Postbus 2705 • 6401 DE Heerlen • T 088 - 35 35 763
Postbus 2296 • 5600 CG Eindhoven • T 088 - 35 35 764
www.aevitae.com • info@aevitae.com

Policy Conditions 2018
Avéro Achmea Zorg Plan Selectief

From January 1st 2018

Contents

AEV-18455 (A)

These are the conditions of the basic insurance policy Zorg Plan Selectief 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 insurance do we offer?
We offer the basic insurance Zorg Plan Selectief (an arranged care police withselective contracting).

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? 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 noncontracted 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 Zorg Plan Selectief'.

Please note! Avéro Achmea has contracted a limited number of hospitals for specialist medical care for Zorg Plan Selectief. Won't you be visiting one of these hospitals for plannable care? Then you will receive a lower reimbursement. You can read more about this in article 4.3.2 of the chapter 'General terms and conditions basic insurance Zorg Plan Selectief'.

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.

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.aevitae.com/zoek-avero-zorgverlener 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 insurance Zorg Plan Selectief.

The conditions are organised as follows:
- the 'General conditions of the basic insurance Zorg Plan Selectief' (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 Zorg Plan Selectief' (the care to which you are entitled and the conditions that apply);

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 Zorg Plan Selectief can be found on pages 27 to 62.

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 2017 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 10).

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 11).

General conditions of the basic insurance Zorg Plan Selectief

1 What is the regulatory basis for our basic health insurance Zorg Plan Selectief?

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 Healthcare 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 certainforms 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 treatment carried out by you or 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 seconddegree 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 abovementioned 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 or healthcare institutions that do not have a contract with us (non-contracted care providers, healthcare institutions or 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.aevitae.com/zoek-avero-zorgverlener 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 or der 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.aevitae.com/zoek-avero-zorgverlener 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.

Please note! This article does not apply to any supplementary insurance policy you have taken out.

4.3.1 Arranged care policy with selective contracting (Zorg Plan Selectief)

You have a arranged care policy with selective contracting. Do you use a non-contracted care provider? In that case you are entitled to a reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers).

In addition to the in Article 4.2 mentioned limitation on care and/or treatments which Avéro Achmea has not contracted in each hospital or zbc, you will be eligible for medical specialist care (Article 25, 26 paragraph 1, 27 and 30) at a limited number of contracted hospitals in the Netherlands with the Zorg Plan Selectief. This is what we call ‘selective contracting’.

The hospitals that are contracted for the Zorg Plan Selectief can be found on our website or obtained from us. Are you receiving treatment or care from a non-contracted hospital? In that case you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers).

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.aevitae.com/zoek-avero-zorgverlener 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.

4.4 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.

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 Nederlandse Zorgautoriteit (NZa) (Dutch Healthcare Authority).

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-treatmentcombination (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-treatmentcombination (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 marktordeninggezondheidszorg (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-treatmentcombination
Will treatment be invoiced in the form of a diagnosis-treatmentcombination (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)).

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 bo thdiscounts 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, 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.

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 as sistance 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 el sewhere 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 in to 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 gr oup 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 Longterm 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 policies';
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 ofillegal registration

Was an insurance contract issued for you under the 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 www.XE.com. We use the rate that was applicable on the date of the treatment. 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 yourillness, 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 becomeill, 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 Complaint Management Department (Afdeling Klachtenmanagement). You must do this within 6 months of the date on which we informed you of our decision or provided the service. You can no tify 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 Complaint Management Department (Afdeling Klachtenmanagement) 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 (www.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 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 guarantee the safety and integrity of the financial services sector;
d to perform statistical analysis;
e to conduct scientific research;
f to maintain relationships;
g 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)). The abovementioned 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 Aevitae, Postbus 2705, 6401 DE Heerlen, The Netherlands;
b by telephone number 088 - 35 35 763;
c via our website.

19.3 We refer to the Central Information System when processing applications

To ensure responsible acceptance policy, Zilveren Kruis 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. We do 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 me an 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 gr ounds 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 (DBC) care product
As of 1 January 2012 new specialist medical care services are defined as DBC care products. This system is known as DOT (DBCs leading to Transparency). A DBC care product is a service that can be billed under the Dutch Healthcare Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)) as part of the specialist medical care that is the result of the total process, from the diagnosis made by the care provider up to and including (any) treatment. The DBC process commences the moment you submit a request for care and is completed when treatment ends, or after 120 days
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 healthcare

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 healthcare

A doctor who is listed as such, with the profile Juvenile healthcare, 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 ze lfstandigheid (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 or thopaedics 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 Registratiecommissie Geneeskundig Specialisten(RGS) (Medical Specialists Registration Committee) of the Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG) (Royal Dutch Medical Association).
Psychosomatic physiotherapist
A psychosomatic 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 psychosomatic physiotherapist in the Centraal Kwaliteitsregister (CKR) (Central Quality Register) Fysiotherapie or the Dutch Quality Physiotherapy Certification Foundation (Stichting Keurmerk Fysiotherapie).
Psychosomatic remedial therapist
A psychosomatic 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).
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 te chnicians (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 persons 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 competences of the care providers. The corresponding registers list the names of care providers who meet the statutory requirements.
We/us
Aevitae B.V.
District nurse
A level-5 nurse (article 3a of the Dutch BIG Act, Bachelor's degree) or nursing specialist (article 14 of the Ducth 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 theill 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.
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 policy Zorg Plan Selectief

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

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.aevitae.com/zoek-avero-zorgverlener, 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which occupational therapists we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 Simms 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 in tact 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 or thoses. 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 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 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 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.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 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.aevitae.com/zoek-avero-zorgverlener 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.aevitae.com/zoek-avero-zorgverlener 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.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

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

In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 noncontracted 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 Zorg Plan Selectief’.

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 if treatment is provided by a non-contracted care provider
Please note! Do you order your medical devices from a non-contracted supplier? In that case you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which suppliers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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, undermm, 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 healthcare, 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which pharmacies we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 healthcare and dentistry

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.

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which dental surgeons we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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. 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 healthcare 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which dental surgeons we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 te chnician 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 7.
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 permissionCare covered by the basic insurance policies 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 costestimate 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which dental surgeons we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). 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.aevitae.com/zoek-avero-zorgverlener 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 af fects 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which dental surgeons we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 healthcare, 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which audiology centres we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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.aevitae.com/zoek-avero-zorgverlener 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 healthcare, 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which audiology centres we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 the overcoming or compensation 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.

Condition 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 healthcare

15 General basic mental healthcare 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 General 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 healthcare for insured persons aged 18 or older (secondary mental healthcare)

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

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 healthcare
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 TThe 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 healthcare 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. Lower reimbursement if treatment is provided by a noncontracted care provider.

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 healthcare 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 or a 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 mu nicipality 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 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 de Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener.

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 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;
f to a care provider from whom or an institution in which an insured person under the age of 18 will receive mental healthcare 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 healthcare. 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 seated patient transport is medically inadvisable.
4 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 € 0.30 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 be tween 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 Dutch Long-term Care Act (Wet langdurige zorg (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 up on seated patient transport, because you are being treated for a longterm 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

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.

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which centres we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 de Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener.

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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). This procedure must be carried out by a contracted care provider;
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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 in dependence 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 healthcare or an other 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 BIGregistered 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.

Condition 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. 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 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.aevitae.com/zoek-avero-zorgverlener 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 healthcare, a physician assistant, a nursing specialist, 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 healthcare (GGZ) does not fall under this article. Do you want to know what mental healthcare you are entitled to? In that case, please read articles 16 and 17 of 'Care covered by the basic insurance policies' on nonclinical specialist mental healthcare (secondary mental healthcare) 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 in dependent 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 necessity' (31.1) and 'without medical necessity' (31.2).

31.1 With medical necessity
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 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 necessity

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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 womans 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 medical statement from your doctor 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 in dications
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 at tempt 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 Stichting Kinderoncologie Nederland (SKION) (Dutch Child Oncology Group). 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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

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 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 treatment. 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.aevitae.com/zoek-avero-zorgverlener to find contracted directaccess 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which dietitians we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the 'General conditions of the basic insurance Zorg Plan Selectief'.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). 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.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract?
In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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 you receive a lower reimbursement of up to 75% of the average tariff we pay for this care (provided by contracted care providers). You can read more about this in article 4 of the ‘General conditions of the basic insurance Zorg Plan Selectief’.

Do you want to know with which care providers we have a contract? In that case use the Medical Provider Search Tool on www.aevitae.com/zoek-avero-zorgverlener 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.