

# Avéro Achmea Keuze Zorg Plan Conditions and reimbursements

Date of commencement 1 January 2014

## Contents

	page		page
<b>General conditions of the Keuze Zorg Plan</b>	<b>3</b>	<b>Physiotherapy and remedial therapy</b>	<b>20</b>
Article 1 What are the grounds for the basic insurance?	3	Article 3 Physiotherapy and remedial therapy	20
Article 2 What does the basic insurance cover (reimbursements) and for whom is it intended?	3	<b>Medical devices</b>	<b>21</b>
Article 3 What is not insured (exclusions)?	3	Article 4 Medical devices	21
Article 4 What is reimbursed? And to which care provider or care institution can you apply?	4	<b>Medicines and dietary preparations</b>	<b>22</b>
Article 5 What obligations rest upon you?	5	Article 5 Pharmaceutical Care: medicines and dietary products	22
Article 6 What is your mandatory excess?	6	Article 6 Orthodontics (brace) in exceptional cases	23
Article 7 What is a voluntarily chosen excess?	7	Article 7 Dental care up to the age of 18 years	23
Article 8 What will you have to pay?	8	Article 8 Dental care for insured clients aged 18 years and older - dental surgery	24
Article 9 What will happen if you do not pay the premium in time?	8	Article 9 Dental care of clients aged 18 years and older - full sets of removable dentures (set of false teeth)	24
Article 10 What will happen if you have payment arrears?	9	Article 10 Implants	25
Article 11 What if your premium and/or conditions alter?	10	Article 11 Dental care for insured clients with a handicap	25
Article 12 When does your basic insurance commence?	10	Article 12 Dental care in exceptional cases	25
Article 13 When can you cancel your basic insurance?	11	<b>Eyes and ears</b>	<b>26</b>
Article 14 When will we cancel your basic insurance?	11	Article 13 Audiological centre	26
Article 15 When do you have a right to reimbursement of health care received abroad?	12	<b>Psychological care</b>	<b>26</b>
Article 16 Not liable for damage due to a care provider or health care institution	12	Article 14 General basic GGZ (mental health care)	26
Article 17 What should you do if (a) third party/parties is/are liable?	12	Article 15 Non-clinical specialised GGZ (second-line GGZ)	27
Article 18 Do you have a complaint?	13	Article 16 Admission to a Psychiatric Hospital	28
Article 19 What do we do with your personal details?	13	<b>Speech and reading</b>	<b>28</b>
Article 20 What are the consequences of fraud?	14	Article 17 Dyslectic Care	28
Article 21 Definitions	14	Article 18 Speech therapy	29
<b>Reimbursements via the Keuze Zorg Plan</b>	<b>19</b>	<b>Transport</b>	<b>29</b>
<b>Bones, muscles and joints</b>	<b>19</b>	Article 19 Transporting patients	29
Article 1 Occupational therapy	19		
Article 2 Foot care for insured clients suffering from diabetes mellitus	19		

	page		page
<b>Hospital, treatment and nursing</b>	<b>30</b>	<b>Pregnancy/baby/child</b>	<b>35</b>
Article 20 The Asthma Centre in Davos (Switzerland)	30	Article 33 Childbirth and obstetric care	35
Article 21 Genetic research and advice	30	Article 34 In vitro fertilisation (IVF), other forms of fertility-enhancing treatments, sperm cryopreservation and oocyte vitrification	36
Article 22 Mechanical respiration	30	Article 35 Maternity care	37
Article 23 Care provided by medical specialists (extramurally)	31	Article 36 Oncological examination in children	38
Article 24 Care provided by medical specialists (in an extramural environment)	31	Article 37 Prenatal screening	38
Article 25 Dialysis at home	32		
Article 26 Organ transplants	32	<b>Miscellaneous</b>	<b>38</b>
Article 27 Plastic surgery	33	Article 38 Dietary advice	38
Article 28 Convalescence	33	Article 39 General practitioner care	38
Article 29 Second opinion	34	Article 40 Integrated care for diabetes mellitus type 2 and COPD	39
Article 30 Nursing (extramurally) outside the hospital	34	Article 41 Stop smoking programme	39
Article 31 Independent treatment centre	34	Article 42 Thrombosis Service	39
Article 32 Hospital nursing and day-time treatment in a hospital	35		

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.

#### **These are the conditions of your basic insurance and the supplementary insurance**

The basic insurance we provide is known as the Keuze Zorg Plan. It is a restitution policy. This means that in some cases you are entitled to reimbursement of the costs of care (refunds). You can add 1 or more forms of supplementary insurance to this basic insurance.

#### **The government determines the contents of the basic insurance**

The government stipulates the conditions of the basic insurance. These are laid down in the Health Insurance Act and the corresponding legislation. Every health insurer must comply strictly with these conditions.

#### **What information can be found in the conditions?**

These conditions inform you about which care is and which is not reimbursed via the Keuze Zorg Plan and any supplementary insurance. The conditions are organised as follows:

- the general conditions of the basic insurance (general information on the Keuze Zorg Plan, such as the premium, the deductible excess and rules with which you must comply);
- the reimbursements of the Keuze Zorg Plan (what are your reimbursements and what conditions apply to them);
- the general conditions of the supplementary insurances;
- reimbursements from the supplementary insurances.

#### **Do you need permission?**

You will see that we must have given permission in advance for a number of reimbursements. Such permission can be requested by telephone, by post or by e-mail. More information about asking for permission can be found on our website. The application forms can also be downloaded from our website.

#### **Mandatory deductible excess**

Basic insurance for everyone aged 18 years and older always has a mandatory deductible excess. The government determines the size of the mandatory deductible excess. You do not pay deductible excess for:

- care that is reimbursed from supplementary insurance(s) that you have taken out;
- care provided by a General Practitioner or Family Doctor;
- care for children up to 18 years of age;
- items on loan, excluding maintenance costs and costs of use;
- maternity care and obstetric care (but excluding medicines, tests for measuring blood pressure, chorionic villus sampling or transport of patients);
- integrated care;
- after-care for a donor.

Find out more about the mandatory deductible excess in Article 6 of the general conditions of the Keuze Zorg Plan.

#### **Voluntarily chosen deductible excess**

In addition to the mandatory deductible excess, you can also opt for a voluntarily chosen deductible excess. This means that you can increase your deductible excess by € 100.00, € 200.00, € 300.00, € 400.00 or € 500.00. This will reduce your premium for the Keuze Zorg Plan.

Find out more about the voluntarily chosen deductible excess in Article 7 of the general conditions of the Keuze Zorg Plan.

# General conditions of the Keuze Zorg Plan

## Article 1 What are the grounds for the basic insurance?

**1.1** This insurance contract is based on:

- a the Health Insurance Act (Zorgverzekeringswet (Zvw)) and the accompanying explanations;
- b the Health Insurance Decision (Besluit zorgverzekering) and the accompanying explanations;
- c the Health Insurance Regulations (Regeling zorgverzekering) and the accompanying explanations;
- d the application form that you (policyholder) have completed.

**1.2** ALSO BASED ON ESTABLISHED MEDICAL SCIENCE AND MEDICAL PRACTICE

Furthermore, the extent and contents of your right to the reimbursement of the costs of health care as defined in the basic insurance, is also determined by established medical science and medical practice. Doesn't such a standard exist? In that case, the standard is whatever the professional field involved regards as responsible and adequate care and services.

## Article 2 What does the basic insurance cover (reimbursements) and for whom is it intended?

**2.1** This basic insurance gives you a right to reimbursement of the costs of health care. The government decides which care is insured. The insurance can be taken out with or for:

- a people who live in the Netherlands and are obliged to take out insurance;
- b people who live abroad and are obliged to take out insurance.

'Reimbursements via the Keuze Zorg Plan' lists forms of care that are covered by your basic insurance.

**2.2** PROCEDURES FOR TAKING OUT INSURANCE

You (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** APPLYING AND REGISTERING

When you apply to us, we determine whether you fulfil the registration conditions stipulated by the Health Insurance Act. Do you fulfil them? In that case we issue a policy certificate. The insurance contract is set out in the policy certificate. You (policyholder) receive this policy certificate from us once a year. We also provide you with a health care card. You need to present the policy certificate or the health care card to a care provider when obtaining health care. After this you have a right to reimbursement of the costs of health care in accordance with this act.

**2.4** THE HEALTH INSURANCE ACT DETERMINES TO WHICH CARE AND TO WHICH QUANTITY YOU ARE ENTITLED

Your right to reimbursement of the costs of health care, is stipulated in the Health Insurance Act, the Health Insurance Decision, and the Health Insurance Regulations. These stipulate which care is involved (the content) and how much care is involved (the amount). You are only entitled to health care if you can reasonably be said to depend upon that care and that amount of care.

## Article 3 What is not insured (exclusions)?

**3.1** You have no right to reimbursement of the costs of health care, if you need the care as a consequence of one of the following situations in the Netherlands:

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

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

**3.2** CHECK-UP, FLU VACCINATION, A DOCTOR'S STATEMENT AND CERTAIN TREATMENTS

You have no right to reimbursement of the costs of:

- a check-ups;
- b flu vaccinations;
- c treatments for snoring (ovuloplastie);
- d treatment with a correction helmet for plagiocephaly and brachycephaly without craniostenosis;
- e treatments for realising sterilisation;
- f treatments for reversing sterilisation;
- g treatments for circumcision;
- h issuing doctor's statements.

In some cases you have a right to reimbursement of the costs of this care.

Please note! in that case the policy conditions must explicitly state that it is reimbursed.

### **3.3 IF YOU FAIL TO KEEP YOUR APPOINTMENTS OR DO NOT PICK UP PRESCRIBED MEDICINES**

You do not have a right to reimbursement of the costs of care, if you:

- do not comply with care agreements;
- do not pick up medical devices, medicines and dietary preparations.

In this respect it is irrelevant who asked the care provider or health care institution to supply: you or the prescriber.

### **3.4 LABORATORY EXAMINATION REQUESTED BY A DOCTOR WHO PRACTICES ALTERNATIVE MEDICINE**

You have no right to reimbursement of the costs of a laboratory examination and/or X-rays if they are requested by a general practitioner or medical specialist who at that moment is working in the field of alternative or complementary medicine.

### **3.5 COSTS OF TREATMENT CARRIED OUT BY YOU OR A MEMBER OF YOUR FAMILY**

You may not treat yourself and claim the costs involved against your own insurance. You are not entitled to this care, nor do you have a right to reimbursement of the costs of this care. Do you want your partner, a family-member and/or a first-degree or second-degree family-member to treat you? And do you want to declare the costs of this treatment? In that case we must have given you permission in advance.

### **3.6 REIMBURSEMENTS THAT RESULT FROM TERRORISM**

#### **3.6.1**

Is care needed as a consequence of one or more terrorist acts? In that case you may have a right to reimbursement of some of the costs of this care. This happens if very many insured clients claim from their health insurance as a consequence of one or more terrorist acts. In that case, only a percentage is reimbursed for each insured client. In order words: are the total damages (resulting from terrorist acts) declared in a calendar year against general insurance, life insurance or funeral insurance with in-kind benefits that are subject to the Financial Supervision Act (Wet op het financieel toezicht (Wft)) expected to exceed the maximum sum that the insurance company reinsures per calendar year? In that case you are only entitled to reimbursements of the costs 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 Terrorisemeschade N.V. (NHT)).

#### **3.6.2**

The precise definitions and provisions that apply to the above-mentioned reimbursement appear in the NHT's clause sheet on terrorism cover. This clause and the corresponding Protocol on the settlement of claims are an integral part of this policy. The protocol can be found on [www.terrorisneverzekerd.nl](http://www.terrorisneverzekerd.nl). The clause sheet can be downloaded from our website or obtained from us.

#### **3.6.3**

We may receive an additional payment after a terrorist act. This possibility exists on the grounds of Article 33 of the Health Insurance Act. In that case, you are entitled to an additional reimbursement as defined in Article 33 of the Health Insurance Act.

## **Article 4 What is reimbursed? And to which care provider or care institution can you apply?**

### **4.1**

This basic insurance means you have a right to reimbursement of the costs of health care. We reimburse the part of these costs that does not fall under personal contributions (including your mandatory excess). The amount of your reimbursement will depend on, among other things, the care provider or health care institution that you choose. You can choose from:

- care providers or health care institutions who have entered into a contract with the health insurer (contracted care providers or health care institutions);
- care providers or health care institutions with whom the health insurer does not have a contract (non-contracted care providers or health care institutions).

### **4.2 CONTRACTED CARE PROVIDERS OR HEALTH CARE INSTITUTIONS**

Do you need care that is covered by the basic insurance? In that case you can choose any care provider or health care institution in the Netherlands who has a contract with the health insurer. This care provider or health care institution submits cost declarations directly to us. Do you want to know with which care providers and health care institutions the health insurer has a contract? In that case use the Medical Provider Search Tool on [www.averachmea.nl/zoekuwzorgverlener](http://www.averachmea.nl/zoekuwzorgverlener) or contact us.

### **4.3 NON-CONTRACTED CARE PROVIDERS OR HEALTH CARE INSTITUTIONS**

Do you want care from a care provider or a care institution with whom the health insurer does not have a contract? In that case the reimbursement is up to, at the most, the (maximum) tariff that has currently been fixed on the basis of the Health Care Market Regulation Act (Wet marktordening gezondheidszorg (Wmg)). Has no (maximum) tariff been fixed on the basis of the health care market regulation Act (Wmg)? In that case you will be reimbursed for costs up to the maximum sum of the market price in the Netherlands. A list of the amounts of reimbursements can be found on our website or obtained from us.

### **4.4 OCCASIONALLY YOU WILL HAVE TO REPAY AN AMOUNT**

We sometimes pay a care provider or health care institution more than the sum to which you are entitled according to the insurance contract. This could happen, for instance, if you have to pay part of the amount yourself, due to a personal contribution or due to your mandatory excess. In that case, you (policyholder) must pay that sum back to us. We collect such sums by direct debit. This is because you (policyholder) actually authorise us when you take out this insurance with us.

### **4.5 IF YOU REQUIRE HEALTH CARE MEDIATION**

You are entitled to health care mediation. This means, for instance, that you receive information about treatments, about waiting times and about differences in quality between care providers or health care institutions. Based on this information:

- you can make your own choice, or
- we mediate for you with the care provider or health care institution in case of waiting lists. And we arrange an appointment for you. We call this waiting list assistance.

If you are looking for a new care provider or health care institution, possibly because you have relocated, you are also entitled to health care mediation. In that case we help you to find the care provider or health care institution.

Do you want health care mediation and/or waiting list assistance? In that case, contact us.

## Article 5 What obligations rest upon you?

**5.1** The following is a list of your obligations. Have you damaged our interests by failing to fulfil these obligations? In that case, you do not have a right to reimbursement of the costs of care.

### 5.2 GENERAL OBLIGATIONS

Do you want to have care reimbursed? In that case you must 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:
  - driver's 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 advisor.
- c You must provide all the information we need and cooperate in our efforts to obtain this information. This is for our medical advisors or for people responsible for monitoring or investigation. We do, of course, take privacy legislation into account.
- d You must cooperate if we want to recover costs from an accountable third party.
- e You are obliged to report to us (possible) irregularities or fraud by care providers (e.g. in claims).
- f You are obliged to hand over a recent referral or statement in cases in which this is required. The referral or statement may not be older than 1 year.

### 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 or health care institution? In that case send us the original and clearly specified invoices (keep a copy for your own files). Alternatively, you can scan original invoices and submit them to us digitally. We do not accept copy invoices, reminders, pro-forma invoices, estimates, cost estimates etc. We will only be able to reimburse your costs if we have an original and clearly specified invoice.

Do you (policyholder) submit the invoices digitally? Then you (policyholder) are obliged to retain the original invoices for 1 year after we have received them. We may ask you to submit these original invoices.

Invoices of the care provider treating you must be written out in his own name. Is the care provider a legal person (such as a foundation, a practice or a limited company)? Then the invoice should specifically state who (e.g., which doctor or specialist) treated you. Reimbursements to which you are entitled are always paid to you (policyholder), via the bank account known to us. Any claim you have on us may not be transferred to a third party.

### 5.5 OBLIGATION: SUBMIT CLAIMS WITHIN A SPECIFIED TIME

Be sure to submit your invoices to us as soon as possible. You should do this, in any case, within 12 months after the year in which you were treated.

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

Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? In that case the moment at which the treatment started determines the right to reimbursement. In the case of a DBC you are only entitled to reimbursement of the costs of care incurred in the period during which you had taken out basic insurance with us. Furthermore, the moment of commencement must have been during this insurance. Do you want to know what applies to your situation? In that case, contact us.

Are you submitting invoices later than 12 months after the year in which you were treated? In that case you may receive a lower reimbursement than that to which you were entitled, according to the reimbursement. We do not process invoices if you submit them later than 3 years after the date of treatment and/or the date on which care was given. This is stipulated in Article 942, Book 7 of the Dutch Civil Code.

### 5.6 OBLIGATION: INFORM US ABOUT ALTERATIONS IN YOUR SITUATION WITHIN 1 MONTH

Has anything altered in your personal situation? Or in that of one of the other insured persons? In that case, you (policyholder) must inform us about it within 1 month. This relates to all events that could be relevant to keep your basic insurance up to date. For instance, the termination of an obligation to be insured, relocation, divorce, death or a long-term stay abroad. If we write to you (policyholder) at your last known address, then we assume that this letter reached you (policyholder).

## Article 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 the size of this mandatory excess. In 2014 the mandatory excess is €360.00 per insured client, per calendar year.

### **6.2 YOU PAY THE FIRST € 360.00 OF YOUR HEALTH CARE COSTS YOURSELF**

We deduct the mandatory excess from your entitlement to health care and/or from reimbursements of the costs of health 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 these costs directly to the hospital. You (policyholder) subsequently receive an invoice from us for € 360.00.

### **6.3 THERE IS NO MANDATORY EXCESS FOR SOME HEALTH CARE COSTS**

We do not deduct mandatory excess from:

- a the costs of health care or other services incurred in 2014 but for which the invoices are not received until after 31 December 2015;
- b the costs of care normally provided by general practitioners. An exception is formed by costs of examination relating to general practitioner care, if the examination is carried out elsewhere and invoiced separately. 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 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 that has been fixed in the health Care Market Regulation Act (Wmg) as the availability tariff;
  - 2 reimbursements relating to how general practitioner medical care is provided by a general practitioner, in a general practitioners' practice or in the institution. Or relating to the characteristics of the patient database or with the location of the practice or institution. This is in so far as we have agreed these reimbursements with your general practitioner or institution and in so far as a general practitioner or institution is allowed to charge us for these reimbursements 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, six months;
- 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 has been established on the basis of the Wmg.

### **6.4 MANDATORY EXCESS EXEMPTION**

- 1 The costs of the online programme 'Kleurjeleven.nl' ('Colour your life') in Article 14 of 'Reimbursements via the Keuze Zorg Plan' are exempt from the mandatory excess. This only applies if you actually complete the entire programme.
- 2 The direct costs of the medication assessment of chronic use of prescription medicines, carried out by a pharmacist/dispensing general practitioner who the health insurer has contracted for this purpose.

### **6.5 HEALTH CARE COSTS THAT WE DO NOT REIMBURSE DO NOT COUNT FOR THE MANDATORY EXCESS**

In some cases you pay for part of the reimbursement of the costs of care covered by the basic insurance. For example, for maternity care and certain medicines. Or if you are entitled to a lower reimbursement due to non-contracted care. These sums are unrelated to the mandatory excess, which means they do not count towards the €360.00 mandatory excess that we deduct.

### **6.6 MANDATORY EXCESS COMMENCES WHEN YOU REACH 18 YEARS OF AGE**

Will you turn 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 months over which we can deduct mandatory excess. For instance, will you turn 18 on 26 June? In that case, we calculate your mandatory excess over 6 months (from 1 July).

### **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 months you are insured in that calendar year. For example, will your insurance commence on 1 October? In that case we calculate your mandatory excess over 3 months.

### **6.8 MANDATORY EXCESS IF YOUR BASIC INSURANCE ENDS EARLIER.**

Will your basic insurance end in the course of the calendar year? In that case we calculate your mandatory excess for the part of the calendar year that you were insured. For example: your insurance ends on 30 September. In that case we calculate your mandatory excess over 9 months.

### **6.9 MANDATORY EXCESS IN RELATION TO A DIAGNOSIS-TREATMENT-COMBINATION**

Will treatment be invoiced in the form of a diagnosis-treatment-combination (DBC)? In that case the moment at which the treatment started determines the mandatory excess that we have to apply. More about reimbursements in relation to DBCs can be found in Article 5.5 of these general conditions.

### **6.10 DEDUCTING MANDATORY EXCESS**

Are you receiving care from a contracted care provider, health care institution or a care provider with whom the health insurer a contract? In that case we reimburse the costs of that care directly to the care provider or health care institution. Do you still have a sum in mandatory excess payable? In that case this sum will be set off against payments to you or you will be invoiced to this amount. We will collect the sum via direct debit collection. This is because you (policyholder) actually authorise us when you take out this insurance with us.

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

## Article 7 What is a voluntarily chosen excess?

**7.1** Each calendar year an insured client 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 size of the discount you receive can be found in the overview of premium discounts on our website. This overview is an integral part of this policy.

### **7.2 CONSEQUENCE OF A VOLUNTARILY CHOSEN EXCESS**

We deduct the voluntarily chosen excess from reimbursements of the costs of health care. We do this after we have deducted the full amount of the mandatory excess. These are the costs that you incur on the basic insurance during the course of the calendar year. For example: you (policyholder) opt for, in addition to the mandatory excess, a voluntarily chosen excess of €200.00. This means your total excess is (€360.00 + €200.00 =) €560.00. Is your care provider going to receive €950.00 from us for care that you received? In that case we will deduct from it the total of the excess. This €560.00 is automatically deducted from the account of the policyholder (see also Article 6.10 of these general conditions).

### **7.3 THERE IS NO VOLUNTARILY CHOSEN EXCESS FOR SOME HEALTH CARE COSTS**

We do not deduct voluntarily chosen excess from:

- a the costs of care normally provided by general practitioners. An exception is formed by costs of examination relating to general practitioner care, if the examination is carried out elsewhere and invoiced separately. 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 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 that has been fixed in the Health Care Market Regulation Act (Wmg) as the availability tariff;
  - 2 Reimbursements relating to how general practitioner medical care is provided by a general practitioner, in a general practitioners' practice or in the institution. Or relating to the characteristics of the patient database or with the location of the practice or institution. This is in so far as we have agreed these reimbursements with your general practitioner or institution and in so far as a general practitioner or institution is allowed to charge us for these reimbursements 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, six months;
- e 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 has been established on the basis of the Wmg.

### **7.4 HEALTH CARE COSTS THAT WE DO NOT REIMBURSE DO NOT COUNT FOR THE VOLUNTARILY CHOSEN EXCESS**

In some cases you pay part of the reimbursement of the costs of care covered by the basic insurance. For example, for maternity care and certain medicines. Or if you are entitled to a lower reimbursement due to non-contracted care. 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 turn 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 months over which we can deduct voluntarily chosen excess. For instance, will you turn 18 on 26 June? In that case, we calculate your voluntarily chosen excess over 6 months (from 1 July).

### **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 months you are insured in that calendar year. For example, will your insurance commence on 1 October? In that case, we calculate your voluntarily chosen excess over 3 months.

### **7.7 VOLUNTARILY CHOSEN EXCESS IF YOUR BASIC INSURANCE ENDS EARLIER.**

Will your basic insurance end in the course of the calendar year? In that case we calculate your voluntarily chosen excess for the part of the calendar year that you were insured. For example, will your insurance end on 30 September? In that case, we calculate your voluntarily chosen excess over 9 months.

### **7.8 VOLUNTARILY CHOSEN EXCESS IN RELATION TO A DIAGNOSIS-TREATMENT-COMBINATION**

Will treatment be invoiced in the form of a diagnosis-treatment-combination (diagnose-behandelcombinatie (DBC))? In that case the moment at which the treatment started determines the voluntarily chosen excess that we have to apply. More about reimbursements in relation to DBCs can be found in Article 5.5 of these general conditions.

### **7.9 DEDUCTING VOLUNTARILY CHOSEN EXCESS**

Are you receiving care from a contracted care provider, health care institution or a care provider with whom the health insurer has a contract? In that case we reimburse the costs of that care directly to the care provider or health care institution. Do you still have a sum in voluntarily chosen excess payable? In that case this sum will be set off against payments to you or you will be invoiced to this amount. We will collect the sum via direct debit collection. This is because you (policyholder) actually authorise us when you take out this insurance with us.

If you (policyholder) do not pay the voluntarily chosen excess in time, we can charge you administration 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.

## **Article 8 What will you have to pay?**

### **8.1 WE DETERMINE YOUR PREMIUM**

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

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

**8.1.3** At the moment that you (policyholder) no longer participate in a group, you have no further right to the group discount.

### **8.2 YOU (POLICYHOLDER) PAY THE PREMIUM**

You (policyholder) must pay the premium in advance. You may not set off the premium that you (policyholder) have to pay against your reimbursements of the costs of care.

Has your basic insurance been terminated prematurely by you (policyholder) or by us? Then we will refund you with any excess premium that you have paid. 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 can subtract a sum in administration costs from the premium that we have to refund.

### **8.3 HOW YOU (POLICYHOLDER) PAY THE PREMIUM AND OTHER COSTS**

We prefer you (policyholder) to pay the following sums via direct debit collection:

- a premium;
- b mandatory excess and voluntarily chosen excess;
- c statutory personal contributions;
- d personal payments;
- e any other claims.

Have you (policyholder) opted for a different method of payment than via direct debit collection? In that case you (policyholder) may have to pay administration costs.

### **8.4 YOU WILL BE NOTIFIED OF A DIRECT DEBIT 14 DAYS IN ADVANCE**

You (policyholder) receive from us advance notification of the direct debit collection. We try to send this advance notification to you (policyholder) 14 days before we collect the sum payable. We announce the direct debit collection of the premium once a year on the policy certificate that you receive from us.

## **Article 9 What will happen if you do not pay the premium in 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 FOR DAMAGES**

Do you (policyholder) still have to pay overdue premium to us and have you submitted to us claims for damages that we have to pay to you (policyholder)? In that case we set off the premium against the claims for damages.

If you (policyholder) do not pay in time, we can charge you (policyholder) administration costs, costs of collection and statutory interest.

### **9.3 IF YOU (POLICYHOLDER) DO NOT COMPLY WITH THE TERMS OF PAYMENT**

Have you (policyholder) opted to pay the premium per quarter or, per six months or per year? And you have failed to pay the premium within the period we stipulated? In that case we retain the right to demand that you (policyholder) shall 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 (policyholder) may not cancel the basic insurance until you have paid the premium owed and any administration costs, costs of collection and statutory interest. One exception to this is 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 (policyholder) within 2 weeks that we confirm the cancellation.



## Article 10 What will happen if you have payment arrears?

**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, within 10 working days, we will send you (policyholder) a payment arrangement in writing. This payment arrangement means that:

- a you (policyholder) authorise us to collect new monthly premiums from you (policyholder) or a third party by direct debit;
- b you (policyholder) agree with us to pay back to us, in instalments, the arrears and debts incurred for the health care insurance;
- 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 (policyholder) withdraw the authorisation described under a, or if you (policyholder) fail to comply with the payment agreements stipulated under b.

The letter states that you (policyholder) have 4 weeks time in which to accept the arrangement. It also informs you (policyholder) what will happen if you (policyholder) have not paid the monthly premium for 6 months. Furthermore, the offer provides you (policyholder) with information about assistance with debts, how you (policyholder) can obtain such assistance and what assistance with debts is available.

### **10.2 A PAYMENT ARRANGEMENT IF YOU (POLICYHOLDER) INSURE SOMEONE ELSE**

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

- a the insured client has taken out basic insurance elsewhere for himself on the date that the payment arrangement comes into force; and
- b if this insured client has taken out basic insurance with us, the insured client authorises us to collect new monthly premiums by direct debit.

### **10.3 INSURED CLIENT(S) RECEIVE(S) COPIES OF INFORMATION ABOUT THE PAYMENT ARRANGEMENT**

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

### **10.4 WHAT WILL HAPPEN IF YOU (POLICYHOLDER) HAVE NOT PAID YOUR MONTHLY PREMIUM FOR 4 MONTHS?**

Have you (policyholder) failed to pay the monthly premium for 4 months (excluding administration costs, costs of collection and statutory interest)? In that case you (policyholder) and anyone co-insured with you will be informed that we intend to report you (policyholder) to the Health Care Insurance Board (College voor zorgverzekeringen (CVZ)), at the moment at which you (policyholder) have not paid any monthly premiums for 6 months or longer. Have we reported you (policyholder) to the Health Care Insurance Board (CVZ)? In that case the Health Care Insurance Board (CVZ) will collect an administrative premium from you (policyholder).

You (policyholder) can also ask us if we are willing to enter into a payment arrangement with you (policyholder). You (policyholder) can read about what this payment arrangement entails in Article 10.1 of these general conditions. If we enter into a payment arrangement with you (policyholder), we will not report you (policyholder) to the Health Care Insurance Board (CVZ) as long as you (policyholder) pay the new monthly premiums in time.

### **10.5 IF YOU (POLICYHOLDER) DISAGREE WITH THE PAYMENT ARREARS**

Do you (policyholder) disagree with the payment arrears and/or our plan to report you to the Health Care Insurance Board (CVZ) as described in Article 10.4? In that case you should inform us by sending us a letter of objection. In that case we will not yet report you (policyholder) to the Health Care Insurance Board (CVZ). We will first investigate whether we calculated your debt correctly. Is our conclusion that we calculated your debt correctly? In that case you (policyholder) will be informed. If you (policyholder) disagree with our opinion, then you (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 (policyholder) must do this within 4 weeks after you (policyholder) received the letter with our opinion. In this case also, we will not yet report you (policyholder) to the Health Care Insurance Board (CVZ). See also Article 18 of these general conditions about processing complaints.

### **10.6 WHAT WILL HAPPEN IF YOU (POLICYHOLDER) HAVE NOT PAID YOUR MONTHLY PREMIUM FOR 6 MONTHS**

Have we established that you (policyholder) have not paid the monthly premium (excluding administration, costs of collection and statutory interest) for 6 months? In that case we report you (policyholder) to the Health Care Insurance Board (CVZ). From this moment on you will no longer pay a flat-rate premium to us. Instead the Health Care Insurance Board (CVZ) imposes the administrative premium on you (policyholder). To this end, we provide CVZ with your personal details and those of any person(s) that you (policyholder) have insured with us. We pass on to CVZ only the personal details that they need to be able to charge you (policyholder) the administrative premium. You (policyholder) and the person(s) whom you (policyholder) have insured will receive notification about this from us.

### **10.7** Have all the premiums been paid? In that case we terminate your (policyholder's) registration with the Health Care Insurance Board (CVZ)

We terminate your (policyholder's) registration with the Health Care Insurance Board (CVZ), if, after CVZ's mediation, you (policyholder) have paid the following sums:

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

Once we have terminated your (policyholder's) registration with the Health Care Insurance Board (CVZ), the collection of the administrative premium will cease. Instead you (policyholder) will start paying us the flat-rate premium again.

## **10.8 WHAT WE REPORT TO YOU (POLICYHOLDER) AND THE HEALTH CARE INSURANCE BOARD (CVZ)**

We inform you (policyholder and insured client) and the Health Care Insurance Board (CVZ) 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 (policyholder);
- c a contract has been entered into as defined in Article 18c, second paragraph, part d of the Health Insurance Act. This contract must have been entered into via the mediation of a debt counsellor as referred to in Article 48 of the Consumer Credit Act (Wet op het consumentenkrediet). Or we will inform you (policyholder) and the Health Care Insurance Board (CVZ) about the date on which a debt arrangement has been realised. Apart from yourself (policyholder), the debt arrangement must also involve, at least, your health insurer.

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

## **Article 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 (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 (policyholder) about it. You (policyholder) can cancel the basic insurance as of the day on which the alteration comes into force (usually 1 January). This means that you (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 REIMBURSEMENTS ALTER**

Are there any alterations in the conditions and/or reimbursements that are disadvantageous for the insured client? In that case you (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 (policyholder) can cancel the basic insurance as of the day on which the alteration comes into force. This means that you (policyholder) have 1 month to cancel your basic insurance from the moment that we informed you (policyholder) about the alteration.

## **Article 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 (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 (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 (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 after another basic insurance was cancelled as of 1 January? In that case this insurance will commence with retrospective effect up to 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 (policyholder) can alter this as of 1 January of the next calendar year. You will receive written confirmation of this. You should inform us about the alteration by 31 December at the latest.

### **12.6 AGREEMENTS ABOUT THE DATE OF COMMENCEMENT IN THE EVENT OF A GROUP DISCOUNT**

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

## Article 13 When can you cancel your basic insurance?

### 13.1 REVOKING YOUR BASIC INSURANCE

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

Have you (policyholder) revoked your basic insurance with us? In that case you (policyholder) will receive a refund of any premium that has already been paid. If we have already reimbursed you with health care costs, then you (policyholder) must pay these sums back to us.

### 13.2 CANCELLING YOUR BASIC INSURANCE

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

- a You (policyholder) can send a letter or e-mail in which you (policyholder) cancel your basic insurance. We must have received this cancellation at the latest by 31 December. In this case the basic insurance will end on 1 January of the following year. Have you (policyholder) cancelled your basic insurance with us? In that case the cancellation is irrevocable.
- b You (policyholder) can make use of the cancellation service provided by your new health insurer. Have you (policyholder) taken out basic insurance, at the latest by 31 December of the current calendar year, for the next calendar year? In that case the new health insurer will cancel, on your (policyholder's) behalf, the basic insurance you have with us.
- c Have you (policyholder) insured someone other than yourself and has that insured client taken out another basic insurance? In that case you (policyholder) can send a letter or e-mail to cancel this insurance for the insured client. 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 client'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 (policyholder) cancelled.
- d You (policyholder) may have switched from one group basic insurance to another, because you (policyholder) ended your employment and/or commenced new employment. In that case you (policyholder) have up to 30 days after the old employment ended in which to cancel the old basic insurance. The cancellation does not take place retrospectively and commences on the first day of the next month.
- e Another possibility is that you stop participating in a group basic insurance via an authority that pays your allowance. The reason for cancellation may be that you (policyholder) will start participating in a group basic insurance via an authority that pays your allowance in a different municipality, or that you (policyholder) will start participating in a group basic insurance because you (policyholder) have new employment. You (policyholder) have 30 days after your participation in the group ended in which 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 asked for your insurance to be cancelled? In that case we will notify you (policyholder). The notification will state on which date the insurance will end.

## Article 14 When 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 you no longer fulfil the requirements for registering for basic insurance;
- b at the moment when you are no longer insured on the basis of the AWBZ;
- 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;
- e upon 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.

Are we cancelling your insurance? In that case we will notify you (policyholder). The notification will inform you of the reason why we are cancelling your insurance and on which date it will end.

### 14.2 BASIC INSURANCE ALSO LAPSES IN THE EVENT OF ILLEGAL REGISTRATION

Has an insurance contract been realised for you on the grounds of the Health Insurance Act, and it subsequently emerges that you were not obliged to take out insurance? In that case the insurance contract lapses retrospectively up to the moment at which you were no longer obliged to take out insurance. Have you (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 (policyholder) subsequently received. We will refund you (policyholder) with the balance if you (policyholder) have paid more premiums than you (policyholder) received in reimbursements. Did you (policyholder) receive more in reimbursements than you (policyholder) paid in premiums? In that case we shall charge you (policyholder) those costs. In this case we assume that a month has 30 days.

### 14.3 CANCELLING IF YOU WERE REGISTERED ON THE GROUNDS OF ARTICLE 9A TO D INCL. OF THE HEALTH INSURANCE ACT

**14.3.1** Did the Health Care Insurance Board (CVZ) insure you with us on the grounds of the Investigation and Insurance of Persons without Health Insurance Act? In that case you can have this insurance annulled (nullified). This must take place within 2 weeks, calculated from the date on which the Health Care Insurance Board (CVZ) informed you that you were insured with us. In order to nullify the insurance you must prove to the Health Care Insurance Board (CVZ) and to us that you were already insured during the past three months by virtue of another health insurance. This is the period as referred to in Article 9d, paragraph 1 of the Health Insurance Act.

**14.3.2** We are authorised to nullify - on account of error - an insurance contract entered into with you, if it emerges retrospectively 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 Health Insurance Act, during the first 12 months of its term of validity. This is a departure for you from Article 7 of the Health Insurance Act, unless the fourth paragraph of that Article applies. In that case you are able to cancel.

## **Article 15 When do you have a right to reimbursement of health care received abroad?**

- 15.1** Are you receiving care in a treaty country, a country in the EU or a member of the EEA? 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 given by a care provider or health care institution abroad with whom we have entered into a contract;
  - c Reimbursement of the costs of care given by a care provider or care institution with whom we do not have a contract. In that case you are entitled to reimbursement according to the 'Reimbursements via the Keuze Zorg Plan' up to a maximum of:
    - the lower reimbursement if it is mentioned next to a reimbursement in the Keuze Zorg Plan;
    - the (maximum) tariff that is currently stipulated on the basis of the Health Care Market Regulation Act (Wmg);
    - the general market price in the Netherlands. This applies if no (maximum) tariff exists that has been established based on the Health Care Market Regulation Act (Wmg).
- The reimbursement is reduced by any personal contribution that you are liable to pay.
- 15.2** **REIMBURSEMENT OF CARE IN A COUNTRY THAT IS NOT A TREATY COUNTRY, AN EU COUNTRY OR A MEMBER OF THE EEA**  
Do you receive 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 of a care provider or health care institution that we have not contracted in accordance with the 'Reimbursements via the Keuze Zorg Plan' up to a maximum of:
- a the lower reimbursement if it is mentioned next to an reimbursement in the Keuze Zorg Plan;
  - b the (maximum) tariff that is currently stipulated on the basis of the Health Care Market Regulation Act (Wmg);
  - c the general market price in the Netherlands. This applies if no (maximum) tariff exists that has been established based on the Health Care Market Regulation Act (Wmg).
- The reimbursement is reduced by any personal contribution that you are liable to pay.
- 15.3** **CONVERSION RATE OF FOREIGN CURRENCIES**  
We reimburse you (policyholder) with the costs of care of a non-contracted care provider or health care institution in euros. We do this according to the daily conversion rates published by the European Central Bank. We use the rate that was applicable on the date of the invoice. Reimbursements to which you are entitled are always paid to you (policyholder), via the bank account known to us. This must be an account number of a bank that has its registered office in the Netherlands.
- 15.4** **INVOICES FROM ABROAD**  
Health care 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.

## **Article 16 Not liable for damage due to a care provider or health care institution**

If you suffer damages due to an act or negligence on the part of a care provider or health care institution, we are not liable for this. This applies even if the care or assistance provided by the care provider or health care institution was covered by the basic insurance.

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

- 17.1** Is a third party liable for costs that are a consequence of your illness, accident or injury? In that case you must provide us, free of charge, with all information that is necessary in order to recover the costs from the person responsible. The right of recovery is based on statutory regulations. This does not apply to liability that results from statutory insurance, health insurance subject to public law or a contract between you and another (legal) person.
- 17.2** **YOU ARE OBLIGED TO REPORT**  
Have you become ill, suffered an accident or become injured in some 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 lodge a report (or have it lodged) with 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 enter into an arrangement with a third party, or with someone who acts on behalf of that third party, if you have received written permission from us.

## Article 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 Central Complaints Coordination Department (afdeling Centrale Klachtencoördinatie). You must do so within 6 months after we informed you about the decision or provided you with the service. You can send your complaint to us by letter, e-mail, telephone, our website or a faxed message.
- Complaints must be written in Dutch or English. If you put your complaint to us in a different language, you will have to pay any translation costs.
- 18.2** **WHAT WILL WE DO WITH YOUR COMPLAINT?**  
As soon as we have received your complaint, it is incorporated into our complaint registration system. You will receive confirmation of receipt. Furthermore, we will let you have our response regarding the matter, at the latest within 3 weeks. We will let you know if more time is necessary in order to deal with your complaint.
- 18.3** **DISAGREE WITH OUR RESPONSE? REASSESSMENT IS POSSIBLE**  
Do you disagree with how we dealt with your complaint? In that case you can ask us to reassess your complaint. An application for reassessment can be sent to the Central Complaints Coordination Department by letter, e-mail, telephone, our website or a faxed message. You will receive confirmation of receipt. Furthermore, we will let you have our response regarding the matter, at the latest within 3 weeks. We will let you know if more time is necessary in order to reassess your complaint.
- 18.4** **INSTEAD OF REASSESSMENT, EXAMINATION BY THE SKGZ IS ALSO POSSIBLE**  
Not interested in a reassessment? Or did the reassessment fail to fulfil your expectations? In that case you can have your complaint examined by the Health Insurance Complaints and Disputes Board (SKGZ), Postbus 291, 3700 AG Zeist, the Netherlands ([www.skgz.nl](http://www.skgz.nl)). The SKGZ will be unable to accept your request if a judicial authority is already examining your case or has already ruled on it.
- 18.5** **HANDLING IN A CIVIL COURT**  
Instead of approaching the SKGZ, you can also take your complaint to the civil court. You can also approach the civil court even after the SKGZ has issued advice. In that case the court will examine whether the way in which the advice was realised is acceptable. You can also approach the civil court if we failed to comply with the advice of the 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**  
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. Or you can obtain this brochure from us.

## Article 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. These are for our use within Achmea:
- in order to implement contracts;
  - to inform you about, and offer to you, relevant products and/or services provided by companies belonging to Achmea BV;
  - to guarantee the safety and integrity of the financial sector;
  - for statistical analysis;
  - for maintaining relationships;
  - in order to comply with statutory obligations.
- When using your personal data we must comply with the 'Behavioural code for Processing the Personal Data by Health Insurers' (Gedragcode Verwerking Persoonsgegevens Zorgverzekeraars). We process your data in accordance with the requirements of the Personal Data Protection Act.
- The above-mentioned data processing is registered with the Dutch Data Protection Authority (College Bescherming Persoonsgegevens (CBP)).
- 19.2** **IF YOU DO NOT WANT TO RECEIVE INFORMATION ABOUT OUR PRODUCTS AND SERVICES**  
Do you not want to receive information about our products and/or services? Or do you want to withdraw your permission to use your e-mail address? There are 3 ways in which you can inform us:
- send a letter to Aon serviced by Aevitae, Postbus 1005, 3000 BA, Rotterdam;
  - by telephone number + 31 (0)10 448 82 00;
  - via our website.
- 19.3** When deciding on acceptance, we consult the Central Information System (CIS, a foundation that retains insurance data for companies) In order to pursue responsible acceptance policy, Achmea is allowed to consult your data via the Central Information System Foundation (stichting CIS) in Zeist. Participants in the CIS Foundation can also exchange data with one another. The purpose of this is to manage risks and combat fraud. The CIS privacy regulations govern all information that is exchanged via the CIS Foundation. More information can be found on [www.stichtingcis.nl](http://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, health care institutions, suppliers, Vecozo (Health Care Communication Centre), Vektis (National Information Centre of health insurers) and the Health Care Insurance Board (CVZ)). We are allowed to do this in so far 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.

#### **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 health care 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 Health Insurance Act are under the same obligation. This means that we use your BSN when we communicate with these parties.

### **Article 20 What are the consequences of fraud?**

#### **20.1** Fraud is when someone obtains a reimbursement from an insurer, or obtains an insurance contract with us:

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

In this contract we define it specifically 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:

- a have misrepresented the facts;
- b have submitted false or misleading documents;
- c have provided an untrue account about 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 ENTITLEMENT, NOR REIMBURSEMENT, IN CASES OF FRAUD**

In cases involving fraud, all entitlement to care and/or right to reimbursement of the costs of care covered by the basic insurance is cancelled. This includes matters in relation to which a true account was provided 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 that case you will only be able to take out an insurance contract with us again after 5 years;
- c register you in acknowledged signalling systems between insurers (such as the CIS);
- d reclaim reimbursement(s) that were paid out and (examination) costs that were incurred.

### **Article 21 Definitions**

The following list explains specific concepts that are mentioned in this insurance agreement. What do we mean by the following concepts?

#### **Pharmacy**

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

#### **A dispensing general practitioner or pharmacist**

A dispensing general practitioner or an established pharmacist who appears in the register of established pharmacists or a pharmacist who recruits the assistance of other pharmacists who appear in this register. A dispensing general practitioner or pharmacist also includes a legal person who provides care via pharmacists who appear in the above-mentioned register.

#### **Doctor**

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

#### **AWBZ**

The Exceptional Medical Expenses Act (De Algemene Wet Bijzondere Ziektekosten).

#### **Basic insurance**

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

#### **Company doctor**

A doctor who is listed as a company doctor in the register, set up by the Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten (RGS)), of the Royal Dutch Medical Society (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)) 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 according to the conditions as referred to in Article 3 of the Individual Health Care Professions Act (BIG) and who also appears as a pelvic physiotherapist in the register for pelvic physiotherapy of the Central Quality Register (Centraal Kwaliteitsregister (CKR)) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie (KNGF)).

**Youth Care Agency**

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

**Centre for Special Dentistry**

A university centre, or a centre that we deem the equivalent thereof, for providing 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 Special Medical Procedures Act (Wbmv) for applying clinical genetic research and providing genetic advice.

**Contract with preferential policy**

We define this as a contract between the health insurer and the dispensing general practitioner/pharmacist in which specific agreements are made about preferential policy and/or the supply and payment of pharmaceutical care.

**Day-time treatment**

Admission lasting less than 24 hours.

**Diagnosis-Treatment-Combination (DBC) care product**

Since 1 January 2012 new care provisions for medical-specialist care are defined as DBC care products. This system is known as DOT (DBCs leading to Transparency). A DBC care product is a provision that can be declared on the grounds of the Health Care Market Regulation Act in relation to medical-specialist care that is the result of the total trajectory, from the care provider's diagnosis up to and including (any) treatment. The DBC trajectory starts at the moment that you report your care requirement and is completed when treatment ends, or after 365 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).

**Dyslexia (severe cases)**

A reading and spelling disorder that is the consequence of a neurobiological function disorder that is genetically determined and can be distinguished from other reading and spelling-related problems.

**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).

**An 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, Greece, Hungary, Ireland, Italy, Croatia, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, 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 in relation to medication assessment and the responsible use of medication, hereby taking into account the Achmea Reglement Farmaceutische Zorg (Regulations on Pharmaceutical Care) as determined by Achmea.

**Physiotherapist**

A physiotherapist who is registered as such in accordance with the conditions as referred to in Article 3 of the Individual Health Care Professions Act (BIG). A physiotherapist also includes a physiotherapeutic masseur as referred to in Article 108 of the Individual Health Care Professions Act (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.

**Specialised mental health care**

Diagnostics and specialised treatment of complex mental disorders. This requires the involvement of a specialist (psychiatrist, clinical psychologist or psychotherapist).

**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 Fees and Educational Expenses (Allowances) Act (Wet tegemoetkoming onderwijsbijdrage en schoolkosten (WTOS)) or to the deduction of extraordinary expenses based on tax legislation.

**Health care psychologist**

A health care psychologist who is registered according to the conditions as referred to in Article 3 of the Individual Health Care Professions Act (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 Individual Health Care Professions Act (BIG).

**General practitioner**

A doctor who is listed as a general practitioner in the register of accredited general practitioners, set up by the Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten (RGS)), of the Royal Dutch Medical Society (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)) 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 dispensing general practitioner/pharmacist in which specific agreements have been made about pharmaceutical care.

**Doctor specialised in juvenile health care**

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

**Dental surgeon**

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

**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 who is registered according to the conditions as referred to in Article 3 of the Individual Health Care Professions Act (BIG) and is listed in the Child and Youth Psychologists' Register of the Dutch Institute of Psychologists (Register Kinder- en Jeugdpsycholoog van het Nederlands Instituut van Psychologen (NIP)).

**Clinical psychologist**

A health care psychologist who is registered according to the conditions as referred to in Article 14 of the Individual Health Care Professions Act (BIG).

**Maternity centre**

An institution that offers obstetric care 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 examination**

Examination carried out by a legally accredited laboratory.

**Speech and language 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).



**Medical advisor**

A doctor who advises us on medical matters.

**Medical specialist**

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

**Oral Hygienist**

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

**Multidisciplinary collaboration**

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

**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.

**Orthodontist**

A dental specialist who appears in the Register of Specialists in denotomaxillary orthopaedics of the Dutch Dental Association (Nederlandse Maatschappij tot bevordering der Tandheelkunde (NMT)).

**General remedial educationalist**

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

**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 (policyholder) and the health insurer.

**Preferred medicines**

The preferred medicines we have designated within a group of identical, mutually replaceable medicines.

**Psychiatrist/neuropathist**

A doctor who is listed as a psychiatrist/neuropathist in the Register of Specialists, set up by the Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten (RGS)), of the Royal Dutch Medical Society (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)). For the purposes of this insurance agreement, the terms 'psychiatrist' and 'neuropathist' are interchangeable.

**Psychotherapist**

A health care psychologist who is registered according to the conditions as referred to in Article 3 of the Individual Health Care Professions Act (BIG).

**Convalescence**

Examination, advice and treatment the nature of which is medical-specialist, paramedical, or relates to the behavioural sciences and convalescence techniques. This care is provided by a multidisciplinary team of experts, under the guidance of a medical specialist, affiliated with an institution authorised for convalescence 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 Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten (RGS)), of the Royal Dutch Medical Society (Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst (KNMG)). This specialism only came into being on 1 January 2009. This specialism has succeeded nursing home medicine. Doctors who started this study before 1 January 2009 are registered as nursing home doctors, but are now also referred to as geriatric specialists.

**Dentist**

A dentist who is registered as such according to the conditions in Article 3 of the Individual Health Care Professions Act (BIG).

**Clinical dental technician**

A clinical dental technician who has been trained in accordance with what is known as the Dental Prosthetics-maker (Professional Training Requirements and Area of Expertise) Decree.

**You/your**

The insured person. This person's name appears on the policy certificate. When we say you (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 client is not entitled to, or has no right to, the 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 Australia (only temporary stay), Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Serbia and Montenegro, Tunisia and Turkey.

**Obstetrician**

An obstetrician who is registered as such in accordance with the conditions as referred to in Article 3 of the Individual Health Care Professions Act (BIG).

**Referral/Statement**

A referral is valid for a maximum of one year.

**Insured client**

Every person who is mentioned as such in the policy certificate.

**Policyholder**

The person who entered into the insurance contract with us.

**The BIG Act**

The Individual Health Care 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 fulfil the statutory requirements.

**We/us**

Aon serviced by Aevitae.

**Independent treatment centre**

An institution for medical-specialist care (IMSZ) for nursing, examinations and treatment that is permitted as such in accordance with the rules stipulated in or by virtue of the law.

**Hospital**

An institution for medical-specialist care (IMSZ) for nursing, examinations and treatment of patients, that is authorised as such in accordance with the rules stipulated in or by virtue of the law.

**Care group**

This is a group of care providers from different disciplines who jointly supply integrated care.

**Care provider**

The care provider or health care institution that provides care.

**Health insurer**

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

## Reimbursements via the Keuze Zorg Plan

The following is a summary of care included in the basic insurance. You will also see which conditions apply to the entitlement or reimbursement. Unable to find what you are looking for? First take a look at the contents of these policy conditions.

### Bones, muscles and joints

#### Article 1 Occupational therapy

We reimburse the costs of 10 hours of advice, tuition, training or treatment given by an occupational therapist. This means 10 hours per calendar year. The idea is that the occupational therapy promotes or improves your ability to cope better by yourself. The extent of care provided is limited to the care that occupational therapists normally provide.

##### Conditions for reimbursement

- 1 You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether, according to the basic insurance, you are entitled to reimbursement of the costs of occupational therapy.
- 2 Receiving treatment at school? In that case we only reimburse your costs 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 you do not need a statement for reimbursement. This is because the health insurer has entered into agreements with a number of contracted occupational therapists about immediate 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)). Via the Medical Provider Search Tool on [www.averoachmea.nl/zoekuwzorgverlener](http://www.averoachmea.nl/zoekuwzorgverlener), you can find a list of contracted care providers who offer DTE.

Are you unable to travel for treatment because of your symptom(s)? Then you will not be able to obtain DTE. 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.

More information about occupational therapy can be found in the brochure 'Paramedische Zorg'. This brochure is an integral part of your policy. It can be found on our website or obtained from us.

##### What we do not reimburse

We do not reimburse the costs of surcharges for:

- a appointments outside regular working hours;
- b appointments that were not kept;
- c simple, short reports or more complicated, time-consuming reports.

#### Article 2 Foot care for insured clients suffering from diabetes mellitus

Do you have diabetes mellitus? In that case, if you have a moderately increased or high risk of a diabetic foot (ulcers), we reimburse the costs of an examination of your feet and treatment by a podiatrist or a pedicure. This applies in so far as described in the care-profiles of the Dutch Association of Podiatrists (NVvP) and Provoet and in so far as this foot care is covered by the basic insurance. The care profiles also describe what can be treated and how.

##### Conditions for reimbursement

- 1 If a pedicure carries out the treatment, our requirements are as follows:
  - The pedicure must be registered as a medical pedicure in ProCert's Quality Register for Pedicures (Kwaliteitsregister voor Pedicures (KRP)) or be listed in it with the designation Diabetic Foot (DV).
  - If the care provider is a (pedicure) chiropodist or a health-care pedicure, they must be registered in Stipezo's Quality Register for Paramedical Foot Care (Kwaliteitsregister Paramedische Voetzorg (RPV)).
- 2 Are you receiving treatment in connection with your diabetic foot/feet (classification Simm's 1 and higher)? In that case, in order to claim, you must send us, once only, a medical indication from a general practitioner, a medical specialist or a diabetes nurse.
- 3 On the invoice, your care provider must indicate which type of diabetes (1 or 2) you have and the Simm's classification. The invoice must also indicate that your pedicure is included in ProCert's register or in the RPV.

##### What do we not reimburse

- a do you have diabetes mellitus type 2 and do you have a right to the reimbursement of the costs of the corresponding integrated care which includes foot care? In that case you do not have a right to reimbursement of the costs of a foot examination and treatment by a podiatrist or pedicure. In this case these treatments for feet are covered by the entitlement within integrated care (see article 40 of 'Reimbursements via the Keuze Zorg Plan').
- b We do not reimburse the costs of devices for foot treatment, such as podiatric soles and orthoses. More information about this can be found in the Achmea Reglement Hulpmiddelen (Achmea Regulations on Medical Devices). These regulations can be found on our website or you can obtain them from us.

## Physiotherapy and remedial therapy

### Article 3 Physiotherapy and remedial therapy

We reimburse the costs of physiotherapy and remedial therapy. The following is a summary of the care involved and the conditions that apply for reimbursement.

#### 3.1 PHYSIOTHERAPY, REMEDIAL THERAPY FOR INSURED CLIENTS AGED 18 YEARS OR OLDER

Are you 18 years or older? In that case we reimburse the costs of the 21st treatment and subsequent treatments by a physiotherapist or by a remedial therapist. This must involve a disorder that appears on the list drawn up by the Minister of Health, Welfare and Sport (VWS), "Annex 1 relating to article 2.6 of the Health Insurance Decision (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 includes 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 are also allowed treatment by a skin therapist.

The extent of care provided is limited to the care normally provided by physiotherapists, remedial therapists, and - when manual lymph drainage is involved - skin therapists.

##### Conditions for reimbursement

- 1 You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether, according to the basic insurance, you are entitled to reimbursement of the costs of physiotherapy and remedial therapy.
- 2 Receiving treatment at school? In that case we only reimburse your costs if we have entered into agreements about this with your care provider.

More information about physiotherapy and remedial therapy can be found in the brochure 'Paramedische Zorg'. This brochure is an integral part of your policy. It can be found on our website or obtained from us.

##### What we do not reimburse

We do not reimburse the costs of:

- a the first 20 treatment sessions;
- b an individual treatment or group treatment, the only purpose of which 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 regular working hours;
  - appointments that were not kept;
  - simple, short reports or more complicated, time-consuming reports.
- e bandages and medical devices supplied by your physiotherapist or remedial therapist.

#### 3.2 PHYSIOTHERAPY, REMEDIAL THERAPY FOR INSURED CLIENTS UP TO THE AGE OF 18 YEARS

Are you younger than 18 years? And do you have a disorder that appears on the list drawn up by the Minister of Health, Welfare and Sport (VWS), "Annex 1 relating to article 2.6 of the Health Insurance Decision"? In that case we reimburse the costs of all treatments by a physiotherapist or by a remedial therapist. The list drawn up by the Minister of Health, Welfare and Sport also includes 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 are also allowed treatment by a skin therapist.

Do you have a disorder that does not appear on the list drawn up by the Minister of Health, Welfare and Sport? In that case we reimburse the costs of 9 treatments by a physiotherapist or 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 we reimburse a maximum of 9 extra treatments. We only do this if the extra treatments are medically necessary. In total, therefore, we reimburse a maximum of 18 treatments for insured clients up to the age of 18 years. The extent of care provided is limited to the care normally provided by physiotherapists, remedial therapists, and - when manual lymph drainage is involved - skin therapists.

##### Conditions for reimbursement

- 1 You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether, according to the basic insurance, you are entitled to the reimbursement of the costs of physiotherapy and remedial therapy.
- 2 Receiving treatment at school? In that case we only reimburse your costs if we have entered into agreements about this with your care provider.

More information about physiotherapy and remedial therapy can be found in the brochure 'Paramedische Zorg'. The brochure 'Paramedische Zorg' is an integral part of your policy. It can be found on our website or obtained from us.

#### **Sometimes no statement is necessary for contracted physiotherapists and remedial therapists**

Please note! In some cases you do not need a statement from the referring doctor for reimbursement. This is because the health insurer has entered into agreements with a number of contracted physiotherapists and remedial therapists about immediate access: These physiotherapists and remedial therapists can treat you without a referral. We refer to this as Direct Access to Physiotherapy (Directe Toegang Fysiotherapie (DTF)) or Direct Access to Remedial therapy (Directe Toegang Oefentherapie (DTO)). The contracted care providers and the PlusPraktijken for physiotherapy who offer DTF or DTO can be found via the Medical Provider Search Tool on [www.averoachmea.nl/zoekuwzorgverlener](http://www.averoachmea.nl/zoekuwzorgverlener). You can also obtain this information from us.

In DTF or DTO, the screening counts as 1 treatment. The intake and the examination after this screening also count as 1 treatment. However, when a PlusPraktijk provides DTF, the screening, the intake and the examination after this screening only count as 1 treatment.

Are you unable to travel for treatment because of your symptom(s)? Then you will not be able to obtain DTF or DTO. 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 we do not reimburse**

We do not reimburse the costs of:

- a an individual treatment or group treatment, the only purpose of which 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 regular working hours;
  - appointments that were not kept;
  - simple, short reports or more complicated, time-consuming reports.
- d bandages and medical devices supplied by your physiotherapist or remedial therapist.

### **3.3 PELVIC PHYSIOTHERAPY IN CONNECTION WITH URINARY INCONTINENCE FOR INSURED PERSONS OF 18 YEARS AND OLDER**

Are you 18 years or older and do you suffer from urine-incontinence? And would you like to use pelvic physiotherapy to treat this? In that case we reimburse, once per indication, the costs of the first 9 treatments by a pelvic physiotherapist. The extent of care provided is limited to the care normally provided by physiotherapists.

#### **Condition for reimbursement**

You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether, according to the basic insurance, you are entitled to reimbursement of the costs of pelvic physiotherapy.

More information about pelvic physiotherapy can be found in the brochure 'Paramedische Zorg'. This brochure is an integral part of your policy. It can be found on our website or obtained from us.

#### **What we do not reimburse**

We do not reimburse the costs of:

- a pregnancy gymnastics, postnatal gymnastics, (medical) fitness, (sports) massage and work and activity therapy;
- b surcharges for:
  - appointments outside regular working hours;
  - appointments that were not kept;
  - simple, short reports or more complicated, time-consuming reports.
- c bandages and medical devices supplied by your pelvic physiotherapist.

## **Medical devices**

### **Article 4 Medical devices**

We reimburse the costs of:

- a supplying functioning medical devices and bandages for personal use (not on loan). A statutory personal contribution or a statutory maximum reimbursement sometimes applies for a medical device;
- b customizing, replacing or repairing medical devices;
- c spare medical devices.

#### **Conditions for reimbursement**

The detailed conditions for reimbursement of medical devices appear in Achmea Regulations on Medical Devices. These regulations, which are an integral part of this policy, can be found on our website or obtained from us.

You do not need prior permission for the supply, customization, replacement or repair of a large number of medical devices. You can contact a contracted supplier directly. Article 4 of Achmea Regulations on Medical Devices lists the medical devices to which this applies.

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, cost-effective and whether it is not unnecessarily expensive or complicated. You always have to ask for our prior permission when non-contracted suppliers are involved.

In some cases medical devices are loaned out to you. This is indicated in Achmea Regulations on Medical Devices. In that case we deviate from that which is stipulated in this article under a. and in article 2.1 of the 'General conditions of the Keuze Zorg Plan'.

### What we do not reimburse

Do you need a medical device that is related to the care provided by medical specialists? In that case, we do not reimburse the costs based on this article. These medical devices are subject to articles 23, 24, 31 and 32 of the 'Reimbursements via the Keuze Zorg Plan'.

## Medicines and dietary preparations

### Article 5 Pharmaceutical Care: medicines and dietary products

Pharmaceutical care is defined as:

- a medicines and dietary preparations that are covered in your insurance agreement and with which you are provided 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.

The detailed conditions for pharmaceutical care are specified in Achmea Reglement Farmaceutische Zorg. These regulations, which are an integral part of this policy, can be found on our website or obtained from us. We reimburse the costs of the provision of medicines, 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. 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 pharmacist or dispensing general practitioner who has entered into an IDEA contract with us;
- b medicines indicated for reimbursement by a ministerial decision are included in the GVS in so far as we have designated them and included them in Achmea Regulations on Pharmaceutical Care. The provision of medicines, advice and guidance must be carried out by a pharmacist or dispensing general practitioner who has entered into a preferential policy contract with us or the same without a contract;
- 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. The health insurer has defined 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, in the dispensary, by or on the orders of a pharmacist/dispensing general practitioner;
  - medicines that, according to article 40, third paragraph, under c, of the Medicines Act, in response to a request by a doctor as referred to in that provision, are prepared in the Netherlands by a manufacturer, as referred to in article 1, first paragraph, under mm, of the Medicines Act;
  - medicines that, according to article 40, third paragraph under c, of the 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 Achmea Regulations on Pharmaceutical Care. In addition, on our website you can find a summary of the maximum reimbursements that we have established for (partial) provisions relating to pharmacy, medicines and dietary preparations. You will also find the registered medicines that the health insurer has designated. You can of course also obtain this information from us.

#### Conditions for reimbursement of medicines and dietary preparations

- 1 The medicines or dietary preparations must have been prescribed by a general practitioner, a medical specialist, a dentist, a geriatric specialist, a specialist in the mentally handicapped, an obstetrician or a suitably qualified nurse (after this has been regulated via the ministry).
- 2 Medicines must be supplied by a pharmacist or a dispensing general practitioner. Dietary preparations may also be supplied by other specialised medical suppliers.
- 3 Are there identical medicines that are mutually replaceable? In that case we reimburse only the medicines that we have designated. You are only entitled to the reimbursement of a non-designated medicine in the event of medical urgency. This is where 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.

Article 4.4 of Achmea Regulations on Pharmaceutical Care mentions a number of supplementary conditions for the reimbursement of specific medicines and dietary preparations. We only reimburse the costs of these dietary preparations and the medicines if you fulfil these conditions.

#### Conditions for reimbursement of (partial) provisions

We stipulate supplementary 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. We only reimburse these (partial) provisions if these supplementary requirements have been fulfilled. Find out for which (partial) provisions these conditions apply in Achmea Regulations on Pharmaceutical Care.

#### **What we do not reimburse**

We do not reimburse the following medicines and/or (partial) pharmaceutical provisions:

- a contraceptives for insured clients 21 years and older, except in a case of a medical indication. Within the framework of this article, our definition of a medical indication is endometriosis or menorrhagia (severe blood loss).
- b medicines and/or advice on preventing an illness within the framework of travelling abroad;
- c pharmaceutical care that may not be reimbursed according to the Health Insurance Regulation (Regeling zorgverzekering);
- d medicines for research that appear in article 40, third paragraph, under b of the Medicines Act;
- e medicines that appear in article 40, third paragraph, under f of the Medicines Act;
- f medicines that are - or almost - the therapeutic equivalent of any non-designated, registered medicine;
- g self-care products that do not appear in the Health Insurance Regulation. Self-care products are medicines that you can purchase without a prescription;
- h all pharmaceutical (partial) provisions that are not regarded as insured care. The descriptions per (partial) pharmaceutical provision can be found in Achmea Regulations on Pharmaceutical Care;
- i homeopathic, anthroposophical and/or other alternative (medicinal) products.

#### **Oral health care and dentistry**

We reimburse the costs of necessary dental care as is normally provided by dentists, clinical dental technicians, dental surgeons, oral hygienists and orthodontists. We discuss these in more detail in the following articles (from 6 up to and including 12). More information can be found in the brochure 'Mondzorg'. This brochure can be found on our website or obtained from us.

### **Article 6 Orthodontics (brace) in exceptional cases**

Do you have such a serious developmental disorder or a growth disorder of the teeth/jaw/mouth that, without orthodontic treatment, you would be unable to attain or retain a dental function that is equivalent to the dental function that you would have had without this disorder? In that case we reimburse the costs of this treatment.

#### **Conditions for reimbursement**

- 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 your dentist, dental specialist or general practitioner must have referred you.
- 3 This treatment requires a joint diagnosis or co-treatment with other than dental disciplines.
- 4 We must have given you permission in advance. When asking for our permission, you must also send a treatment plan and a cost estimate. Your care provider will draw up this plan and the estimate. We subsequently assess the cost-effectiveness and legitimacy of your application.

#### **What you are not entitled to**

Have you lost or damaged existing orthodontic provisions due to your own fault or negligence? In that case you no right to reimbursement of the costs of repairs or a replacement.

### **Article 7 Dental care up to the age of 18 years**

If you are younger than 18 years, we reimburse the costs of the following dental treatments:

- a periodical preventive dental examination once a year (annual check-up), or several times a year, if there is a medical necessity for such dental care;
- b an occasional dental consultation;
- c the removal of scale;
- d fluoride treatment at the most twice a year, from the moment your permanent teeth appear, unless there are medical reasons for such dental care more often. We must have given you permission in advance for this;
- e sealing (plugging the ridges of teeth);
- f periodontal care (treatment of gums);
- g anaesthesia;
- h endodontic care (root canal therapy);
- i repairing dental elements with plastic materials (fillings);
- j gnathological care (care of jaws problems);
- k removable dentures;
- l non-plastic tooth replacement materials and the application of dental implants. We only reimburse these costs if the replacement is involved of one or more permanent incisors or canine teeth that are missing due to agenesis, or as a result of an accident;
- m surgical dental care. This care does not include installing dental implants;
- n X-rays, with the exception of an X-ray that is part of orthodontic care.

#### Conditions for reimbursement

- 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 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 We must have given you permission in advance for the replacement of front teeth with an implant and for prosthetic follow-up treatment (crown or bridge).
- 4 You only have a right to reimbursement of the costs of the placing of bone anchors for orthodontic treatment if yours is a case of orthodontics in exceptional cases (see article 6 of 'Reimbursements via the Keuze Zorg Plan'). For this you will already have received our permission in advance.
- 5 Do you need care as described in articles 6, 11 or 12 of 'Reimbursements via the Keuze Zorg Plan'? In that case we must have given you permission in advance. Read more about this in the following articles.

### Article 8 Dental care for insured clients aged 18 years and older - dental surgery

We reimburse the costs of surgical dental care of a specialist nature and the X-rays this involves. This could be combined with a stay in hospital. However, we do not reimburse periodontal surgery, the fixation of a dental implant (see article 10.1 of 'Reimbursements via the Keuze Zorg Plan') and an uncomplicated extraction (molar or tooth).

#### Conditions for reimbursement

- 1 The treatment must be carried out by a dental surgeon.
- 2 You must have been referred by a general practitioner, dentist, company doctor, a geriatric specialist, a specialist in the mentally handicapped, a doctor specialised in juvenile health care or another medical specialist.
- 3 Will you be attending a hospital or an independent treatment centre for the treatment? In that case we must have given you permission in advance for the following treatments:
  - osteotomy (jaw operation) unless this is a part of a combined surgical or orthodontic treatment. In that case you must have a right to reimbursement of the costs of orthodontics in exceptional cases (see article 6 of 'Reimbursements via the Keuze Zorg Plan'). For this you will already have received our permission in advance;
  - chin plastic surgery as an independent operation;
  - pre-implantological surgery;
  - plastic surgery.
- 4 Extractions may only be carried out under narcosis in the event of urgent medical grounds.
- 5 You have a right to reimbursement of the costs of a sinus lift, jaw widening and/or lifting if you have a right to reimbursement of the costs of the accompanying implants by virtue of the basic insurance.
- 6 Are you having bone anchors placed for orthodontic treatment? In that case take into account that you have only a right to reimbursement of costs of this operation if yours is a case of orthodontics in exceptional cases (see article 6 of 'Reimbursements via the Keuze Zorg Plan'). For this you will already have received our permission in advance.
- 7 Are you asking for permission for dental treatment? In that case we will assess the cost-effectiveness and legitimacy of your application.

### Article 9 Dental care of clients aged 18 years and older - full sets of removable dentures (set of false teeth)

We reimburse the costs of having the following dentures made and placed:

- 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 of a full set of removable dentures;
- d a full set of removable overdentures on natural elements.

A statutory personal contribution of 25% applies to these dentures. Are you having a full set of initial dentures, an existing full set of removable dentures, or an existing full set of overdentures repaired or rebased? In that case you do not need to pay a statutory personal contribution.

We apply a maximum sum for costs of technology and materials. These sums can be found on our website or obtained from us.

#### Conditions for reimbursement

- 1 The treatment must be carried out by a dentist or a clinical dental technician.
- 2 If the prosthesis needs to be replaced within 5 years or an initial prosthesis needs to be replaced within 6 months, we must have given you permission in advance. We assess the cost-effectiveness and legitimacy of your application.
- 3 Are you having a combined upper and lower prosthesis made and placed? And do the total costs exceed € 1,230.00? In that case we must have given you permission in advance. This maximum sum includes the maximum in costs of technology.
- 4 Are you having a full upper or a full lower set of dentures made and placed? And do the total costs of a full upper set of dentures exceed € 575.00 or the costs of a full lower set of dentures exceed € 600.00? In that case we must have given you permission in advance. This maximum sum includes the maximum in costs of technology.



## Article 10 Implants

### 10.1 IMPLANTS

Do you have such a serious developmental disorder, growth disorder or an acquired deformity of the teeth/jaw/mouth that, without the placement of implants, you would not attain or retain a dental function that is equivalent to the dental function you would have had without this disorder? In that case you have a right to reimbursement of the costs of the dental implants that are necessary for a full set of removable dentures. You must have a severely shrunken, toothless jaw and the implants that you are having placed will serve to attach the removable dentures.

We apply a maximum sum for costs of technology and materials. These sums can be found on our website or obtained from us.

#### Conditions for reimbursement

- 1 The treatment must be carried out by an orthodontist or a Centre for Exceptional Dentistry.
- 2 Are you attending a Centre for Exceptional Dentistry for treatment? In that case your dentist, dental specialist, clinical dental technician or general practitioner must have referred you. The clinical dental technician may only refer you to a dental surgeon. This is only possible if you have no teeth whatsoever.
- 3 We must have given you permission in advance for this treatment. When asking for our permission, you must also send a treatment plan and a cost estimate. We subsequently assess the cost-effectiveness and legitimacy of your application.

Please note! You may also have a right to reimbursement of the costs of implants by virtue of article 12 of 'Reimbursements via the Keuze Zorg Plan'.

### 10.2 FULL SET OF REMOVABLE DENTURES ON IMPLANTS

Do you have such a serious developmental disorder, growth disorder or an acquired deformity of the teeth/jaw/mouth that, without a full set of removable dentures on implants, you would not attain or retain a dental function that is equivalent to the dental function you would have had without this disorder? In that case you have a right to reimbursement of the costs of this prosthesis. A statutory personal contribution applies to this prosthesis of € 125.00 per upper or lower jaw. You have also a right to reimbursement of the costs of the repair and rebasing of a full set of removable dentures on implants. You must have a severely shrunken, toothless jaw.

We apply a maximum sum for costs of technology and materials. These sums can be found on our website or obtained from us.

#### Conditions for reimbursement

- 1 The treatment must be carried out by a dentist, a clinical dental technician, or a Centre for Exceptional Dentistry.
- 2 Are you attending a Centre for Exceptional Dentistry for treatment? In that case your dentist, dental specialist or general practitioner must have referred you.
- 3 We must have given you permission in advance for the treatment. When asking for our permission, you must also send a treatment plan and a cost estimate. We subsequently assess the cost-effectiveness and legitimacy of your application.

Please note! You may also have a right to reimbursement of the costs of a removable prosthesis on implants by virtue of article 12 of 'Reimbursements via the Keuze Zorg Plan'.

## Article 11 Dental care for insured clients 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 have a right to reimbursement of dental care.

#### Conditions for reimbursement

- 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 your dentist, dental specialist or general practitioner must have referred you.
- 3 You have only a right to reimbursement of the costs of this care if you are not already entitled to dental care by virtue of the Exceptional Medical Expenses Act (AWBZ).
- 4 We must have given you permission in advance for the care. When asking for our permission, you must also send a treatment plan and a cost estimate. Your care provider will draw up this plan and the estimate. We subsequently assess the cost-effectiveness and legitimacy of your application.

## Article 12 Dental care in exceptional cases

In the following exceptional cases you have a right to reimbursement of the costs of dental treatment:

- a if you have such a serious developmental disorder, growth disorder or acquired deformity of the teeth/jaw/mouth that, without the treatment you would not attain or retain a dental function that is equivalent to the dental function you would have had without this disorder;
- b if medical treatment without the dental care would have demonstrably insufficient results. And if, without the dental care, you are unable to attain or retain the same dental function, that you would have had without the medical disorder;
- 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 clients age 18 years and older pay a contribution equal to the sum that would be charged to the insured client concerned if this article did not apply. For instance, do you go to a dentist specialised in anxiety? In that case you usually pay a higher tariff than for a normal dentist. You have only a right to reimbursement of the costs of the additional costs. You must pay the standard tariff for a normal dentist yourself.

#### Conditions for reimbursement

- 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 your dentist, dental specialist or general practitioner must have referred you.
- 3 We must have given you permission in advance. When asking for our permission, you must also send a treatment plan and a cost estimate. Your care provider will draw up this plan and the estimate. We subsequently assess the cost-effectiveness and legitimacy of your application.

Please note! You may also have a right to reimbursement of the costs of implants by virtue of article 10 of 'Reimbursements via the Keuze Zorg Plan'.

## Eyes and ears

### Article 13 Audiological centre

#### 13.1 HEARING PROBLEMS

Do you have hearing problems? In that case you have a right to reimbursement of the costs of care in an audiological 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 reimbursement

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

#### 13.2 SPEECH AND LANGUAGE DISORDERS IN CHILDREN

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

#### Condition for reimbursement

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

## Psychological care

### Article 14 General basic GGZ (mental health care)

Do you have a non-complex mental disorder? In that case we reimburse the costs of General basic GGZ (hereafter referred to as: Basic GGZ).

One of the following care providers can act as the principle carer:

- a a health care psychologist;
- b a psychiatrist;
- c a clinical psychologist;
- d a psychotherapist;
- e a general remedial educationalist who is a member of the Dutch Association of Pedagogues and Educationalists (NVO);
- f a child and youth psychologist who is a member of the Dutch Institute of Psychologists (NIP);
- g only for the product chronic Basic GGZ (BC) within an institution or practice contracted for Basic GGZ: a nursing specialist.

The principle carer should for the most part provide the care personally, but can make use of a co-carer for, at the most, 50% of the time. Permitted co-carers are carers whose profession appears in the list of professions from the DBC Regulations for GGZ 2013 (Spelregels DBC GGZ 2013).

The amount of care provided is limited by the care that clinical psychologists normally provide.

#### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, company doctor, a medical specialist, a geriatric specialist, a specialist in the mentally handicapped or a doctor specialised in juvenile health care.
- 2 Is the patient a minor as defined in the Youth Care Act? And is care involved as described in article 9b, paragraph 5 of the AWBZ? In that case, an indication decision from the Youth Care Agency is necessary. In addition, according to article 10 of the implementation decision on the Youth Care Act, the referral may also be issued by a doctor or a different carer within the Youth Care Agency.
- 3 The referral is implemented in accordance with the referral model for Basic GGZ (General Basic GGZ, Bureau HHM, Enschede, January 2013).
- 4 The letter of referral must clearly state who is referred, the reason for the referral and who issued the referral on which date. This means that in any case the following items must be included in the letter of referral:
  - personal details of the client being referred;
  - reason for the referral;
  - for what care the referral is (Basic GGZ and possibly a specific care provider);
  - name and position of the referrer;
  - signature of the referrer;
  - date (prior to the start of treatment).

A referral is valid for a maximum of one year. After that year, no new referral is needed for follow-up treatment involving the same diagnosis. If treatment is interrupted for longer than a year, a new referral will be needed for follow-up treatment.

- 5 No referral is necessary for crisis care. A referral is necessary for any treatment that takes place after the crisis is over. This referral must be issued before treatment starts. In the event that circumstances make this impossible, is it also sufficient to demonstrate the active involvement of the general practitioner in the acute care and his being informed in good time about the follow-up.

#### What we do not reimburse

We do not reimburse the costs of:

- 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 interventions that do not comply with established medical science and medical practice. In this respect we adhere to CVZ's "Dynamic overview of Psychological interventions that do not comply with established medical science and medical practice". Your care provider can tell you more about this. We also publish this overview on our website.

## Article 15 Non-clinical specialised GGZ (second-line GGZ)

Do you have a complex mental disorder and do you receive non-clinical specialised medical health care from a GGZ institution, a psychiatrist, a psychotherapist or a clinical psychologist? In that case we reimburse the costs of specialised mental health care;

The amount of care provided is limited by the care that psychiatrists and clinical psychologists normally provide. Are you receiving care in a GGZ institution? In that case your treatment must take place subject to the accountability of the principle carer - a psychiatrist, a clinical psychologist, a psychotherapist or a GZ psychologist in an MDO (multidisciplinary consultation) construction.

#### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, company doctor, a medical specialist, a geriatric specialist, a specialist in the mentally handicapped or a doctor specialised in juvenile health care.
- 2 Is the patient a minor as defined in the Youth Care Act? And is care involved as described in article 9b, paragraph 5 of the AWBZ? In that case, an indication decision from the Youth Care Agency is necessary. In addition, according to article 10 of the implementation decision on the Youth Care Act, the referral may also be issued by a doctor or a different carer within the Youth Care Agency.
- 3 The referral is implemented in accordance with the referral model for Basic GGZ (General Basic GGZ, Bureau HHM, Enschede, January 2013).
- 4 The letter of referral must clearly show who is referred, the reason for the referral and who issued the referral on which date. This means that in any case the following items must be included in the letter of referral:
  - personal details of the client being referred;
  - reason for the referral;
  - for what care the referral is (specialised GGZ and possibly a specific care provider);
  - name and position of the referrer;
  - signature of the referrer;
  - date (prior to the start of treatment).

A referral is valid for a maximum of one year. After that year, no new referral is needed for follow-up treatment involving the same diagnosis. If treatment is interrupted for longer than a year, a new referral will be needed for follow-up treatment.

- 5 No referral is necessary for crisis care. A referral is necessary for any treatment that takes place after the crisis is over. This referral must be issued before treatment starts. In the event that circumstances make this impossible, is it also sufficient to demonstrate the active involvement of the general practitioner in the acute care and his being informed in good time about the follow-up.

#### What we do not reimburse

We do not reimburse the costs of:

- 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 interventions that do not comply with established medical science and medical practice. In this respect we adhere to CVZ's "Dynamic overview of Psychological interventions that do not comply with established medical science and medical practice". Your care provider can tell you more about this. We also publish this overview on our website.

## Article 16 Admission to a Psychiatric Hospital

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 we reimburse the costs of:

- a specialised mental health care by virtue of article 15 of 'Reimbursements via the Keuze Zorg Plan';
- b your stay with or without nursing and care;
- c paramedical care, medicines, medical devices and bandages that are part of your treatment during the admission.

Your treatment must take place subject to the accountability of a principle carer: a psychiatrist, a clinical psychologist, a psychotherapist, or a GZ psychologist in an MDO construction.

The amount of care provided is limited by the forms of care normally provided by psychiatrists and clinical psychologists in an MDO construction.

How many days of admission we reimburse

In a case of a psychiatric admission, we reimburse your costs for a maximum period of 365 days that you spend, without interruption, in a GGZ institution.

In this respect, the following forms of admission also count:

- a admission to a convalescence centre or a hospital whereby the goal is convalescence;
- b admission to a non-psychiatric hospital.

We do not regard an interruption of up to 30 days as an interruption, but we do not count these days when calculating the 365 days.

Was your admission interrupted by a weekend's leave or a holiday? In that case we do include such days in our calculation.

### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, company doctor, a medical specialist, a geriatric specialist, a specialist in the mentally handicapped or a doctor specialised in juvenile health care.
- 2 Is the patient a minor as defined in the Youth Care Act? And is care involved as described in article 9b, paragraph 5 of the AWBZ? In that case, an indication decision from the Youth Care Agency is necessary. In addition, according to article 10 of the implementation decision on the Youth Care Act, the referral may also be issued by a doctor or a different carer within the Youth Care Agency.
- 3 The referral is implemented in accordance with the referral model for Basic GGZ (General Basic GGZ, Bureau HHM, Enschede, January 2013).
- 4 The letter of referral must clearly show who is referred, the reason for the referral and who issued the referral on which date. This means that in any case the following items must be included in the letter of referral:
  - personal details of the client being referred;
  - reason for the referral;
  - for what care the referral is (specialised GGZ and possibly a specific care provider);
  - name and position of the referrer;
  - signature of the referrer;
  - date (prior to the start of treatment).

A referral is valid for a maximum of one year. After that year, no new referral is needed for follow-up treatment involving the same diagnosis. If treatment is interrupted for longer than a year, a new referral will be needed for follow-up treatment.

- 5 No referral is necessary for crisis care. A referral is necessary for any treatment that takes place after the crisis is over. This referral must be issued before treatment starts. In the event that this is not possible due to circumstances, it is also sufficient to demonstrate the active involvement of the general practitioner in the acute care and his being informed in good time about the follow-up.

### What we do not reimburse

We do not reimburse the costs of:

- 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 interventions that do not comply with established medical science and medical practice. In this respect we adhere to CVZ's "Dynamic overview of Psychological interventions that do not comply with established medical science and medical practice". Your care provider can tell you more about this. We also publish this overview on our website.

## Speech and reading

### Article 17 Dyslectic Care

We reimburse the costs of diagnosis and treatment of severe dyslexia in children, as long as the child attends primary education.

The law stipulates the following conditions for dyslectic care:

- a The care starts when the child is 7, 8, 9, 10, 11 or 12 years old.
- b The care is provided by an institution specialised in dealing with dyslexia. Work in this institution takes place on the basis of multidisciplinary collaboration, subject to the final accountability of a health care psychologist, a psychologist specialised in children and juveniles or a general remedial educationalist.
- c The person bearing final responsibility must be competent, on the grounds of specific standards for his profession, to carry out the diagnosis and treatment of severe dyslexia.
- d The institution providing care works according to the Guidelines on multidisciplinary collaboration in the diagnosis and treatment of severe dyslexia. These guidelines were drawn up by the professional associations: NIP, NVO, LBRT and NVLF.

#### Conditions for reimbursement

- 1 For reimbursement of the diagnosis, the child must have a referral from the school. The school must have first followed the Protocol for Reading Problems and Dyslexia. This is how the school tests whether it is a suspected case of severe dyslexia. It must not be a case of other reading or spelling problems, as this involves a course of treatment via GGZ or the municipality.
- 2 For the reimbursement of treatment, diagnostic examination by a competent institution must subsequently reveal that the child is severely dyslectic. It must also be apparent that the dyslexia is not part of more complex problems. Diagnosis takes place according to the Protocol for the Diagnosis and Treatment of Dyslexia (Protocol Dyslexie Diagnose en Behandeling). Treatment is also according to this protocol. You can download the protocol from our website or obtain it from us.

## Article 18 Speech therapy

We reimburse the costs of treatment by a speech therapist in so far as it has a medical objective. The treatment can be expected to restore or improve the ability to speak. The extent of care provided is limited to the care that speech therapists normally provide. This also applies to stutter therapy given by a speech therapist.

#### Conditions for reimbursement

- 1 You will need a statement from the referring doctor (general practitioner, medical specialist, or dentist). This statement enables us to determine whether, according to the basic insurance, you have a right to reimbursement of the costs of speech therapy.
- 2 Receiving treatment at school? In that case we only reimburse your costs 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 you do not need a statement for reimbursement. This is because the health insurer has entered into agreements with a number of contracted speech therapists about immediate access: these speech therapists can treat you without a referral. We call this Direct Access Speech Therapy (Directe Toegang Logopedie (DTL)). Do you want to know which contracted care providers offer DTL? In that case use the Medical Provider Search Tool on [www.averoachmea.nl/zoekuwzorgverlener](http://www.averoachmea.nl/zoekuwzorgverlener) or contact us.

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.

More information about speech therapy can be found in the brochure 'Paramedische Zorg'. This brochure is an integral part of your policy. It can be found on our website or obtained from us.

#### What we do not reimburse

We do not reimburse the costs of:

- a treatments that we do not define as speech therapy. This is the treatment of dyslexia and of language developmental disorders relating to dialect or speaking a different language;
- b surcharges for:
  - appointments outside regular working hours;
  - appointments that were not kept;
  - simple, short reports or more complicated, time-consuming reports.

## Transport

### Article 19 Transporting patients

We reimburse the costs of the following forms of transport:

- a transport by ambulance;
- b seated transport of patients via public transport (lowest tariff), transport by taxi (for more than one person) or a mileage allowance of € 0.31 per kilometre for transport by private car. We reimburse the costs for:
  - insured clients who are undergoing haemodialysis;
  - insured clients who are undergoing oncological treatment with radiotherapy or chemotherapy;
  - insured clients who are visually handicapped and unable to travel without supervision;
  - insured clients who depend upon a wheelchair.
- c transport of a companion if guidance is necessary, or for the guidance of insured clients up to 16 years.

We reimburse the costs of the transport of patients:

- a to and from a care provider or care-providing institution, if the care they supply is reimbursed either in full or in part by virtue of this basic insurance;
- b to an institution where you will be staying at the expense of the AWBZ (not for care provided during only part of a day);
- c from an AWBZ institution to a care provider or institution where you have to undergo an examination or treatment at the full or partial expense of the AWBZ;
- d from a AWBZ institution to a care provider or institution who measures up or customises a prosthesis. The prosthesis must have been provided entirely or partially at the expense of the AWBZ;
- e from the above-mentioned care providers or institutions to your home, or to a different home if you cannot reasonably receive care in your home.

#### **Personal contribution for the seated transport of patients**

A statutory personal contribution of € 96.00 per person, per calendar year, applies for the seated transport of patients (by public transport, by taxi (for more than one person) or by private car).

#### **Hardship provision for the seated transport of patients**

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

#### **Conditions for reimbursement**

- 1 We will only reimburse the costs of transport by ambulance if there are medical reasons why seated transport of patients would be irresponsible.
- 2 We must have granted you permission in advance for the seated transport of patients (via public transport, a taxi (for more than one person) or by private car). We will determine whether you are entitled to reimbursement of the costs of transport. We also decide to which form of transport you are entitled.
- 3 The transport must be related to care that we reimburse by virtue of your basic insurance or which is reimbursed by virtue of the AWBZ.
- 4 Is the seated transport of patients by public transport, a taxi (for more than one person), a private car, or ambulance not possible? In that case we must have given you permission in advance for a different means of transport.
- 5 In exceptional cases guidance by 2 companions is permitted. In this case too we must have given you permission in advance.
- 6 You will only be eligible for reimbursement of the costs of transport if you do not have to travel more than 200 kilometres for your care provider. This does not apply if we have agreed differently with you.

## **Hospital, treatment and nursing**

### **Article 20 The Asthma Centre in Davos (Switzerland)**

Do you suffer from asthma? In that case you are eligible for reimbursement of the costs of treatment in the Dutch Asthma Centre in Davos.

#### **Conditions for reimbursement**

- 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 have given you written permission in advance.

### **Article 21 Genetic research and advice**

Would you like to have genetic research carried out? Or would you like to obtain advice? In that case you are entitled to reimbursement of these costs in a centre for genetic research. This care comprises:

- a research into and about disorders by means of research into your family tree;
- b chromosomal research;
- c biochemical diagnostics;
- d ultra-sound research and DNA research;
- e genetic advice and psychosocial guidance that this care involves.

If necessary in order to advise you, the centre will also examine other persons as well as you. The centre can also advise these persons.

#### **Condition for reimbursement**

You must have a referral from your doctor or obstetrician.

### **Article 22 Mechanical respiration**

We reimburse the costs of necessary mechanical respiration and the care this involves as provided by medical specialists. The care can take place in a treatment centre or at home.

#### **Mechanical respiration at home**

Respiration can take place at home, under the responsibility of a respiration centre. In that case:

- a the respiration centre provides the necessary apparatus - ready-to-use - for every treatment;
- b the respiration centre supplies the care of medical specialists and the appropriate pharmaceutical care involved in mechanical respiration.

#### **Condition for reimbursement**

You must have been referred by a lung specialist.

## Article 23 Care provided by medical specialists (extramurally)

Are you being treated by a medical specialist working in an extramural environment? This means a medical specialist who is not employed in a hospital or an independent treatment centre. In that case we reimburse the costs of:

- a care provided by medical specialists;
- b medicines, medical devices and bandages that are part of the treatment.

If admission is medically necessary, then we reimburse it based on articles 31 and 32 of the 'Reimbursements via the Keuze Zorg Plan'. The amount of care provided is limited to the care that medical specialists normally provide.

Temporary entitlement to reimbursement exists for some treatments.

The efficacy of some forms of treatment regarded as care provided by medical specialists has not yet been sufficiently demonstrated. We are able to reimburse some of these forms of treatment temporarily. These are the following forms of treatment:

- a until 1 January 2016: the use of anaesthesiological techniques for the treatment of chronic aspecific low back complaints if you are participating in the research funded by ZonMw;
- b until 1 January 2017: the use of percutaneous renal denervation for the treatment of therapy-resistant hypertension, if you are participating in the research funded by ZonMw;
- c until 1 January 2017: the use of intra-arterial thrombolysis (IAT) for the treatment of a cerebral infarction, if you are participating in the randomised, multicentre study: 'Multicenter Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands' (MR CLEAN);
- d until 1 January 2018: treatment by means of a transluminal endoscopic step-up approach to infected pancreatic necrosis, if you are participating in the research funded by ZonMw;
- e until 1 January 2018: carrying out an autologous stem-cell transplant in a case of severe therapy-refractory Crohn's disease, if you are participating in the research funded by ZonMw.

Transitional arrangement: a transitional arrangement applies for treatments referred to under a, b and c, for insured clients who started treatment before 1 January 2014. This means that you are not obliged to participate in the research mentioned. You must fulfil the conditions that applied on 31 December 2013.

### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, a company doctor, a geriatric specialist, a specialist in the mentally handicapped, a doctor specialised in juvenile health care, an obstetrician if obstetric care is involved, an optometrist if ophthalmology is involved, or a different medical specialist.
- 2 A hearing-aid specialist can also refer you to an ENT specialist.

### What we do not reimburse

This article does not cover reimbursements for mental health care (GGZ). Do you want to know to which reimbursement you are entitled for GGZ? In that case read Article 15 Non-clinical specialised GGZ (second-line GGZ).

## Article 24 Care provided by medical specialists (in an extramural environment)

Are you receiving treatment involving care provided by a medical specialist in an extramural environment? In that case we reimburse the costs of:

- a care provided by medical specialists;
- b paramedical care, medicines, medical devices and bandages that are part of the treatment.

If admission is medically necessary, then we reimburse it based on articles 31 and 32 of the 'Reimbursements via the Keuze Zorg Plan'.

The amount of care provided is limited to the care that medical specialists normally provide.

Temporary entitlement to reimbursement exists for some treatments.

The efficacy of some forms of treatment regarded as care provided by medical specialists has not yet been sufficiently demonstrated. We are able to reimburse some of these forms of treatment temporarily. These are the following forms of treatment:

- a until 1 January 2016: the use of anaesthesiological techniques for the treatment of chronic aspecific low back complaints if you are participating in the research funded by ZonMw;
- b until 1 January 2017: the use of percutaneous renal denervation for the treatment of therapy-resistant hypertension, if you are participating in the research funded by ZonMw;
- c until 1 January 2017: the use of intra-arterial thrombolysis (IAT) for the treatment of a cerebral infarction, if you are participating in the randomised, multicentre study: 'Multicenter Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands' (MR CLEAN);
- d until 1 January 2018: treatment by means of a transluminal endoscopic step-up approach to infected pancreatic necrosis, if you are participating in the research funded by ZonMw;
- e until 1 January 2018: carrying out an autologous stem-cell transplant in a case of severe therapy-refractory Crohn's disease, if you are participating in the research funded by ZonMw.

Transitional arrangement: a transitional arrangement applies for treatments referred to under a, b and c, for insured clients who started treatment before 1 January 2014. This means that you are not obliged to participate in the research mentioned. You must fulfil the conditions that applied on 31 December 2013.

#### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, a company doctor, a geriatric specialist, a specialist in the mentally handicapped, a doctor specialised in juvenile health care, an obstetrician if obstetric care is involved, an optometrist if eyecare is involved, or a different medical specialist.
- 2 A hearing-aid specialist can also refer you to an ENT specialist.

#### What we do not reimburse

This article does not cover reimbursements for mental health care (GGZ). Do you want to know to which reimbursement you are entitled for GGZ? In that case read Article 15 of 'Reimbursements via the Keuze Zorg Plan' about non-clinical specialised GGZ (second-line GGZ).

### Article 25 Dialysis at home

Are you receiving dialysis treatment at home? In that case we reimburse the costs involved. 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 modifications that 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 reimbursement

We must have given you written permission in advance. You must have submitted an estimate of the costs.

Please note! The regular costs of home dialysis, such as apparatus, expert guidance, research and treatment are reimbursed on the basis of care provided by medical specialists. For this, see article 23, 24, 31 and 32 of 'Reimbursements via the Keuze Zorg Plan'.

### Article 26 Organ transplants

In relation to organ transplants we reimburse the costs of the following treatments:

- a the transplant of tissue and organs in a hospital. The transplant must be carried out 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 the transplant of tissues and organs in an independent treatment centre competent to that purpose on the grounds of laws and legislation;

For a proposed organ transplant you are entitled to reimbursement of the costs of care provided by medical specialists in connection with:

- a choosing the donor;
- b the surgical removal of the transplant material from the chosen donor;
- c examining, preserving, removing and transporting the transplant material postmortally.

The donor is entitled to reimbursement of the costs of:

- a care which is reimbursed by virtue of this policy. The donor has this right for at the most 13 weeks, or 6 months in the case of a liver transplant, after the date of being discharged from the hospital. This must be the hospital where the donor was admitted for selecting or removing the transplant material. Furthermore, reimbursement only exists if the care provided relates to that admission;
- b transport in the cheapest form of public means of transport, or - in the event of medical necessity - by car. The transport must relate to the selection process, or admission to or discharge from hospital or to the care defined under point a;
- c transport of a donor who lives abroad to and from the Netherlands. We only reimburse the costs of the donor if you are undergoing a kidney, bone marrow or liver transplant in the Netherlands. We also reimburse the other costs of the transplant of the donor connected with the fact that the donor lives abroad.

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

#### Condition for reimbursement

Are you having the transplant done in a hospital? And is this hospital not contracted by the health insurer? In that case you must apply for our written permission in advance. Do you want to know with which hospitals the health insurer has a contract? In that case use the Medical Provider Search Tool on [www.averachmea.nl/zoekuwzorgverlener](http://www.averachmea.nl/zoekuwzorgverlener) or contact us.



## Article 27 Plastic surgery

We reimburse the costs of: interventions in the form of -plastic surgery carried out by a medical specialist in a hospital or independent treatment centre (ZBC), if these interventions are to correct:

- a defects in a person's appearance that are accompanied by demonstrable, physical, functional disorders;
- 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 that are the consequence of a congenital defect or a chronic disorder present at birth;
- e the stomach wall (the abdominoplastic), 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 intervention must be carried out by a care provider with whom we have a contract.

If admission is medically necessary, then we reimburse it based on articles 31 and 32 of the 'Reimbursements via the Keuze Zorg Plan'.

### Conditions for reimbursement

- 1 You must have a referral from a general practitioner or medical specialist.
- 2 We must have given you written permission in advance.

### What we do not reimburse

Some surgical interventions involving plastic-surgery are not covered by your insurance. We do not reimburse the costs of the following interventions:

- a the operative placing or operative replacement of breast implants, unless the operation is carried out following a (partial) breast amputation;
- b the operative removal of a breast prosthesis without a medical necessity;
- c liposuction of the stomach;
- d treatment of upper eyelids that are paralysed or weakened, unless the paralysis or weakening is the result of a congenital defect or a chronic disorder present at birth.

## Article 28 Convalescence

We reimburse the costs of convalescence provided by medical specialists (28.1) and convalescence by geriatric specialists (28.2).

### 28.1 CONVALESCENCE PROVIDED BY MEDICAL SPECIALISTS

Do you need to convalesce? In that case we reimburse these costs for you. You are only entitled to reimbursement of convalescence provided by medical specialists if it is indicated as the most effective method of preventing, reducing or surmounting 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 convalescence must enable you to achieve or maintain a degree of independence that is reasonably possible with your limitations.

#### Clinical and non-clinical convalescence

We reimburse the costs if you convalesce non-clinically (part-time or day-time treatment). In a number of cases, we also reimburse clinical convalescence if you are admitted for several days. We only do this if convalescence with admission quickly leads to better results than convalescence without admission.

#### How many days of clinical admission we reimburse

Have you been admitted? In that case we reimburse your costs for a period of, at most, 365 days that you stay in the clinic without interruption. The same applies to other admissions into (psychiatric) hospitals. We do not regard an interruption of up to 30 days as an interruption, but we do not count these days when calculating the 365 days. Was your admission interrupted by a weekend's leave or a holiday? In that case we do include such days in our calculation.

#### Condition for reimbursement

You must have been referred by a general practitioner, a geriatric specialist, a specialist in the mentally handicapped or a different medical specialist.

## 28.2 GERIATRIC CONVALESCENCE

Are you eligible for geriatric convalescence? In that case we reimburse the costs of this care. Geriatric convalescence care comprises integral, multidisciplinary convalescence care. This is care normally provided by geriatric specialists in connection with vulnerability, complex multimorbidity and reduced learning and training ability. Geriatric convalescence focuses on improving functional limitations. The objective of convalescence is that you return to your home situation.

The law stipulates the following conditions for this care:

- 1 The care starts immediately after your stay in a hospital as defined in article 2:10 of the Health Insurance Decision. In this hospital you received medical care that is normally provided by a medical specialist or a similar care provider.
- 2 You were not residing in a nursing home for treatment before being admitted to this hospital. We are referring here to a nursing home as defined in article 9 of the AWBZ Entitlements to Care Decision (Besluit zorgaanspraken AWBZ). In addition, we are referring to treatments as defined in article 8 of the same decision.
- 3 Upon commencement the care is linked to residence in a hospital or care institution, as defined in article 2:10 of the Health Insurance Decision.

### How many days of convalescence we reimburse

We reimburse geriatric convalescence for a maximum of 6 months. In exceptional cases we can allow a longer period.

### Condition for reimbursement

You must have been referred by a general practitioner, a specialist in the mentally handicapped or a medical specialist.

## Article 29 Second opinion

Do you want a second opinion? In that case we reimburse these costs for you. Getting a second opinion means having the diagnosis or treatment that was determined by your doctor reassessed. Your doctor can also request a second opinion. A second, independent doctor carries out the new assessment. This doctor must have the same specialism or be employed in the same field as the first doctor.

### Conditions for reimbursement

In addition, for reimbursement we stipulate the following conditions:

- 1 The second opinion must relate to diagnostics or treatment that is covered by the provisions of the basic insurance.
- 2 You must have been referred by a general practitioner, a medical specialist, a clinical psychologist or a 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 we do not reimburse

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.

## Article 30 Nursing (extramurally) outside the hospital

Articles 15, 16, 25, 31 and 32 of the 'Reimbursements via the Keuze Zorg Plan' stipulate the conditions for nursing in an intramural institution. However, you are also entitled to reimbursement of the costs of nursing as normally provided by nurses in your home situation. This is the case if such nursing is necessary in connection with care provided by medical-specialists. It also relates to activities that are subject to the direct supervision of the specialist and/or necessary instructions and information directly related to treatment provided by a medical specialist.

### Condition for reimbursement

You are only entitled to reimbursement of the costs of nursing at home if you are still being treated by a medical specialist.

### What we do not reimburse

You are not entitled to reimbursement of the costs of nursing that is necessary in connection with respiration at home or palliative care.

## Article 31 Independent treatment centre

Are you being treated in an independent treatment centre? In that case we reimburse the costs of:

- a your stay, including nursing and care, based on the lowest class
- b care provided by medical specialists;
- c during your admission and treatment: paramedical care, medicines, medical devices and bandages that are part of the treatment.

The amount of care provided is limited to the care that medical specialists normally provide.

### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, a company doctor, a geriatric specialist, a specialist in the mentally handicapped, a doctor specialised in juvenile health care, an obstetrician if obstetric care is involved, or a different medical specialist.
- 2 A hearing-aid specialist can also refer you to an ENT specialist.
- 3 The referring doctor (under 1) informs our medical advisor of the reason for your admission. For this you must authorise the referring doctor.
- 4 Is plastic surgery involved? In that case we only reimburse your costs if you have requested our permission. This must take place at least 3 weeks before the treatment. As proof of our permission, we issue the independent treatment centre with a guarantee statement.

## Article 32 Hospital nursing and day-time treatment in a hospital

Do you need day-time treatment in a hospital? Or will you be staying in hospital for longer than 1 day? In that case we reimburse the costs of:

- a your stay, including nursing and care, based on the lowest class;
- b care provided by medical specialists;
- c during your admission and treatment: paramedical care, medicines, medical devices and bandages that are part of the treatment.

The amount of care provided is limited to the care that medical specialists normally provide.

### How many days of admission we reimburse

Have you been admitted to hospital? In that case we reimburse your costs for a period of, at most, 365 days that you stay in the hospital without interruption.

The following forms of admission also count:

- a admission to a convalescence centre or a hospital whereby the goal is convalescence;
- b admission to a psychiatric hospital.

We do not regard an interruption of up to 30 days as an interruption, but we do not count these days when calculating the 365 days. Was your admission interrupted by a weekend's leave or a holiday? In that case we do include such days in our calculation.

### Conditions for reimbursement

- 1 You must have been referred by a general practitioner, a company doctor, a geriatric specialist, a specialist in the mentally handicapped, a doctor specialised in juvenile health care, an obstetrician if obstetric care is involved, or a different 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 admission. For this you must authorise the referring doctor.
- 4 Are you being admitted for plastic surgery? In that case we only reimburse your costs if you have requested our permission. This must take place at least 3 weeks before the treatment. As proof of our permission, we issue the hospital with a guarantee statement.

### What we do not reimburse

This article does not cover reimbursements for mental health care (GGZ). Do you want to know to which reimbursement you are entitled for GGZ? In that case read article 16 of 'Reimbursements via the Keuze Zorg Plan' about admission to a psychiatric hospital.

## Pregnancy/baby/child

### Article 33 Childbirth and obstetric care

With respect to the reimbursement of obstetric care and care during delivery, we distinguish between medical urgency (33.1) and the lack of medical urgency (33.2).

#### 33.1 WITH MEDICAL URGENCY

We reimburse insured female clients the costs of:

- a obstetric care by an obstetrician, or, if none is available, by a general practitioner. Are you receiving obstetric care from an obstetrician in a hospital? In that case this care must be subject to the accountability of a medical specialist;
- b the use of the delivery room if delivery takes place in a hospital (as an outpatient or clinically).

The extent of care provided is limited to the care that obstetricians normally provide.

#### 33.2 WITHOUT MEDICAL URGENCY

We reimburse insured female clients the costs of:

- 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 € 33.00 per admission day (€ 16.50 for the mother and € 16.50 for the child). Does the hospital charge a sum that is higher than € 233.00 per day (€ 116.50 for the mother and € 116.50 for the child)? In that case, in addition to the € 33.00, you will also have to pay the sum over and above the € 233.00 per day.
- b obstetric care by an obstetrician, or, if none is available, by a general practitioner.

The extent of care provided is limited to the care that obstetricians normally provide.

## **Article 34 In vitro fertilisation (IVF), other forms of fertility-enhancing treatments, sperm cryopreservation and oocyte vitrification**

You are entitled to reimbursement of the costs of IVF (34.1), other fertility-enhancing treatments (34.2), sperm cryopreservation (34.3) and oocyte vitrification (34.4).

### **34.1 IVF**

Would you like to undergo IVF treatment? And are you younger than 43 years? In that case, you are entitled to reimbursement of costs of, per ongoing pregnancy to be realised, the first, second and third attempts, including any medicines used.

What is the definition of an IVF attempt to become pregnant

An IVF attempt to become pregnancy is comprised of going through, at the most, the following sequential phases:

- a ripening of oocytes by hormonal treatment within the woman's body;
- b obtaining ripe oocytes (follicle puncture);
- c oocyte fertilisation and culturing embryos in the laboratory;
- d placement of 1 or 2 of the resulting embryos in the uterus to allow pregnancy to occur. Are you younger than 38 years? In that case only 1 embryo may be placed back during the first and second attempts.

An attempt only counts if the follicular puncture was successful (phase b). After this, all attempts count that are interrupted until one can speak of an ongoing pregnancy. A new attempt after an ongoing pregnancy counts again as a first attempt. The placement of frozen embryos is regarded as part of the IVF attempt during which they were created.

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 pregnancy after an IVF treatment lasting at least 10 weeks, counting from the follicular puncture after a non-frozen embryo was placed back. Or at least 9 weeks and 3 days after a vitrified embryo was placed.

#### **Conditions for reimbursement**

- 1 The treatment must take place in an authorised hospital.
- 2 You will need a medical statement from your doctor before submitting your application.
- 3 We must have given you written permission in advance for treatment in a hospital abroad.

#### **Maximum reimbursement for medicines**

We reimburse medicines that are necessary for an IVF attempt. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. Our website provides an overview where you can find the maximum reimbursement of medicines.

#### **What we do not reimburse**

We do not reimburse the costs of medicines that are necessary for a 4th and any successive IVF attempt.

### **34.2 OTHER TREATMENTS THAT ENHANCE FERTILITY**

Are you younger than 43 years? In that case you are also entitled to treatments other than IVF that enhance fertility, including the medicines these involve.

#### **Conditions for reimbursement**

For entitlement to other treatments that enhance fertility, we stipulate the following conditions:

- 1 You will need a medical statement from your doctor before submitting your application.
- 2 We must have given you written permission in advance for treatment in a hospital abroad.

#### **Maximum reimbursement for medicines**

We reimburse medicines that are necessary for a fertility treatment. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. Our website provides an overview where you can find the maximum reimbursement of medicines.

#### **What we do not reimburse**

We do not reimburse the costs of medicines that are necessary for a 4th and any successive IVF attempt.

### **34.3 FREEZING OF THE SEMEN**

Are you undergoing treatment by a medical specialist that may result in unintended infertility? In that case you are entitled to reimbursement of the costs of 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. It must involve:

- 1 a large operation on or close to your genitals;
- 2 a chemotherapeutic and/or radiotherapy treatment whereby your genitals will be exposed to radiation.

#### 34.4 VITRIFICATION (FREEZING) OF HUMAN OOCYTES AND EMBRYOS

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

- a You are undergoing chemotherapy with the risk of a permanent fertility disorder;
- b You are undergoing radiotherapy treatment whereby your ovaries will be exposed to radiation and could be permanently damaged as a result;
- c You are undergoing an operation, for a medical indication, whereby (large parts of) both your ovaries will have to be removed.

##### Reimbursement also exists for other medical indications

The following medical indications involve an increased risk of you becoming prematurely infertile. This is the case if you suffer from premature ovarian insufficiency (poi) before reaching the age of 40 years. In this case you are entitled to reimbursement of the costs of vitrification. The medical indications involved are those relating to the following characteristics of female fertility:

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

For these medical indications you are entitled to reimbursement of the costs of the following components of treatment:

- a follicular stimulation;
- b oocyte puncture;
- c vitrification of the oocytes.

##### Reimbursement also exists for an IVF-related indication

In some cases, during an IVF attempt you will also be entitled to reimbursement of the costs of vitrification if it is based on considerations of cost-effectiveness. In that case, the attempt must be covered by your basic insurance. This is the case in the following situations:

- a You have an unexpected lack of semen of sufficient quality;
- b Oocytes are vitrified instead of embryos.

For an IVF-related indication you are only entitled to reimbursement of the costs of the vitrification of oocytes.

##### Possibilities after the vitrification of oocytes

Are you having your oocytes thawed out after having them vitrified, with the intention of becoming pregnant? In that case you are limited to phases c and d of an IVF attempt (see article 34.1 of 'Reimbursements via the Keuze Zorg Plan'). Please note! You must be younger than 43 years when implantation takes place.

##### Conditions for reimbursement

- 1 The vitrification must take place in an authorised hospital.
- 2 Are you being treated in a hospital abroad? In that case we must have given you written permission in advance.
- 3 You are only entitled to vitrification on the basis of these indications if you are younger than 43 years.

##### Maximum reimbursement for medicines

We reimburse medicines that are necessary for the vitrification of oocytes. This applies up to a certain maximum that we have stipulated for all (partial) pharmaceutical and medicinal provisions. Our website provides an overview where you can find the maximum reimbursement of medicines.

### Article 35 Maternity care

We reimburse insured female clients the costs of maternity care. The extent of care provided is limited to the care that maternity carers normally provide.

##### Maternity care can be provided:

- a at home

A statutory personal contribution of €4.10 per hour applies for maternity care at home.

- b in hospital or in a birth centre or a maternity centre

Are you staying in a hospital or in a birth centre or a maternity centre without a medical indication? In that case a statutory personal contribution of € 33.00 per (admission) day applies (€ 16.50 for the mother and € 16.50 for the child). Does the hospital or the birth centre or maternity centre charge a sum that exceeds € 233.00 per day (€ 116.50 for the mother and € 116.50 for the child)? In that case, in addition to the € 33.00, you will also have to pay the sum over and above the € 233.00 per day. You are entitled to a maximum of 10 days' maternity care, calculated from the day of the delivery. If a mother and child leave the hospital, birth centre or maternity centre together before these 10 days have lapsed, an entitlement still exists to maternity care at home for the remaining days.

##### To how much maternity care are you entitled?

The number of hours maternity care to which you are entitled depends on your personal situation after the delivery. The birth centre or maternity centre determines this in consultation with you. The centre adheres to the National Indication Protocol on Maternity Care (Landelijk Indicatieprotocol Kraamzorg) in this matter. The protocol and an explanation can be found on our website or you can contact us. The brochure, 'Zwangerschap en geboorte' can also be found on our website. This brochure tells you more about our maternity care service. The brochure can be found on our website or obtained from us.

## Article 36 Oncological examination in children

We reimburse the costs of care from the Dutch Foundation for Children and Cancer (Stichting Kinderoncologie Nederland (SKION)) The SKION coordinates and registers body material it receives and establishes the diagnosis.

## Article 37 Prenatal screening

Insured female clients are entitled to:

- a counselling explaining to you the procedures involved in prenatal screening;
- b a structural echoscopic examination (SEO), also known as the 20-week ultrasound scan;
- c the combination test (a nuchal scan combined with a blood test) for congenital disorders during the first trimester of pregnancy. You are entitled to this care if you:
  - are 36 years or older;
  - are younger than 36 years and you have been referred by a general practitioner, an obstetrician or a medical specialist.

### Condition for reimbursement

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.

## Miscellaneous

### Article 38 Dietary advice

We reimburse the costs 3 hours' of dietary advice by a dietitian. This means 3 hours per calendar year. Dietary advice includes information and advice in the field of nutrition and eating habits. Dietary advice must have a medical objective. The extent of care provided is limited to the care that dietitians normally provide.

### Conditions for reimbursement

- 1 You will need a statement from the referring doctor (general practitioner, company doctor or medical specialist). This statement enables us to determine whether, according to the basic insurance, you are entitled to reimbursement of the costs of dietary advice.
- 2 Receiving advice at school? In that case we only reimburse your costs 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 you do not need a statement from the referring doctor for reimbursement. This is because the health insurer has entered into agreements with a number of contracted dietitians about immediate access: these dietitians can advise you without a referral. We call these Direct Access Dietitians (Directe Toegang Diëtist (DTD)). Via the Medical Provider Search Tool on [www.averachmea.nl/zoekuwzorgverlener](http://www.averachmea.nl/zoekuwzorgverlener), you can find a list of contracted dietitians who offer DTD. You can also obtain this information from 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.

More information about dietary advice can be found in the brochure 'Paramedische Zorg'. The brochure, 'Paramedische Zorg' is an integral part of your policy. It can be found on our website or obtained from us.

We do not reimburse the costs of surcharges for:

- a appointments outside regular working hours;
- b appointments that were not kept;
- c simple, short reports or more complicated, time-consuming reports.

### Article 39 General practitioner care

We reimburse the costs of medical care provided by a general practitioner. The care can also be provided by a comparable doctor or care provider who is subject to the accountability of a general practitioner. If requested by a general practitioner, you are also entitled to reimbursement of the costs of X-rays and laboratory examinations. The extent of care provided is limited to the care that general practitioners normally provide.

## Article 40 Integrated care for diabetes mellitus type 2 and COPD

We reimburse the costs of integrated care for diabetes mellitus type 2 (for insured clients aged 18 years and older) and COPD, if we have entered into agreements about this with a care group. Integrated care is a care programme for a specific chronic disorder such as COPD or diabetes mellitus type 2. A number of care providers from various disciplines participate in this programme.

### Condition for reimbursement

Are you receiving integrated care? In that case all care components involved must comply with the care standard for Diabetes Mellitus or the care standard for COPD.

### Reimbursement for a non-contracted care group

Please note! Are you receiving integrated care for diabetes mellitus type 2 (for insured clients aged 18 years and older) and COPD from a care group that we have not contracted? Or do you have diabetes mellitus type 2 and are you younger than 18 years? In that case we reimburse only the care that is normally provided by general practitioners, dietitians and medical specialists. This is the care as defined in articles 23, 24, 38 and 39 of 'Reimbursements via the Keuze Zorg Plan'. In addition, in cases of diabetes mellitus type 2 you are entitled to foot care as described in article 2 of 'Reimbursements via the Keuze Zorg Plan'.

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

## Article 41 Stop smoking programme

We reimburse, at most once per calendar year, the costs of a stop smoking programme the objective of which is to stop smoking. This stop smoking programme must comprise of medical and, possibly, pharmacotherapeutic interventions that support behavioural change, whereby the objective is to stop smoking. This involves such support as that normally provided by general practitioners, medical specialists or clinical psychologists.

### Conditions for reimbursement

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

## Article 42 Thrombosis Service

Do you suffer from thrombosis? In that case we reimburse the costs of care from a Thrombosis Service. The care involves the Service:

- 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 can also get 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 apparatus and guides you when you carry out measurements;
- e advising you about using medicines to influence your coagulation time.

### Condition for reimbursement

You must have been referred by a general practitioner, a geriatric specialist, a specialist in the mentally handicapped or a medical specialist.