
3 This treatment requires a joint diagnosis or must involve other disciplines in addition to dental disciplines.
4 We must give you permission in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.

What you are not entitled to (under this article)
Have you lost or damaged existing orthodontic appliances through your own fault or negligence? In that case you are not entitled to repair or replacement.

7 Dental care for insured persons up to the age of 18

Are you under the age of 18? Then you are entitled to the following dental treatment:

a a periodical preventive dental examination once a year (annual check-up), or several times a year, if you are reliant on more frequent check-ups to maintain dental health;
b an occasional dental consultation;
c the removal of scale;
d a maximum of 2 fluoride treatments a year, from the moment permanent teeth appear, unless you are reliant on several fluoride treatments a year to maintain dental health, in which case, we must give you permission in advance;
e sealing of ridges in molars;
f periodontal care (treatment of gums);
g anaesthesia;
h endodontic care (root canal therapy);
i repairing of dental elements with plastic materials (fillings);
j gnathological care (treatment of jaw problems);
k removable dentures (metal frame dentures, partial (plate) dentures or full dentures);
l surgical dental care. This care does not include the fitting of dental implants;
m X-rays, with the exception of X-rays performed as part of orthodontic care.

Conditions for entitlement to dental care for insured persons up to the age of 18

1 The treatment must be carried out by a dentist, a dental surgeon, an oral hygienist or a clinical dental technician. This person must be competent and qualified to carry out the treatment involved.
2 Will you be undergoing treatment by a dental surgeon? In that case you need a referral from your dentist, dental specialist or a general practitioner.
3 You are only entitled to the fitting of bone anchors as part of orthodontic care provided in exceptional cases (see article 6 of 'Care

covered by the basic insurance policies'), in which case you will already have received our permission in advance.
4 Do you require the care described in articles 6, 10.2, 11 or 12 of 'Care covered by the basic insurance policies'? In that case we must give you permission in advance. You can read more about this in the following articles.
5 We must give you permission in advance for an X-ray of the whole jaw (X21). Your care provider can request permission from us on your behalf. We will then assess the appropriateness and legitimacy of the request.

What you are not entitled to (under this article)
You are not entitled to:
a shaping and/or fluoridation of milk teeth (code M05).
b orthodontic care. With the exception of the orthodontic care in exceptional cases described in article 6 of 'Care covered by the basic insurance policies', this is not covered by basic insurance. It may be reimbursed under a supplementary insurance policy;
c implants. These may be reimbursed under article 10.1 'Implants', article 12 'Dental care in exceptional cases', or supplementary dental insurance.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

Please note! Standard orthodontic treatment is not covered by basic insurance. You can take out supplementary insurance for orthodontic care. Please note! This only applies to insured persons up to the age of 18!

8 Dental care for insured persons aged 18 or older - dental surgery

You are entitled to surgical dental care of a specialist nature and the X-rays this involves. This could be combined with a stay in hospital. However, you are not entitled to periodontal surgery, the fitting of a dental implant (see article 10.1 of 'Care covered by the basic insurance policies') or an uncomplicated extraction (the removal of a molar or tooth) by a dental surgeon. (This may be reimbursed by supplementary dental insurance.)

You are entitled to nursing and or hospital accommodation if these forms of care are necessary in connection with dental surgery. See article 30 of 'Care covered by the basic insurance policies' (Specialist medical care, nursing and hospital stay).

Conditions for entitlement to dental surgery
1 The treatment must be carried out by a dental surgeon.
2 You must be referred by a general practitioner, a dentist, an orthodontist, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor who specialises in juvenile health care or another medical specialist.
3 We must give you permission in advance for the following treatments:
- osteotomy (jaw surgery) for the treatment of obstructive sleep apnea syndrome (OSAS);
- chin plastic surgery as an independent operation;
- pre-implantological surgery;
- plastic surgery.

4 Extractions may only be carried out under anaesthetic in the event of urgent medical grounds.
5 You are only entitled to a sinus lift and/or jaw widening and/or lifting if you are entitled to the accompanying implants under the basic insurance.
6 Are you having bone anchors placed for orthodontic treatment? It is important to bear in mind that entitlement to this treatment only exists if it qualifies as orthodontic care in exceptional cases (see article 6 of 'Care covered by the basic insurance policies'), in which case you will already have received our permission in advance.
7 Have you requested permission for dental treatment? In that case we will assess the cost-effectiveness and legitimacy of your application.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

9 Dental care for insured persons aged 18 or older – full set of (implant-retained) removable dentures (false teeth)

You are entitled to have the following dentures made, fitted, repaired and rebased:
a a full set of removable dentures for the upper and/or lower jaw;
b a full set of removable initial dentures;
c a replacement set of full removable dentures;
d a full set of removable overdentures on natural elements;
e a full set of upper and/or lower implant-retained (click-tight) dentures (false teeth) and attachment materials (such as press studs and rods).

A statutory personal contribution of 25% applies for the dentures referred to in (a) to (d). A statutory personal contribution of 8% for the upper jaw and 10% for the lower jaw applies for the implant-retained dentures referred to in (e).
The personal contribution for the combination of implant-retained dentures on one jaw and non-implant-retained dentures on the other jaw (code J50) is 17%. For the attachment materials (such as press studs and rods) on dentures (e) applies a statutory contribution of 8% for the upper jaw and 10% for the lower jaw.

Are you having a full set of initial dentures, an existing full set of removable dentures or overdentures, or an implant-retained denture repaired or rebased? Then a statutory personal contribution of 10% applies.

We apply maximum amounts for the costs of dental technician services and materials. These amounts can be found on our website or obtained from us

Conditions for entitlement to a full set of removable dentures
1 The treatment must be performed by a dentist or clinical dental technician or at a Centre for Exceptional Dentistry.
2 Are you attending a Centre for Exceptional Dentistry for treatment? In that case you must be referred by your dentist or dental specialist.
3 A clinical dental technician may perform the repairs described in condition 8.
4 If the dentures referred to in (a), (c) and (d) above need to be replaced within 5 years or the initial dentures referred to in (b) need to be replaced within six months, we must give you permission in advance. We assess the appropriateness and legitimacy of your request.
5 We apply maximum amounts for the costs of dental technician services and materials. These amounts can be found on our website or obtained from us Are you having a full set of upper or lower dentures made and fitted? And do the costs of dental technician services and materials exceed the maximum amounts we apply? In that case we must give you permission in advance.
6 Are you having a new full set of upper and/or lower implant-retained (click-tight) dentures (false teeth) and attachment materials (such as press studs and rods) made? In that case we must give you permission

in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. We will then assess the appropriateness and legitimacy of your request. This is not necessary for the repair and rebasing of a full set of removable implant-retained dentures that are more than 5 years old.

7 You are entitled to the repair of a full set of dentures if the procedure is performed by a clinical dental technician and no oral treatment is required. This applies to the extraoral repair of a crack or simple break in the dentures such that the parts of the dentures fit together easily. Or the extraoral attachment of a tooth or molar to the denture.

What you are not entitled to (under this article)

You are not entitled to the materials that serve to attach the full set of overdentures to the natural elements (your own tooth roots).

10 Implants

10.1 Implants

Do you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth or an acquired deformity of the teeth, jaw or mouth? And are you unable to retain or attain a dental function equivalent to the dental function you would have had without the disorder or deformity without the fitting of implants? And do you have a severely shrunken, toothless jaw? In that case you are entitled to dental implants that serve to retain a full set of removable (click-tight) dentures.

We apply maximum amounts for the costs of dental technician services and materials. These amounts can be found on our website or obtained from us

Conditions for entitlement to implants

1 The treatment must be carried out by a dentist, a dental surgeon, or a Centre for Exceptional Dentistry.
2 Are you attending a Centre for Exceptional Dentistry or jaw surgery for treatment? In that case you must be referred by your dentist or dental implantologist. A clinical dental technician may only refer you to a dentist or dental implantologist.
3 We must give you permission for the treatment in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. We will then assess the appropriateness and legitimacy of your request.

Please note! You may also be entitled to implants under article 12 of 'Care covered by the basic insurance policies'.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

10.2 Front tooth replacement for insured persons up to the age of 23

Are you missing one or more permanent incisors or canine teeth that need to be replaced due to hypodontia or because the missing teeth are a direct result of an accident and is there a record of this diagnosis having been made before the age of 18? In that case you are entitled to non-plastic tooth replacement materials. Among other things these include a fixed bridge, an acid-etched or bonded bridge or an implant-retained crown and the fitting of dental implants in the front of the mouth.

Conditions for entitlement to the fitting of dental implants in the front of the mouth.

1 The treatment must be carried out by a dentist or dental surgeon.
2 Will you be undergoing treatment by a dental surgeon? In that case you need a referral from your dentist or dental specialist.
3 We must give you permission for the treatment in advance. A treatment plan with a cost estimate and available X-rays must be submitted with your request for approval. The treatment plan must be prepared by your dentist or dental surgeon.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

11 Dental care for insured persons with a handicap

Do you have a non-dental physical and/or mental handicap? And are you unable, without dental care, to retain or attain a dental function that is equivalent to the dental function you would have had without the physical and/or mental handicap? In that case you are entitled to dental care.

Conditions for entitlement to dental care for insured persons with a handicap

1 The treatment must be carried out by a dentist, an oral hygienist, a clinical dental technician, an orthodontist, a dental surgeon, or a Centre for Exceptional Dentistry.
2 Are you attending a Centre for Exceptional Dentistry for the care? Or are you being treated by a dental surgeon? In that case you must be referred by your dentist, dental specialist or general practitioner.
3 You are only entitled to this care if you are not entitled to dental care under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
4 We must give you permission for the care in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

12 Dental care in exceptional cases

In the following exceptional cases you are entitled to dental treatment:

a If you suffer from a serious development or growth disorder that affects the teeth, jaw or mouth, or an acquired deformity of the teeth, jaw or mouth and are unable to retain or attain a dental function equivalent to the dental function you would have had without the condition without dental care.
b If, without the dental care, medical treatment would have demonstrably insufficient results. And if, without the dental care, you

are unable to attain or retain a dental function equivalent to the dental function you would have had without the medical condition;
c If you suffer from extreme anxiety about dental treatment, according to the validated anxiety scales as described in the guidelines of the Centres for Exceptional Dentistry.

In so far as care is involved that is not directly linked to the indication for exceptional dental care, insured persons aged 18 or older pay a contribution equal to the sum that would be charged to the insured person concerned if this article did not apply. For instance, do you go to a dentist who specialises in anxiety? In that case you usually pay a higher tariff than for a normal dentist. You are only entitled to the additional costs. You must pay the standard tariff for a normal dentist yourself.

Conditions for entitlement to dental care in exceptional cases

1 The treatment must be carried out by a dentist, an oral hygienist, an orthodontist, a dental surgeon, or a Centre for Exceptional Dentistry.
2 Are you attending a Centre for Exceptional Dentistry for treatment? Or are you being treated by a dental surgeon? In that case you must be referred by your dentist, dental specialist or general practitioner.
3 We must give you permission in advance. When requesting our permission, you must also submit a treatment plan, a cost estimate and available X-rays. The treatment plan and cost estimate will be drawn up by your care provider. We will then assess the appropriateness and legitimacy of your request.
4. Treatments performed under anaesthetic are only reimbursed as a last resort in an anxiety management process. The treatment performed under anaesthetic must be carried out at a Centre for Exceptional Dentistry or by a Dentist who meets our expertise, organisational and safety requirements for treatments performed under anaesthetic. We must give you permission in advance for every treatment performed under anaesthetic. We assess entitlement to treatment performed under anaesthetic each time the treatment is requested.

Please note! You may also be entitled to implants under article 10.1 of 'Care covered by the basic insurance policies'.

Lower reimbursement if treatment is provided by a non-contracted dental surgeon

Please note! Do you want to use a non-contracted dental surgeon? In that case the reimbursement may be lower than for a contracted dental surgeon. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted dental surgeons can also be found on our website or obtained from us.

Eyes and ears

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

13 Audiology centre

13.1 Hearing problems

Do you have hearing problems? In that case you are entitled to care in an audiology centre. This care means that the centre:

a examines your hearing function;
b advises you about hearing aids you may need to purchase;
c provides you with information about using any aids;
d provides you with psychosocial care if this is necessary for your hearing problem.

Condition for entitlement to care in an audiology centre

You must be referred by a general practitioner, company doctor, geriatric specialist, doctor who specialises in juvenile health care, paediatrician, ENT specialist or hearing-aid specialist.

Lower reimbursement for a non-contracted audiology centre

Please note! Do you want to use a non-contracted audiology centre? In that case the reimbursement may be lower than for a contracted audiology centre. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which audiology centres we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted audiology centres can also be found on our website or obtained from us.

13.2 Speech and language disorders in children

Does your child have a speech or language disorder? An audiology centre contracted for this purpose can assist in establishing a diagnosis. Do you want to know with which audiology centres we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Condition for entitlement to care in an audiology centre

You must be referred by a general practitioner, company doctor, geriatric specialist, doctor who specialises in juvenile health care, paediatrician, ENT specialist or hearing-aid specialist.

Lower reimbursement for a non-contracted audiology centre

Please note! Do you want to use a non-contracted audiology centre? In that case the reimbursement may be lower than for a contracted audiology centre. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which audiology centres we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted audiology centres can also be found on our website or obtained from us.

14 Sensory impairment care

You are entitled to sensory impairment care. This is multidisciplinary care that focuses on learning to cope with, overcoming or compensating for the limitation. This care is designed to enable you to function as independently as possible.

You are eligible for this care if you:

a have a hearing impairment (you are deaf or hearing impaired) and/or
b a visual impairment (you are blind or visually impaired) and/or
c a communication impairment (you have significant difficulties with speech and/or language) caused by a primary language development disorder and are under the age of 23.

The multidisciplinary care consists of:

a action-oriented diagnostics;
b interventions that help a person learn mental strategies for coping with the disability;
c interventions that overcome or compensate for the disability and therefore increase self-reliance (the ability to cope independently).

In the case of hearing and communication impairments the healthcare psychologist is ultimately responsible for the multidisciplinary care and the care plan. This task may also be performed by remedial educationalists or developmental psychologists.

In the case of visual impairments the ophthalmologist or a medical physicist who specialises in the visual system is ultimately responsible for the multidisciplinary care when it comes to coordination of the treatment of the 'vision problem'. The healthcare psychologist or a similar behavioural specialist is ultimately responsible for the multidisciplinary care when it comes to coordination of the treatment of mental and/or behavioural problems and learning to cope with the disability. This task may also be performed by practitioners trained in other disciplines.

Conditions for entitlement to sensory impairment care

1 In the case of hearing and communication impairment you must be referred by a medical physicist audiologist who works at an audiology centre or a medical specialist.
2 In the case of visual impairment you must be referred by an ophthalmologist or another medical specialist. Was your sensory impairment disorder previously diagnosed by a medical physicist audiologist, ophthalmologist or medical specialist? And has a sensory impairment-related care need arisen without there being any change in the sensory impairment disorder? In that case you can also be referred by a general practitioner or a doctor who specialises in juvenile health care.
   You do not need a new referral for simple rehabilitation care (that falls within Care Programme 11*) if:
   - the referral is a repeat referral;
   - there has been no change in the sensory impairment disorder, but there has been a change in the medical or personal situation that necessitates further treatment under your basic insurance;
   - the sensory impairment care provider has established that the care need(s) can be met within Care Programme 11;
   - the sensory impairment care provider notifies the general practitioner in writing of the process that has been followed. The general practitioner adds the information to the patient's medical file.

* Care Programme 11 enables 'fast-track' admission for people who have received treatment and/or training in the past who need further treatment. It is also for adults confronted (for the first time) with visual impairment (caused by conditions such as retinitis pigmentosa) whose care needs usually involve being able to make optimal use of their remaining vision, and older people (55+) with an acquired visual impairment who are specifically seeking to retain their independence. The condition is known, the person's vision has been assessed, and the person has one or two specific care needs. These care needs involve learning to compensate for their visual impairment and/or make optimal use of their remaining vision in order to retain their independence. In most cases these care needs can be met within 10 hours.

What you are not entitled to (under this article)

You are not entitled to:
a elements of care designed to support social functioning;
b complex, lifelong and lifewide support for deaf and blind adults and prelingually deaf adults (who became deaf or hard of hearing before the age of 3).

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Mental health care

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

15 General basic mental health care for insured persons aged 18 or older

Do you have mild to moderate non-complex mental health problems or stable chronic problems? In that case you are entitled to general basic mental health care (Basic GGZ).
The nature and extent of the care provided is limited to the care normally provided by psychiatrists and clinical psychologists.

Conditions for entitlement to Basic GGZ.

1 You must be 18 or older.
2 You must be referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, or a doctor who specialises in emergency medicine.
3 The referral must comply with the 'Mental Health Referral Agreements' ('Afspraken verwijzing Geestelijke gezondheidszorg') established by the Dutch Minister of Health, Welfare and Sport (VWS).
4 A referral is valid for a maximum of 9 months. This means that your treatment must commence within 9 months of the date on which the referral is issued. What if it is more than 9 months since the referral was issued? Then you must ask for another referral.
5 Your care provider must have a quality charter registered with www.ggzkwaliteitsstatuut.nl. You can request a copy of the quality charter or view it on your care provider's website.

What you are not entitled to (under this article)

Among other things you are not entitled to:
a treatment of adjustment disorders;
b assistance with work-related and relationship problems;
c assistance with psychiatric complaints that do not involve a mental disorder;
d Basic GGZ for insured persons up to the age of 18. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of other problems and diagnoses not treated under basic insurance, and psychological interventions to which you are not entitled under basic insurance, can be found on our website.

Please note! In principle, the doctor treating you can only arrange one Basis GGZ service for you per year. The doctor treating you may only arrange a second Basis GGZ service for you within the same year if you suffer a relapse or if, counter to expectations, you return with the same or other symptoms after the previous treatment has been completed.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

16 Non-clinical specialist mental health care for insured persons aged 18 or older (secondary mental health care)

Do you suffer from a complex mental disorder? In that case you are entitled to non-clinical specialist mental health care.

The nature and extent of the care provided is limited to the care normally provided by psychiatrists and clinical psychologists.

Conditions for entitlement to non-clinical specialist mental health care

1 You must be 18 or older.
2 You must be referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, doctor who specialises in treating the mentally handicapped or a doctor who specialises in emergency medicine.
3 The referral must comply with the 'Mental Health Referral Agreements' ('Afspraken verwijzing Geestelijke gezondheidszorg') established by the Dutch Minister of Health, Welfare and Sport (VWS).
4 A referral is valid for a maximum of 9 months. This means that your treatment must start within 9 months after being referred. Is the period of time between the referral and the start of your treatment longer than 9 months? Then ask for a new referral. Your care provider has a quality charter registered with www.ggzkwaliteitsstatuut.nl. Visit the website of your care provider or ask for the quality charter.

What you are not entitled to (under this article)

You are, among others, not entitled to:
a treatment of adjustment disorders;
b assistance with work-related and relationship problems;
c assistance with psychiatric complaints that do not involve a mental disorder;
d non-clinical specialist mental health care for insured persons up to the age of 18 years. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of remaining problems and diagnoses for which the treatment is not covered under basic insurance and psychological interventions to which you are not entitled under basic insurance can be found on our website.Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

17 Stay in a psychiatric hospital for insured persons aged 18 or older

Have you been admitted to a GGZ institution, such as a psychiatric hospital, a psychiatric university clinic or the psychiatric ward of a hospital? In that case you are entitled to:
a specialist mental health care in accordance with article 16 of 'Care covered by the basic insurance policies';
b your stay with or without nursing and care;
c paramedical care, medicines, medical devices and dressings that are part of your treatment during your stay.

The nature and extent of the care provided is limited to the care normally provided by psychiatrists and clinical psychologists.

Conditions for entitlement to a stay in a psychiatric hospital

1 You must be 18 or older.
2 You must be referred by a general practitioner, a company doctor, a medical specialist, a geriatric specialist, doctor who specialises in treating the mentally handicapped
3 The referral must comply with the most recent national agreements regarding cooperation between mental health services.
4 A referral is valid for a maximum of 9 months. This means hat your treatment must start within 9 months. This means that your treatment must start within 9 months after tbeing referred. Is the period of time between the referral and the start of your treatment longer than 9 months? Then ask for a new referral.
5 The stay must be medically necessary for the purpose of medical care.
6 Your care provider has a quality charter registered with www.ggzkwaliteitsstatuut.nl. Visit the website of your care provider or ask for the quality charter.

What you are not entitled to (under this article)

You are, among others, not entitled to:
a treatment of adjustment disorders;
b assistance with work-related and relationship problems;
c assistance with psychiatric complaints that do not involve a mental disorder;
d stay in a psychiatric hospital for insured persons up to the age of 18. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

Tip! A list of remaining problems and diagnoses for which the treatment is not covered under basic insurance and psychological interventions to which you are not entitled under basic insurance can be found on our website.

How many days stay with treatment are you entitled to?

In the case of a stay in a psychiatric hospital with treatment you are entitled to an uninterrupted stay in a GGZ institution for a period of up to 1,095 days. The following forms of stay also count towards the calculation of the 1,095 days:
a stay in a rehabilitation centre or a hospital for the purpose of rehabilitation;
b stay in a non-psychiatric hospital;
c primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Speech and reading

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

18 Speech therapy

You are entitled to treatment sessions with a speech therapist insofar as this care has a medical purpose. The treatment must be expected to restore or improve the ability to speak. The nature and extent of the care provided is limited to the care normally provided by speech therapists. This also applies to stutter therapy given by a speech therapist.

Conditions for entitlement to care

1 You need a statement from the referring doctor (general practitioner, medical specialist, or dentist). This statement enables us to determine whether you are entitled to speech therapy under the basic insurance.
2 Are you receiving treatment at school? In that case, you are only entitled to speech therapy if we have entered into agreements about this with your care provider.

Sometimes no statement is necessary for contracted speech therapists

Please note! In some cases no statement is needed for entitlement to speech therapy. This is because we have entered into agreements with a number of contracted speech therapists about direct access. These speech therapists can treat you without a referral. We call this Direct Access Speech Therapy (Directe Toegang Logopedie (DTL)). Do you want to know which contracted care providers offer DTL? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener.

Are you unable to travel for treatment because of your symptom(s)? Then you will not be able to obtain DTL. In that case you will need a statement from a referring doctor. The referring doctor should indicate on the statement that treatment must be provided at home.

What you are not entitled to (under this article)

You are not entitled to:
a treatments that we do not define as speech therapy, which include the treatment of dyslexia and of language developmental disorders relating to dialect or speaking a different language;
b surcharges for:
- appointments outside of regular working hours;
- missed appointments;
- simple, brief reports or more complicated, time-consuming reports.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Transport

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

19 Ambulance transport or seated patient transport

19.1 Ambulance transport

You are entitled to the following forms of ambulance transport:
a ordered ambulance transport requested via the ambulance dispatch centre;
b ambulance transport requested via the Transport Telephone Line (Vervoerslijn) (in the case of transport for patients on waiting lists).

Please note! Do you need emergency ambulance transport? This is usually reported through the EU emergency services number, 112, in which case you do not need a referral. Nor do you need to request permission from us in advance. This transport is also covered by your basic insurance.

You are entitled to ambulance transport:
a to and from a care provider or institution, if the care provided is partially or entirely reimbursed by this basic insurance;
b to an institution if the costs of your stay are covered by the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) (this does not apply if care is provided for part of a day only);
c from a Wlz institution to a care provider or institution where you have to undergo an examination or treatment, the costs of which are fully or partially reimbursed under the Wlz;
d from a Wlz institution to a care provider or institution that measures you for, fits or adjusts a prosthesis. The costs of the prosthesis must be fully or partially reimbursed under the Wlz;
e from the above-mentioned care providers or institutions to your home, or to another place of residence if you cannot reasonably receive care in your home.
f to a care provider from whom or an institution in which an insured person under the age of 18 will receive mental health care that is fully or partially reimbursed under the Dutch Youth Act (Jeugdwet).

Conditions for entitlement to ambulance transport
1 For ordered ambulance transport you must be referred by a general practitioner, a medical specialist, a geriatric specialist, a doctor who specialises in treating the mentally handicapped or a doctor who specialises in juvenile health care. You do not need a referral for emergency transport.
2 Our Transport Telephone Line (Vervoerslijn) must authorise ambulance transport for patients on waiting lists in advance. The telephone number is 071 365 41 54. One of our Transport Telephone Line (Vervoerslijn) staff will determine whether you are entitled to transport. This person also decides to which form of transport you are entitled.
3 You are only entitled to ambulance transport if you do not have to travel more than 200 kilometres to your care provider. This does not apply if we have made a different agreement with you.

19.2 Seated patient transport

You are entitled to:
a seated patient transport by (the lowest class of) public transport, (multi-person) taxi or a kilometre allowance of €0,28 per kilometre for transport by private car if you are:
- undergoing kidney dialysis;
- undergoing oncological treatment (radio-, chemo- or immunotherapy);
- are visually impaired and unable to travel without an escort;
- wheelchair dependent;
- under the age of 18 and entitled to nursing and care for complex somatic problems or a physical handicap, because you require permanent supervision or need care available in the vicinity 24 hours a day.

b transport of a companion if an escort is needed, or to accompany insured persons up to the age of 16.

The number of reimbursable kilometres is based on the fastest route between the postcodes of your departure address and destination.

You are entitled to seated patient transport:

a to and from a care provider or institution, if the care provided is partially or entirely reimbursed by the basic insurance;
b to an institution if the costs of your stay are covered by the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) (this does not apply if care is provided for part of a day only);
c from a Wlz institution to a care provider or institution where you have to undergo an examination or treatment, the costs of which are fully or partially reimbursed under the Wlz;
d from a Wlz institution to a care provider or institution that measures you for, fits or adjusts a prosthesis. The costs of the prosthesis must be fully or partially reimbursed under the Wlz;
e from the above-mentioned care providers or institutions to your home, or to another place of residence if you cannot reasonably receive care in your home.

Personal contribution for seated patient transport

A statutory personal contribution of €101.00 per person, per calendar year, applies for seated patient transport (by public transport, (multi-person) taxi or private car).

Hardship clause for seated patient transport

If the above-mentioned criteria do not apply to you, you may be entitled to seated patient transport under the hardship clause. Firstly, you must depend upon seated patient transport, because you are being treated for a long-term illness or disorder. Secondly, the fact that we are not reimbursing transport must be regarded as a case of extreme inequity. We assess whether you are entitled to reimbursement under the hardship clause.

Conditions for entitlement to seated patient transport

1 You must obtain advance permission for seated patient transport (by public transport, (multi-person) taxi or private car) and/or the transport of an escort from our Transport Telephone Line (Vervoerslijn). The telephone number is 071 365 41 54. One of our Transport Telephone Line (Vervoerslijn) staff will determine if you are entitled to transport and, if so, the form of transport to which you are entitled. This person will also determine whether an insured person aged 16 or older needs an escort.
2 The transport must be related to care to which you are entitled under your basic insurance or care reimbursed under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz).
3 Is seated patient transport by public transport, (multi-person) taxi, private car or ambulance not possible? In that case we must give you permission for a different means of transport in advance.
4 A two-person escort is permitted in exceptional cases. If this is the case, we must also give you permission in advance.
5 You are only entitled to patient transport if you do not have to travel more than 200 kilometres to your care provider. This does not apply if we have made a different agreement with you.

Lower reimbursement if treatment is provided by non-contracted taxi services

Please note! Do you want to use a non-contracted taxi service? In that case the reimbursement may be lower than for a contracted taxi service. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which taxi services we have a contract? In that case please contact our Transport Telephone Line (Vervoerslijn) on 071 365 41 54. A list that gives an indication of the reimbursement tariffs that apply for non-contracted taxi services can also be found on our website or obtained from us.

How do I claim my transport costs?

A contracted transport service must send us an invoice for the transport costs. What if you use a non-contracted taxi service, public transport or your own transport? Then please use the claim form to request reimbursement of your transport costs. You can find the claim form on our website. You must be able to provide proof that you incurred the transport costs if we ask for it.

Hospital, treatment and nursing

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

20 The Asthma Centre in Davos (Switzerland)

Do you suffer from asthma? In that case you are entitled to treatment at the Dutch Asthma Centre in Davos.

Conditions for entitlement to care

1 Similar treatment in the Netherlands was unsuccessful and we regard the treatment in Davos as cost-effective.
2 You must have a referral from a lung specialist or a paediatrician.
3 We must give you written permission in advance.

21 Genetic research and advice

Do you want to have genetic research carried out? Or do you want advice? In that case you are entitled to obtain it in a centre for genetic research. This care comprises:

a research into and on hereditary disorders by means of genealogical analysis;
b chromosomal research;
c biochemical diagnostics;
d ultrasound scanning and DNA research;
e genetic advice and psychosocial counselling provided as part of this care.

If it is necessary in order to be able to advise you, the centre will also examine persons other than yourself. The centre can also advise these persons.

Condition for entitlement to genetic research and advice

You must have a referral from your doctor, obstetrician or midwife.

Lower reimbursement for a non-contracted centre for genetic research

Please note! Do you want to use a non-contracted centre for genetic research and advice? In that case the reimbursement may be lower than for a contracted centre. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which centres we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply to services provided by non-contracted centres can also be found on our website or obtained from us.

22 Mechanical respiration

You are entitled to necessary mechanical respiration and the specialist medical care this involves. The care can take place in a treatment centre or at home.

Mechanical respiration at home

Mechanical respiration can be provided at home, under the responsibility of a respiratory centre. In that case:

a the respiratory centre provides the necessary apparatus – ready-to-use – for every treatment;
b the respiratory centre supplies specialist medical care and the corresponding pharmaceutical care involved in mechanical respiration.

Condition for entitlement to mechanical respiration
You must be referred by a lung specialist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

23 Home dialysis

Are you receiving dialysis treatment at home? In that case, you are entitled to reimbursement of the associated costs. These are:

a any modifications necessary in and around the home and for subsequently returning things back to their original state. We only reimburse the costs of alterations we consider reasonable. Furthermore, we only reimburse these modification costs if they are not already covered by other statutory regulations;
b other reasonable costs directly related to your dialysis at home (such as the costs of water and electricity). These too will only be reimbursed if they are not covered by other statutory regulations.

Condition for entitlement to reimbursement of these costs
We must give you written permission in advance. You must have submitted an estimate of the costs.

Please note! The regular costs of home dialysis, such as equipment, expert supervision, research and treatment, are reimbursed as specialist medical care, see article 30 of 'Care covered by the basic insurance policies'.

24 Transplantation of organs and tissues

In the case of organ transplants you are entitled to the following treatments:

a transplantation of tissues and organs in a hospital. The transplant procedure must be performed in:
   - a member state of the European Union;
   - a state that is party to the Agreement on the European Economic Area;
   - another state. In that case, the donor must live in that state and must be your spouse, registered partner or a first, second or third degree blood relative;
b transplantation of tissues and organs in an independent treatment centre legally qualified and competent to perform these procedures.

In the case of proposed transplantation of an organ you are entitled to reimbursement of the costs of specialist medical care associated with:

a the choosing of the donor;
b the surgical removal of the transplant tissue from the chosen donor;
c examination, preservation, removal and transportation of postmortem transplant tissue.

You are entitled to reimbursement of the costs of:

a care to which the donor is entitled in accordance with this policy. The donor is entitled to reimbursement for a maximum of 13 weeks, or 6 months in the case of a liver transplant, from the date of discharge from the hospital. This must be the hospital in which the donor stayed for the selection or removal of the transplant material. Furthermore, you are only entitled to reimbursement of the costs of the care provided if it relates to that hospital stay;
b transport of the donor by the cheapest form of public transport, or, if medically necessary, by car. The transport must be related to the selection process, the stay in hospital, discharge from hospital or the care referred to in point a;
c transport of a donor who lives abroad to and from the Netherlands. The donor is only entitled to transport if you are undergoing a kidney, bone marrow or liver transplant in the Netherlands. You are also entitled to other transplant-related costs incurred as a result of the donor residing abroad.

Please note! This does not include accommodation costs in the Netherlands or any loss of income.

In the case of b and c, if the donor has basic insurance, entitlement to reimbursement of the costs of transport applies under the donor's basic insurance. If the donor does not have basic insurance, these costs will be covered by the recipient's basic insurance.

Condition for entitlement to this care
Are you having the transplant done in a hospital? And is this hospital not contracted by us? In that case you must request our permission in writing in advance. Do you want to know with which hospitals we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

25 Plastic surgery

You are entitled to plastic-surgery procedures performed by a medical specialist at a hospital or independent treatment centre (ZBC) if these procedures help to correct:

a abnormalities in personal appearance associated with demonstrable physical dysfunction;
b mutilations that are the result of an illness, an accident or a medical intervention;
c the following congenital deformities:
   - cleft lip, jaw and palate;
   - deformities of the facial bones;
   - benign proliferations of blood vessels, lymphatic vessels or connective tissue;
   - birthmarks or
   - deformities of the urinary tract and genital organs;
d paralysed or weakened upper eyelids if the paralysis or weakening seriously impairs the field of vision (if the lower edge of the upper eyelid, or overhanging skinfold, is within 1 mm of the centre of the pupil), or if the paralysis or weakening is a consequence of a congenital defect or a chronic disorder present at birth;
e the abdominal wall (abdominoplasty), in the following cases:
   - mutilations the severity of which is comparable with that of third degree burns;
   - untreatable inflammation (intertrigo) in skin folds;
   - an extremely severe limitation in the freedom to move (if your belly covers at least a quarter of your upper legs);
f primary sexual characteristics in cases of confirmed transsexuality (including epilation of the pubic region and beard).
g female breast agenesis/aplasia and a similar situation in trans women (also referred to as male-to-female transgender persons).

If a stay is medically necessary, you are entitled to this care in accordance with article 30 of 'Care covered by the basic insurance policies'.

Conditions for entitlement to plastic surgery

1 You must be referred by a general practitioner or a medical specialist.
2 We must give you written permission in advance.

What you are not entitled to (under this article)

1 Some plastic surgery procedures are-not covered by your insurance. You are not entitled to the following procedures:
   a surgical placement or replacement of breast implants, unless the surgery is performed following a (partial) mastectomy or in the case of female breast agenesis/aplasia;
   b surgical removal of a breast prosthesis without a medical necessity;
   c liposuction of the stomach;
   d treatment to correct paralysed or weakened upper eyelids, unless the paralysis or weakening seriously impairs the field of vision (if the lower edge of the upper eyelid, or overhanging skinfold, is within 1 mm of the centre of the pupil), or if the paralysis or weakening is a consequence of a congenital defect or a chronic disorder present at birth.
2 You are not entitled to treatment at a private clinic.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

26 Rehabilitation

You are entitled to specialist medical rehabilitation (26.1) and geriatric rehabilitation (26.2).

26.1 Specialist medical rehabilitation

Do you need rehabilitation care? In that case you are only entitled to specialist medical rehabilitation if this is indicated as the most effective method of preventing, reducing or overcoming your handicap. Furthermore, your handicap must be the consequence of:

a disorders or limitations in your ability to move;
b a disorder of the central nervous system that leads to limitations in communication, cognition or behaviour.

The rehabilitation care must enable you to achieve or maintain a degree of independence that is reasonably possible given your limitations.

Clinical and non-clinical rehabilitation care

You are entitled to clinical or non-clinical (part-time or day-treatment) rehabilitation care. In some cases you are also entitled to clinical rehabilitation care if you are admitted for several days. We only reimburse if rehabilitation care provided during a stay quickly leads to better results than rehabilitation care that does not involve a stay.

Conditions for entitlement to specialist medical rehabilitation

1 You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor who specialises in juvenile health care or another medical specialist;
2 The stay must be medically necessary for the purpose of specialist medical rehabilitation.

How many days of clinical stay are you entitled to?

Have you been admitted? In that case you are entitled to an uninterrupted stay in a clinic for a period of up to 1,095 days.

The following forms of stay also count towards the calculation of the 1,095 days:

a (psychiatric) hospital stay;
b primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

26.2 Geriatric rehabilitation

You are entitled to geriatric rehabilitation. This care comprises integrated, multidisciplinary rehabilitation care. This applies to care normally provided by geriatric specialists if an acute condition has resulted in acute motility disorders or reduced self-reliance and specialist medical care has previously been provided for this condition (in connection with vulnerability, complex multimorbidity and reduced learning and training ability). Geriatric rehabilitation focuses on improving functional limitations. The purpose of the rehabilitation care is to enable you to return to your home situation.

How many days of geriatric rehabilitation are you entitled to?

You are entitled to geriatric rehabilitation for a maximum of 6 months. In exceptional cases we may allow a longer period.

Conditions for entitlement to geriatric rehabilitation

1 You must be referred by a general practitioner, a doctor who specialises in treating the mentally handicapped or a medical specialist.
2 The stay must be medically necessary for the purpose of geriatric rehabilitation.
3 The care must commence within 1 week of a stay in hospital, as defined in article 2.12 of the Health Insurance Decree (Besluit zorgverzekering). In this hospital you must receive medical care as is normally provided by a medical specialist or a similar care provider.
4 You were not residing in a nursing home for treatment before being admitted to this hospital. In this case we are referring to a nursing home as defined in article 3.1.1. of the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
5 The care must initially involve a stay in a hospital or healthcare institution, as defined in article 2.12 of the Health Insurance Decree.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

27 Second opinion

Do you want a second opinion? In that case you are entitled to one. Getting a second opinion means having the diagnosis made by your doctor or treatment proposed by your doctor reassessed. Your doctor can also request a second opinion. The reassessment is performed by a second, independent doctor. The second doctor must possess the same area of expertise and must practice the same profession as the first doctor.

Conditions for entitlement to a second opinion

1 The second opinion must relate to diagnostics or treatment that is covered by the basic insurance.
2 You must be referred by a general practitioner, medical specialist, clinical psychologist or psychotherapist.
3 The second opinion must relate to medical care that is intended for you and which you have discussed with your first doctor.
4 When obtaining a second opinion, you give a copy of your first doctor's medical file to the second doctor.
5 You must return to the first doctor with the second opinion. This doctor remains in charge of your treatment.

What you are not entitled to (under this article)

Insured care does not cover a second opinion if the purpose of the second opinion is to obtain treatment that is not included in the basic insurance.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

28 Nursing and care in your own surroundings (extramural)

The conditions that apply for entitlement to nursing care in an intramural institution (such as a hospital for example) are set out in articles 16, 17, 30 and 31 of 'Care covered by the basic insurance policies'. However, you are also entitled to nursing and care in your own surroundings. The nature and extent of the care provided is limited to the care normally provided by nurses and carers, which is specified in the occupational profiles defined by Verpleegkundigen & Verzorgenden Nederland (V&VN) (Netherlands Nurses and Carers Association).

You are entitled to nursing and care related to (a high risk of) the need for medical care.

Please note! If you fall within in a particular target group you can apply for a personal care allowance (persoonsgebonden budget (Zvw-pgb)) that you can use to purchase nursing and care in your own surroundings. The target groups to which this applies and the conditions that apply are set out in the Reglement Zvw-pgb (Personal Care Allowance Regulations). These regulations form part of this policy and can be found on our website or obtained from us.

Conditions for entitlement to nursing and care in your own surroundings

1 a. For adults aged 18 or older, a care needs assessment conducted in accordance with the standards that apply to the assessment of care needs and the organisation of nursing and care in one's own surroundings must be carried out by a professionally (HBO) qualified BIG-registered nurse.
b. For children under the age of 18, a care needs assessment conducted in accordance with the medical childcare system (Medisch Kindzorgsysteem (MKS)) must carried out by a professionally qualified paediatric nurse employed by a care provider affiliated with Vereniging Gespecialiseerde Verpleegkundige Kindzorg (VGVK) (Association for Specialist Nurse-Supervised Childcare) and/or Brancheorganisatie Medische Kindzorg Thuis (BMKT) (Professional Association for Medical Childcare at Home). The care needs assessment must be conducted in your home with you present. A BIG-registered nurse must conduct a care needs assessment in advance. This means that the district nurse will discuss your needs with you and determine what care you need in your particular situation and the intended results. As part of the care needs assessment, the agreements that have been made and the need for care are specified in a care plan. In the care plan the professionally (HBO) qualified BIG-registered nurse notes the care need and the care that is to be provided. The care plan specifies the number of hours of nursing and the number of hours of care. The care needs must be defined in accordance with the 6 standards listed in the document 'Standards for needs assessment and organisation of nursing and care in one's own surroundings' ('Normen voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving').
2 In the case of palliative terminal care you need a statement from the referring doctor. The statement must confirm that the estimated life expectancy is less than 3 months. The nature and extent of the care provided is detailed in the care plan. Provision of care must be aligned with the Palliative Care care module (adopted nationally in 2013) or the quality framework for palliative care (issued in 2018).
3 For specialist nursing, a request must be issued by a medical specialist in advance. Specialist nursing must be provided by a BIG-registered nurse who is competent and qualified to provide the necessary care for the condition in question. The nature, content and extent of the care must be detailed in the care plan.

What you are not entitled to (under this article):

a you are not entitled to maternity care under this article. This is reimbursed under article 33 of 'Care covered by the basic insurance policies';
b you are not entitled to personal care under the basic insurance if you are entitled to personal care under the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)).

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Please note! We are aware that, when it comes to district nursing services, the quality of care provided varies considerably. We are committed to the principle of quality care. We set high quality standards for our contracted care providers and we ensure that our requirements are met. To ensure that care provided by non-contracted care providers also meets our requirements, we have an authorisation procedure. If you (wish to) use a non-contracted care provider, the following additional conditions apply. Please be aware that if you use a non-contracted care provider, you will have to wait longer for reimbursement. Please also note that there are plenty of contracted care providers in all regions.

Additional conditions if care is provided by a non-contracted care provider

1 Are you using a non-contracted care provider? In that case you must request permission from us in advance. To request permission, you must use the 'Authorisation to use non-contracted district nursing care' ('Aanvraag machtiging niet-gecontracteerde wijkverpleegkundige zorg') Request form, which can be found on our website. When requesting permission, you need to supply the following:

- the care needs assessment and the care plan (these must meet the conditions listed above);
- the nursing diploma held by the professionally (HBO) qualified BIG-registered nurse who conducted the care needs assessment;
- and, in the case of palliative terminal care, a statement confirming that the estimated life expectancy is less than 3 months.

We will then assess the appropriateness and legitimacy of your request. We will notify you whether your request has been approved or denied.

2 You must submit the invoices you receive from your non-contracted care provider to us for reimbursement. Invoices will only be reimbursed if authorisation to use a non-contracted care provider has been requested and approved.

Transitional arrangement for insured persons who on 31 December 2017 are receiving nursing and care from a care provider not contracted by us in 2018.

If on 31 December 2017 you are using a care provider not contracted by us, you must submit the Authorisation Request form by 30 September 2018. We will let you know whether your care provider, your care needs assessment and care plan meet our (quality) requirements by 12 November 2018 at the latest.

If your care provider and/or your care needs assessment and care plan are not approved, you will no longer be entitled to reimbursement of the costs of this care from 1 January 2019. You can contact the Care Coach for help with finding another care provider who meets our quality requirements.

29 Primary care stay

You are entitled to primary care stay. The stay must be medically necessary for the purpose of medical care and may involve nursing and (paramedical) care. Your general practitioner must consider that recovery is to be expected in the short term. The purpose of the stay must be to enable you to return to your home situation.

Has your doctor indicated that that your estimated life expectancy is less than 3 months? In that case you are entitled to palliative terminal care at an institution where patients can stay for primary care.

Primary care stay consists of:

- a stay that is medically necessary for the purpose of medical care;
- 24-hour availability and provision of nursing and/or care;
- medical care provided by a general practitioner, a geriatric specialist and/or a doctor who specialises in treating the mentally handicapped;
- paramedical care (physiotherapy, Cesar or Mensendieck remedial therapy, speech therapy, dietetic therapy and/or occupational therapy) required in connection with the need for the stay.

The nature and extent of the medical care provided is limited to the care normally provided by general practitioners.

Conditions for entitlement to primary care stay.

1 You must be referred by a general practitioner, a medical specialist, a doctor who specialises in emergency medicine, a geriatric specialist or a doctor who specialises in treating the mentally handicapped.
2 If your stay commences on or after 1 January 2018 and lasts for more than 3 months, you must request permission to continue your stay beyond the first 3 months before the 60th day of your stay. This does not apply in the case of palliative care. When requesting permission, you must also supply your care plan.

What you are not entitled to (under this article)

You are not entitled to primary care stay:

a if you have been allocated a complete or modular home care package or a personal care allowance (PGB) to pay for care in your own home under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)), or if you receive care through a form of clustered housing. In that case the cost of the stay is covered under the Long-term Care Act (Wlz);
b in the case of respite care. Respite care is temporary assumption of full responsibility for the provision of care to provide relief for the usual informal carer;
c if you are under the age of 18 and need mental health care. This falls under the Dutch Youth Act (Jeugdwet). You can contact your municipality about this.

How many days of clinical stay are you entitled to?

Days of primary care stay count towards the calculation of the maximum of 1,095 days of stay. The following forms of stay also count towards the calculation of the 1,095 days:

a (psychiatric) hospital stay;
b stay in a rehabilitation centre or a hospital for the purpose of rehabilitation.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract?

In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

30 Specialist medical care and stay

You are entitled to specialist medical care and hospital accommodation. This care can be provided in:

a a hospital;
b an independent treatment centre, or
c a practice in the home of an (extramural) medical specialist attached to an institution accredited in accordance with the Dutch Care Institutions (Accreditation) Act (Wet toelating zorginstellingen (WTZi))

The care consists of:

a specialist medical care;
b your treatment and possible stay (based on the lowest class accommodation and care) in a hospital or independent treatment centre, including nursing and care, paramedical care, medicines, medical devices and dressings that are part of the treatment.

The nature and extent of the care provided is limited to the care normally provided by medical specialists.

Conditions for entitlement to specialist medical care

1 You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, a doctor who specialises in juvenile health care, a physician assistant, a nursing specialist, a doctor who specialises in emergency medicine, an assistant physician, a clinical physicist audiologist, an obstetrician or midwife if obstetric or midwifery care is involved, an optometrist if eyecare is involved, or another medical specialist.
2 A hearing-aid specialist can also refer you to an ENT specialist.
3 The referring doctor (see under 1) informs our medical advisor of the reason for your stay. You must authorise the referring doctor to provide this information.
4 Are you being admitted for plastic surgery? In that case you are only entitled to this care if you have requested our permission. This must be done at least 3 weeks before the stay. As proof of our permission, we issue the hospital or independent treatment centre with a guarantee statement.
5 The stay must be medically necessary for the purpose of specialist medical care.

Please note! Aspects of specialist medical care are treated separately in the following articles of 'Care covered by the basic insurance policies'.

The articles in question are:

Article 8	Dental care for insured persons aged 18 or older - dental surgery
Article 13	Audiology centre
Article 17	Stay in a psychiatric hospital (mental health care)
Article 20	The Asthma Centre in Davos (Switzerland)
Article 21	Genetic research and advice
Article 22	Mechanical respiration
Article 23	Home dialysis
Article 24	Transplantation of organs and tissue
Article 25	Plastic surgery
Article 26	Rehabilitation
Article 31	Childbirth and obstetric or midwifery care
Article 32	In vitro fertilisation (IVF), other forms of fertility-enhancing treatments, etc.
Article 34	Oncological examination of children
Article 40	Thrombosis service

What you are not entitled to (under this article)

You are not entitled to:

a specialist medical care and/or accommodation, as described in this article, if you are treated at a private clinic;
b treatments for snoring (uvulopalatoplasty);
c treatment with a corrective helmet for plagiocephaly and brachycephaly without craniostenosis;
d treatments designed to result in sterilisation;
e treatments designed to reverse sterilisation;
f treatments for circumcision without medical necessity;

Mental health care (GGZ) does not fall under this article. Do you want to know what mental health care you are entitled to? In that case, please read articles 16 and 17 of 'Care covered by the basic insurance policies' on non-clinical specialist mental health care (secondary mental health care) and stay in a psychiatric hospital.

How many days stay are you entitled to?

Have you been admitted to a hospital or independent treatment centre? In that case you are entitled to an uninterrupted stay in a hospital or independent treatment centre for a period of up to 1,095 days.
The following forms of stay also count towards the calculation of the 1,095 days:

a stay in a rehabilitation centre or a hospital for the purpose of rehabilitation;
b stay in a psychiatric hospital;
c primary care stay.

An interruption of up to 30 days is not treated as an interruption and these days are not counted when calculating the 1,095 days. What if your stay is interrupted for a weekend break or a holiday? In that case we count these days in our calculation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Pregnancy/baby/child

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

31 Childbirth and obstetric or midwifery care

When assessing entitlement to obstetric or midwifery care and care during delivery we draw a distinction between 'with medical indication' (31.1) and 'without medical indication' (31.2).

31.1 With medical indication

Female insured persons are entitled to:

a obstetric or midwifery care provided by a medical specialist. This also includes care provided in a hospital and by obstetrician or midwife supervised by a medical specialist;
b use of the delivery room if delivery takes place in a hospital (in the hospital itself or in the outpatient department).

The nature and extent of the care provided is limited to the care normally provided by medical specialists.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

31.2 Without medical indication

Female insured persons are entitled to:

a the use of the delivery room if there is no medical indication for giving birth in a hospital or a birth centre. For this you will be required to pay a statutory personal contribution of €34.00 for each day of your stay (€17.00 for the mother and €17.00 for the child). Does the hospital charge more than €245.00 per day (€122.50 for the mother and €122.50 for the child)? In that case, in addition to the €34.00, you will also have to pay the sum over and above the €245.00 per day;
b obstetric or midwifery care during the pregnancy and home birth provided by an obstetrician or midwife if there is one available, or if not, by a general practitioner.

The nature and extent of the care provided is limited to the care normally provided by obstetricians and midwives.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

32 In vitro fertilisation (IVF), other forms of fertility-enhancing treatments, sperm cryopreservation and oocyte vitrification

You are entitled to IVF (32.1), other forms of fertility-enhancing treatments (32.2), sperm cryopreservation (32.3) and oocyte vitrification (32.4).

32.1 IVF (in vitro fertilisation)

Do you want to undergo IVF treatment? And are you under the age of 43? In that case, per ongoing pregnancy achieved, you are entitled to reimbursement of the first, second and third IVF attempts, including any medicines used.

What is the definition of an IVF attempt to achieve pregnancy?

An IVF attempt to achieve pregnancy involves undergoing, at most, the following sequential phases:

a ripening of oocytes within the woman's body by means of hormonal treatment;
b retrieval of the ripe oocytes (follicular puncture);
c oocyte fertilisation and cultivation of embryos in the laboratory;
d replacement of 1 or 2 of the resulting embryos in the uterus to allow pregnancy to occur. Are you under the age of 38? In that case only 1 embryo may be replaced during the first and second attempts.

The process only counts as an attempt if follicular puncture (phase b) is successful. From then on, we count all attempts that are interrupted before an ongoing pregnancy is achieved. A new attempt after an ongoing pregnancy is treated as a first attempt. The replacement of frozen embryos is regarded as part of the IVF attempt during which the embryos were created, as long as an ongoing pregnancy has not already been initiated. If an ongoing pregnancy has been initiated, any remaining frozen embryos may be replaced after this pregnancy. If this fails to produce results, further IVF treatment can be initiated. This then counts as a first attempt.

ICSI treatment (intracytoplasmic sperm injection) is the equivalent of an IVF attempt.

What is the definition of an ongoing pregnancy?

A distinction is drawn between 2 different forms of ongoing pregnancy:

a physiological pregnancy: a (spontaneous) pregnancy lasting at least 12 weeks from the first day of the last menstruation;
b IVF-induced pregnancy lasting at least 10 weeks from the follicular puncture after a non-frozen embryo is replaced. Or at least 9 weeks and 3 days after a frozen embryo was replaced.

Conditions for entitlement to IVF

1 The treatment must take place in an authorised hospital.
2 You need a statement from your doctor that states the medical indication before submitting your application.
3 We must give you written permission in advance for treatment in a hospital abroad.

Entitlement to medicines up to a maximum amount

You are entitled to medicines that are necessary for an IVF attempt. This applies up to a certain maximum amount that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of the maximum amounts that apply for medicines can be found on our website or obtained from us.

What you are not entitled to (under this article)

You are not entitled to medicines that are necessary for the fourth and subsequent IVF attempts.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

32.2 Other fertility-enhancing treatments

Are you under the age of 43? In that case you are also entitled to reimbursement of fertility-enhancing treatments other than IVF and the medicines involved.

Conditions for entitlement to other fertility-enhancing treatments

For entitlement to other forms of fertility-enhancing treatments the following conditions apply:

1 You need a statement from your doctor that states the medical indication before submitting your application.
2 We must give you written permission in advance for treatment in a hospital abroad.

Entitlement to medicines up to a maximum amount

You are entitled to medicines that are necessary for a fertility enhancing treatment. This applies up to a certain maximum amount that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of the maximum amounts that apply for medicines can be found on our website or obtained from us.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

32.3 Sperm cryopreservation

Are you undergoing specialist medical treatment that may result in unintended infertility? In that case you are entitled to the collection, freezing and storage of semen.

The law stipulates that the freezing of semen must be a part of the oncological care given by a medical specialist. It could also be a comparable treatment that is not oncological. This must involve:

a major surgery on or close to your genitals;
b chemotherapy and/or radiotherapy treatment during which your genitals are exposed to radiation.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

32.4 Vitrification (freezing) of human oocytes

Do you want to have human oocytes or embryos frozen? In that case you are entitled to this procedure for the following medical indications:

a you are undergoing chemotherapy which carries the risk of permanent fertility problems;
b you are undergoing radiotherapy treatment during which your ovaries are exposed to radiation and could be permanently damaged as a result;
c you are undergoing surgery during which (large parts of) both of your ovaries will be removed for medical reasons.

Entitlement to freezing procedures also exists for other medical indications

The following medical indications involve an increased risk of you becoming prematurely infertile. This is the case if you suffer from premature ovarian insufficiency (POI) before you reach the age of 40. Also in this instance you are entitled to freezing procedures. The medical indications involved are those relating to the following characteristics of female fertility:

a fragile X syndrome;
b Turner syndrome (XO);
c galactosemia.

If these medical indications are present, you are entitled to reimbursement of the following parts of the treatment:

a follicular stimulation;
b oocyte puncture;
c freezing of oocytes.

Entitlement to freezing procedures also exists for IVF-related reasons

In some cases, you will also be entitled to freezing procedures during an IVF attempt based on (cost-)effectiveness considerations. In that case, the attempt must be covered by your basic insurance. This is the case in the following situations:

a there is an unexpected lack of sperm of sufficient quality;
b oocytes are frozen instead of embryos;

You are only entitled to the freezing of oocytes if IVF-related reasons apply.

Possibilities after the freezing of oocytes

Are you having your frozen oocytes thawed with the aim of becoming pregnant? In that case you are limited to phases c and d of an IVF attempt (see article 32.1 of 'Care covered by the basic insurance policies'). Please note! You must be under the age of 43 when the embryo is replaced.

Conditions for entitlement to freezing procedures

1 The freezing procedures must take place in an authorised hospital.
2 Are you being treated in a hospital abroad? In that case we must give you written permission in advance.
3 You are only entitled to freezing procedures for the reasons listed above if you are under the age of 43.

Entitlement to medicines up to a maximum amount

You are entitled to medicines that are necessary for the freezing of oocytes. This applies up to a certain maximum amount that we have stipulated for all (partial) pharmaceutical and medicinal provisions. A list of the maximum amounts that apply for medicines can be found on our website or obtained from us.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

33 Maternity care

Female insured persons are entitled to maternity care. The nature and extent of care provided is limited to the care normally provided by maternity carers.

Maternity care can be provided:

a **at home**
A statutory personal contribution of €4.30 per hour applies for maternity care provided at home.
b **at a birth or maternity centre**
A maximum of 8 hours of maternity care is charged per bed-day in a birth or a maternity centre. Also in this case, a statutory personal contribution of €4.30 per hour applies. You are entitled to a maximum of 4 bed-days. You are entitled to receive the remainder of the indicated maternity care at home.
c **in hospital**
Are you staying in a hospital without a medical indication? In that case a statutory personal contribution of €34.00 applies for each day (of your stay) (€17.00 for the mother and €17.00 for the child). Does the hospital charge more than €245.00 per day (€122.50 for the mother and €122.50 for the child)? In that case, in addition to the €34.00, you will also have to pay the sum over and above the €245.00 per day. You are entitled to a maximum of 10 days' maternity care, calculated from the day of the delivery. If the mother and child leave the hospital together before these 10 days have lapsed, there is still entitlement to maternity care at home for the remaining days. Entitlement will only be allocated for days 9 and 10 on the basis of a reassessment by an obstetrician or midwife.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

How much maternity care are you entitled to?

The number of hours of maternity care to which you are entitled depends on your personal situation following delivery. The birth centre or maternity centre will determine this in consultation with you. This will be done in accordance with the National Maternity Care Indication Protocol (Landelijk Indicatieprotocol Kraamzorg). The protocol and explanatory notes can be found on our website. Or you can contact us.

34 Oncological examination of children

You are entitled to care provided by the Dutch Child Oncology Group (Stichting Kinderoncologie Nederland (SKION)). SKION coordinates and registers tissue material it receives and establishes the diagnosis.

35 Prenatal screening

As a female insured person you are entitled to:

a counselling that explains the procedures involved in prenatal screening;
b a structural echoscopic examination, also known as the 20-week ultrasound scan;
c the combined test (a nuchal scan combined with a blood test) for congenital disorders during the first trimester of pregnancy. You are only entitled to these forms of care if you have been referred for medical reasons by a general practitioner, obstetrician, midwife or medical specialist;
d Non-Invasive Prenatal Testing (NIPT). You are only entitled to NIPT if you have a medical indication or if the result of the combined test is positive. Is the result of the combined test 1 in 200 or higher? In that case the result of the combined test is considered to be positive;
e invasive diagnostics. You are only entitled to these diagnostic procedures if you have a medical indication or if the result of the combined test or Non-Invasive Prenatal Testing is positive. Is the result of the combined test or Non-Invasive Prenatal Testing 1 in 200 or higher? In that case the result of the test is considered to be positive.

Please note! The costs of NIPT will be deducted from your mandatory excess.

Condition for entitlement to prenatal screening

The care provider who carries out the prenatal screening must have a permit as defined in the Population Screening Act (WBO-vergunning) or work in collaboration with a regional centre that has such a permit.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

Other medical care

Your insurance policies are shown on your policy certificate. Do you have a ZorgPlan Natura? In that case, you have arranged care insurance and are entitled to care (arranged by us). Do you have a ZorgPlan Restitutie policy? In that case, you have reimbursement insurance and are entitled to reimbursement of the costs of care.

36 Dietetic therapy

You are entitled to 3 hours of dietetic therapy by a dietitian. This means 3 hours per calendar year. Dietetic therapy includes information and advice on nutrition and eating habits. Dietetic therapy must have a medical objective. The nature and extent of the care provided is limited to the care normally provided by dietitians.

Conditions for entitlement to dietetic therapy

1 You will need a statement from the referring doctor (general practitioner, company doctor, dentist or medical specialist). This statement enables us to determine whether you are entitled to dietetic therapy under the basic insurance.
2 Are you receiving advice at school? In that case, you are only entitled to dietetic therapy if we have entered into agreements about this with your care provider.

Sometimes no statement is necessary for contracted dietitians

Please note! In some cases no statement is needed from the referring doctor for entitlement to dietetic therapy. This is because we have entered into agreements with a number of contracted dietitians about direct access: these dietitians can advise you without a referral. We call these Direct Access Dietitians (Directe Toegang Diëtist (DTD)). You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener to find contracted direct-access dietitians. You are also welcome to contact us.

Are you unable to travel for advice because of your symptom(s)? Then you will not be able to obtain DTD. In that case you will need a statement from a referring doctor. The referring doctor should indicate on the statement that advice must be provided at home.

What you are not entitled to (under this article)

You are not entitled to:

a appointments outside of regular working hours;
b missed appointments;
c simple, brief reports or more complicated, time-consuming reports.

Lower reimbursement for a non-contracted dietitian

Please note! Do you want to use a non-contracted dietitian? In that case the reimbursement may be lower than for a contracted dietitian. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which dietitians we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply to non-contracted dietitians can also be found on our website or obtained from us.

37 General practitioner care

You are entitled to medical care provided by a general practitioner. The care can also be provided by a care provider under the supervision of the general practitioner. If requested by a general practitioner, you are also entitled to X-rays and laboratory tests. The nature and extent of the care provided is limited to the care normally provided by general practitioners.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

38 Integrated care for diabetes mellitus type 2, COPD, asthma and/or VRM

You are entitled to integrated care for diabetes mellitus type 2 (for insured persons aged 18 or older), COPD, asthma or vascular risk management (VRM) if we have made agreements with a care group. In the provision of integrated care the patient with a chronic condition is the primary concern. Care providers from various disciplines play a role in the care programme. We currently purchase integrated care for diabetes mellitus type 2, COPD, asthma and VRM. The content of these programmes is aligned with the current care standards for diabetes mellitus, COPD, asthma and VRM.

Entitlement to integrated care provided by a non-contracted care group

Please note! Are you receiving integrated care for diabetes mellitus type 2 (for insured persons aged 18 or older), COPD, asthma or VRM provided by a non-contracted care group? In that case the reimbursement may be lower than for a contracted care group. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you have diabetes mellitus type 2 and are you under the age of 18? Or is your care provider not affiliated with a care group? In that case you are only entitled to care normally provided by medical specialists, dietitians and general practitioners. This is the care as defined in articles 30, 36 and 37 of 'Care covered by the basic insurance policies'. In the case of diabetes mellitus type 2 you are also entitled to foot care as defined in article 2 of 'Care covered by the basic insurance policies'.

Do you want to know with which care groups we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

39 Stop smoking programme

You are entitled to a maximum of 1 stop smoking programme designed to help you give up smoking per calendar year. This stop smoking programme must consist of medical and, possibly, pharmacotherapeutic interventions that support behavioural change, whereby the objective is to stop smoking. This involves support such as that normally provided by general practitioners, medical specialists and clinical psychologists.

Conditions for entitlement to a stop smoking programme

1 You must be referred by a general practitioner, a company doctor, a geriatric specialist, a doctor who specialises in treating the mentally handicapped, an obstetrician or midwife or a medical specialist.
2 Pharmacotherapy with nicotine-replacement medicines, nortriptyline, bupropion and varenicline is only reimbursed in combination with support that focuses on behaviour.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

40 Thrombosis service

Do you suffer from thrombosis? In that case you are entitled to care from a thrombosis service. The care provided by this service includes:

a taking regular blood samples;
b carrying out the necessary laboratory tests in order to determine the coagulation time of your blood. The thrombosis service may also arrange for a third party to carry out these tests. The thrombosis service remains accountable;
c providing you with apparatus and equipment so you can measure the coagulation time of your blood yourself;
d training you to use this equipment and supervising you when you carry out measurements;
e advising you on the use of medicines to influence the coagulation time of your blood.

Condition for entitlement to care from a thrombosis service

You must be referred by a general practitioner, geriatric specialist, doctor who specialises in treating the mentally handicapped or medical specialist.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Do you want to use a non-contracted care provider? In that case the reimbursement may be lower than for a contracted care provider. Whether this applies and, if so, the level of reimbursement depends on your basic insurance. You can read more about this in article 4 of the 'General conditions of the basic insurance policies'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us. A list that gives an indication of the reimbursement tariffs that apply for non-contracted care providers can also be found on our website or obtained from us.

General conditions of the supplementary insurance policies

The general conditions that apply to your basic insurance, also apply to your supplementary insurance, with the exception of article 1.1, clauses a-d (This insurance contract is based on), and article 4.3 (Non-contracted care providers).

In other words, these articles of the 'General conditions of the basic insurance policies' do not apply to your supplementary insurance.

There are also articles that apply specifically to your supplementary insurance. These articles are listed below.

1 How do you apply for the supplementary insurance?

1.1 Applying for supplementary insurance

Everyone who is entitled to take out our basic insurance can also apply for supplementary insurance should they wish to do so. You (the policyholder) can apply for supplementary insurance by signing and returning an application form that you have completed in full. You can also complete the application form on our website. But you can only do this if you are applying for our basic health insurance at the same time. We only provide supplementary insurance with retroactive effect if the situation referred to in article 6.1 of these general conditions applies.

1.2 We cannot always provide supplementary insurance

There are some situations in which we cannot provide supplementary insurance. We will reject your application if:

- a premium payment for an existing insurance you (the policyholder) have with us is overdue;
- you have committed fraud as defined in article 20 of the 'General conditions of the basic insurance policies';
- the state of your health warrants such a decision;
- you need some form of healthcare when you apply. Or if you are likely to need some form of healthcare which, due to its nature and extent, would be covered by the supplementary insurance.

1.3 Children have the same supplementary insurance as their parents

Are your children also covered by your basic health insurance? In that case you can also take out supplementary insurance for your children. You do not have to pay a premium for supplementary insurance for children under 18. So it is not possible to arrange supplementary insurance for children that is more extensive than the supplementary insurance arranged for yourself or a partner covered by the same policy.

Please note! Does your partner have their own basic and supplementary insurance policies, either with us or with another insurer? In that case you must indicate whether your children are to be added to your policy or your partner's policy.

2 What does the supplementary insurance cover?

2.1 What we reimburse

You are entitled to reimbursement of expenses under your supplementary insurance if the expenses in question were incurred during the period covered by the supplementary insurance. In this respect the determining factor is the date on which treatment and/or care was/were provided. The date of treatment is the date of treatment noted on the bill, not the date on which the bill was issued. Are you claiming for treatment provided within the context of a Diagnosis Treatment Combination (DBC) care product? Then the start date of your treatment is the determining factor.

Reimbursement for non-contracted care providers or healthcare institutions

In the case of some of the reimbursements listed under 'Reimbursements covered by supplementary insurance policies', we only reimburse the costs if you are treated by a contracted care provider. You can read about this in the respective article. It may also be the case that we do not fully reimburse a non-contracted care provider or healthcare institution. You can also read about this in the respective article.

2.2 Reimbursement of the costs of medical treatment abroad

Reimbursement of the costs of medical treatment abroad is subject to certain conditions and exclusions. These are listed in the articles under 'Reimbursements covered by supplementary insurance policies'. The foreign care provider or healthcare institution must be recognised by the local authorities in the country in question. The foreign care provider or healthcare institution must also meet requirements equivalent to the statutory requirements that must be met by Dutch healthcare providers and institutions, as defined by the conditions of your insurance. Article 15 of the 'General conditions of the basic insurance policies' also applies to medical treatment abroad.

Please note! Do our conditions mention 100% or full reimbursement? Then, in the context of the article in question, expenses will be reimbursed up to a maximum of 100% of the fee normally charged for the same treatment in the Netherlands.

This article does not apply to articles listed in the conditions of your insurance as pertaining specifically to the situation that applies in the Netherlands, or to article 9 of 'Reimbursements covered by supplementary insurance policies'. We only reimburse the costs of medical treatment abroad if these costs would be covered by your supplementary insurance if the treatment were provided in the Netherlands.

2.3 What we do not reimburse (non-reimbursement of related expenses)

You are only entitled to reimbursement of expenses that are not, or only partially, reimbursed by statutory regulations. The expenses in question must also be covered by your supplementary insurance. Your supplementary insurance does not include cover that compensates for:

a a lower reimbursement covered by your basic insurance for care provided by non-contracted care providers;
b expenses offset against the excess of your basic insurance, unless we are providing group supplementary insurance that covers the mandatory excess;
c statutory personal contributions and amounts over and above the statutory maximum reimbursement, unless the reimbursement in question is explicitly listed as being covered by the supplementary insurance.

Medical expenses that are covered by law or another plan or insurance (including travel insurance), irrespective of which policy was issued first, or medical expenses that would have been covered by law or another plan or (travel) insurance if this supplementary insurance did not exist, are not covered by this supplementary insurance.

2.4 Costs incurred as a result of terrorism

Have costs been incurred as a result of terrorism? In that case your supplementary insurance will reimburse these costs up to the maximum amount listed in the clause sheet on terrorism cover issued by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V. (NHT)). This clause sheet and the corresponding claim handling protocol form an integral part of these policy conditions. The protocol can be found at www.terrorismeverzekerd.nl. The clause sheet can be downloaded from our website or obtained from us.

2.5 Sequential application of multiple insurance policies

Do you have several insurance policies with us? Then we will reimburse the bills you submit by applying the policies in the following order:

- your basic insurance;
- supplementary dental insurance;
- supplementary insurance.

3 Is there a mandatory and voluntarily chosen excess?

The mandatory excess and any voluntarily chosen excess that you have opted to take out only apply to your basic insurance. In other words, an excess does not apply to reimbursements covered by your supplementary insurance.

4 What will you have to pay?

4.1 The amount of your premium

The premium you have to pay is determined by your age. Do you have to pay a higher premium because you have entered a new age bracket? Then the premium will change on 1 January following the year in which you enter the new age bracket.

What if you are a parent who has taken out basic and supplementary insurance with us? Then children under 18 who are covered by your insurance do not have to pay a premium for the supplementary insurance. What happens when these children reach the age of 18? Then you (the policyholder) must pay a premium as of the first of the month following the month in which the child reaches the age of 18.

4.2 If you do not pay the premium on time

Did you (the policyholder) fail to pay your premium on time? Then, in addition to articles 9 and 10 of the 'General conditions of the basic insurance policies', the following conditions also apply: We will terminate your supplementary insurance (policies), if you (the policyholder) do not pay your premium within the grace period specified in our second written demand for payment. Your right to reimbursement will then automatically cease to apply from the first day of the month following the expiry of the stipulated term of payment. The payment obligation continues to apply.

Have you paid all outstanding premiums? Then you can reapply for supplementary insurance (policies) from 1 January of the following year. You may be required to undergo a preliminary medical assessment.

5 What if your premium and/or the conditions of your insurance alter?

5.1 We may alter your premium and/or the conditions of your insurance

We have the right to alter the premium and/or the conditions of our supplementary insurance policies for all policyholders or certain groups of policyholders. Any such changes will be effective from a date specified by us. These changes will apply to your (existing) insurance (policies) with us.

5.2 If you do not agree to the alterations

Are you not prepared to pay the higher premium or do you not accept more restrictive terms and conditions? Then please notify us to this effect by sending us a letter or email within 30 days of the date on which we announced the change. We will then cancel your insurance on the date on which the new premium and/or new conditions become effective.

5.3 Sometimes you do not have the option of cancelling your insurance if we alter the premium and/or the conditions

In some cases you cannot cancel your insurance prior to the expiry date if we change the premium and/or the conditions. This applies if:

- the higher premium and/or more restrictive conditions and/or reimbursements are stipulated by statutory regulations;
- you have to pay a higher premium because you have entered a new age bracket.

In the situations listed above, you can cancel your insurance by following one of the procedures described in article 7 of these general conditions.

6 When does your supplementary insurance commence? And how do you change this?

6.1 Your supplementary insurance commences on 1 January

You (the policyholder) can take out supplementary insurance in addition to your basic insurance with us. You can apply for supplementary insurance up until 31 January of the current calendar year. If your application is approved, the supplementary insurance will be retroactively effective from 1 January. We must agree to this in writing. If you apply for supplementary dental insurance, you may be required to undergo a preliminary medical assessment.

6.2 To change your supplementary insurance

Do you (the policyholder) want to change your supplementary insurance with us? Then you can apply for supplementary insurance up until 31 January of the current calendar year. If your application is approved, we will change your supplementary insurance with retroactive effect from 1 January. We must agree to this in writing. You may be required to undergo a preliminary medical assessment.

Have you (the policyholder) changed your supplementary insurance with us? Then any reimbursements that you have already received will count towards the new supplementary insurance policy. This applies to periods that apply for certain healthcare entitlements and the calculation of the (maximum) reimbursement.

Did you have a set of full removable dentures fitted prior to this calendar year? And have you yet to submit a claim under your supplementary dental insurance in the current calendar year? Then you are entitled to alter or cancel your supplementary dental insurance, in which case the change will apply from the first day of the month that follows the calendar month in which we received the request to change or cancel the insurance.

7 How do you cancel your supplementary insurance?

You (the policyholder) can cancel your supplementary insurance in the following ways:

a By sending us a letter or email notifying us that you wish to cancel your supplementary insurance. We must receive notice of cancellation by 31 December at the latest. We will then cancel your supplementary insurance on 1 January of the following year. Have you asked us to cancel your supplementary insurance? In that case the cancellation is irrevocable.

b By using the cancellation service provided by your new health insurer. Have you (the policyholder) taken out supplementary insurance for the next calendar year with another health insurer prior to 31 December of the current calendar year? Then your new health insurer will cancel your supplementary insurance with us on your (the policyholder's) behalf. If you (the policyholder) do not wish to make use of this cancellation service, you (the policyholder) must note this on the application form of your new health insurer.

8 In what situations will we cancel your supplementary insurance?

We will terminate your supplementary insurance on a date to be determined by us. This applies to both your own supplementary insurance and the supplementary insurance provided for any other persons covered by your policy. We will do this if you (the policyholder) do not pay your premium within the grace period specified in our second written demand for payment.

We will terminate your supplementary insurance on a date to be determined by us if we decide, for reasons that we consider to be compelling, to no longer offer supplementary insurance.

We will also cancel your supplementary insurance with immediate effect if:

a you do not respond on time to a request for information (which may need to be supplied in writing), if the requested information is required to enable efficient administration of our supplementary insurance;

b if it subsequently transpires that you failed to complete the application form correctly and in full, or if it subsequently transpires that you failed to disclose circumstances that are important to us.

c it has been established that you have committed fraud. What we mean by 'fraud' is defined in article 20 of the 'General conditions of the basic insurance policies'.

Please note! On termination of your membership of a group supplementary insurance scheme, you will cease to benefit from the reduced rate for group insurance and other advantages. These include, for example, additional reimbursements covered by the group supplementary insurance scheme.

9 How do we check the legitimacy and cost-effectiveness of the submitted invoices?

We check the legitimacy and cost-effectiveness of the invoices submitted to us. In checking legitimacy we verify that the care provider actually provided the care. In checking cost-effectiveness we verify that the care provided was the most appropriate care given the state of your health. Our monitoring procedures are conducted in accordance with the provisions of, or pursuant to, the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)) as this applies to the basic insurance.

10 Definitions

Terms used in these conditions that relate specifically to your supplementary insurance are explained below. What do we mean by the following terms?

Supplementary insurance
The supplementary insurance (policies) you have taken out in addition to your basic insurance. These include:

- supplementary dental insurance;
- supplementary insurance.

We/us
Achmea Zorgverzekeringen N.V.
Health insurer
Achmea Zorgverzekeringen N.V. is the health insurers that provide your supplementary insurance. In other words, they administer your supplementary insurance for you. Achmea Zorgverzekeringen N.V. is registered with the Chamber of Commerce under number 28080300 and with the Netherlands Authority for the Financial Markets (AFM) under number 12000647.

Reimbursements covered by supplementary insurance policies

You can take out various supplementary insurance policies with us. The insurance policies you have taken out are listed on your policy certificate. The care covered by the various supplementary insurance policies is detailed below. The elements of care covered by the insurance and the extent of the reimbursement are listed for each type of care. The conditions under which reimbursement is covered are also listed below. Unable to find what you are looking for? Then first refer to the contents page at the start of these policy conditions.

Intro, Start, Royaal and Excellent

Alternative therapies

1 Alternative forms of treatment, therapies and medicines

We reimburse the costs of consultations and treatments provided by alternative healthcare professionals who offer the following therapies:

Alternative therapies (general)

a acupuncture
b APS therapy
c ayurvedic medicine
d craniosacral therapy
e homeopathy
f kinesiology
g mesology therapy
h natural health therapies
i neural therapy
j orthomolecular medicine
k reflex zone therapy
l shiatsu therapy

Alternative therapies (musculoskeletal system)

a chiropractic treatment
b haptotherapy
c manual medicine / orthomanipulation
d neuromuscular therapy
e orthopaedic medicine
f osteopathy

Alternative therapies (mental health modalities)

a gestalt therapy
b haptotherapy
c hypnosis and regression therapy
d integrative and/or body-oriented therapy
e expressive arts therapy

Anthroposophic medicine

a Anthroposophic medicine administered by an anthroposophical doctor
b eurythmy therapy
c art therapy
d psychological care

We also reimburse the costs of homeopathic and anthroposophic medicines prescribed by a doctor.

Conditions for reimbursement

1 Your alternative healer or therapist must be a member of a professional association that meets our criteria. The list of professional associations that meet our criteria is an integral part of this policy. We only reimburse consultations and treatments that fall within the specific field for which the professional association is listed. The list of professional associations can be found on our website or obtained from us.
2 The consultation must be conducted within the context of medical treatment.
3 The consultation must be provided on an individual basis. In other words, it must be only for you.
4 The homeopathic and anthroposophic medicines must be listed as homeopathic or anthroposophic medicines in the Z-Index G-Standaard database. The Z-Index is a database which lists all of the medicines available from pharmacies.
5 The homeopathic and anthroposophic medicines must be dispensed by a contracted pharmacy. Do you want to know with which pharmacies we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of:

1 care if your alternative healer or therapist is also your general practitioner;
2 (laboratory) tests;
3 manual therapy provided by a physiotherapist;
4 treatments, examinations and courses of a social nature or designed to promote well-being and/or prevention;
5 work or school-related coaching.

Supplementary cover

Intro	no coverage
Start	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: maximum of €40.00 per day. Maximum of €450.00 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.
Royaal	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: maximum of €40.00 per day. Maximum of €650.00 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.
Excellent	homeopathic and anthroposophic medicines: 100%, consultations provided by alternative healers or therapists: maximum of €40.00 per day. Maximum of €850.00 per person per calendar year for alternative treatments and anthroposophic and/or homeopathic medicines combined.

Bones, muscles and joints

2 Occupational therapy

Is reimbursement of the costs of 10 hours of occupational therapy covered by your basic health insurance? Then, in addition to this reimbursement, we also reimburse the costs of additional hours of occupational therapy.

Condition for reimbursement

Entitlement to reimbursement of these additional hours is subject to the same conditions as apply to reimbursement of occupational therapy covered by our basic insurance (see article 1 of the section on 'Care covered by the basic insurance policies').).

Supplementary cover

Intro	no coverage
Startno	coverage
Royaal	3 hours per person per calendar year
Excellent	4 hours per person per calendar year

3 Exercise programmes

We reimburse the costs of exercise programmes. Exercise programmes are designed for people who are supposed to exercise more to manage their disease or condition but are unable to do so. During the exercise programme a physiotherapist and/or a Cesar or Mensendieck remedial therapist will teach you to move without assistance so you can continue to exercise on your own on completion of the programme.

We reimburse exercise programmes if you:

a suffer from obesity (BMI over 30);
b are recovering from earlier heart failure;
c suffer from rheumatoid arthritis (we use the definition of rheumatoid arthritis established by the Reumafonds (Dutch Arthritis Association));
d have type 2 diabetes;
e suffer from mild to moderate COPD with a pulmonary function value of FEV1/VC < 0.7, a distress score of >2 on the MRC scale and a health score of >1 to >1.7 based on the CCQ scale;
f suffer, or are recovering, from an oncological condition.

Condition for reimbursement

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

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €350.00 per person per condition throughout the duration of the supplementary insurance
Excellent	maximum of €350.00 per person per condition throughout the duration of the supplementary insurance

4 Remedial therapy in a hot water pool for rheumatoid arthritis

Do you suffer from rheumatoid arthritis or any other rheumatic disease? Then we reimburse the costs of remedial therapy in a hot water pool.

Conditions for reimbursement

1 You must submit a statement issued by a general practitioner or medical specialist. (You are only required to submit this statement once.) The statement must state that you require remedial therapy in a hot water pool because you suffer from rheumatoid arthritis.
2 The remedial therapy must be provided in a group session under the responsibility of a physiotherapist, a Cesar or Mensendieck remedial therapist and/or a rheumatoid arthritis patients' association.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €150.00 per person per calendar year
Excellent	maximum of €200.00 per person per calendar year

5 Pedicure care for rheumatoid, diabetic and medical foot conditions

We reimburse the costs of pedicure care for rheumatoid (5.1), diabetic (5.2) and medical (5.3) foot conditions. The conditions for reimbursement are listed below.

5.1 Pedicure care for a rheumatoid foot condition

Do you suffer from a rheumatoid foot condition? Then we reimburse the costs of foot care services provided by a pedicure.

Conditions for reimbursement

1 You must submit a statement issued by a general practitioner or medical specialist. (You are only required to submit this statement once.) The statement must state that you require foot care services because you suffer from:
   - arthritis associated with intestinal disease
   - psoriatic arthritis (inflammation of the joints in people suffering from psoriasis)
   - ankylosing spondylitis (Bechterew's disease)
   - chondrocalcinosis (crystal deposition disease)
   - juvenile rheumatoid arthritis
   - chronic gout in one or both feet
   - Paget's disease (bone disease)
   - polyneuropathy Chronic reactive arthritis
   - rheumatoid arthritis
   - scleroderma
   - Still's disease (juvenile rheumatoid arthritis)
   - severe osteoarthritis of the foot with misalignment and/or deformity.
2 The pedicure must be listed in the KwaliteitsRegister voor Pedicures (KRP) (ProCert Quality Register for Pedicures), as being qualified to treat 'rheumatoid foot' conditions (RV) or as a medical pedicure (MP).
3 What if the foot care is provided by a (medical) chiropodist or a healthcare pedicure? Then the care provider must be listed in the Stipezo Register Paramedische Voetzorg (RPV) (Register for Paramedical Foot Care).
4 The invoice must also state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.
5 In the case of a rheumatoid foot condition, the invoice should state whether it relates to an examination, treatment or special technique and specify the nature of the rheumatoid foot condition.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a the removal of calluses for cosmetic reasons;
b non-medically necessary trimming of toenails.

5.2 Pedicure care for a diabetic foot condition

Do you suffer from a diabetic foot condition and has your care profile been established as Care Profile 1 (Zorgprofiel 1)? Then we reimburse the costs of foot care services provided by a pedicure.

Conditions for reimbursement

1 You must provide the pedicure with a statement issued by a general practitioner, internist or geriatric specialist. (You are only required to present a statement once.) This statement must confirm that you fall under Care Profile 1 (Zorgprofiel 1).
2 The pedicure must be listed in one of the following registers:
   - the ProCert Kwaliteitsregister voor Pedicures (KRP) (Quality Register for Pedicures) with the designation 'foot care for diabetics' (DV) or as a medical pedicure (MP).
   - the Kwaliteitsregister Medisch Voetzorgverleners (KMV) (Quality Register for Medical Foot Care Providers) maintained by Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ) (Health Professional Registration and Accreditation Agency) in partnership with Nederlandse Maatschappij van/voor Medisch Voetzorgverleners (NMMV) (Dutch Medical Foot Care Provider Association).
3 What if the foot care is provided by a (medical) chiropodist or a healthcare pedicure? Then the care provider must be listed in the Stipezo Register Paramedische Voetzorg (RPV) (Register for Paramedical Foot Care).
4 The care provider must note the Care Profile (Zorgprofiel) on the invoice. The invoice must also state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a foot examination. From Care Profile 1 (Zorgprofiel 1) onwards this is covered by your basic insurance (see articles 2 and 38 of the section on 'Care covered by the basic insurance policies');
b treatments, from Care Profile 2 (Zorgprofiel 2) onwards. These are covered by your basic insurance (see articles 2 and 38 of the section on 'Care covered by the basic insurance policies');
c the removal of calluses for cosmetic reasons;
d non-medically necessary trimming of toenails.

5.3 Pedicure care for a medical foot condition

Do you suffer from a medical foot condition? Then we reimburse the costs of foot care services provided by a medical pedicure, medical chiropodist or healthcare pedicure. You are considered to suffer from a medical foot condition if you have one of the disorders listed below and develop medical complaints if you are not treated.

Conditions for reimbursement

1 You must submit a statement issued by a general practitioner or medical specialist. (You are only required to submit this statement once.) The statement must state that you require foot care services because you suffer from:
   - peripheral neuropathy
   - hereditary motor and sensory neuropathies (HMSN)
   - paresis of the foot (due to a cerebrovascular accident (CVA)) for example)
   - paraplegia
   - Sudeck's dystrophy/post-traumatic dystrophy
   - arteriosclerosis obliterans
   - chronic thrombophlebitis
   - thromboangiitis obliterans (Buerger's disease)
   - arterial insufficiency
   - severe malpositioning (resulting in the development of excessive calluses and corns)
   - hammer toes
   - palmoplantar keratoderma
   - tylotic eczema
   - recurrent erysipelas
   - psoriatic nails
   - chemotherapy involving problems of the nails and feet
   - problems of the nails and feet due to MS, ALS, spasm, multiple myeloma (Kahler's disease), Parkinson's disease or epidermolysis bullosa.
2 The pedicure must be listed as a medical pedicure (MP) in the ProCert KwaliteitsRegister voor Pedicures (KRP) (Quality Register for Pedicures).
3 What if the foot care is provided by a (medical) chiropodist or a healthcare pedicure? Then the care provider must be listed in the Stipezo Register Paramedische Voetzorg (RPV) (Register for Paramedical Foot Care).
4 The invoice must also state that the pedicure is listed in the ProCert Quality Register for Pedicures or the Stipezo Register for Paramedical Foot Care.
5 The invoice should state whether it relates to an examination, treatment or special technique and specify the nature of the medical foot condition.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a the removal of calluses for cosmetic reasons;
b non-medically necessary trimming of toenails.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €25.00 per treatment up to a maximum of €100.00 per person per calendar year for articles 5.1, 5.2 and 5.3 combined
Excellent	maximum of €25.00 per treatment up to a maximum of €150.00 per person per calendar year for articles 5.1, 5.2 and 5.3 combined

6 Podiatry/podology/podopostural therapy and (sport) arch supports

We reimburse the costs of treatment provided by a (sports) podiatrist, podologist or podopostural therapist and/or (sport) arch supports. The consultation and the costs of fitting, manufacturing, supplying and repairing podiatry or podology insoles and orthoses are included in the treatment.

Conditions for reimbursement

1 The podiatrist must be registered in the Paramedics Quality Register (Kwaliteitsregister Paramedici).
2 The sports podiatrist who provides the treatment must be accredited by the Dutch Sports Health Care Professionals Certification Association (Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS)).
3 The podologist who provides the treatment must be registered as a Registered Podologist B with the Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry), or must meet the quality criteria established by LOOP.
4 The podopostural therapist who provides the treatment must be registered with the Stichting Landelijk Overkoepelend Orgaan voor de Podologie (LOOP) (National Umbrella Body for Podiatry) or must meet the quality criteria established by LOOP.
5 The arch supports must be supplied or repaired by an arch support supplier affiliated with NVOS Orthobanda (the professional association for suppliers of orthopaedic devices). Sports arch supports must be supplied by a sports podiatrist accredited by the Dutch Sports Health Care Professionals Certification Association (Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS)) or the VSO-Netwerk (a network that specialises in corrective arch supports). A list of SCAS-accredited sports podiatrists can be found at www.sportzorg.nl/zoek-een-sportzorgprofessional. The members of the VSO-Netwerk are listed at www.vsonetwerk.nl. Sports arch supports may also be supplied by an arch support supplier that meets the quality criteria established by NVOS Orthobanda or the VSO-Netwerk.
6 The invoice must specify the nature of the service(s) provided (examination, treatment, supply of a medical device and/or use of a special technique).

What we do not reimburse (under this article)

We do not reimburse the costs of:

a footwear and alterations of footwear;
b foot examination and treatment of diabetic foot.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €150.00 per person per calendar year, including a maximum of 1 pair of (sports) arch supports
Excellent	maximum of €200.00 per person per calendar year, including a maximum of 1 pair of (sports) arch supports

Abroad

7 Transport of the insured person and mortal remains to the Netherlands (repatriation)

We reimburse the costs of:

a medically-necessary patient transport by ambulance or aircraft from abroad to a healthcare institution in the Netherlands;
b transport of mortal remains from the place of death to the insured person's home in the Netherlands.

Conditions for reimbursement

1 Patient transport must be required in connection with urgent medical treatment abroad.
2 Eurocross Assistance must give you permission in advance and must also arrange the transport.

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

8 Vaccinations and preventive medication required for foreign travel

Are you travelling abroad? In that case we reimburse the costs of consultations, necessary vaccinations and/or preventive medication required for a stay abroad.
By 'necessary vaccinations and/or preventive medication' we mean vaccinations and/or preventive medication identified as necessary by the Landelijk Coördinatiecentrum Reizigersadvisering (LCR) (National Coordination Centre for Travel Advice). The vaccinations recommended by the LCR for each country are listed on their website, www.lcr.nl/Landen.

Conditions for reimbursement

1 We only reimburse consultations, medication and vaccinations required to prevent rabies if you will be staying in a country where rabies is endemic (permanently present as a disease in certain areas) for a prolonged period. And where adequate medical assistance is not readily available.
2 You must also meet at least one of the following conditions:
   - you will be spending several days walking or cycling outside of tourist areas;
   - you will be spending more than 3 months (staying) with the local population;
   - you will be staying outside of a resort or protected environment;
   - you are under the age of 12.
3 Preventive medication (such as malaria tablets) must be prescribed by a doctor affiliated with LCR and supplied by a contracted pharmacy.
4 What if you choose a non-contracted pharmacy? Then you receive no reimbursement.

Lower reimbursement if treatment is provided by a non-contracted care provider

Please note! Was treatment provided by a non-contracted care provider? Then a personal payment may be required for consultations and vaccinations.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of non-prescription drugs not listed in the Regeling zorgverzekering (Health Insurance Regulations). Non-prescription drugs are drugs that can be purchased over the counter in the Netherlands.

Supplementary cover

Intro
- consultations and vaccinations:
  - provided by a contracted care provider: 100%
  - provided by a non-contracted care provider: maximum of €75.00 per person per calendar year
- preventive medication (such as malaria tablets) supplied by a contracted pharmacy: 100%

Start
- consultations and vaccinations:
  - provided by a contracted care provider: 100%
  - provided by a non-contracted care provider: maximum of €75.00 per person per calendar year
- preventive medication (such as malaria tablets) supplied by a contracted pharmacy: 100%

Royaal
- consultations and vaccinations:
  - provided by a contracted care provider: 100%
  - provided by a non-contracted care provider: maximum of €100.00 per person per calendar year
- preventive medication (such as malaria tablets) supplied by a contracted pharmacy: 100%

Excellent
- consultations and vaccinations:
  - provided by a contracted care provider: 100%
  - provided by a non-contracted care provider: maximum of €125.00 per person per calendar year
- preventive medication (such as malaria tablets) supplied by a contracted pharmacy: 100%

9 Medical treatment abroad

We reimburse the costs of medical treatment abroad. This applies to urgent medical treatment abroad (9.1), urgent pharmaceutical care abroad (9.2), transport costs following healthcare mediation if care is provided in Belgium or Germany (9.3), overnight stay and transport costs of family members following healthcare mediation if care is provided in Belgium or Germany (9.4), and overnight stay and transport costs in the case of treatments requiring particular expertise provided abroad (9.5). The conditions for reimbursement are listed below.

9.1 Urgent medical treatment abroad

We reimburse the costs of medically-necessary healthcare during a stay in a country other than your country of residence for a holiday, study or business trip. The need for care must have been unforeseeable when you travelled abroad. And the medical care must be immediately necessary in an emergency situation resulting from an accident or illness. This reimbursement covered by your supplementary insurance only applies in addition to the reimbursement covered by your basic health insurance.

We reimburse the costs of:

a treatment by a general practitioner or medical specialist;
b hospital accommodation and surgery;
c treatments, examinations, medicines and dressings prescribed by a doctor;
d medically-necessary ambulance transportation to and from the nearest doctor and/or the nearest hospital;
e dental treatment for insured persons up to the age of 18.

Please note! We only reimburse dental care for insured persons aged 18 or older if you have supplementary dental insurance. These costs are covered by this dental insurance.

Conditions for reimbursement

1 The costs will only be reimbursed if these costs would be covered by your basic insurance if the treatment were provided in the Netherlands.
2 If you stay in a hospital abroad, you must notify us immediately through Eurocross Assistance.

Supplementary cover

Intro supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days
Start supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days
Royaal supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days
Excellent supplementary cover up to a maximum of the cost price in the case of a stay abroad of up to 365 days

9.2 Urgent pharmaceutical care abroad

We reimburse the costs of medicines in the event that you require urgent medical treatment abroad. This applies to medicines prescribed by a doctor that are not covered by your basic insurance.

Conditions for reimbursement

1 The medicines must be prescribed by a general practitioner, a medical specialist or a dentist.
2 The medicines must be prescribed in connection with urgent medical treatment abroad.
3 The medicines must be dispensed by a pharmacy.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a non-prescription drugs not listed in the Regeling zorgverzekering (Health Insurance Regulations). Non-prescription drugs are drugs that can be purchased over the counter in the Netherlands;
b dietary and liquid nutrition products;
c dressings;
d vaccinations and medication required for foreign travel;
e contraceptives;
f homeopathic, anthroposophic and/or other alternative medicines and remedies.

Supplementary cover

Intro	maximum of €50.00 per person per calendar year
Start	maximum of €50.00 per person per calendar year
Royaal	maximum of €50.00 per person per calendar year
Excellent	maximum of €50.00 per person per calendar year

9.3 Transport costs following healthcare mediation if care is provided in Belgium or Germany

We reimburse the costs of return transport from the Netherlands to a hospital in Belgium or Germany if a hospital stay is arranged by our Healthcare Mediation team. We reimburse the costs of taxi transport, own transport and public transport.

Conditions for reimbursement

1 A contracted taxi service must send us an invoice for the transport costs. What if you use public transport or your own transport? Then please use the claim form to request reimbursement of your transport costs. You can find the claim form on our website.
2 The waiting time for treatment must be reduced.
3 Our Transport Telephone Line (Vervoerslijn) must approve the transport in advance. Our Transport Telephone Line will determine if you are entitled to reimbursement of the costs of transport and the form of transport to which you are entitled. You can call our Transport Telephone Line on 071 365 41 54.
4 Taxi transport must be provided by a contracted taxi firm.

Supplementary cover

Intro	no coverage
Start	taxi transport: 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre
Royaal	taxi transport: 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre
Excellent	taxi transport: 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre

9.4 Overnight stay and transport costs of family members following healthcare mediation if care is provided in Belgium or Germany

Do you have to travel from the Netherlands to be admitted to a foreign healthcare institution for treatment in accordance with article 9.3 of 'Reimbursements covered by supplementary insurance policies'? Then we reimburse the following costs for your family members:

a overnight guest house accommodation in the vicinity of the hospital;
b taxi transport, own transport or public transport to and from the hospital. We reimburse €0.30 per kilometre.

Conditions for reimbursement

1 A contracted taxi service must send us an invoice for the transport costs. What if you use a non-contracted taxi service, public transport or your own transport? Then please use the claim form to request reimbursement of your transport costs. You can find the claim form on our website.
2 You must be able to provide proof that you incurred the transport and/or accommodation expenses if we ask for it.

Supplementary cover

Intro	no coverage
Start	transport and/or accommodation expenses: maximum of €35.00 per night up to a maximum of €500.00 per calendar year for all family members combined
Royaal	transport and/or accommodation expenses: maximum of €35.00 per night up to a maximum of €500.00 per calendar year for all family members combined
Excellent	transport and/or accommodation expenses: maximum of €35.00 per night up to a maximum of €500.00 per calendar year for all family members combined

9.5 Overnight stay and transport costs in the case of treatments requiring particular expertise provided abroad

Have we approved a non-urgent treatment requiring particular expertise that can only be provided abroad? In that case we reimburse:

a overnight accommodation in the vicinity of the hospital;
b return transport between the Netherlands and the hospital.
c transport and/or accommodation expenses for 1 specialist escort if an escort is medically necessary;
d transport and/or accommodation expenses for 1 family member, or 2 family members for insured persons up to the age of 16.

A treatment requiring particular expertise is a medical treatment provided abroad that complies with established medical science and medical practice, which cannot be performed and/or is not currently available in the Netherlands. You must also be reasonably reliant on the treatment in question in terms of both its nature and its extent. Our medical adviser will determine whether a treatment qualifies as a treatment requiring particular expertise.

Conditions for reimbursement

1 We must give you written permission in advance.
2 You must be referred for the treatment by a medical specialist.
3 You must provide us with a specification of the incurred costs.
4 The medical necessity of an escort and the type of escort (such as a nurse for example) will be determined by us.

Supplementary cover

Intro	accommodation expenses: maximum of €75.00 per person per night. transport costs: flights (economy class): 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre We reimburse accommodation expenses and transport costs up to a maximum of €5,000.00 for you and your companion combined.
Start	accommodation expenses: maximum of €75.00 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre We reimburse accommodation expenses and transport costs up to a maximum of €5,000.00 for you and your companion combined.
Royaal	accommodation expenses: maximum of €75.00 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre We reimburse accommodation expenses and transport costs up to a maximum of €5,000.00 for you and your companion combined.
Excellent	accommodation expenses: maximum of €75.00 per person per night transport costs: flights (economy class): 100%, public transport (lowest class): 100%, own transport: €0.30 per kilometre We reimburse accommodation expenses and transport costs up to a maximum of €5,000.00 for you and your companion combined.

Physiotherapy and Cesar or Mensendieck remedial therapy

10 Physiotherapy and Cesar or Mensendieck remedial therapy

We reimburse the costs of treatment provided by a physiotherapist and/or a Cesar or Mensendieck remedial therapist for insured persons aged 18 or older (10.1) and insured persons up to the age of 18 (10.2). We also reimburse the costs of post-care physiotherapy for certain conditions (10.3). The conditions for reimbursement are listed below.

10.1 Physiotherapy and/or Cesar or Mensendieck remedial therapy for insured persons aged 18 or older

We reimburse the costs of treatment by a physiotherapist and/or a Cesar or Mensendieck remedial therapist. We also reimburse the costs of manual lymphatic drainage by a skin therapist if the treatment is prescribed for serious lymphoedema.

Are you entitled to physiotherapy or Cesar or Mensendieck remedial therapy under your basic insurance? In that case the first 20 treatment sessions per condition are not reimbursed by your basic insurance (see article 3.1 of the section on 'Care covered by the basic insurance policies'). The reimbursement provided by your supplementary insurance applies to these first 20 treatment sessions.

Conditions for reimbursement

1 You must be referred by a general practitioner, a company doctor or a medical specialist.
2 Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register) maintained by the Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF) (Royal Dutch Association for Physiotherapy), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
   - paediatric physiotherapy
   - pelvic physiotherapy
   - manual therapy
   - oedema therapy
   - geriatric physiotherapy
   - psychosomatic physiotherapy
   - paediatric remedial therapy
   - psychosomatic remedial therapy.

   Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.
3 Are you receiving treatment at school? In that case, you are only entitled to physiotherapy and Cesar or Mensendieck remedial therapy if we have entered into agreements about this with your care provider.
4 What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day? In that case a specific letter of referral issued by the referring doctor (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

Please note! In some cases you do not need a statement from the referring doctor for reimbursement. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists: these physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a statement from the referring doctor. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Cesar or Mensendieck Remedial Therapy (Directe Toegang Oefentherapie Cesar/Mensendieck (DTO)). You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener, to find contracted care providers and PlusPraktijk physiotherapy and Cesar or Mensendieck remedial therapy practices offer DTF and DTO. You are also welcome to contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;
b pregnancy gymnastics and postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - simple, brief reports or more complicated, time-consuming reports;
d bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist;
e individual treatment if you are already taking part in an exercise programme, as described in article 3 of 'Reimbursements covered by supplementary insurance policies', for the same condition.

Supplementary cover

Intro	maximum of 9 treatments per person per calendar year.
Start	maximum of 12 treatments per person per calendar year (with a maximum of 9 manual therapy treatments)
Royaal	maximum of 27 treatments per person per calendar year (with a maximum of 9 manual therapy treatments)
Excellent	maximum of 40 treatments per person per calendar year (with a maximum of 9 manual therapy treatments)

10.2 Physiotherapy and Cesar or Mensendieck remedial therapy for insured persons up to the age of 18

We reimburse the costs of treatment by a physiotherapist and/or a Cesar or Mensendieck remedial therapist. We also reimburse the costs of manual lymphatic drainage by a skin therapist if the treatment is prescribed for serious lymphoedema.

Are you entitled to physiotherapy or Cesar or Mensendieck remedial therapy under your basic insurance? Then the reimbursement covered by your supplementary insurance applies in addition to the reimbursement covered by your basic insurance (see article 3.2 of the section on 'Care covered by the basic insurance policies').

Conditions for reimbursement

1 You must be referred by a general practitioner, a company doctor or a medical specialist.
2 Are you receiving specialist physiotherapy or remedial therapy? In that case we only reimburse the costs if the therapist is registered in the corresponding section of the Centraal Kwaliteitsregister (CKR) (Central Quality Register) maintained by the Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF) (Royal Dutch Association for Physiotherapy), or in the subspecialisation register maintained by the Vereniging van Oefentherapeuten Cesar en Mensendieck (VvOCM) (Association of Cesar and Mensendieck Remedial Therapists). By 'specialist physiotherapy or remedial therapy' we mean:
   - paediatric physiotherapy
   - pelvic physiotherapy
   - manual therapy
   - oedema therapy

- geriatric physiotherapy
- psychosomatic physiotherapy
- paediatric remedial therapy
- psychosomatic remedial therapy.

Do you want to know which therapists provide specialist care that qualifies for reimbursement? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

3 Are you receiving treatment at school? In that case, you are only entitled to physiotherapy and Cesar or Mensendieck remedial therapy if we have entered into agreements about this with your care provider.
4 What if you need several physiotherapy and Cesar/Mensendieck remedial therapy treatments, or need to be treated by more than one physiotherapist or Cesar or Mensendieck remedial therapist on the same day? In that case a specific letter of referral issued by the referring doctor (a general practitioner, a company doctor or a medical specialist) must state that it is medically necessary. We must give you permission prior to the treatment.

No statement is needed for contracted physiotherapists and Cesar or Mensendieck remedial therapists

Please note! In some cases you do not need a statement from the referring doctor for reimbursement. This is because we have made agreements regarding direct access with our contracted physiotherapists and Cesar or Mensendieck remedial therapists: these physiotherapists and Cesar or Mensendieck remedial therapists can treat you without a statement from the referring doctor. We call this Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Cesar or Mensendieck Remedial Therapy (Directe Toegang Oefentherapie Cesar/Mensendieck (DTO)). You can use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener, to find contracted care providers and PlusPraktijk physiotherapy and Cesar or Mensendieck remedial therapy practices that offer DTF and DTO. You are also welcome to contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a individual or group treatment if the only purpose of the treatment is to improve your fitness by means of training;
b pregnancy gymnastics and postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
c surcharges for:
   - appointments outside of regular working hours;
   - missed appointments;
   - simple, brief reports or more complicated, time-consuming reports;
d bandages and medical devices supplied by your physiotherapist or Cesar or Mensendieck remedial therapist;
e individual treatment if you are already taking part in an exercise programme, as described in article 3 of 'Reimbursements covered by supplementary insurance policies', for the same condition.

Supplementary cover

Intro	100% (with a maximum of 9 manual therapy treatments)
Start	100% (with a maximum of 9 manual therapy treatments)
Royaal	100% (with a maximum of 9 manual therapy treatments)
Excellent	100% (with a maximum of 9 manual therapy treatments)

10.3 Post-care physiotherapy

We reimburse the costs of post-care physiotherapy as part of:

1 post-oncology care: treatment designed to maintain or improve fitness during or following medical treatment of cancer and recovery-oriented treatment designed to reduce or eliminate symptoms of (imminent) lymphoedema, scar tissue or other problems caused by medical treatment of cancer;
2 post-CVA care: physiotherapy treatment following a stroke or cerebrovascular accident (CVA) by a physiotherapist who specialises in recovery-oriented physiotherapy;
3 cardiovascular disease management by a physiotherapist who specializes in recovery-oriented physiotherapy.

Are you entitled to physiotherapy under your basic insurance? Then the reimbursement covered by your supplementary insurance applies in addition to the reimbursement covered by your basic insurance (see article(s) 3.1 and/or 3.4 of the section on 'Care covered by the basic insurance policies').

Condition for reimbursement

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

We only reimburse contracted care

Please note! Do you want to receive reimbursement for all treatments? In that case post-care physiotherapy must be provided by a PlusPraktijk physiotherapy practice contracted for this purpose. What if you choose a care provider who we have not contracted for this purpose? In that case you are only entitled to reimbursement under articles 10.1 and 10.2.

Do you want to know which PlusPraktijk physiotherapy practices we have contracted for this purpose? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

Skin

11 Skin care

We reimburse the costs of acne treatment (11.1), lessons in camouflage (11.2) and electric epilation, IPL or laser epilation (11.3). The conditions for reimbursement are listed below.

11.1 Acne treatment

We reimburse the costs of (facial) acne treatment provided by a beautician or skin therapist;

Conditions for reimbursement

1 You must be referred by a general practitioner or a medical specialist.
2 The skin therapist must be affiliated with the Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch association of Skin Therapists) or comply with the relevant quality criteria established by the NVH.
3 The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty Therapy Industry Association) or must meet the quality criteria established by the association.

What we do not reimburse (under this article)

We do not reimburse the costs of cosmetic products.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €250.00 per person per calendar year
Excellent	maximum of €250.00 per person per calendar year

11.2 Camouflage therapy

We reimburse the costs of lessons in camouflage taught by a beautician or skin therapist and the necessary fixatives, ointments and powders (etc.).

Conditions for reimbursement

1 You must be referred by a general practitioner or a medical specialist.
2 Camouflage therapy must relate to the treatment of scars, naevi or pigment marks on the neck or face.
3 The skin therapist must be affiliated with the Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch association of Skin Therapists) or comply with the relevant quality criteria established by the NVH.
4 The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty

Therapy Industry Association) or must meet the quality criteria established by the association.

Supplementary cover

Intro	no coverage
Star	no coverage
Royaal	maximum of €200.00 throughout the duration of the supplementary insurance
Excellent	maximum of €200.00 throughout the duration of the supplementary insurance

11.3 Electrical epilation, IPL or laser epilation

We reimburse the costs of:

a electrical epilation and Intense Pulsed Light (IPL) hair removal treatments provided by a beautician or skin therapist for women with unsightly facial and/or neck hair;
b laser hair removal treatments performed by a skin therapist or at an institution with an associate dermatologist for women with extremely unsightly facial and/or neck hair.

Conditions for reimbursement

1 You must be referred by a general practitioner or a medical specialist.
2 The skin therapist must be affiliated with the Nederlandse vereniging van Huidtherapeuten (NVH) (Dutch association of Skin Therapists) or comply with the relevant quality criteria established by the NVH.
3 The beautician must be registered with the Algemene Nederlandse Branche Organisatie Schoonheidsverzorging (ANBOS) (Dutch Beauty Therapy Industry Association) or must meet the quality criteria established by the association.

What we do not reimburse (under this article)

We do not reimburse the costs of cosmetic treatments.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €300.00 per person per calendar year
Excellent	maximum of €300.00 per person per calendar year

Medical devices

12 Medical devices

We reimburse the costs of medical devices, or the personal contribution that applies for these products. The medical devices covered by your insurance and the conditions under which reimbursement is provided are listed below.

12.1 Personal contribution for wigs

We reimburse the personal contribution that applies to wigs.

Condition for reimbursement

You must be entitled to reimbursement of a wig under your basic insurance (see article 4 of the section on 'Care covered by the basic insurance policies').

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €100.00 per person per calendar year
Excellent	maximum of €200.00 per person per calendar year

12.2 Headwear or Toupim in the case of medical treatment or alopecia (hair loss)

We reimburse the costs of headwear or a toupim (headband wig) for insured persons suffering from hair loss due to alopecia, or (temporary) hair loss due to chemotherapy or another medical treatment.

Condition for reimbursement

You must submit a statement issued by a general practitioner or medical specialist. The statement must confirm that you are suffering from hair loss due to the medical condition alopecia, or (temporary) hair loss due to chemotherapy or another medical treatment.

What we do not reimburse (under this article)

a We do not reimburse the costs of any wig other than a toupim under this article.
b We do not reimburse the costs of headwear or a toupim for insured persons suffering from alopecia androgenetica (classic male-pattern baldness).

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €100.00 per person per calendar year
Excellent	maximum of €100.00 per person per calendar year

12.3 Personal alert system required for medical reasons

We reimburse the subscription fee associated with the use of a personal alert system.

Conditions for reimbursement

1 You must be entitled to reimbursement of a personal alert system under your basic insurance (see article 4 of the section on 'Care covered by the basic insurance policies').
2 If supplied by a non-contracted service, we must give you permission in advance.

Lower reimbursement for a non-contracted supplier

Please note! Is your personal alert system supplied by a non-contracted service? Then we reimburse part of the subscription fee.

You can contact the contracted service directly. Do you want to know with which services we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	100% if supplied by a contracted service, or a maximum of €60.00 per calendar year if supplied by a non-contracted service
Excellent	100% if supplied by a contracted service, or a maximum of €60.00 per calendar year if supplied by a non-contracted service

12.4 Adhesive strips for breast prosthesis

Do you wear an external breast prosthesis after having a mastectomy? Then we reimburse the costs of the adhesive strips used to attach the prosthesis.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

12.5 (Custom) prosthetic nipple

We reimburse the costs of a self-adhesive nipple prosthesis worn by women with a full or partial breast prosthesis. This also applies to women who have undergone breast reconstruction surgery and are waiting for a permanent nipple reconstruction.

We reimburse the costs of a custom-made prosthetic nipple if reimbursement is not covered by your basic health insurance.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

12.6 Bedwetting alarm
We reimburse the costs of purchase or hire of a bedwetting alarm. We also reimburse the costs of the pants that go with the alarm system.

Supplementary cover

Intro	no coverage
Start	maximum of €100.00 per person throughout the duration of the supplementary insurance
Royaal	maximum of €100.00 per person throughout the duration of the supplementary insurance
Excellent	maximum of €100.00 per person throughout the duration of the supplementary insurance

12.7 Incontinence therapy
We reimburse the costs of hiring a TRANS therapy (nerve stimulation) device if you use the device to treat incontinence.

Condition for reimbursement
You must be referred by a doctor, pelvic-floor physiotherapist or incontinence nurse.

We only reimburse contracted care
Please note! The device must be supplied by a contracted supplier. What if you choose a non-contracted supplier? Then you receive no reimbursement.

Do you want to know with which suppliers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	100%
Excellent	100%

12.8 Hand splint
We reimburse the costs of a hand splint needed for post-care physiotherapy in the case of hand problems that require specialist treatment.

Condition for reimbursement
The hand splint must be supplied by a CHT-NL-qualified hand therapist. CHT-NL-qualified hand therapist are listed at www.handtherapie.com/zoek-uw-handtherapeut.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €40.00 per person per calendar year for a finger or small thumb splint maximum of €60.00 per person per calendar year for a wrist, hand or large thumb splint maximum of €90.00 per person per calendar year for a dynamic or static splint
Excellent	maximum of €40.00 per person per calendar year for a small finger or thumb splint maximum of €60.00 per person per calendar year for a wrist, hand or large thumb splint maximum of €90.00 per person per calendar year for a dynamic or static splint

Medicines and dietary preparations

13 Pharmaceutical care

We reimburse the statutory personal contribution for pharmaceutical care (13.1). We also reimburse the costs of some medicines: melatonin (13.2), contraceptives (13.3) and registered medicines and pharmacy preparations not covered by your basic insurance (13.4). The conditions for reimbursement are listed below.

13.1 Statutory personal contribution (upper limit GVS price)
You yourself have to pay part of the costs of some medicines. The remainder of the costs is covered by your basic health insurance. The part that you have to pay is the statutory personal contribution. We reimburse this statutory personal contribution (the upper limit GVS price) if the pharmaceutical care in question is covered by your basic health insurance or supplementary insurance. GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem). The GVS states which medicines can be reimbursed under the basic insurance. We make a distinction between reimbursement of the personal contribution towards the costs of (medicines that contain) Methylphenidate Retard, Atomoxetine, Dexamfetamine and Guanfacine (article 13.1.1) and reimbursement of the personal contribution towards the costs of other medicines (article 13.1.2).

13.1.1 Statutory personal contribution towards the costs of Methylphenidate Retard, Atomoxetine, Dexamfetamine and Guanfacine
We reimburse the statutory personal contribution (the upper limit GVS price) towards the costs of the following medicines:

1 Methylphenidate Retard
2 Atomoxetine
3 Dexamfetamine
4 Guanfacine

What we do not reimburse (under this article)
We do not reimburse:
a The personal contribution you have to pay because you have exceeded the maximum limit set for reimbursement of pharmacy-dispensed medicines and dietary preparations;
b The statutory personal contribution (the upper limit GVS price) towards the costs of medicines other than (those that contain) Methylphenidate Retard, Atomoxetine, Dexamfetamine and Guanfacine. If you have supplementary insurance (part of) the costs will be reimbursed under article 13.1.2.
c The statutory personal contribution (the upper limit GVS price) towards the costs of contraceptives. If you have supplementary insurance, these costs will be reimbursed under article 13.3.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	no coverage
Excellent	maximum of €200.00 per person per calendar year

13.1.2 Statutory personal contribution towards the costs of other medicines
We reimburse the statutory personal contribution (the upper limit GVS price) towards the costs of medicines other than (those that contain) Methylphenidate Retard, Atomoxetine, Dexamfetamine or Guanfacine.

What we do not reimburse (under this article)
We do not reimburse:
a the personal contribution you have to pay because you have exceeded the maximum limit set for reimbursement of pharmacy-dispensed medicines and dietary preparations;
b the statutory personal contribution (the upper limit GVS price) towards the costs of (medicines containing) Methylphenidate Retard, Atomoxetine, Dexamfetamine or Guanfacine prescribed to treat conditions such as Attention Deficit Hyperactivity Disorder (ADHD) that

are reimbursed by your basic insurance. If you have 4 star Supplementary Insurance (part of) the costs will be reimbursed under article 13.1.1.

c the statutory personal contribution (the upper limit GVS price) that applies for contraceptives. If you have supplementary insurance, these costs will be reimbursed under article 13.3.

Supplementary cover

Intro	maximum of €750.00 per person per calendar year
Start	maximum of €750.00 per person per calendar year
Royaal	maximum of €750.00 per person per calendar year
Excellent	maximum of €750.00 per person per calendar year

13.2 Melatonin

We reimburse the costs of generic melatonin tablets.

Conditions for reimbursement

1 The melatonin tablets must be prescribed by a (child) psychiatrist, paediatrician or (paediatric) neurologist associated with a contracted healthcare institution. Do you want to know with which institutions we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.
2 The melatonin tablets must be obtained from the eFarma online pharmacy.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	100%
Excellent	100%

13.3 Contraceptives

For female insured persons we reimburse:

a the costs of hormonal contraceptives and intrauterine devices (IUDs) for insured persons over the age of 20. The reimbursements for these contraceptives are subject to the maximum reimbursements set by us;
b the statutory personal contribution (the upper limit GVS price) that applies for contraceptives reimbursed by your basic health insurance.

Conditions for reimbursement

1 A general practitioner, a doctor in a centre for sexuality, an obstetrician or midwife, or a medical specialist must have prescribed the contraceptive.
2 In the case of the contraceptive pill, a prescription issued by a general practitioner, a doctor in a centre for sexuality, an obstetrician or midwife, or a medical specialist must be submitted the first time the pill is dispensed. (This is not necessary thereafter.)
3 For reimbursement, the contraceptive must be listed in the GVS. GVS stands for Medicinal Products Reimbursement System (Geneesmiddelenvergoedingssysteem). The GVS states which medicines can be reimbursed under the basic insurance.

We only reimburse contracted care

Please note! The contraceptive must be dispensed by a contracted pharmacy. What if you choose a non-contracted pharmacy? Then you receive no reimbursement.

Do you want to know with which pharmacies we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of contraceptives prescribed to treat a medical condition covered by your basic health insurance. In the context of this article, by 'medical condition' we mean endometriosis or menorrhagia (abnormally heavy menstrual periods).

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

13.4 Registered medicines and pharmacy preparations not covered by your basic insurance

We reimburse the costs of a limited number of registered medicines and pharmacy preparations not covered by your basic health insurance.
We reimburse the costs of medicines and pharmacy preparations in one of the following cases:

a the medicine in question is not, no longer, or not yet listed in the GVS as a medicine that can be covered by basic health insurance;
b the pharmacy preparation in question is not covered by your basic health insurance.

Conditions for reimbursement

1 We must give you written permission in advance.
2 There is no reimbursable alternative in your situation.
3 The medicine must be used to treat a condition which is listed in relation to that medicine on a list compiled by us. This list contains registered medicines and pharmacy preparations in combination with health conditions and can be found on our website or obtained from us.

We only reimburse contracted care

Please note! The medicine must be prescribed by a contracted medical specialist or general practitioner and dispensed by a contracted pharmacy. What if you choose a non-contracted medical specialist, general practitioner or pharmacy? Then you receive no reimbursement.

Do you want to know with which care providers and pharmacies we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	maximum of €750.00 per person per calendar year
Start	maximum of €750.00 per person per calendar year
Royaal	maximum of €750.00 per person per calendar year
Excellent	maximum of €750.00 per person per calendar year

Oral health care and dentistry

We reimburse the costs of necessary dental care normally provided by a dentist, clinical dental technician, dental surgeon, oral hygienist or orthodontist. The dental care to which this applies is described in detail in the following articles (articles 14 to 17). Do you also have dental insurance with us? In that case, if the costs are reimbursed by both polices, we reimburse the bills you submit by applying the policies in the following order: first your supplementary dental insurance, then your supplementary insurance.

14 Orthodontic treatment for insured persons up to the age of 18

We reimburse the costs of orthodontic treatment (correction of dental misalignment) for insured persons up to the age of 18. We also reimburse the costs of a second opinion. Costs are claimed using treatment codes for orthodontic care stipulated by the Nederlandse Zorgautoriteit (NZa) (Dutch Healthcare Authority) which end with the letter 'A'.

Condition for reimbursement

An orthodontist or dentist must perform the treatment or provide a second opinion.

What we do not reimburse (under this article)

Have you lost or damaged existing orthodontic appliances through your own fault or negligence? Then we do not reimburse the costs of repair or replacement.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €2,000.00 for insured persons up to the age of 18 throughout the duration of the supplementary insurance
Excellent	maximum of €2.500.00 for insured persons up to the age of 18 throughout the duration of the supplementary insurance

15 Dental care – Statutory personal contribution towards the costs of dentures

Has the cost of (the repair or rebasing of) a full set of removable dentures (false teeth) been reimbursed under your basic insurance (see article 9 of the section on 'Care covered by the basic insurance policies')? Then we reimburse the statutory personal contribution.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	no coverage
Excellent	100%

16 Dental care for insured persons up to the age of 18 – crowns, bridges, inlays and implants

For insured persons up to the age of 18 we reimburse the costs of crowns, bridges, inlays and implants and the associated dental technician costs only.

Conditions for reimbursement

1 The treatment must be performed by a dentist or dental surgeon or a Centre for Exceptional Dentistry.
2 We must give you permission in advance. Before approving your request for treatment we will assess whether the treatment is appropriate and legitimate.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

Please note! The costs of orthodontic treatment are reimbursed under article 14 of these policy conditions.

17 Dental care required as a result of an accident for insured persons aged 18 or older

For insured persons aged 18 or older we reimburse the costs of dental care by a dentist, orthodontist or dental surgeon. The treatment must be required to repair a direct injury caused by an accident that occurs during the period covered by this insurance. To qualify for reimbursement, the treatment must be performed within 1 year of the accident, unless it is necessary to defer the (definitive) treatment because the jaw is not yet fully formed. Our consultant dentist will assess whether temporary treatment is required because the jaw is not yet fully formed. Cover must be provided by this insurance both when the accident occurs and when treatment is provided.

Conditions for reimbursement

1 We must give you permission in advance. Before approving your request for treatment we will assess whether the treatment is appropriate and legitimate.
2 A treatment plan with a cost estimate and available X-rays must be submitted with your request for approval. The treatment plan must be prepared by your dentist, orthodontist or dental surgeon.

What we do not reimburse (under this article)

We do not reimburse costs that result directly or indirectly from:

a an illness or pathological abnormality suffered by the insured person;
b gross negligence or wilful intent on the part of the insured person;
c the consumption of alcohol and/or use of drugs by the insured person;
d engagement in physical fighting by the insured person other than for the purpose of self-defence.

Supplementary cover

Intro	maximum of €10,000.00 per accident
Start	maximum of €10,000.00 per accident
Royaal	maximum of €10,000.00 per accident
Excellent	maximum of €10,000.00 per accident

Eyes and ears

18 Spectacles and contact lenses

We reimburse the costs of spectacles frames with prescription lenses and prescription or overnight contact lenses per period of 3 calendar years. A period of 3 calendar years is seen as 3 years that run from 1 January to 31 December. The 3-year period commences on 1 January of the year of the first purchase.

Condition for reimbursement

The spectacles and/or contact lenses must be supplied by an optician or optical retailer.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a non-prescription sunglasses, spectacles and contact lenses;
b prism spectacles;
c the statutory personal contribution for spectacle and/or contact lenses reimbursed under your basic insurance (see article 4 of the section on 'Care covered by the basic insurance policies');
d separate spectacle frames and/or accessories;
e coloured contact lenses.

Supplementary cover

Intro	no coverage
Start	maximum of €100.00 per person per 3 calendar years for spectacles and contact lenses combined
Royaal	maximum of €150.00 per person per 3 calendar years for spectacles and contact lenses combined
Excellent	maximum of €250.00 per person per 3 calendar years for spectacles and contact lenses combined

19 Refractive eye surgery and lens implants

This article informs you about conditions for the reimbursement of the costs of refractive surgery (19.1) and lens implantation (19.2).

19.1 Refractive surgery

We reimburse the costs of refractive eye surgery.

Condition for reimbursement

The ophthalmologist who performs the treatment must be registered as a refractive surgeon with the Nederlands Oogheelkundig Genootschap (NOG) (Netherlands Ophthalmological Society). A specialist who is not registered with the NOG must meet the quality criteria established by the society and follow the guidelines set out in the Consensus on Refractive Surgery (Consensus Refractiechirurgie) published by the society.

Please note! Ophthalmologists not registered as refractive surgeons are also listed in the NOG register. However, treatment only qualifies for reimbursement when performed by an ophthalmologist who is registered as a refractive surgeon.

19.2 Lens implantation

We reimburse the additional costs of an intraocular lens other than a (standard) monofocal intraocular lens if cataract surgery is reimbursed under the basic insurance.

Conditions for reimbursement

1 If you are entitled to reimbursement of lens implantation under your basic insurance, your supplementary insurance will only cover additional expenses.
2 In the case of a toric lens implant you must be able to submit a medical statement issued by your doctor, which explains why you do not wear spectacles.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €500.00 per person throughout the duration of the supplementary insurance for costs reimbursed under articles 19.1 and 19.2 combined
Excellent	maximum of €750.00 per person throughout the duration of the supplementary insurance for costs reimbursed under articles 19.1 and 19.2 combined

20 Ear position correction (without medical necessity) for insured persons up to the age of 18

For insured persons up to the age of 18 we reimburse the costs of a cosmetic surgery procedure designed to correct the position of the ear performed by a medical specialist.

We only reimburse contracted care

Please note! The corrective procedure must be performed by a care provider contracted for this purpose. What if you choose a non-contracted care provider? Then you receive no reimbursement.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

Speech and reading

21 Stutter therapy

We reimburse the costs of stutter therapy. The stutter therapy must employ:

a the method taught at the Del Ferro Institute in Amsterdam;
b the method taught at the Hausdörfer Institute for Natural Speech in Winterswijk;
c the BOMA method taught at the De Pauw Institute in Harlingen;
d the McGuire programme.

Condition for reimbursement

You must be referred by a general practitioner, a medical specialist or a dentist.

Supplementary cover

Intro	no coverage
Start	maximum of €225.00 per person throughout the duration of the supplementary insurance
Royaal	maximum of €450.00 per person throughout the duration of the supplementary insurance
Excellent	maximum of €900.00 per person throughout the duration of the supplementary insurance

Transport

22 Personal contribution towards transport costs

Are you entitled to reimbursement of transport under article 19 of the section on 'Care covered by the basic insurance policies'? Then we reimburse the statutory personal contribution you are required to pay towards the costs of patient transport.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	no coverage
Excellent	100% of the statutory personal contribution

Hospital, treatment and nursing

23 Mammaprint

We reimburse the costs of a Mammaprint (specific breast cancer test). In some cases a mammaprint enables the doctor providing treatment to make a more accurate diagnosis. A mammaprint also enables the doctor providing treatment to determine whether or not chemotherapy is needed.

Condition for reimbursement

The diagnostic test must be performed by the Agendia laboratory.

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

24 Overnight guest house accommodation and transport for visitors in the case of a hospital stay

Are you staying at a hospital in the Netherlands, Belgium or Germany? Then for your visitors we reimburse the costs of:

a overnight accommodation in a Ronald McDonald guest house, or another guest house, in the vicinity of the hospital;
b own transport or transport by taxi between the home address and the hospital or guest house and the costs of transport between the guest house and the hospital. We reimburse €0.30 per kilometre;
c return travel by (second class) public transport from the home address to the hospital or guest house, and the costs of public transport between the guest house and the hospital.

Conditions for reimbursement

1 The distance between the hospital at which you are staying and your home address must be more than 50 kilometres.
2 What if you are staying at a hospital in Belgium or Germany? Then we only reimburse the costs if your hospital stay was not arranged by our Healthcare Mediation team, as referred to in article 9.4 of 'Reimbursements covered by supplementary insurance policies'.
3 A contracted taxi service must send us an invoice for the transport costs. What if you use a non-contracted taxi service, public transport or your own transport? Then please use the claim form to request reimbursement of your transport costs. You can find the claim form on our website. 4. You must be able to provide proof that you incurred the transport and/or accommodation expenses if we ask for it.

Supplementary cover

Intro	no coverage
Start	maximum of €35.00 per night for the accomodations expenses. Maximum of €500.00 per calendar year for all visitors combined for the transport and/or accommodation expenses
Royaal	maximum of €35.00 per night for the accomodations expenses. Maximum of €500.00 per calendar year for all visitors combined for the transport and/or accommodation expenses
Excellent	maximum of €35.00 per night for the accomodations expenses. Maximum of €500.00 per calendar year for all visitors combined for the transport and/or accommodation expenses

25 Overnight guest house accommodation during outpatient treatment

Are you receiving outpatient treatment? Then we reimburse the costs of overnight accommodation in a Ronald McDonald guest house, or another guest house, in the vicinity of the hospital. You must receive outpatient treatment on 2 or more consecutive days without staying in the hospital.

What we do not reimburse (under this article)

We do not reimburse the costs of overnight accommodation the night before the start of treatment.

Supplementary cover

Intro	no coverage
Start	maximum of €35.00 per night
Royaal	maximum of €35.00 per night
Excellent	maximum of €35.00 per night

26 Sterilisation

We reimburse the costs of sterilisation.

Conditions for reimbursement

The treatment must be performed at:

1 the practice of a general practitioner qualified to perform the procedure if the insured person is male;
2 a hospital or independent treatment centre (outpatient or day treatment).

We only reimburse contracted care

Please note! The treatment must be performed by a general practitioner or medical specialist contracted for this purpose. What if you choose a general practitioner who is not qualified to provide this treatment or a non-contracted medical specialist? Then you receive no reimbursement.

Do you want to know with which medical specialists we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What we do not reimburse (under this article)

Is this a sterilisation reversal operation? Then we do not reimburse the costs.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	100%
Excellent	100%

27 2nd Doctor Online

We reimburse the costs of 2nd Doctor Online (2de Arts Online). This is an online platform through which you can ask a (medical) specialist of your choice about a diagnosis and/or recommended treatment about which you have doubts.

Condition for reimbursement

To request this service, please call the Personal Care Coach on 071 751 00 98. Your Personal Care Coach will send the request to 2nd Doctor Online (2de Arts Online). With a login you can enter the details in the online tool and choose a medical specialist with the relevant expertise

The medical specialist you choose on 2nd Doctor Online (2de Arts Online) will answer the question you submit through the online tool within 3 working days and will explain the diagnosis, treatment and/or examination procedure.

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

28 Second opinion arranged through Royal Doctors

We reimburse the costs of a second opinion arranged through Royal Doctors. The second opinion will be provided by a(n international) specialist in the Royal Doctors network. The assessment will be based on your medical records. You will not be examined by a Royal Doctors specialist.

Condition for reimbursement

You must request a second opinion in advance by calling the Personal Care Coach on 071 751 00 98.

Supplementary cover

Intro	100%
Start	100%
Royaal	100%
Excellent	100%

Pregnancy/baby/child

29 Maternity care related to adoption or medical screening required for adoption

We reimburse the costs of maternity care related to adoption, or the costs of medical screening (as a preventive measure) required for adoption. This applies if you have legally adopted one or more children during the period covered by your basic insurance and have added the child(ren) to your basic insurance.

Conditions for reimbursement

1 To qualify for reimbursed maternity care, your adopted child must be less than 12 months old at the time of adoption and must not yet be part of your family.
2 You can only opt for medical screening if you are adopting a child from abroad.
3 The medical screening must be performed by a paediatrician.
4 The medical screening must be a compulsory part of the adoption process.

What we do not reimburse (under this article)

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

Supplementary cover

Intro	no coverage
Start	maternity care related to adoption: maximum of 10 hours or medical screening required for adoption: maximum of €300.00 per adopted child
Royaal	maternity care related to adoption: maximum of 10 hours or medical screening required for adoption: maximum of €300.00 per adopted child
Excellent	maternity care related to adoption: maximum of 10 hours or medical screening required for adoption: maximum of €300.00 per adopted child

30 Personal contribution towards the costs of childbirth and obstetric or midwifery care

Did you give birth in a hospital or birth centre as an outpatient under the supervision of a midwife, obstetrician or general practitioner without having a medical reason? Then you are required to pay a statutory personal contribution towards the costs under your basic health insurance. We reimburse the statutory personal contribution payable by female insured persons.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

31 Breast pump device

For female insured persons we reimburse the costs of purchase or hire of a breast pump device.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a spare parts of the breast pump device;
b the purchase of used breast pumps.

Supplementary cover

Intro	no coverage
Start	maximum of €75.00 per pregnancy
Royaal	maximum of €75.00 per pregnancy
Excellent	maximum of €75.00 per pregnancy

32 Maternity package

We will deliver a maternity package to the home of a female insured person well in advance of the anticipated delivery date.

Condition for reimbursement

You must request the maternity package at least 2 months in advance of the anticipated delivery date.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

33 Maternity care

The conditions under which reimbursement of the statutory personal contribution and/or personal payment towards the costs of maternity care is covered by your supplementary insurance are listed below.

33.1 Personal contribution towards the costs of maternity care provided at home or at a birth or maternity centre

Are you required to pay a statutory personal contribution towards the costs of maternity care provided at home or at a birth or maternity centre under your basic health insurance? Then we reimburse the statutory personal contribution payable by female insured persons.

Supplementary cover

Intro	no coverage
Start	100%
Royaal	100%
Excellent	100%

33.2 Personal contribution towards the costs of maternity care in a hospital without medical indication

Are you required to pay a statutory personal contribution towards the costs of non-medically indicated maternity care provided at a hospital under your basic health insurance? Then we reimburse the statutory personal contribution payable by female insured persons.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	no coverage
Excellent	100%

33.3 Postponed maternity care

For female insured persons we reimburse the costs of postponed maternity care provided by a maternity centre. Postponed maternity care is maternity care provided from the 11th day after the birth onwards.

Condition for reimbursement

The maternity centre must consider the postponed maternity care to be medically necessary.

Supplementary cover

Intro	no coverage
Start	maximum of 15 hours per pregnancy, you pay a personal contribution of €4,30 per hour
Royaal	maximum of 15 hours per pregnancy, you pay a personal contribution of €4,30 per hour
Excellent	maximum of 15 hours per pregnancy

34 Lactation care

For female insured persons who are having problems with breastfeeding after a birth, we reimburse the costs of advice and assistance provided by a lactation expert.

Condition for reimbursement

The lactation expert must be a member of the Nederlandse Vereniging van Lactatiekundigen (NVL) (Dutch Association of Lactation Experts), or must meet the quality criteria established by the association. Alternatively, the lactation expert must be employed by one of our contracted maternity centres.

Supplementary cover

Intro	no coverage
Start	maximum of €80.00 per person per calendar year
Royaal	maximum of €80.00 per person per calendar year
Excellent	maximum of €115.00 per person per calendar year

35 TENS during delivery

For female insured persons we reimburse the costs of a TENS device used for pain relief during delivery. The delivery must be supervised by an obstetrician or a general practitioner acting in this capacity.

We only reimburse contracted care

Please note! The device must be supplied by a contracted supplier. What if you choose a non-contracted supplier? Then you receive no reimbursement.

Do you want to know with which suppliers we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	no coverage
Start	1 device throughout the duration of the supplementary insurance
Royaal	1 device throughout the duration of the supplementary insurance
Excellent	1 device throughout the duration of the supplementary insurance

36 Slimmer Zwanger pregnancy self-help programme

We reimburse the costs of a subscription to the Slimmer Zwanger self-help programme for a healthy pregnancy. A subscription to the Slimmer Zwanger programme lasts 26 weeks and the programme can be followed both before and during the pregnancy.

Supplementary cover

Intro	no coverage
Start	1 subscription throughout the duration of the supplementary insurance
Royaal	1 subscription throughout the duration of the supplementary insurance
Excellent	1 subscription throughout the duration of the supplementary insurance

37 Antenatal classes

For female insured persons we reimburse the costs of:

a antenatal courses during pregnancy that help prepare you for and/or guide you through the delivery process;

b courses that promote physical recovery following delivery,

Conditions for reimbursement

1 You must provide us with proof of registration for the classes and payment of the fees.

2 The classes must be run by:
- a home nursing agency or maternity care institution;
- a midwife or obstetrician practice or a health centre;
- a qualified care provider who is a member of the Samen Bevallen antenatal classes association and meets the quality criteria established by the association;
- a physiotherapist or a remedial therapist qualified to teach the Cesar or Mensendieck postural correction system;
- a qualified hypnobirthing practitioner;
- a qualified care provider who is a member of the Zwanger en Fit pregnancy fitness association;
- a care provider qualified to teach the psychoprophylaxis method (to help reduce fear of childbirth);
- Mom in Balance (motherhood support organisation).

Supplementary cover

Intro	no coverage
Start	maximum of €50.00 per person per pregnancy
Royaal	maximum of €50.00 per person per pregnancy
Excellent	maximum of €75.00 per person per pregnancy

Other medical care

38 Hospice

We reimburse the personal contributions an insured person is required to pay while staying in a hospice. The hospice must form part of the palliative care network within the region. The hospice must not be part of a healthcare institution, such as a nursing home, retirement home or care home.

What we do not reimburse (under this article)

We do not reimburse the personal contribution payable under the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)) for a stay in a hospice.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €40.00 per day
Excellent	maximum of €40.00 per day

39 Assistance at home for insured persons aged 18 or older who experience ADL loss (inability to perform daily living activities) after a hospital stay

Did you spend more than 24 hours in a hospital bed? And were you allowed to go home after being discharged? In that case, as an insured person aged 18 or older, you are entitled to an allowance (budget) for extra assistance at home. The amount of the allowance depends on the degree of ADL loss (inability to perform daily living activities such as washing and dressing yourself). You can use the allowance to pay for additional care to compensate for your ADL loss.

Conditions for reimbursement

1 Do you want to be considered for this reimbursement? Then please call the Personal Care Coach on 071 751 00 98 within 10 working days of being discharged from hospital.

2 The Personal Care Coach will go through a protocol to determine the extent of your ADL loss. We will determine the financial allowance to which you are entitled on the basis of the outcome. The questions must be answered truthfully and you must also be able to provide us with evidence that confirms your statements if we ask for it.

3 You may only apply for an allowance for assistance at home immediately after a hospital stay with discharge to home.

4 You are only entitled to one allowance if you undergo several hospital stays within a period of 8 weeks.

What we do not reimburse (under this article)

We do not reimburse the costs of assistance at home for insured persons unable to perform daily living activities:

a after a stay in hospital following the birth of a child, unless there were complications;

b after a stay in the rehabilitation or psychiatric department of a hospital or psychiatric hospital.

c after rehabilitation or a primary care stay in a healthcare institution immediately after the hospital stay;

d after outpatient treatment that allows you to return home within 24 hours;

e if you do not call us within 10 working days of being discharged from hospital.

Supplementary cover

Intro	maximum of €1,000.00 per person after a hospital stay (depending on the degree of ADL loss)
Start	maximum of €1,000.00 per person after a hospital stay (depending on the degree of ADL loss)
Royaal	maximum of €1,000.00 per person after a hospital stay (depending on the degree of ADL loss)
Excellent	maximum of €1,000.00 per person after a hospital stay (depending on the degree of ADL loss)

40 Child care during and after a parental hospital stay

Are you a parent insured with us, and have you been (or will you be) admitted to hospital? Then we arrange home child care outside the hours your child normally spends in child care from the third day of your hospital stay to the third day after you are discharged from hospital. This applies to children up to the age of 12 who are living at home. The number of hours of child care we reimburse depends on the age of your youngest child.

Condition for reimbursement

Do you want to arrange child care? Then you need prior approval from us. Please contact us to request approval.

We only reimburse contracted care

Please note! The child care must be arranged and provided by a contracted child care institution. What if you choose a non-contracted institution? Then you receive no reimbursement.

Do you want to know with which child care institutions we have a contract? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a child care if you stay in a psychiatric hospital;

b extended hours at the child day care centre you normally use.

Supplementary cover

Intro	no coverage
Start	maximum of 50 hours per week. Administration fees: 100%
Royaal	maximum of 50 hours per week. Administration fees: 100%
Excellent	maximum of 50 hours per week. Administration fees: 100%

41 Lifestyle interventions

The conditions under which reimbursement of lifestyle interventions is covered by your supplementary insurance are explained below.

41.1 Dietetic therapy by a dietitian

We reimburse the costs of dietetic therapy by a dietitian. Dietetic therapy involves the provision of information about, and advice on, nutrition and eating habits for medical reasons. Are you entitled to dietetic therapy under your basic insurance? Then the reimbursement covered by your supplementary insurance applies in addition to the reimbursement covered by your basic health insurance.

What we do not reimburse (under this article)

We do not reimburse the costs of both dietetic therapy and nutrition education (41.2) for the same diagnosis.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	no coverage
Excellent	maximum of 2 hours per person per calendar year

41.2 Nutrition education by a weight management consultant or (sports) nutritionist

We reimburse the costs of nutrition education by a weight management consultant or (sports) nutritionist. Nutrition education involves the provision of information about, and advice on, nutrition and eating habits without there being a medical reason.

Conditions for reimbursement

1 The weight management consultant must be a member of the Beroepsvereniging Gewichtsconsulenten Nederland (BGN) (Dutch professional association for Weight Consultants) or must meet the quality criteria established by the association.
2 The sports nutritionist must be accredited by the Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS) (Dutch Sports Health Care Professionals Certification Association). A list of SCAS-accredited sports nutritionists can be found at www.sportzorg.nl/zoek-een-sportzorgprofessional.

What we do not reimburse (under this article)

We do not reimburse the costs of:

a both nutrition education and dietetic therapy (41.1) for the same diagnosis.
b group nutrition education by a weight management consultant.

Supplementary cover

Intro	maximum of €120.00 per person per calendar year
Start	maximum of €120.00 per person per calendar year
Royaal	maximum of €120.00 per person per calendar year
Excellent	maximum of €120.00 per person per calendar year

41.3 (Preventive) courses

We reimburse the costs of the following (preventive) courses:

a For insured persons suffering from **heart problems** we reimburse the costs of a course that teaches patients how to cope with heart problems. The course must be organised by a home care agency. We do not reimburse the costs of a sports club or fitness centre.
b For insured persons suffering from lymphoedema we reimburse the costs of a **lymphoedema** awareness and/or self-management course that teaches patients how to be proactive in helping to prevent, detect and/or treat lymphoedema. The course must be organised by a qualified instructor who has completed the lymphoedema self-management training course run by the Stichting Lymfologie Centrum Nederland (SLCN) (Dutch Lymphology Centre Foundation). A list of qualified instructors can be found on our website or obtained from us.
c For insured persons suffering from **rheumatoid arthritis, osteoarthritis or ankylosing spondylitis (Bechterew's disease)** we reimburse the costs of a course that teaches patients how to cope with their condition. The course must be organised by the Reumafonds (Dutch Arthritis Association) or a home care agency.
d For insured persons suffering from **diabetes type 2** we reimburse the costs of a patient, basic, or follow-up educational course organised by the Diabetesvereniging Nederland (DVN) (Dutch Diabetes Association) or a home care agency.
e For insured persons who need to **lose weight**: 1 of the following selection of courses for dietary advice:
   - one of the print and online programmes organised by Happy Weight;
   - the range of courses provided by Biamed Nederland;
   - the range of courses provided by Lekker Puh!;
   - the range of courses provided by Weight Watchers;
   - the course 'Sportief afvallen' (lose weight with sport) provided by a home care agency;
   - a course on healthy nutrition for the elderly organised by a home care agency.
f A **basic resuscitation course** offered by a training institute registered with Nederlandse Reanimatieraad (NRR) (Dutch Resuscitation Council).
g A **first aid course** that results in an Oranje Kruis First Aid diploma or a Dutch Red Cross First Aid certificate. (We do not reimburse the costs of emergency response training for companies, including child first aid courses required to qualify for registration under the Dutch Childcare Act (Wet kinderopvang (Wk)).
h A **course on first aid for children's accidents** that results in an Oranje Kruis or Dutch Red Cross first aid certificate. (We do not reimburse the costs of emergency response training for companies, including child first aid courses required to qualify for registration under the Dutch Childcare Act (Wet kinderopvang (Wk)).
i A **course on feeling good about your body**. The course must be organised by a home care agency.
j **Courses organised by patient associations**. The course must be organised by a patient association affiliated with Patiëntenfederatie Nederland (Dutch Federation of Patient Associations) or the Ieder(in) network for those with physical or mental disability or chronic illness.
k A **course on self-respect for kids**. The classes must be run by licensees affiliated with Instituut voor Kanjertrainingen B.V. (Institute for Self-Respect for Kids Training Courses).
l The programme offered by **Meer Bewegen voor Ouderen** (MBvO) (More Exercise for the Elderly).

Condition for reimbursement

You must provide us with the original confirmation of registration for the course.

Supplementary cover

Intro	no coverage
Start	maximum of €115.00 per course per person per calendar year
Royaal	maximum of €115.00 per course per person per calendar year
Excellent	maximum of €115.00 per course per person per calendar year

41.4 'Afvallen & Afblijven' diet and exercise programme

We reimburse the costs of the 12-week diet and exercise programme 'Afvallen & Afblijven' (losing weight and keeping it off).

Condition for reimbursement

The programme must be organised by an agency with which we have agreements.

Do you want to know with which care provider(s) we have agreements? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	maximum of €250.00 per person per calendar year
Start	maximum of €250.00 per person per calendar year
Royaal	maximum of €250.00 per person per calendar year
Excellent	maximum of €250.00 per person per calendar year

41.5 Sleep improvement course
We reimburse the costs of:
a an online sleep improvement course or 'the sleep coach', which provides professional advice and practical solutions online to help improve your sleep. The course must be organised by Somnio.
b a 'You can learn to sleep' course. The course must be organised by a home care agency.

Condition for reimbursement
You must provide us with the original confirmation of registration for the course.

Supplementary cover

Intro	maximum of €150.00 per person per calendar year
Start	maximum of €150.00 per person per calendar year
Royaal	maximum of €150.00 per person per calendar year
Excellent	maximum of €150.00 per person per calendar year

41.6 Course designed to reduce alcohol consumption
We reimburse the costs of (preventive) courses designed to reduce alcohol consumption.

Condition for reimbursement
You must provide us with the original confirmation of registration for the course.

Supplementary cover

Intro	maximum of €300.00 per person per calendar year
Start	maximum of €300.00 per person per calendar year
Royaal	maximum of €300.00 per person per calendar year
Excellent	maximum of €300.00 per person per calendar year

41.7 Mindfulness training
We reimburse the costs of mindfulness training.

Condition for reimbursement
The mindfulness training must be provided by a trainer who is a member of the Vereniging Mindfulness Based Trainers Nederland en Vlaanderen (VMBN) (Community of Mindfulness-Based Trainers in the Netherlands and Flanders. The members of the community are listed at www.vmbn.nl.

Supplementary cover

Intro	maximum of €250.00 per person per calendar year
Start	maximum of €250.00 per person per calendar year
Royaal	maximum of €250.00 per person per calendar year
Excellent	maximum of €250.00 per person per calendar year

41.8 Counselling
We reimburse the costs of counselling. Counselling is a short-term form of individual psychosocial support.

Condition for reimbursement
The counsellor who works with you must be a member of the General Professional Association for Counselling (Algemene Beroepsvereniging voor Counselling (ABvC)).

Supplementary cover

Intro	maximum of €300.00 per person per calendar year
Start	maximum of €300.00 per person per calendar year
Royaal	maximum of €300.00 per person per calendar year
Excellent	maximum of €300.00 per person per calendar year

41.9 Care for women
We reimburse the costs of health advice: Menopause complaints, Getting pregnant & Pregnancy, Menstruation problems, Contraception and Breast self-examination.

Condition for reimbursement
The consultation must be provided by a consultant who is a member of Care for Women. In the case of menopause complaints the consultation can also be provided by a menopause consultant who is a member of the Vereniging Verpleegkundig Overgangsconsulenten (VVOC) (Association of Medical Menopause Consultants). Or a care provider who meets the quality criteria established by one of these organisations.

What we do not reimburse (under this article)
We do not reimburse the costs of food supplements or medicines.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €115.00 per person per calendar year
Excellent	maximum of €115.00 per person per calendar year

41.10 IncoCure self-help programme
For female insured persons who suffer from incontinence we reimburse the costs of the therapeutic online process offered by IncoCure.
This self-help programme consists of an online questionnaire that diagnoses the type of incontinence. You are given personal advice on treatment. To complete the questionnaire, you can go straight to the website: www.incocure.com.

Supplementary cover

Intro	no coverage
Start	maximum of €15.00 per person per calendar year
Royaal	maximum of €15.00 per person per calendar year
Excellent	maximum of €15.00 per person per calendar year

41.11 Lifestyle training courses
We reimburse the costs of a maximum of 1 basic lifestyle training course for:
a heart patients;
b whiplash patients;
c people suffering from stress and conditions associated with burnout.

Conditions for reimbursement
1 You must be referred by a general practitioner, a company doctor or a medical specialist.
2 The course must be organised by Leefstijl Training & Coaching (a personal development and health management institute).

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €1,000.00 per person per calendar year
Excellent	maximum of €1,250.00 per person per calendar year

41.12 Health Check
We reimburse the costs of a Health Check (a preventive health test).

We only reimburse contracted care
Please note! We reimburse the costs of Health Checks performed by Care for Human nurses contracted for this purpose and Health Checks performed by other care providers with whom we have agreements. Do you want to make an appointment with a Care for Human nurse? Then please go to their website. What if you choose a non-contracted supplier? Then you receive no reimbursement.

Do you want to know with which care provider(s) we have agreements? In that case use the Medical Provider Search Tool on www.averoachmea.nl/zoekuwzorgverlener or contact us.

Supplementary cover

Intro	1x per person per calendar year
Start	1x per person per calendar year
Royaal	1x per person per calendar year
Excellent	1x per person per calendar year

42 Support for informal caregivers and recipients

Are you an informal caregiver or do you receive informal care? Then we provide an allowance to help cover the costs of necessary support services to ensure that you can keep providing or receiving informal care. You can use the allowance to pay for things such as:

- temporary replacement care in your own home while your main informal caregiver is away;
- temporary professional support provided by an informal care agent who can take over various administrative tasks in the areas of care, welfare and finance among others;
- training, coaching and courses on informal care.

You receive an allowance that covers the costs of necessary support services up to the maximum insured amount.

Informal care involves (intensive) provision of unpaid care for a chronically ill or handicapped person (on a long-term basis).

Conditions for reimbursement

1 We must give you permission in advance. To inquire about this, please call the Personal Care Coach on 071 751 00 98. The Personal Care Coach will first see if they can provide the information and assistance you need and will then determine what kind of support you need and how much it will cost. The Personal Care Coach will then determine the amount of the allowance.
2 If the informal caregiver and the person receiving informal care both have supplementary insurance that provides an allowance for informal caregivers and recipients, the allowance will first be reimbursed by the informal caregiver's supplementary insurance and then by the recipient's supplementary insurance. If several informal caregivers provide informal care for the same person, an allowance will only be provided for 1 informal caregiver.
3 If you want to use the allowance to pay for a replacement caregiver, your informal caregiver must be away when the replacement (informal) care is provided.

What we do not reimburse (under this article)

a Costs can only be claimed once. The costs of the services provided are not reimbursed for both the informal caregiver and the person receiving informal care.
b The costs of the services provided are not reimbursed in the case of paid informal care or if these costs are covered by the Dutch Health Insurance Act (Zorgverzekeringswet (Zvw)), the Dutch Social Support Act (Wet maatschappelijke ondersteuning (Wmo)), the Dutch Youth Act (Jeugdwet (JW)) or the Dutch Long-term Care Act (Wet langdurige zorg (Wlz)).
c The costs of replacement (informal) care are not reimbursed if a personal care allowance (persoonsgebonden budget (PGB)) is used to pay for informal care.
d The costs are not reimbursed if you provide or receive informal care for a period of less than 3 months or fewer than 8 hours per week.
e The costs are not reimbursed for additional hours of informal care required as a result of a (temporary) deterioration in the recipient's health. You must apply for a care needs assessment.

Supplementary cover

Intro	no coverage
Start	maximum of €750.00 per person per calendar year (depending on the amount needed to cover the costs of necessary support services)
Royaal	maximum of €1,000.00 per person per calendar year (depending on the amount needed to cover the costs of necessary support services)
Excellent	maximum of €1,250.00 per person per calendar year (depending on the amount needed to cover the costs of necessary support services)

43 Sports medical examination by a sports doctor

We reimburse the costs of the following examinations by a sports doctor at a Sports Medical Institution:

a a sports medical examination;
b a sports check-up;
c an exertion test.

Condition for reimbursement

The sports doctor or Sports Medical Institution must be accredited by the Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS) (Dutch Sports Health Care Professionals Certification Association). A list of SCAS-accredited Sports Medical Institutions can be found at www.sportzorg.nl/zoek-een-sportzorgprofessional.

Supplementary cover

Intro	maximum of €200.00 per person per calendar year
Start	maximum of €200.00 per person per calendar year
Royaal	maximum of €200.00 per person per calendar year
Excellent	maximum of €200.00 per person per calendar year

44 Sports medical advice and guidance

We reimburse the costs of sports medical advice and guidance (advice on sports training and a personal training programme based on the results of the sports medical examination) provided by a sports doctor at a sports medical institution.

Condition for reimbursement

1 A sports medical examination must be performed by a sports doctor at a Sports Medical Institution before the advice is provided.
2 The Sports Medical Institution must be accredited by the Stichting Certificering Actoren in de Sportgezondheidszorg (SCAS) (Dutch Sports Health Care Professionals Certification Association). A list of SCAS-accredited Sports Medical Institutions can be found at www.sportzorg.nl/zoek-een-sportzorgprofessional.

Supplementary cover

Intro	maximum of €150.00 per person per calendar year
Start	maximum of €150.00 per person per calendar year
Royaal	maximum of €150.00 per person per calendar year
Excellent	maximum of €150.00 per person per calendar year

45 Sports or ice pack brace

We reimburse the costs of a sports or ice pack brace.

Supplementary cover

Intro	1 sports or ice pack brace per person per calendar year up to a maximum of €50.00
Start	1 sports or ice pack brace per person per calendar year up to a maximum of €50.00
Royaal	sports or ice pack brace per person per calendar year up to a maximum of €50.00
Excellent	1 sports or ice pack brace per person per calendar year up to a maximum of €50.00

46 Running coaching to prevent or accommodate injuries

We reimburse the costs of the FysioRunning online coaching programme. The process consists of a screening questionnaire and coaching for a maximum of 13 weeks. To register and complete the screening questionnaire, go to www.fysiorunning.nl.

Supplementary cover

Intro	1 FysioRunning online coaching programme per person per calendar year
Start	1 FysioRunning online coaching programme per person per calendar year
Royaal	1 FysioRunning online coaching programme per person per calendar year
Excellent	1 FysioRunning online coaching programme per person per calendar year

47 Therapeutic holiday camps

We reimburse the costs of therapeutic holiday camps for children (47.1) and the disabled (47.2). At these holiday camps children and the disabled learn to cope with their illness, condition or disability, by learning and practising with others in the same situation.

47.1 Therapeutic holiday camp for children

For children under the age of 18 we reimburse the costs of a stay at a therapeutic holiday camp organised by:

a Stichting Heppie (for children who suffer from asthma and/or constitutional eczema);
b Diabetes Jeugdvereniging Nederland (for children with diabetes);
c Stichting Kinderoncologische Vakantiekampen (for children being treated for cancer);
d Stichting De Ster (Sterkamp and Maankamp) (to increase self-confidence and self-esteem);
e Nederlandse Hartstichting (Jump) (for children with cardiovascular disease);
f Bas van de Goor Foundation (sports camps for diabetics).

Condition for reimbursement

You must provide us with proof of payment for the course.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €150.00 per person per calendar year
Excellent	maximum of €150.00 per person per calendar year

47.2 Therapeutic holiday camp for the disabled

For insured persons with a disability we reimburse the costs of a stay at a therapeutic holiday camp.

Condition for reimbursement

You must provide us with proof of payment for the course.

Supplementary cover

Intro	no coverage
Start	no coverage
Royaal	maximum of €150.00 per person per calendar year
Excellent	maximum of €150.00 per person per calendar year

Reimbursements covered by Supplementary Dental Insurance (T Start, T Extra, T Royaal of T Excellent)

Dental care for insured persons aged 18 or older
Are you 18 or older? And do you have T Start, T Extra, T Royaal or T Excellent Supplementary Dental Insurance? In that case we reimburse the costs of dental treatment by a dentist, a dental surgeon, an oral hygienist or a clinical dental technician.
A clinical dental technician may perform the repairs described under 'Reimbursement of costs declared by a clinical dental technician'.

Do you visit a dentist? In that case we reimburse 100% of the costs of anaesthesia (A codes), consultations (C codes) and a second opinion, oral hygiene (M codes), periodontal treatment (codes T21 and T22), fillings (V codes), dental photos (X codes) and extractions (H codes).

Reimbursement of other treatments
Do you have T Start, T Extra or T Royaal Supplementary Dental Insurance? In that case we reimburse a maximum of 75% of the costs of other treatments. If you have T Excellent Supplementary Dental Insurance we reimburse 100% of the costs.

Reimbursement of costs declared by an oral hygienist
In addition to oral hygiene, an oral hygienist can also treat gum disorders and place small fillings. Depending on the type of treatment you receive, an oral hygienist can charge for both oral hygiene treatments (M codes) and periodontal treatments (T codes). Has your oral hygienist charged for T codes? (other than codes T21 and T22)? In that case we reimburse up to 75% if you have T Start, T Extra or T Royaal Supplementary Dental Insurance. If you have T Excellent Supplementary Dental Insurance we reimburse 100% of the costs.

Reimbursement of costs declared by a dental surgeon
You are entitled to periodontal surgery, the fitting of a dental implant and an uncomplicated extraction (removal of a tooth or molar) performed by a dental surgeon. Specialist dental surgery and the X-rays this involves are not reimbursed by T Start, T Extra, T Royaal or T Excellent Supplementary Dental Insurance. These costs are covered by your basic insurance (see article 8 of 'Care covered by the basic insurance policies').

Reimbursement of costs declared by a clinical dental technician
You are entitled to minor repairs of a partial (plate or frame) denture performed by a clinical dental technician if no oral treatment is required. These include the reattachment or replacement of a tooth or molar and the repair of a crack in the partial denture. What if there is a break in your denture? Then the repair must be performed by a dentist and not by a clinical dental technician. A crack in your denture means that the denture is broken but still in one piece. A break in your denture means that the denture has broken into 2 or more pieces.

Please note! We only reimburse the costs of dental care if the maximum reimbursement provided by your chosen Supplementary Dental Insurance has not yet been reached.

What we do not reimburse (under this article)
We do not reimburse the costs of:
a dental check-up reports and dental statements (C70, C75 and C76);
b missed appointments (C90);
c external bleaching of teeth and molars (E97, E98 and E00);
d a mandibular advancement splint (MAS: a brace used to prevent snoring), and the related diagnostic and follow-up care (G71, G72 and G73);
e orthodontic care;
f subscriptions;
g general anaesthetic;
h a complicated extraction by a dental surgeon. (This is reimbursed under the basic insurance.)
i partially completed work.

Maximum reimbursements
The maximum total reimbursement depends on your package.
The reimbursements provided by the different packages are listed below.

T Start Supplementary Dental Insurance
– We reimburse 100% of A codes, C codes, M codes, codes T21 and T22, V codes, X codes and H codes.
– We reimburse 75% of the costs of other codes.
– The maximum total reimbursement is €250.00 per person per calendar year.

T Extra Supplementary Dental Insurance
– We reimburse 100% of A codes, C codes, M codes, codes T21 and T22, V codes, X codes and H codes.
– We reimburse 75% of the costs of other codes.
– The maximum total reimbursement is €500.00 per person per calendar year.

T Royaal Supplementary Dental Insurance
– We reimburse 100% of A codes, C codes, M codes, codes T21 and T22, V codes, X codes and H codes.
– We reimburse 75% of the costs of other codes.
– The maximum total reimbursement is €1,000.00 per person per calendar year.

T Excellent Supplementary Dental Insurance
– We reimburse 100% of the costs of all treatments.
– The maximum total reimbursement is €1,250.00 per person per calendar year.

Service & Contact

Visit our website:

www.averoachmea.nl/zorg
www.averoachmea.nl/vergoedingen
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Call us:

- Customer Service (071) 751 00 22.
- You can call our Transport Telephone Line (Vervoerslijn) on +31 71 365 41 54
- Contact our emergency centre Eurocross Assistance for urgent medical care abroad on +31 71 364 18 50 (available 24 hours a day, 7 days a week)
- Are you abroad and do you have a medical question? Contact our Holiday doctor (Vakantiedokter) on +31 71 36 41 802

E-mail us:

avero.zorgverzekering@achmea.nl

What do we do and who are we? We offer insurance policies and financial services. We ourselves are not involved in selling our products and solutions to our clients. For this we cooperate with advisors. Our advisors provide you with independent advice. This is to make certain you take out insurance that fits you best.

For list of contracted care providers, the Medical Devices Regulations (Reglement Hulpmiddelen), the Pharmaceutical Care Regulations (Reglement Farmaceutische Zorg), the Personal Care Allowance Regulations - (Reglement pgb-Zvw), a list of professional associations of alternative healers who meet our criteria, conditions, brochures, forms and information about our insurance policies, visit our website: www.averoachmea.nl.

Health insurance policies offered by Avéro Achmea are insured by Avéro Achmea Zorgverzekeringen N.V. (Chamber of Commerce 30208633, AFM 12001023). Supplementary insurance policies offered by Avéro Achmea are insured by Achmea Zorgverzekeringen N.V. (Chamber of Commerce 28080300, AFM 12000647).

As a courtesy we provide you with an English translation of our policy conditions. You can and may not derive any rights, entitlements or obligations from this English translation. Our health insurance policies are regulated by Dutch law and as such, our Dutch conditions and entitlements documents are the only legal documents from which you can derive your rights, entitlements and obligations.

You can read more about our privacy regulations on www.averoachmea.nl/privacy-statement.

KKV Keurmerk Klantgericht Verzekeren

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