2021

Health Basic and Health Premium

general rules and regulations and coverage

ONVZ

Health Basic & Health Premium

For health care in the Netherlands

These health-care plans only cover the costs of health care provided in the Netherlands. Health-care costs incurred abroad only qualify for reimbursement if they involve emergency medical assistance.

Here's how the health-care plan works
Your health-care plan has *general rules and regulations* and *coverage*. The general rules and regulations are the rules and regulations and agreements that apply to Health Basic and Health Premium. They provide details of things like when the health-care plan commences and how we reimburse the costs of health care.

The coverage describes the health care and services to which you are entitled, and what you need to do in order to get them.

How health care in the Netherlands works
In the Netherlands, the general practitioner plays an important role. You can register with the practice of a general practitioner close to you, and if you have any health problems, this general practitioner will be your first port of call. You can often get the help you need there, from the general practitioner, or from other staff working at the practice. If necessary, the general practitioner will refer you to another health-care provider, like a medical specialist or the hospital.

In the Netherlands, you cannot go directly to the hospital, you need to have been given a referral. Even if you have an urgent medical problem, you first have to call the general practitioner or, outside surgery hours, the out-of-hours practice (*huisartsenpost*). You should only call an ambulance in a life-threatening situation. The number to call is 1-1-2.

You do not need a referral for allied health care, a homeopathic doctor or a dentist. If you need help finding a health-care provider, or if you have any other health-care-related questions, our *ZorgConsulent* advisers are your personal guides through the health-care landscape.

Questions
If you have any questions, please see the general information available at www.onvz.nl. Of course, you can also call our Service Centre on +31 (0)30 639 62 22.

Contact details

ONVZ
Postbus 392
3990 GD Houten
Netherlands
Telephone: +31 (0)30 639 62 22
Fax: +31 (0)30 635 12 75
Internet: www.onvz.nl

ONVZ Service Centre
For general questions about your health-care plan
Telephone: +31 (0)30 639 62 22
Available on working days between 8am and 6pm
Internet: www.onvz.nl/contact

ONVZ *Machtigingen*
If you require authorisation in order to receive reimbursement for health care
Telephone: +31 (0)30 639 62 22
Available on working days between 8.30am and 5.30pm
Internet: www.onvz.nl/contact

ONVZ *ZorgConsulent*
Information about treatment methods, help arranging health care and health-care mediation
Telephone: 0800 022 14 50 (free of charge)
Available on working days between 8.30am and 5.30pm
Email: zorgconsulent@onvz.nl

ONVZ *Kraamzorg Service*
Information on and requests for maternity care
Telephone: +31 (0)88 668 97 05
Available on working days between 8am and 5.30pm
Internet: www.onvz.nl/kraamzorg

ONVZ *Zorgassistance*
Help and advice on medical care in emergency situations abroad
Telephone: +31 (0)88 668 97 67
Available 24 hours a day

ONVZ *Verhaalszaken*
Aid for claims against liable third parties for injury
Telephone: +31 (0)30 639 62 64
Available on working days between 8.30am and 5pm

Transportation by taxi
Transvision
Telephone: 0900 333 33 30
Available on working days between 8.30am and 5pm

ONVZ complaints service
For submitting a complaint
Postbus 392
3990 GD Houten
Netherlands
Email: klachtenservice@onvz.nl

Health Basic and Health Premium general rules and regulations

Contents

Introduction

These are the general rules and regulations for the Health Basic and Health Premium health-care plans. Together with the coverage for Health Basic and Health Premium, these specify what you are entitled to and what you need to do to get it.

This document also explains the rules that apply to taking out these health-care plans.

These general rules and regulations are divided into 4 sections.

1. Health Basic and Health Premium health-care plans
2. I'm a new ONVZ customer
3. I'm already insured with ONVZ
4. I'm switching from ONVZ, or ONVZ has terminated the health-care plan

Key information is shown in **bold** so you can quickly find what you are looking for.

The risk bearer is ONVZ Aanvullende Verzekering N.V. (Utrecht: Trade Register no. 30209308, AFM number 12001024), located in Houten, Netherlands. Postbus 392, 3990 GD Houten, Netherlands.
Telephone: +31 (0)30 639 62 22, Fax: +31 (0)30 635 12 75.
Internet: www.onvz.nl

1. Health Basic and Health Premium health-care plans

Nearly everyone in the Netherlands is required to take out a 'basic health-care plan'. This is a legal obligation. The basic health-care plan covers all of the most important health-care costs.

It could be that you are unable to take out a basic health-care plan in the Netherlands. Perhaps you are only staying here temporarily and do not work for a Dutch employer, for example, or you are a highly-skilled migrant. It is especially for these situations that Health Basic and Health Premium have been set up, so that you can be well-insured for health care in the Netherlands. With Health Basic, you are covered in the Netherlands for the most important risks, like hospital costs and medicine. Health Premium provides more comprehensive coverage, like for dental care, physiotherapy and maternity care.

About our health-care plans

1. Health Basic and Health Premium entitle you to reimbursement of the costs of health care and services These are **reimbursement health-care plans**.

   From this point on, we will use the terms 'health-care plan' and 'reimbursement of the costs of health care'.

   Furthermore, in this brochure, where we say 'ONVZ', 'we' or 'us' we mean ONVZ Aanvullende Verzekering N.V.

2. **This brochure states:**
   - **which types of health care** and services are covered
   - **who** may provide the health care
   - **which other terms and conditions** apply

   The health-care plans reimburse the costs of **medically necessary** health care and services. The term 'medically necessary' is defined in general rule 18.

Policyholder, insured persons and holders of medical insurance cards

3. The official term for the person who takes out a health-care plan is the **policyholder**. **We refer to this person as the 'primary insured person'.** A primary insured person can take out a health-care plan for himself/herself or for someone else, for example a partner or children. The person who is insured is referred to as **the insured person**. If you take out a health-care plan for yourself, you are the primary insured person *and* the insured person.

4. **We will send the health-care policy to the primary insured person.** This is proof of the health-care plan. The health-care policy will state the name of the insured person or persons and which health-care plan has been taken out.

Which rules and regulations determine the health-care plan and the premium

5. The general rules and regulations and the coverage determine the specifics of your health-care plan.

6. The health-care plan is also based on the information you provide us, when taking out your health-care plan for example.

7. The premium table, which lists the (age-related) premiums for the health-care plans, along with the discounts and surcharges, also forms part of our general rules and regulations.

8. If you are insured under a collective health-care plan, the general rules and regulations for that collective health-care plan will also apply. You can request these from the party who took out the health-care plan with ONVZ. This is often the employer.

2. I’m a new ONVZ customer

If you would like to become an ONVZ customer, we look forward to welcoming you!

Taking out or applying for a health-care plan: as easy as 1-2-3

9. You can take out one of our health-care plans directly online. Alternatively, you can send us the application form by post or email. You can also take out the health-care plan through your insurance adviser.

10. **You can only take out Health Basic and Health Premium if you live in the Netherlands or if this is your main country of residence.** Another condition is that you do not qualify for a basic health-care plan as defined in the *Zorgverzekeringswet* [Dutch Health Insurance Act].

11. **We will ask you questions about the health of the insured person(s).** We use the answers to determine whether you can take out the health-care plan you are requesting. If you take out the health-care plan for a child within 4 months of the date of birth, the health-care plan will automatically start from the date of birth without you needing to answer any health-related questions.

When your health-care plan commences

12. **The health-care policy states the commencement date of your health-care plan.**

Other important considerations

13. **When you take out a new health-care plan, you have a cooling-off period of 14 days.**
This cooling-off period starts on the date you receive the health-care policy. During this period, you have the right to cancel without stating your reasons. However, if you do you will not be entitled to reimbursement of the costs of health care or services. We will refund any premiums already paid.

14. **If you contact us by email or through social media, we reserve the right to respond using the same means.** We will not do this, however, if privacy regulations specify that we may not do so, or if you have informed us that you would like us to respond through a different channel. If you contact us through the website, we will respond by telephone or email.

3. I’m already insured with ONVZ

If you have Health Basic or Health Premium, you are entitled to reimbursement of the costs of health care and services in accordance with the rules and regulations that apply to that health-care plan. We give more information about this below.

I need health care

15. If you need health care, the following rules determine whether we will reimburse the costs of the health care or services. Reimbursement is usually straightforward. The health-care provider requests reimbursement directly from ONVZ and ONVZ pays the health-care provider directly.

    You may not transfer your right to the reimbursement of health-care costs to a third party (assignment) without permission from ONVZ, nor may you use it as security for your payment of a third party’s invoice (pledge).

    We always pay invoices in euros. If the invoice is in a different currency, we will convert the amount to euros, using the exchange rate in effect on the last working day of the month prior to the month in which you received the care.

16. **Health Basic and Health Premium reimburse the costs of the health care and entitle you to the services listed under coverage,** subject to the terms and conditions and the general rules and regulations being met. These are the terms and conditions stated in the general rules and regulations you are reading right now as well as those specified under coverage.

    The general rules and regulations state, for example, that we only cover health care for which you have a reasonable need. This provision always applies, even if it is not repeated every time.

    Coverage may be subject to you gaining our permission before visiting the health-care provider.

17. **The health-care plan reimburses health care and services for as long as you are insured with us.** In other words, you must be insured with us on the date of treatment or the date of the service (the pharmacy dispensing medication, for example) being provided. If your health-care provider charges a single rate for the entire treatment, like with a DBC for example, you will need to be insured with us on the date the DBC is opened.

18. **We will only reimburse the costs of health care:**
    a. **that, in terms of its composition and scope, is safe and effective**
       This is the case if it has been shown to work effectively both in theory and in practice. If this is not the case, safe and effective health care will be deemed to be what the specific health-care practitioners as a group feel is appropriate, in other words health care that the particular group of health-care practitioners routinely provides.

    b. **and that you reasonably require in terms of its composition and scope**
       This is the case if the health care is adequate for your situation. In other words, the health care must not be unnecessarily expensive or complicated. This applies equally to services.

19. **The rate is sometime set by the *Nederlandse Zorgautoriteit* [Dutch Health-Care Authority] (NZa).** If this is a fixed rate, this is the rate we reimburse. If it is a maximum rate, we never reimburse more than this amount.

    If a fixed or maximum rate has not been set, we reimburse the market price. Market price means that your health-care provider’s price cannot be unreasonably high in comparison with what other health-care providers in the Netherlands charge for the same health care. For specialist medical care, for example, we reimburse a maximum of the price that 95% of health-care providers charge less than. We can make an exception, however, if there is a special medical or other reason in your case.

I pay: personal contributions and excess

20. **Sometimes you will need to pay a personal contribution.**
    A statutory personal contribution applies to certain medicines. This is an amount you have to pay yourself when you are prescribed medicine.

21. **You may also opt for an excess each calendar year. You can choose between €0, €500 and €1,000.** If you opt for an excess of €500 or €1,000, you will have to cover this portion of your health-care costs yourself. You will, however, get a discount on your premium, as shown in the premium table. Your policy will state which excess you have chosen.

    You do not pay an excess on the personal contribution. This is because, when we receive an invoice from you, we deduct your personal contribution first before deducting the excess.

22. **You do not pay an excess until 1 January of the year in which you turn 19.** If you would like to have an excess from that date, you need to let us know before 1 January of that year.

23. When you or your health-care provider submit invoices, in terms of calculating the excess, we look at the year in which you received the treatment, not when we receive the claim. Sometimes the health-care provider is required to claim the consultations, tests and treatment in 1 go, for example with a DBC. The DBC counts towards the excess for the year in which the DBC was opened.

    If the health-care provider opens a new DBC (i.e. a follow-up DBC) for the same treatment the next year, you may have to pay an excess for this treatment in both years.

24. **If you are only insured with us for part of the year, we will adjust the excess proportionally.** We will calculate this in proportion to the number of days the health-care plan was in effect. The result will be rounded off to the nearest whole euro.

    Your health-care plan commences on 3 February. 33 days of the year have passed and there are 332 days remaining. Your excess is 332/365 of, for example, €500, i.e. €454.79. We round this off to €455.

The health-care plan sometimes reimburses less, or nothing at all

25. **In the Netherlands, health care and assistance is also covered under other laws under certain circumstances, including:**
    - *Wet langdurige zorg* [Long-term Care Act] (Wlz)
    - 2015 *Wet maatschappelijke ondersteuning* [Social Support Act] (Wmo)
    - *Jeugdwet* [Youth Act]

    Where this applies, we do not reimburse the costs of health care or assistance, regardless of whether you are covered by the provisions of the Wlz or Wmo. This will also be the case if you do not believe the health care or assistance provided by the care administration office or local council is adequate.

26. **We will not reimburse the following health care and services either.**

    personal contributions payable under the:
    - *Wet langdurige zorg* [Long-term Care Act]
    - *Zorgverzekeringswet* [Health Insurance Act]
    - 2015 *Wet maatschappelijke ondersteuning* [Social Support Act]
    - *Jeugdwet* [Youth Act]

    personal contributions in relation to population screening

    medical examinations relating to employment or a driving licence for example

    medical certificates

    costs incurred for not paying invoices or paying these too late

    missed appointments (no-show)

    costs incurred as a result of war/civil war, insurrection and other similar forms of conflict

    activities designed to achieve a certain sporting level or to improve sporting performance

27. You may receive a lower reimbursement for health care that is required due to an act of terrorism. We have reinsured our liability to cover such health care with the *Nederlandse Herverzekeringsmaatschappij voor Terrorismeschaden N.V.* [Dutch Reinsurance Company for Losses from Terrorist Acts] (NHT). This policy will reimburse up to a maximum of €1 billion per calendar year. If there are additional costs, the NHT will reimburse these in part, and we will reimburse the costs of health care to the same extent. The NHT's terrorism cover clauses sheet sets out the provisions relating to reimbursement.

If we have not insured the health care with the NHT, we will reimburse the health-care costs to the same extent as if they had been insured with the NHT.

We define terrorist acts as follows: violent acts or malicious contamination or preparations to these ends, whereby it may be reasonably assumed that they are planned or carried out with intent to realise political, religious or ideological objectives. Preventive measures are included herein.

Please note: if you do not live in the Netherlands, the health care required due to an act of terrorism may not be covered in full.

28. **Health Basic and Health Premium are subject to the 2 restrictions below, though you will generally not notice these in practice.** Insurers address them together wherever possible.

    1. **Health Basic and Health Premium do not cover anything that is covered by another provision.** These are 'top up' health-care plans, meaning they do not provide cover that is already provided under another provision. They do, however, cover amounts in excess of this up to the maximum amount stipulated. 'Another provision' means other insurance policies, laws and/or arrangements.

    2. **We do not provide coverage in the event of concurrence.** Concurrence occurs when health care or the costs of health care are covered by 2 or more provisions at the same time, or would have been covered by the other provision had the Health Basic or Health Premium health-care plan not existed. It makes no difference whether the other provision commenced before or after the supplementary health-care plan.

29. **We will not reimburse the costs of the following health care either.**
    Health care that is prescribed or provided:
    - by the insured person to himself/herself
    - to the insured person by a first or second-degree family member of the insured person

    We will, however, reimburse the costs of the health care where we have given our prior permission.

I need to claim health-care costs

You have received health care and would like to know how the payment for this is handled. Often this couldn't be easier, as health-care providers will usually send us the invoice directly. If you receive an invoice yourself, there are various ways of sending it to us. You can read more about this below.

30. **Many health-care providers send the invoice directly to us online, and we pay the health-care provider directly. This fulfils our obligation to reimburse your invoice.** If we pay the health-care provider more than you are entitled to, we may ask the health-care provider to repay the difference.

31. **You may need to repay some of the costs of health care to us** If we settle directly with your health-care provider, we will sometimes pay the invoice in full, even if you have to pay some of the invoice yourself on account of the excess or a personal contribution, or when not all costs are covered by Health Basic or Health Premium. We will invoice you for the amount you have to pay yourself. You must pay this amount within 21 days.

32. **If you forward the health-care provider's invoice to us yourself, you must comply with the 3 rules below,** otherwise we may not reimburse the costs or you may have to repay costs we have already reimbursed.

    a. **You must send your invoices to us as soon as possible. We must be in receipt of them within 3 years.** The 3 years start at the time you receive treatment, so not when you receive the invoice from the health-care provider.

    b. **The invoices you send us must be clear and legible.** They must state, among other things, the health care you received and who provided it. They must be written in Dutch, English, German, French or Spanish, otherwise we may request a translation.

    c. If you send us the invoice electronically, for example through the ONVZ app or our website, **you must keep the original invoice for 1 year after we have received it.** We can ask you for the original invoice

       We may occasionally pay a health-care provider more than the amount covered under your health insurance, in which case you agree that ONVZ can ask the health-care provider for a refund of the difference.

33. **We may verify invoices from time to time.** For example, we may check that you actually needed and received the health care or service in question. If this is not the case, you may have to pay back the costs we reimbursed.

I pay the premium

34. **The primary insured person must pay the premiums for the health-care plans in advance.** You can pay monthly, quarterly, half-yearly or annually.

35. **Age-related premiums.** Our premiums are set in age bands, with the premium increasing as you get older. The new premium applies from 1 January of the calendar year following the year in which you enter the new age band. The premiums are listed in the premium table.

36. **You may be entitled to a discount on your premium.** The premium and discounts are listed in the premium table. You will qualify for a discount if you:
    - pay quarterly, half-yearly or annually, rather than monthly
    - opt for an excess
    - join a collective health-care plan

37. If we need to calculate the premium for part of 1 month, we will assume 1 month of 30 days.

38. You are not permitted to offset the premium you owe against any reimbursements you are due to receive from us.

39. In the event that you are held in custody, your health-care plan will be suspended, unless you prefer otherwise. You will not be able to claim health-care costs from us while your health-care plan is suspended, nor will you have to pay a premium. If you wish to have the health-care plan suspended, you must notify us that you are being taken into custody and inform us how long the custody is expected to last. You must also notify us when you are released from custody.

Cooperation and provision of information

40. **If we need information for checks or investigations, you must cooperate with us.** You must ensure that our medical adviser or another member of staff is provided with the information requested, for example by the attending doctor. Privacy regulations apply in this regard. If you refuse to cooperate, it is possible that the costs of your health care or services will not be reimbursed or you may have to repay costs we have already reimbursed.

41. **You must tell us within 1 month of major changes to your situation.** A major change in this context means events we need to know about in order to properly administer your health-care plan. For example:
    - you move abroad or start working abroad
    - you have a new bank account number
    - you have had a child
    - you are obliged to take out a basic health-care plan as defined in the *Zorgverzekeringswet* [Dutch Health Insurance Act]

    If you fail to do this, your invoices might not be reimbursed or you may have to repay costs we have already reimbursed.

42. If someone else is liable for your health-care costs, like if you were involved in a road accident for example, or perhaps you have insurance (like travel insurance) that covers medical expenses, **you must cooperate with us in our efforts to recover the costs of the health care from the other person or insurer.** Any efforts you make to recover costs yourself from the other party may not affect our rights in any way. Otherwise, you might have to pay back the health-care costs to us.

We use your personal data with care

43. **If you have a health-care plan with us (or have requested one), we will record your details in our administrative system.** If you call us, we may record the conversation and store it in written form. Privacy regulations apply in this case. The applicable regulations are documented in the law, our code of conduct, and our privacy statement.

    If there are compelling reasons why we should not share your address, please let us know and we will take the appropriate measures.

44. **We are required to include your *burgerservicenummer* [personal identification number] (BSN) in our records.** We are also required to use it in any contact we have with health-care providers.

45. We will use your information and recorded telephone calls:
    - to administer and improve your health-care plan and our service
    - to satisfy legal requirements
    - for checks, analysis and (scientific or statistical) research
    - for marketing purposes
    - to prevent and tackle fraud and other forms of crime

    Occasionally we may also use medical details. We will only do this if required for the above purposes, with the exception of marketing. Please refer to our privacy statement for more information, including about your rights.

46. *Stichting CIS* maintains a list of people and entities who have committed fraud. We are entitled to check whether your name appears on the list and to share your details with other insurers through CIS if there is good reason to do this. We use this information when processing applications for health-care plans and when dealing with claims. You can find the privacy statement of CIS on their website at www.stichtingcis.nl.

47. In administering your health-care plan, we request your address and policy details from, and provide the same to, health-care providers and medical appliance suppliers for example. We do this electronically through Vecozo, the secure network for communication in health care, or through a secure email connection. This facilitates easy and secure submission of claims for health care you receive.

48. If you are a member of a collective health-care plan through your employer, we will share information with your employer in the course of administering the health-care plan. For example, we may check whether you are entitled (or still entitled) to a premium discount.

49. If you do not wish to receive any post, emails or other materials for marketing purposes, please let us know. We will then stop sending this information.

We may change the health-care plan

50. **We reserve the right to change the terms and conditions and the premium for the health-care plan.** We will tell the primary insured person about any changes, including details of when the changes take effect. This will usually be on 1 January, though it may also be later. You may be able to cancel in such cases, as specified in general rule 52.

You can switch health-care plans

51. The primary insured person may switch from Health Basic to Health Premium and vice versa with effect from 1 January of each year, though if the switch is to Health Premium we will ask a number of health-related questions first.

4. I’m switching from ONVZ, or ONVZ has terminated the health-care plan

Of course, we hope that you decide to stay with us. However, if you do decide to cancel the health-care plan, we explain below how and when you can do that.

Cancellation

52. **The primary insured person can cancel the health-care plan each year.** This can be done by letter, by email or through our website. If we receive notice of cancellation by 31 December, the health-care plan will end on 1 January of the following year.

    The primary insured person is also able to cancel the plan in 5 other instances, during the course of the year.

    a. If you are still in the ‘cooling-off period’ referred to in general rule 13.

    b. If you change employers and you are a member of a collective health-care plan with both your previous *and* new employer. In this case, you must notify us of cancellation within 1 month of your previous employment ending.

    c. If we change the health-care plan or the premium in the meantime, as referred to in general rule 50. The health-care plan will end on the date on which the change would have taken effect. In this case, you must notify us of cancellation before the change takes effect, or within 1 month of the primary insured person being notified of the change. You will not be entitled to cancel the health-care plan if the change is the result of a change in the law or where the change is to your advantage.

    d. If the *Nederlandse Zorgautoriteit* [Dutch Health-Care Authority] (NZa) notifies you that we have viewed your medical details that were not intended for us, though that is something that we would never do. We must receive notification of termination no later than 6 weeks after NZa informs the policyholder of the occurrence. Your health-care plan will then end on the 1st day of the 2nd month following your cancellation.

    e. When the insured person reaches the age of 18. The health-care plan ends on the 1st day of the month after the month in which the insured person turns 18.

Sometimes the health-care plan is terminated without cancellation

53. If, after taking out the Health Basic or Health Premium health-care plan, it emerges that you should have taken out (or need to take out) a basic health-care plan as defined in the *Zorgverzekeringswet* [Dutch Health Insurance Act], your Health Basic or Health Premium health-care plan will terminate from the start date of your basic health-care plan or the date on which you should have been insured under a basic health-care plan. If you have already paid premiums, we will refund these, less any health-care costs we have already reimbursed. If the health-care costs already reimbursed by us exceed the premiums paid, you will need to repay the difference to us.

54. The Health Basic and Health Premium plans also end when the insured party is no longer staying long term or residing in the Netherlands.

55. The health-care plan will end the day after the day of the insured person’s death. We will repay or offset any overpaid premiums.

Sometimes we terminate the health-care plan

56. **We will cancel the health-care plan if you fail to pay the premium on time.** We will take the following actions before cancelling your health-care plan.

    a. We will send you a reminder if you do not pay the premium (or do not pay it on time). We will also send you a reminder if you do not repay (or do not repay on time) any health-care costs advanced by us.

    b. If you are in arrears with your premiums by 2 months, we will write to you with our proposal for a payment plan. If you do not accept our proposal and you do not pay the outstanding amount, we will cancel your health-care plan.

c. If the payment of your health-care costs, the excess or the personal contribution is in arrears, we will also write to you with our proposal for a payment plan. If you do not accept our proposal and you do not pay the outstanding amount, we may cancel your health-care plan.

57. **Any costs that we incur in pursuing premium payment or repayment of any costs advanced by us** will be charged to you. This may include the costs of a debt collection agency or court costs.

58. We may also cancel the health-care plan if you threaten or intimidate our employees or damage our property.

If you commit fraud

59. **We will take action in the event of fraud.** Fraud is where you deliberately break a rule or regulation or arrange for another person to do this, with a view to either your own or another's personal gain. This is the case if you take out or attempt to take out a health-care plan with us using incorrect or incomplete information, or if you obtain or attempt to obtain reimbursement or services from us when you are not entitled to such.

    Examples of fraud include if you:
    - send us falsified documents
    - deliberately give us an incorrect view of your situation
    - make false statements in a claim
    - withhold any information we need

60. We will investigate any cases of suspected fraud in accordance with the *Protocol Verzekeraars en Criminaliteit* [Insurers and Criminality Protocol]. This protocol specifies the agreements insurers have made on how to tackle fraud.

61. In the event of fraud being established:
    - we will not reimburse any fraudulent invoices
    - we will require you to repay the costs we have incorrectly reimbursed to you or your health-care provider
    - we will charge you for the costs of investigating the fraud
    - we may report the matter to the police
    - we may see that your details are added to the registers referred to in general rule 46
    - we may cancel your health-care plan retrospectively with effect from the date on which the fraud took place
    - we may refuse you if you apply for a new health-care plan

If you are dissatisfied or wish to make a complaint

Though we endeavour at all times to serve you as well as possible, there may still be something you are not happy with. Below we set out the steps to take should you wish to make a complaint.

62. **If you are not satisfied with our decision, or are dissatisfied with our services, you can make a complaint to our complaints service.** We will reply within 30 days.

63. **If you are dissatisfied with our reply to your complaint, or if we fail to reply, you can refer your complaint to the complaints and disputes committee *Stichting Klachten en Geschillen Zorgverzekeringen* (SKGZ).** The SKGZ procedure involves 2 steps.

    a. The *Ombudsman Zorgverzekeringen* [Health-Care Insurance Ombudsman] will, in the first instance, attempt to resolve your complaint through mediation.
    b. If this proves unsuccessful, you may refer your complaint to the *Geschillencommissie Zorgverzekeringen* [Health Insurance Disputes Committee].

    Further information is available at skgz.nl/procedure.

    You can refer your complaint to SKGZ in 2 ways.
    a. By completing the online complaints form at skgz.nl/klacht-indienen
    b. By sending a letter to:

    SKGZ
    Antwoordnummer 5518
    3700 VB Zeist
    Netherlands

You will need to refer the complaint to SKGZ in good time. SKGZ has 4 different deadlines.

a. If you have had a reply from us, you can refer your complaint to the Ombudsman up to 1 year after the date of our reply.
b. If we did not reply, you can refer your complaint to the Ombudsman up to 13 months after your request to ONVZ.
c. You can ask SKGZ to refer your complaint straight to the *Geschillencommissie* [Disputes Committee]. This can be done up to 1 year after the act (or omission) of ONVZ referred to in your complaint. If you did not notice the act (or omission) straight away, the deadline of 1 year begins from the point at which you could reasonably have been aware of it.
d. If the Ombudsman has failed to resolve your problem to your satisfaction and you would like to refer the complaint to the *Geschillencommissie* [Disputes Committee], you can do this up to 3 months from the date of the Ombudsman's response.

You may also have the right to bring your complaint before the civil court. In this case, you will no longer be able to refer your complaint to SKGZ.

64. If you are complaining because our forms are too complicated or excessive, you may also contact the *Nederlandse Zorgautoriteit* (NZa) [Dutch Health-Care Authority] by telephone or by email.

Nederlandse Zorgautoriteit
Information helpline: 088 770 87 70
Email: informatielijn@nza.nl

Applicable law

65. The health-care plan is subject to Dutch law.

Health Basic & Health Premium 2021 coverage

ONVZ

2021 coverage

	Health Basic	Health Premium
General practitioners and staying healthy		
General practitioner (general medical care)	•	•
Thrombosis service	•	•
Quitting smoking		•
Medically necessary vaccinations (e.g. for travel) and influenza vaccination		•
Preventive medical investigations		•
Homeopathic or anthroposophic doctor		•
Hospital and medical specialists		
Medical specialist	•	•
Hospital admission	•	•
Specialist medical rehabilitation	•	•
Organ transplants and donation	•	•
Second opinion	•	•
Breast cancer: additional tests	•	•
Fertility treatment		•
In vitro fertilisation (IVF)		•
Plastic surgery		•
Sterilisation		•
Extra care		
Specialist medical nursing care at home	•	•
Stay in a guest house		•
Hospice (overnight costs)		•
Pregnancy and childbirth		
Antenatal screening	•	•
Pregnancy and childbirth	•	•
Maternity care and maternity package		•
Medication and medical appliances		
Medicines under Health Basic	•	•
Medicines under Health Premium		•
Medical appliances under Health Basic	•	•
Medical appliances under Health Premium		•
Oral and dental		
Dental surgery	•	•
Dental health care after an accident	•	•
General dental health care		•
Orthodontics up to the age of 18		•
Psychological health care		
General basic mental health care		•
Specialist mental health care	•	•
Transportation		
Medical transportation by ambulance	•	•
Repatriation in the event of death in the Netherlands	•	•
Other medical transportation		•
Other therapies		
Other therapies		•
Health care abroad and travel		
Emergency medical assistance abroad	•	•
Repatriation		•
Third-party claims for injury		
Third-party claims for injury		•

General practitioners and staying healthy

Coverage

General practitioner (general medical care)
Thrombosis service
Quitting smoking
Medically necessary vaccinations (e.g. for travel) and influenza vaccination
Preventive medical investigations
Homeopathic or anthroposophic doctor

ONVZ

General practitioner (general medical care)

If you have health problems, or questions about your health, your general practitioner will usually be your first port of call. You can also visit the general practitioner if you have a complaint of a psychological nature.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

In the Netherlands, it is customary to register with a general practitioner. Though this is not obligatory, it is a good idea since:
- you will then be able to go directly to a general practitioner when you need health care
- the general practitioner will have your medical record on file

Sometimes you may be treated by your general practitioner
The general practitioner will discuss your queries and symptoms with you, and establish a diagnosis. Where necessary, the general practitioner will arrange for you to undergo blood tests or other tests. In most cases, the general practitioner will be able to treat you independently. Sometimes he or she may refer you to a different health-care provider, like to a physiotherapist, psychologist, or medical specialist, for example.

Sometimes you may be treated by other health-care providers
Other health-care providers (medical assistants) usually work at the general practitioner's practice too, and they can include a nurse specialising in diabetes or lung conditions, or a psychologist. These assistants can treat you independently, under the responsibility of the general practitioner.

Sometimes you may be treated by both your general practitioner and other health-care providers
The general practitioner may also collaborate with health-care providers outside of the practice if you have COPD (chronic obstructive pulmonary disease), type-2 diabetes or cardiovascular disease, with a health-care provider like a physiotherapist or dietitian for example. This 'care chain' approach ensures you get health care tailored to your personal situation.

You may have to go to a different health-care provider for additional tests
The general practitioner may need further tests to be performed in order to establish an accurate diagnosis. Simple tests can generally be done at the practice itself. If a test cannot be performed at the practice, the general practitioner will refer you to a laboratory, a blood test clinic or the outpatient clinic at a hospital. The general practitioner will be notified of the results of the test, and can then treat you further.

Health Basic and Health Premium cover the following types of diagnostic tests:
- a laboratory test, for example a blood or urine test
- imaging, for example an X-ray or a scan
- a functional test, for example an electrocardiogram or pulmonary function test

Urgent health care: first your general practitioner or the out-of-hours practice
If you are in a life-threatening situation, call 112 immediately. If your situation is urgent but not life-threatening, first call your general practitioner or, if the practice is closed, the out-of-hours practice (*huisartsenpost*). They will assess how urgent your situation is and which health-care provider you need. In certain cases, the advice given by the staff at the out-of-hours practice over the telephone will be sufficient. If not, they will ask you to come to the practice. Once there they will, if necessary, give you a referral to the hospital's A&E department. If you turn up at the hospital's A&E department without a referral, you may be turned away or have to wait longer.

This combination of health care is referred to as general medical care, which is covered under the Health Basic and Health Premium health-care plans.

What is not covered
- primary-care admissions
- health care provided by an elderly medical care specialist or doctor for the mentally disabled

Thrombosis service

In cases of thrombosis, the blood clots at the wrong time or in the wrong place and this can block the flow of blood through the blood vessels. Anticoagulants (blood thinners) counteract this.

If you take anticoagulants, you will need regular blood tests to check the clotting time of your blood. This will usually involve the thrombosis service, an organisation that monitors and guides patients who are prescribed anticoagulants by their attending doctor. The thrombosis service has clinics where you can have a blood test, or the service can come to your home. If you would prefer to check the clotting time yourself, the thrombosis service can provide you with test equipment and help using it.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

Health Basic and Health Premium cover:
- blood tests by the thrombosis service
- tests to measure the blood clotting time
- advice on medicines for preventing thrombosis

If you measure the coagulation times of your own blood, Health Basic and Health Premium also cover:
- instruction in how to use the equipment and support with your readings

The coverage for the self-testing device and the related accessories and consumables is as shown under Medical appliances for thrombosis.

What you have to do yourself

You need to have a referral first
You are required to have a referral from your general practitioner/doctor or medical specialist before the health care begins.

Quitting smoking

If you would like to quit smoking, but cannot do it alone, your general practitioner, midwife or medical specialist can help you with brief, supportive advice. Your entitlements in that case are stated in the coverage.

For more intensive support, you can join a programme aimed at quitting smoking by changing your behaviour. Professionals help you by providing advice, personal coaching, telephone coaching and group courses, where necessary in combination with nicotine replacements such as nicotine patches, nicotine lozenges or chewable tablets, or with medicines such as Nortrilen, Zyban or Champix.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• Programme aimed at quitting smoking including nicotine replacement/ medicines once per calendar year • Laser therapy, Allen Carr training or *De Opluchting* training, up to a maximum of €250 per calendar year

What is covered

Health Premium covers:
- a programme aimed at quitting smoking, and the associated prescribed nicotine replacements and medicines, once per calendar year

For a programme aimed at quitting smoking, you can go to:
- general practitioner
- a nurse
- a health-care provider listed on the *Stoppen met Roken* (quit smoking) quality register of the *Stop met Roken* partnership. To see the list of registered health-care providers, visit www.kwaliteitsregisterstopmetroken.nl

You can pick up the nicotine replacements and medicines associated with the treatment at a:
- pharmacy
- dispensing practice

Health Premium also covers the following programmes, up to a combined maximum of €250 per calendar year:
- laser therapy
- Allen Carr training
- *De Opluchting* training (video course, email course or one-day open course)

What you have to do yourself

A prescription is needed for the nicotine replacements and medicines
You will need a prescription from your general practitioner for any nicotine replacements and medicines associated with the treatment, or from a medical specialist, midwife or nursing specialist. The latter 3 must complete an application form, which you must send along with your claim. You will find this form on our website, or you can call our Service Centre.

Medically necessary vaccinations (e.g. for travel) and influenza vaccination

You can be vaccinated against certain diseases. For example, you can get the annual influenza vaccination, and before travelling abroad you can be vaccinated against other diseases like yellow fever and rabies. You can also take malaria tablets.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• Influenza vaccination, once per calendar year • Other medically necessary vaccinations (e.g. for travel) up to a combined maximum of €250 per calendar year

What is covered

Health Premium covers:
- influenza vaccination, once per calendar year

Health Premium also covers the following, up to a combined maximum of €250 per calendar year:
- travel vaccinations and preventive medicines (like malaria tablets) for serious contagious diseases
- other vaccinations to prevent serious contagious diseases

Whom to contact
- general practitioner
- pharmacy
- the municipal public health service (GGD)
- thuisvaccinatie.nl
- a vaccination centre

What is not covered
- vaccination booklet
- administrative costs
- other recommended travel health products like DEET insect repellent and ORS hydration tablets

What you have to do yourself

A prescription is required to pick up preventive medicines and vaccines from the pharmacy
If you are getting malaria tablets for instance, or the health-care provider is asking you to collect a vaccine, the costs are only reimbursed under Health Premium where the tablets or vaccine are prescribed by a doctor and provided by a licensed pharmacist or a dispensing practice.

Preventive medical investigations

You generally have a medical investigation when you have a health problem, in which case this is covered under general medical care or specialist medical care. However, medical investigations can also be performed to detect an illness or other health risk if you are not (yet) experiencing any health problems. An example would be where you are concerned about an illness that runs in your family. This is known as a preventive medical investigation. Preventive medical investigations also start at the practice of the general practitioner.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	75% up to a maximum of €250 per calendar year

What is covered

If you want to undergo a preventive medical investigation for which you have no medical reason, Health Premium will cover 75% of the costs up to €250 per calendar year. It can be a targeted investigation, such as for cardiovascular disease, or a general physical examination. A doctor will discuss the results with you.

Some doctors advise against preventive medical investigations for which there is no medical reason. If you are in any doubt as to whether preventive investigations are appropriate in your case, our *ZorgConsulent* advisers can help by providing more information.

Whom to contact
- general practitioner
- a medical specialist

What is not covered
- population screening. This concerns preventive medical investigations that the Dutch government provides and pays for, such as for breast cancer or bowel cancer. If you are eligible to take part in these, you will be notified automatically
- medical investigations for or through your employer or sports club

What you have to do yourself

The invoice for preventive medical investigations must state that investigations performed by a general practitioner or medical specialist are involved.

Good to know

For more information, please contact the *ZorgConsulent*
Our *ZorgConsulent* advisers also have information about where you can go for the investigations.

Homeopathic or anthroposophic doctor

If you have health problems, or questions about your health, your general practitioner will usually be your first port of call, but you can go to a homeopathic or anthroposophic doctor if you prefer. This homeopathic or anthroposophic doctor will discuss your questions and symptoms with you, and make a diagnosis. Where necessary, the general practitioner will arrange for you to undergo blood tests or other tests.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Maximum of €65 per consultation or treatment + tests + registered medicines, up to a combined maximum of €750 per calendar year

What is covered

Health Premium covers consultations and treatment provided by a homeopathic or anthroposophic doctor where this concerns diagnosing and/or curing an ailment. We reimburse the costs of a maximum of 1 consultation or treatment per day up to a maximum of €65 per consultation or treatment, as well as the costs of registered homeopathic and anthroposophic medicines, and lab tests and other tests/checks that are necessary for your treatment. All this health care combined is covered for up to a maximum of €750 per calendar year.

Whom to contact
- homeopathic or anthroposophic doctor
- for medicines: pharmacy or dispensing general practitioner’s practice

What is not covered
- activities that are not aimed at diagnosing or curing an ailment, like yoga and mindfulness for example

Good to know

For laboratory tests and medicines, you must have a prescription from your doctor

You must collect medicines from the pharmacy or dispensing general practitioner’s practice
We do not reimburse the costs of registered homeopathic and anthroposophic medicines that you collect elsewhere.

Hospital and medical specialists

Coverage

Medical specialist
Hospital admission
Specialist medical rehabilitation
Organ transplants and donation
Second opinion
Breast cancer: additional tests
Fertility treatment
In vitro fertilisation (IVF)
Plastic surgery
Sterilisation

ONVZ

Medical specialist

For specialist health care, you go to the medical specialist. You always need to have a referral, which you will normally get from your general practitioner. The medical specialist works in a hospital, an independent treatment centre or in a private practice.

A medical specialist will usually conduct the initial consultation himself/herself. He/she will establish a diagnosis and discuss treatment with you. He/she will be your primary practitioner. After the initial consultation, the medical specialist may outsource elements of the health care to others, for example a scan or different tests. This all comes under specialist medical health care.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

Health Basic and Health Premium cover specialist medical care and any nursing, allied health care, medicines, medical appliances and dressings associated with your treatment. Other forms of health care are also categorised as medical specialist care, such as in-centre or home dialysis, audiological care, mechanical respiration and genetic testing.

If you need to be admitted, we reimburse the costs of your hospitalisation for a period of no longer than 1 year.

Whom to contact
An anaesthetist, cardiologist, surgeon, cardiothoracic surgeon, dermatologist, gynaecologist, internist, ENT doctor, paediatrician, clinical geneticist, clinical geriatric specialist, pulmonologist, gastroenterologist, medical microbiologist, neurosurgeon, neurologist, nuclear medicine specialist, ophthalmologist, orthopaedic surgeon, pathologist, plastic surgeon, psychiatrist, radiologist, radiation therapist, rheumatologist, rehabilitation specialist, sports doctor or urologist.

A dental surgeon is not classified as a medical specialist in the Netherlands, but does give treatment in a hospital. The costs of dental surgery come under the Oral and dental coverage.

Additional terms and conditions apply to some types of medical specialist care, and some types are not covered by the Health Basic plan, although they are under the Health Premium plan. The additional terms and conditions and the coverage are listed separately
for the following types of health care:
- specialist medical rehabilitation
- organ transplants and donation
- second opinion
- breast cancer: additional tests
- fertility treatment
- in vitro fertilisation (IVF)
- plastic surgery, for certain indications
- sterilisation

What is not covered
- surgery on the uvula (uvuloplasty) to combat snoring
- laser vision correction
- circumcision without medical necessity

What you have to do yourself

You need to have a referral first
Before consulting a medical specialist, you will need a referral from your general practitioner, another medical specialist, a school doctor, a corporate doctor, a doctor for the mentally disabled, or an elderly medical care specialist (a ‘nursing home doctor’). In the case of pregnancy and childbirth, your referral may be from a midwife. For ophthalmology, an orthoptist or optometrist can also provide the referral. No referral is needed in acute cases.

You may need our prior permission
We will only cover treatments specified on the *limitatieve lijst machtigingen medisch specialistische zorg* [exhaustive list of authorisations for specialist medical care][1] where we have given our prior permission. Your medical specialist will, in most cases, seek our permission for you. You will find this list on our website, or you can call our Service Centre.

Good to know

You can also get a second opinion
If you have any concerns or doubts about the diagnosis or proposed treatment, we also cover a second opinion by another medical specialist. You can read more about this in the Second opinion coverage section.

In the event of a waiting list, please contact the *ZorgConsulent*
You can ask our *ZorgConsulent* advisers to help reduce the waiting time on your behalf. The *ZorgConsulent* advisers can also help with other types of health-care mediation.

Hospital admission

Minor operations and tests are usually performed in the outpatient clinic at a hospital or in day treatment, where you can go home the same day.

If extensive tests or treatment performed by a medical specialist or dental surgeon require you to stay in the hospital overnight, we call this hospital admission.

Coverage under each health-care plan

Health Basic	100%, maximum admission of 1 year
Health Premium	100%, maximum admission of 1 year

What is covered

Health Basic and Health Premium cover hospital admission and associated health care for a period of no longer than 1 year.

The following forms part of hospital care:
- nursing and other care
- allied health care
- medicines
- medical appliances and dressings

Whom to contact
- hospital
- independent treatment centre
- institution that specialises in a particular type of treatment, for example a lung clinic or a centre for epilepsy

What you have to do yourself

You need to have a referral first
Before consulting a medical specialist, you will need a referral from your general practitioner, another medical specialist, a school doctor, a corporate doctor, a doctor for the mentally disabled, or an elderly medical care specialist (a ‘nursing home doctor’). In the case of an ophthalmologist, an orthoptist or optometrist may also provide the referral. In the case of pregnancy and childbirth, your referral may be from a midwife. No referral is needed in acute cases.

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Toestemming voor zorg’, or call us on +31 (0)30 639 62 22

Good to know

We only reimburse the costs of admission if we also cover the relevant treatment
Health Basic and Health Premium will only cover admission in connection with specialist medical treatment or dental surgery if the plan covers the treatment involved.

We will cover up to 1 continuous year of admission
In the event of the period of admission being interrupted, we will treat the admission as continuous, providing the interruption is for no more than 30 days, even if you are admitted to different health-care facilities. If the interruption is for a holiday or weekend leave, any such leave will count towards the 1-year total.

Specialist medical rehabilitation

Mobility problems can often be solved through physiotherapy, remedial therapy or occupational therapy. In that case, rehabilitation will be covered under Other therapies. If your situation is slightly more complex than that, you will be referred to a rehabilitation specialist for specialist medical rehabilitation.

The rehabilitation specialist works at the hospital's outpatient clinic or in a rehabilitation centre.

Coverage under each health-care plan

Health Basic	100%, on approval A maximum of 1 year applies to admissions
Health Premium	100%, on approval A maximum of 1 year applies to admissions

What is covered

The rehabilitation specialist will start off by determining the medical indication, assessing whether specialist medical rehabilitation is indeed the right care option for you. You may be treated by the rehabilitation specialist. He or she may also conclude that you need intensive treatment by a team of health-care providers, which is called interdisciplinary specialist medical rehabilitation. If this is the case, it will be stated in the indication.

We reimburse the costs of interdisciplinary specialist medical rehabilitation provided through the rehabilitation specialist only if all 6 of the following conditions are met:
- you have problems with movement or intellectual or behavioural difficulties due to a disorder/ailment affecting your musculoskeletal system, central nervous system, cardio or respiratory system, or an oncological disorder
- you have problems in several areas (such as mobility, personal care and communication), and these problems are interrelated
- treatment by a team of health-care providers is expected to lead to better results in preventing, reducing or overcoming disability
- in the view of your doctor, primary health care (by a general practitioner, physiotherapist or other medical professional) will yield insufficient results
- interdisciplinary specialist medical rehabilitation will enable you to keep functioning independently or retain the level of independence that is possible given your impairments
- ultimate responsibility for the organisation and quality of rehabilitation care will lie with a rehabilitation specialist

If you are already in a process of interdisciplinary specialist medical rehabilitation, and the rehabilitation specialist expects admission to lead to better or faster results than continuing on an outpatient basis, we will also cover the costs involved in admission to hospital or a rehabilitation centre for a period not exceeding 1 year. If you are first admitted to hospital and then to a rehabilitation centre, we will reimburse the costs of up to 1 year for your stay at both combined.

What is not covered
- geriatric rehabilitation. This involves integrated and multidisciplinary rehabilitation care, such as the care generally provided by elderly medical care specialists to elderly people who are vulnerable and suffering from complex multi-morbidity and diminished learning and training ability.

What you have to do yourself

You need to have a referral first
Before you see a rehabilitation specialist, you need a referral from your general practitioner, the corporate doctor, a school doctor, or a medical specialist.

You must seek our permission first
You may have to obtain our permission before you start receiving specialist medical rehabilitation.

This depends on the health-care provider you select. There are 2 options.
1. If your health-care provider is on the list of *Toestemmingsvrije revalidatiecentra* [list of rehabilitation centres for which our permission is not required], you do not have to do anything. We have already made arrangements with these health-care providers concerning giving permission.
2. If your health-care provider has not been included on the list, you will need to ask our permission in advance yourself. If our permission is not obtained in advance, we will not reimburse the costs of the health care.

You can check our website for a list of the rehabilitation centres[1] we have made such arrangements with, or you can call our Service Centre.

Organ transplants and donation

An organ transplant involves replacing a poorly functioning or entirely dysfunctional organ in a 'recipient' with the same organ from another person, i.e. the donor. A donor can be a living person, such as in cases of a kidney transplant or a transplant of a portion of the liver. Tissue transplants are also fairly common, such as skin or cornea transplants.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

If you are the recipient of an organ or tissue, we cover the following medical specialist care for the transplant of bone marrow, bone, cornea, skin tissue, kidney, heart, liver (orthotopic), lung, heart/lung, and kidney/pancreas:
- specialist medical care relating to the selection of the donor
- harvesting the organ or tissue from the donor
- examination, preservation and transport of the organ or tissue for the transplant, if harvested from a deceased donor
- the actual organ or tissue transplant
- all health care for the donor that is covered by this health-care plan and relates to their admission to hospital for selection and harvesting of the organ or tissue. This coverage is provided up to 13 weeks after discharge from hospital following the procedure. In the case of a liver transplant, this period is extended to 6 months after discharge from hospital

If the donor is not covered by a health-care plan was defined in the *Zorgverzekeringswet* [Dutch Health Insurance Act] (with us or with another health insurer), we will also reimburse the costs of:
- 2nd class travel in public transport in the Netherlands from and to the facility where all health care specified above for the donor is provided. Such travel may also be by car if medically necessary
- transport of the donor to the Netherlands and back if the donor lives abroad and the operation to transplant the kidney, bone marrow or liver is taking place in the Netherlands. We also reimburse the other costs relating to the transplant that the donor incurs due to living abroad. Accommodation costs in the Netherlands and any loss of income are not covered

If you are the donor, we cover the costs of 2nd class travel in public transport to and from the facility where all health care specified above is provided. Such travel may also be by car if medically necessary.

The tissue and organs will be transplanted at a hospital in the Netherlands. If the operation must be performed in another country on medical grounds, costs will only be reimbursed if we have given our permission in advance, which we will only do in very exceptional cases.

[1] www.onvz.nl: click 'Snel regelen' and then 'Handige downloads', or call us on +31 (0)30 639 62 22

What is not covered
- the costs of transplants of organs and tissues other than those listed

What you have to do yourself

You must request our permission first
We only cover the costs of this health care if you have obtained permission from us in advance.

Second opinion

If you have any doubts about the diagnosis that the medical specialist has discussed with you, or about a proposed treatment, you can ask for a second opinion from another doctor. This doctor will only give his view and will not take over the treatment.

A second opinion is intended to ensure you are properly informed before making a decision about a treatment. It is important that you discuss your wish for a second opinion with your own medical specialist first, as you will be returning to that medical specialist after receiving the second opinion.

Coverage under each health-care plan

Health Basic	100%, for specialist medical care
Health Premium	100%, for specialist medical care

What is covered

We reimburse the costs of a second opinion provided these 5 conditions are met:
1. the health care is covered under your Health Basic or Health Premium plan
2. the diagnostics or the proposed treatment to which the second opinion relates is also covered by your Health Basic or Health Premium plan
3. the doctor carrying out the second opinion works in the same discipline as your own medical specialist
4. you have a referral from a doctor. This can be your own medical specialist or your general practitioner
5. you return to your own medical specialist with the second opinion

Whom to contact
- a doctor who works in the same discipline as your own medical specialist

What is not covered
- a second opinion about the extent to which you are incapacitated for work
- costs for a copy of your medical file if your own medical specialist or the hospital charges for this

What you have to do yourself

You need to have a referral
We only reimburse the second opinion if you have a referral from a doctor. This can be your own medical specialist, or your general practitioner can write the referral.

Good to know

Our *ZorgConsulent* advisers are ready to help
You can also consult our *ZorgConsulent* advisers for advice and information about getting a second opinion.

Breast cancer: additional tests

If you have been diagnosed with breast cancer, you will decide on your treatment together with your medical specialist. Chemotherapy may also be one of your options.

If there are doubts about whether chemotherapy would work in your case, a MammaPrint or Oncotype DX test may help you and the medical specialist in deciding on your treatment.

Coverage under each health-care plan

Health Basic	MammaPrint and Oncotype DX
Health Premium	MammaPrint and Oncotype DX

What is covered

MammaPrint and Oncotype DX are tests that look at gene activity in the tumour. The test results show the likelihood of metastasis or relapse of the tumour.

Health Basic and Health Premium provide coverage for MammaPrint and Oncotype DX, provided the test is prescribed by your medical specialist.

You can discuss with your medical specialist whether either of these tests would be appropriate in your case, which depends on the kind of breast cancer, the stage and the characteristics of the tumour.

Diagnosis and treatment of breast cancer comes under the coverage for Medical specialist.

What you have to do yourself

You need a prescription from your medical specialist
You do not need to do anything to arrange the test. Your medical specialist will arrange it for you.

Fertility treatment

If you cannot become pregnant for medical reasons, but still want to have children, fertility treatment can possibly help.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100% (up to the age of 43) For IVF: 1st, 2nd and 3rd attempts only, in accordance with the IVF coverage

What is covered

If you a woman under the age of 43, Health Premium will reimburse the costs of:
- specialist medical tests and treatment
- artificial insemination (AI) or intra-uterine insemination (IUI)
- in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI), including freezing of embryos (cryopreservation)
- associated medicines

For IVF and ICSI, additional terms and conditions apply. For this reason, these are listed separately.

Whom to contact
- hospital
- independent treatment centre (fertility clinic)

What is not covered
- costs of sperm or ovum donation. This applies to the costs of the sperm cells or ova (egg cells) and to any costs for medical treatment needed to obtain the sperm cells or ova

What you have to do yourself

You need to have a referral first
Before consulting a medical specialist, you will need a referral from your general practitioner or another medical specialist.

Good to know

An age limit applies
We do not reimburse the costs of fertility treatment where the woman is over 43 years of age.

We consider the likelihood of pregnancy
The age of the woman and the quality of the sperm are key factors in determining the likelihood of pregnancy. The general practitioner determines the likelihood of success. Where you have a good chance of becoming pregnant naturally, Health Premium will only cover the costs of fertility treatment if you have failed to become pregnant over an extended period of time.

Medicines are included in the hospital's costs
You therefore do not collect the medicines yourself from a pharmacy and do not pay for them separately.

You pay for donor sperm yourself
If donor sperm is needed for AI or IUI, you will need to pay these costs yourself. The costs will vary from hospital to hospital. You will also have to pay if you want to reserve sperm from a particular donor.

In vitro fertilisation (IVF)

If you have failed to become pregnant over an extended period of time, the general practitioner can ultimately refer you to the medical specialist who will discuss matters like whether IVF or another form of fertility treatment would be right for you. IVF involves fertilisation outside of the body. If, during IVF, a spermatozoon is injected into the ovum, this is known as an ICSI (intracytoplasmic sperm injection) procedure.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Up to the age of 43, 3 attempts After continuing pregnancy, up to another 3 attempts

What is covered

Health Premium covers the cost of IVF and ICSI if you have a medical indication for this treatment. Each time you wish to become pregnant, we cover the 1st, 2nd and 3rd IVF or ICSI attempts.

An IVF or ICSI attempt has 4 stages:
- stage 1: hormone treatment for maturation of your ova
- stage 2: collection of mature ova from your ovaries (follicle aspiration)
- stage 3: the laboratory stage, in which your ova are fertilised with spermatozoa and develop into embryos
- stage 4: the transfer, on 1 or more occasions, of 1 or 2 embryos into your womb

If stage 2 is successful, the treatment will count as an attempt. The attempt continues until all the frozen embryos have been transferred into your womb, or until the attempt has resulted in a continuing pregnancy, whichever comes first.

- If the attempt results in a continuing pregnancy and frozen embryos remain, the transfer of these at a later time comes under the Fertility treatment cover.
- If the attempt does not result in a continuing pregnancy, the attempt will be deemed to have ended.

If you start again with stage 1 or 2, this will count as a new attempt. Note: If any frozen embryos still remain from a previous attempt, Health Premium will not cover the costs of a new attempt nor the preservation of the embryos from the new attempt.

If this procedure does result in a continuing pregnancy, the number of attempts will start over again and the next treatment will count as a new 1st attempt.

A continuing pregnancy is where the embryo survives for:

- 12 weeks following the last menstruation, in the event of spontaneous pregnancy
- 10 weeks after follicle aspiration
- 9 weeks and 3 days in the case of implantation of a frozen embryo

For this reimbursement, an age limit applies for the woman. You must be under 43 at the start of an attempt, i.e. if you start a new attempt after you reach the age of 43, this will not be covered. If you are under 38 at the time of the 1st or 2nd attempt, Health Premium will only reimburse the costs if no more than 1 embryo is transferred each time.

Whom to contact

- hospital
- independent treatment centre (fertility clinic)

What is not covered

- tests that predict the success rate of IVF, such as the ReceptIVFity test or the ERA test (endometrial receptivity analysis)
- techniques that have not been scientifically proven to be effective, such as assisted hatching and in vitro maturation
- costs of sperm or ovum donation. This applies to the costs of the sperm cells or ova (egg cells) and to any costs for medical treatment needed to obtain the sperm cells or ova

What you have to do yourself

You need to have a referral first

Before consulting a medical specialist, you will need a referral from your general practitioner or another medical specialist.

Good to know

We consider the likelihood of pregnancy

The general practitioner determines whether you have a good chance of becoming pregnant naturally. If you have been referred to the gynaecologist, this practitioner will estimate the chance of a fertility treatment like IVF succeeding. The costs of IVF will be reimbursed under Health Premium as long as, according to the medical guidelines, this is still considered a viable option in your case.

Medicines are included in the hospital's costs

You therefore do not collect the medicines yourself from a pharmacy and do not pay for them separately.

Plastic surgery

Many people think that plastic surgery involves making changes to someone's appearance so they look better. However, it is much more than this. It also covers operations that correct congenital abnormalities or repair the body following accidents, for example in the case of burns. Plastic surgery can also play a role in alleviating scars left after medical procedures.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%, in specific cases

What is covered

Health Premium covers plastic surgery for:
- physical disfigurement that gives rise to a demonstrable physical dysfunction
- the removal or replacement of breast prostheses where this is medically necessary
- correction of paralysed or weak upper eyelids causing serious impairment of the field of vision or where this is the result of a congenital abnormality or chronic condition present at birth
- correction of the position of the ears, for children up to the age of 18 years
- treatment of primary features of genitals where sex reassignment surgery is required

In these cases, Health Premium also covers nursing and other care, allied health care, medicines, medical appliances and dressings.

If you need to be admitted, the costs of your hospitalisation are reimbursed under Health Premium, under the Hospital admission coverage.

Whom to contact
Plastic surgery is usually performed by a plastic surgeon. However, other medical specialists such as an ophthalmologist or an ENT doctor can also perform operations involving plastic surgery.

These medical specialists work in a hospital or an independent treatment centre.

What is not covered
- plastic surgery without medical necessity
- the suction-assisted removal of fatty tissue (liposuction)
- breast enlargement
- tattoos, or skin treatment using cryotherapy, diathermy or lasers
- reconstruction of the uvula (uvuloplasty) to combat snoring

What you have to do yourself

You need to have a referral first
Before consulting a medical specialist, you will need a referral from your general practitioner, another medical specialist, a school doctor, a corporate doctor, a doctor for the mentally disabled, or an elderly medical care specialist (a 'nursing home doctor'). No referral is needed in acute cases.

You will usually need our prior permission
We will only cover treatments specified on the *limitatieve lijst machtigingen medisch specialistische zorg* [exhaustive list of authorisations for specialist medical care][1] where we have given our prior permission. Your medical specialist will, in most cases, seek our permission for you. You will find this list on our website, or you can call our Service Centre.

Good to know

In the event of a waiting list, please contact the *ZorgConsulent*
You can ask our *ZorgConsulent* advisers to help reduce the waiting time on your behalf. The *ZorgConsulent* advisers can also help with other types of health-care mediation.

[1] www.onvz.nl: click 'Snel regelen' and then 'Toestemming voor zorg', or call us on +31 (0)30 639 62 22

Sterilisation

If you do not want any (more) children, sterilisation is usually a permanent way of preventing pregnancy. Both women and men can undergo sterilisation. For men, the operation is called a ‘vasectomy’.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• Up to €1200 for female sterilisation • Up to €400 for male sterilisation Once during the entire term of the health-care plan

What is covered

Health Premium reimburses up to €400 for male sterilisation and up to €1200 for female sterilisation Sometimes a check-up following the procedure will be charged separately. This is also covered. Once the maximum amount has been reached, we do not cover further costs of care, not even in a subsequent year.

Whom to contact
- a medical specialist
- for a vasectomy: also general practitioner

What is not covered
- sterilisation reversal operation

Extra care
Coverage

Specialist medical nursing care at home
Stay in a guest house
Hospice (overnight costs)

ONVZ

Specialist medical nursing care at home

If you need nursing care at home, like after discharge from the hospital for example, the hospital will arrange for you to receive specialist medical nursing care at home.

Coverage under each health-care plan

Health Basic	100%, up to 14 days
Health Premium	100%, up to 14 days

What is covered

Health Basic and Health Premium reimburse the costs of nursing care provided in your home for the purpose of specialist medical care for a maximum of 14 days. This is the care that is required after your discharge from hospital, or that replaces hospital admission altogether. This health care is provided by a nurse or specialist nurse.

Whom to contact
- hospital
- general or specialist nurse

The hospital arranges this health care. The medical specialist remains ultimately responsible for your health care and for the supervision of the nursing provided.

What is not covered
- district nursing
- personal care
- nursing care while admitted

Nursing relating to childbirth comes under the coverage for Maternity care and maternity package and not under the coverage you are reading about now.

What you have to do yourself

You must seek our permission first
We only reimburse the costs of this health care if we have given permission before the health care starts. A treatment plan (or requisition for this care) drawn up by the medical specialist must be submitted along with the application for permission. The treatment plan includes the diagnosis, the nature of the nursing care required, how often this will be needed, and for how long (expected duration).

Stay in a guest house

A hospital admission can be very disruptive and confusing. If your child is admitted to hospital, you, as a parent, will probably want to be close by. And if you are the one who is admitted to hospital, you might want to have a family member close by.

This is precisely why many hospitals have a guest house, such as a Ronald McDonald House, or guest rooms right in the hospital. These guest houses allow parents and family members to spend the night close to the hospital while the patient is awaiting or undergoing a serious operation/treatment.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Stays at a hospital guest house are charged at a daily rate. In the following, we will refer to these costs as overnight costs. Guest houses sometimes refer to their charges as a 'personal contribution'. Health Premium reimburses overnight costs in the following 3 situations:

1. Hospital admission of a child aged under 18
If your child is treated at or admitted to the hospital, the Health Premium plan will cover the parent's overnight costs, provided that the parent is also insured with us.

2. Hospital admission from the age of 18
If you are aged 18 or above, the Health Premium plan will cover the overnight costs of 1 family member during your hospital admission. This family member must, however, also be insured with us.

3. After a transplant or cancer treatment
Health Premium also reimburses the overnight costs for you and a companion:
- after a transplant
- in case of chemotherapy, radiotherapy or immunotherapy for cancer

Whom to contact
- the hospital's guest house/guest rooms
- a Ronald McDonald House

Good to know

The hospital can inform you about your options
Alternatively, you can check the hospital's website for details. Information about the Ronald McDonald Houses is available on the *Ronald McDonald Kinderfonds* website at www.kinderfonds.nl.

Hospice (overnight costs)

If you are approaching the last stage of your life, you have the option of spending this time at a hospice where carers and volunteers provide care and support in a homelike environment. Hospice care is intended to ease pain and discomfort.

Every hospice has different care options. There are hospices that provide fairly straightforward care, which are sometimes referred to as a palliative-care facility, and there are also hospices that provide complex care.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Overnight costs for a maximum of 3 months

What is covered

The coverage provided for hospice care depends on your personal situation, as well as on the hospice. In most cases, Health Basic and Health Premium do not cover this health care. The coverage you are reading about now applies to overnight costs when staying in the hospice.

The hospice will sometimes charge you for these costs or, at any rate, will generally charge you a personal contribution to cover things such as your meals there. At some hospices, you can also 'order' additional facilities, such as an extra bed and meals for your partner, or extra coffee, tea or fruit in your room. Health Premium reimburses the personal contribution for your stay at the hospice (including the extra facilities).

What is not covered
- an income-dependant personal contribution
- primary-care admissions
- nursing and other care

What you have to do yourself

The *Centrum Indicatiestelling Zorg* [Care Needs Assessment Centre] (CIZ), your general practitioner or a medical specialist must have given a medical indication
The medical indication must be enclosed with the claim.

Pregnancy and childbirth
Coverage

Antenatal screening
Pregnancy and childbirth
Maternity care and maternity package

ONVZ

Antenatal screening

Antenatal screening is a test during pregnancy to determine the likelihood of the unborn child having a disorder such as Down's syndrome or spina bifida. You decide whether to have the antenatal screening done. To assist you in making this decision, the midwife, general practitioner or gynaecologist will (if you want) go through with you the types of antenatal screening that are available and what the advantages and disadvantages are. This discussion is referred to as 'counselling'.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

Health Basic and Health Premium cover the costs of counselling, as well as the costs of antenatal screening as specified below.

Antenatal screening between the 9th and 14th weeks of pregnancy
During this period, you can have a combination test or an NIPT(Non-invasive prenatal test). You pay the costs yourself, unless the midwife, general practitioner or gynaecologist determines that there is a medical indication in your case. This could be because of your age, problems in a previous pregnancy or a hereditary condition in your family. Where a medical indication applies, we will reimburse the combination test or the NIPT.

If the tests indicate that your unborn child has an increased risk of a condition, your midwife, general practitioner or gynaecologist will then go over your options for antenatal follow-up tests, such as chorionic villus sampling, amniocentesis, or a more extensive ultrasound (advanced ultrasound scan, GUO). These follow-up tests can provide greater certainty. We cover antenatal follow-up tests in the case of an increased risk of a condition, or where there is another medical indication.

Antenatal screening around the 20th week of pregnancy
At this stage of the pregnancy, you can have a 20-week ultrasound scan (routine ultrasonography (SEO), which is covered under the Health Basic and Health Premium health-care plans. You do not need a separate medical indication for this. If the ultrasound scan suggests there is an indication for further investigation, such as an advanced ultrasound scan (GUO), we will also cover that.

What you have to do yourself

In some cases, you need to have a referral
If you have not had the combination test first, you will need a referral from your midwife, general practitioner or medical specialist for the NIPT, GUO or antenatal follow-up tests.

Pregnancy and childbirth

A pregnancy is an exciting time in your life with many new experiences. It is also a time when you have to make all kinds of arrangements, and you may have all sorts of questions.

A midwife is the person to turn to with questions. If you are pregnant you can make an appointment with a midwife without a referral. The midwife will answer your questions, support you during the pregnancy and prepare you for labour. Some general practitioners can also provide obstetric care. If yours is one of them, you can choose to go to your general practitioner instead of a midwife.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

Very early on in the pregnancy, your midwife or general practitioner will discuss the possibility of antenatal screening with you. They will also ask you where you want to give birth: at home, at a birth centre or in hospital.

If you develop medical problems during your pregnancy, such as high blood pressure or gestational diabetes, your general practitioner or midwife will refer you to a gynaecologist. You will also be referred to a gynaecologist if there is an increased risk of medical problems during pregnancy or labour in your case. The gynaecologist will then take over and you will give birth in hospital.

We reimburse the costs of obstetric care by a general practitioner, midwife or gynaecologist. This applies to the entire pregnancy including check-ups after childbirth. There are 3 options.

1. Home birth
If you would prefer to give birth in your trusted home environment, we will cover obstetric care by the midwife or general practitioner. If there are problems and you have to give birth at the hospital after all, we will cover that as well. In that case, situation 3 will apply.

2. Giving birth at a birth centre, or in hospital without this being medically necessary
If you would prefer to have extra medical care close to home, you can choose to give birth at the hospital's outpatient clinic without this being medically necessary, or at a birth centre. In most cases, your own midwife or general practitioner will support and help you during labour there. in which case we cover the costs of the related obstetric care and maternity care. If you stay in the birth centre for a few days after the birth, we will not reimburse the costs of this after the day of the birth. In case of problems that result in you having to give birth in hospital, situation 3 will apply.

3. Hospital birth based on a medical indication
If there is a risk of complications during labour or you are already under a gynaecologist's supervision, you will give birth at the hospital's outpatient clinic based on a medical indication. Your gynaecologist will help you through labour. We cover obstetric care by a gynaecologist. In the event that hospital admission is needed, we will also cover that.

What is not covered
- sterile water injections
- days spent in the birth centre after the day you give birth
- hotel facilities or other luxury care at the birth centre

What you have to do yourself

You must have a referral in advance for the gynaecologist
Before you see a gynaecologist, you need a referral from your general practitioner or midwife. No referral is needed in acute cases.

Maternity care and maternity package

If you do not experience any problems during your pregnancy, you can choose where to give birth: at home, at a birth centre or in hospital. If there are problems or risks, the delivery will take place in hospital. No matter where you give birth, under the Health Premium plan you are entitled to maternity care after delivery and to a maternity package.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• up to 10 days of maternity care • maternity package

What is covered

Maternity care
After the delivery, the maternity nurse will look after you and your newborn. After delivery, she will help with the care of your baby and provide information and advice. If you spend the days following the birth at home, the maternity nurse will also do some light housekeeping.

Health Premium covers:
- registration and initial interview by the maternity centre or birth centre
- assistance provided by a nurse or maternity nurse during delivery (childbirth assistance), up to a maximum of 2 hours after delivery of the placenta
- maternity care after the birth

The number of hours of maternity care you receive depends on your personal situation and where you give birth. The maternity centre or birth centre determines this on the basis of a protocol. You receive a minimum of 24 hours and maximum of 80 hours. This is divided over a maximum of 10 days from the delivery. The days you spend in hospital are deducted from this number.

Here is a quick overview of the possible situations.

1. **You have given birth at home.** The maternity centre decides the number of hours of maternity care, in that case. In doing so, they look at what you and your baby need.

2. **You have given birth in hospital without this being medically necessary** and the delivery was without complications. You and your baby will be able to go home quickly. The maternity centre decides the number of hours of maternity care. In doing so, they look at what you and your baby need.

3. **You have given birth at a birth centre without any medical problems.** In this case, you and your newborn can usually stay for a couple of days. Health Premium then only covers the costs of the maternity care. We do not cover the costs of a stay in a birth centre past the day on which you give birth. The birth centre or maternity care centre decides the number of hours of maternity care to which you are still entitled upon returning home.

4. **You have given birth in hospital because of a medical indication or you and your baby have spent fewer than 10 days in hospital.** In that case, the number of hours of maternity care will be determined once you go home.

What is not covered
- hotel facilities or other luxury care at the birth centre
- days spent in the birth centre after the day you give birth
- transportation costs that the maternity centre or maternity nurse charges separately. These costs are already included in the maternity care rate

Maternity package
The maternity package contains products that are needed for a home birth, such as a mattress protector and underpads. It also contains products for after delivery, such as maternity towels, for instance. So the maternity package is useful to have at home even if you plan to give birth at a birth centre or hospital.

Health Premium covers the costs of a maternity package from our *Kraamzorg Service*. If you have arranged maternity care through us, you will automatically receive the package at your home address during your 34th week of pregnancy, at the latest. You do not need to do anything.

If you did not arrange maternity care through us, you can request the package from our *Kraamzorg Service*. The telephone number is +31 (0)88 668 97 05. We will make sure the package is delivered to your home address.

The maternity package contains:
- 1 mattress protector/bed canvas
- 1 thick underpad 60 x 90cm
- 10 underpads 60 x 60cm
- 2 boxes of wound compresses 8.5 x 5cm
- 10 wound compresses 10 x 10cm
- 1 bottle of alcohol 70%
- 1 bottle of hand sanitiser
- 1 bottle of liquid hand soap
- 1 sterile umbilical clip
- 2 packs of maternity towels
- 1 pack of sanitary towels
- 1 pack of incontinence pads
- 2 pairs of stretch knickers
- 1 roll of nappy tape
- 1 pack of cotton wadding

What you have to do yourself

Apply for the maternity care on time
This can easily be done using the application form on our website, or by telephone. Simply call our *Kraamzorg Service* on +31 (0)88 668 97 05. They can help you with other questions about maternity care too.

Good to know

Maternity care according to the *Landelijk Indicatie Protocol Kraamzorg*
The maternity centre or birth centre decides the number of hours of maternity care according to the *Landelijk Indicatie Protocol Kraamzorg* (an instrument used in the Netherlands to calculate the extent of the required maternity care).

Medication and medical appliances

Coverage

Medicines
Medical appliances

ONVZ

Medicines

Coverage under each health-care plan

Health Basic	Most medicines
Health Premium	Most medicines + Extra coverage, up to a combined maximum of €500 per calendar year, for: • statutory personal contributions • contraceptives • over-the-counter medication

What is covered

Health Basic and Health Premium cover prescription medicines and the associated pharmacy services. Sometimes you will need to pay a statutory personal contribution. Everything you need to know is explained below.

We cover the following medicines:

1. The medicines designated by the government and listed in appendix 1 to the *Regeling zorgverzekering* [Health Insurance Regulations]. Nearly all the medicines usually prescribed in the Netherlands are included in this. If a medicine on this list is temporarily unavailable, the pharmacy can order a replacement medicine from abroad.

2. Medicines that the pharmacy produces on a small scale ('magistral preparations') or has produced by another pharmacy ('resold preparations'). This cannot be a medicine that is identical or almost identical to a medicine that is not covered under point 1, except where stated otherwise in the *Regeling zorgverzekering* [Health Insurance Regulations]. The document *Doorgeleverde apotheekbereidingen 2021*[1] explains the situation regarding resold pharmacy preparations.

   These medicines produced by the pharmacy must involve rational pharmacotherapy, i.e. they must have been proven effective and the form of administration (e.g. pill, injection, ointment) must be appropriate for you. Your medicine may also not be unnecessarily expensive.

3. Polymeric, oligomeric, monomeric and modular dietary preparations.

For some medicines and dietary preparations, we cover the costs if you meet certain conditions, like if you have a particular ailment for example. These conditions are listed in appendix 2 to the *Regeling zorgverzekering* [Health Insurance Regulations]. Your pharmacist will know to which medicines this applies.

Sometimes you will need to pay a personal contribution
For medicines that work in the same way, the Dutch government decides the maximum amount that we can reimburse. If the medicine you receive is more expensive than this, you will have to pay the difference. This is the statutory personal contribution. Health Premium will reimburse statutory personal contributions, together with contraceptives and over-the-counter medication, up to a combined maximum of €500 per calendar year.

If you know the brand name of your medicine or its active ingredient, you can check medicijnkosten.nl and find out at a glance whether and under what conditions the medicine is covered by the Dutch health-care plan. If it is, Health Basic and Health Premium cover the medicine. The site will also tell you what the maximum coverage is, and whether a personal contribution applies.

Whom to contact
- pharmacy
- dispensing practice

Can I choose which medicine I get?
Your medicine may not be unnecessarily expensive, which is why the pharmacists will generally give you a generic medicine. We reimburse the costs of a branded medicine if there is no generic version or if the branded medicine is medically necessary for you. If you want a brand-name medicine while there is no medical necessity for this, we will only reimburse the lowest price for the generic version of this medicine and you will have to pay the difference yourself.

What is not covered
- medicines being used in clinical trials
- medicines that have not yet been approved on the Dutch market
- medicines for fertility treatment

[1] www.onvz.nl: click 'Snel regelen' and then 'Handige downloads', or call us on +31 (0)30 639 62 22

Extra reimbursements with Health Premium
Health Premium sometimes covers the costs of health care not reimbursed under the Health Basic plan. With Health Premium, you are also covered for the following, up to a combined maximum of €500 per calendar year:
- statutory personal contributions
- contraceptives
- over-the-counter medication

Over-the-counter medication is medicine that you can get without a prescription. We only reimburse this sort of medicine if it has been prescribed by the attending doctor, a medical specialist, dentist, dental specialist (dental surgeon, orthodontist), midwife, specialist nurse or physician assistant.

There is separate coverage for vaccinations and preventive medicines for travel/holidays abroad, as described under Medically necessary vaccinations (e.g. for travel) and influenza vaccination. These do not come under the coverage you are reading about now, nor do homeopathic or anthroposophic medicines, which come under the separate Homeopathic and anthroposophic doctor coverage.

What you pay

The personal contribution
You will need to pay a statutory personal contribution for some medicines. Health Premium will reimburse this personal contribution up to €500 per calendar year. This coverage is for the personal contribution, contraceptives and over-the-counter medication combined.

What you have to do yourself

You must have a prescription for the medicine
We only reimburse medicines if they have been prescribed by the attending doctor, medical specialist, dentist, dental specialist (dental surgeon, orthodontist), midwife, specialist nurse or physician assistant.

For some medicines, you must request permission in advance
There are some medicines for which we only provide reimbursement if we have given permission in advance. This is the case for the medicines in the *Toestemming geneesmiddelen*[1] [Permission for medicines] document, and for the medicines for which there is no marketing authorisation as yet. The *Toestemming geneesmiddelen* document also tells you how to apply for permission. You will find this document on our website, or you can call our Service Centre.

In some cases, you must have permission in advance for dietary preparations for a milk allergy
In the following 3 situations, we only reimburse the costs of dietary preparations to address a milk allergy if you have obtained our permission in advance[1]. This is considered to be the case if:
- a food challenge has not been carried out
- the child is 2 years or older
- more than 1,000ml per day is required

Good to know

Some medicines come under specialist medical care
You do not pay separately for medicines you receive during the course of your care from a medical specialist or during hospital admission. They are included in the bill from the hospital.

You are given a set ‘dispensing quantity’
Per prescription, we will reimburse the costs of a medicine for:
- 15 days or the smallest dosage dispensed for a medicine you have not taken before
- 15 days for antibiotics for an acute ailment or for chemotherapy drugs (cytostatics)
- a maximum of 1 month for sleep-inducing drugs (hypnotics) and anti-anxiety drugs (anxiolytics)
- a maximum of 3 months for a medicine for a chronic illness
- a maximum of 1 year for the contraceptive pill
- a maximum of 1 month for medicines costing more than €1,000 per month during the titration period of 6 months
- a maximum of 1 month in other cases

If a medicine belongs to more than one category, the shortest period applies.

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Toestemming voor zorg’, or call us on +31 (0)30 639 62 22

Medical appliances

Medical appliances are aids to make day-to-day life with an illness or condition easier. Below, we list the medical appliances that are covered under the health-care plan and the conditions that apply. This includes things like whether you need a prescription or have to request prior permission.

A medical appliance must be suitable for the purpose for which it is intended.

You are entitled to a standard medical appliance (‘off the rack’) as long as this is suitable for your situation. Sometimes a standard medical appliance is not adequate, in which case you will be entitled to a tailor-made medical appliance. Your supplier or health-care provider will have to explain to us why a standard medical appliance will not work in your situation.

If you are getting a medical appliance for the first time, it will be ready for immediate use. and if it needs batteries or a charger, you will get these too the first time round. We do not reimburse the normal costs of using a medical appliance. You will have to pay for things like new batteries or the power the appliance consumes yourself. However, there are a few exceptions, which you can read about in the coverage for the particular medical appliance below.

If your medical appliance is no longer suitable to your needs, you can submit a request to us for its repair, modification or replacement. You must use the medical appliance carefully and keep it maintained. Otherwise, if a medical appliance needs to be replaced or repaired due to careless use, we will not reimburse the costs of replacement or repair. This also applies to having to reinstall hardware and/or software when this has crashed as a result of you not handling it with care.

You will sometimes need our prior permission to get a medical appliance. This depends on the medical appliance and on the supplier you select. There are several options:

1. If, in the table for the particular medical appliance, it is stated that permission is not required, you do not have to do anything.
2. If our permission is required, check whether your supplier is on our list of medical appliance suppliers[1] [*overzicht leveranciers hulpmiddelen*]. You will find this list on our website. If your supplier is on the list, you do not have to do anything. We have already made arrangements with these suppliers concerning giving permission.
3. If your supplier has not been included on the list, you will have to seek our prior permission. If our permission is not obtained, we will not reimburse the costs of the medical appliance from this supplier.

For certain medical appliances, we assume that it will last for a particular period (at least), which we call the ‘expected minimum service life’. If you need to have your medical appliance replaced before the end of its expected service life, you will have to ask our permission for this first.

You get a medical appliance on loan, or you purchase it yourself. ‘On loan’ means that we or the supplier remain the owner of the medical appliance and that you can use it for as long as you need it. If you purchase the medical appliance yourself, you are the owner.

If you are getting a medical appliance on loan, the supplier will deliver this to your home. We pay the costs of delivery, maintenance and repair. We also reimburse the costs of the consumables, i.e. the items you need to use the medical appliance and which you throw away when you start using a new item. Batteries are not considered consumables. If you no longer need the medical appliance you have been given on loan, you must return it to the supplier.

The following medical appliances are provided on loan:

- Compression therapy aids
- Feeding pump
- Infusion pump for medications
- Prosthetic for leg or foot, from the age of 18
- Nebuliser
- Mucus suction aspirator
- Sleep position trainer (STP)
- Oxygen therapy equipment
- CPAP machine
- Foot-propelled ‘trippelstoel’ chairs
- Gait trainer or seated scooter
- Adapted table or adapted chair
- Stand aids, dynamic seating and bed orthosis
- Short-term loan of medical appliances for problems with movement

Any medical appliances we cover that are not listed above become your property.

You can also purchase a medical appliance that is normally provided on loan, but you must request permission from us in advance. This is because additional conditions may apply. When requesting the medical appliance, please state that you wish to purchase it yourself. We reimburse the prevailing market price for the simplest form of the medical appliance. You can read more about the prevailing market price under general rule 18.

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Handige downloads’, or call us on +31 (0)30 639 62 22

If your medical appliance often needs to be maintained or repaired and you would otherwise have to do without one for an extended period, we also reimburse the cost of a spare medical appliance. This only applies if you would be severely restricted in carrying out your daily activities if you did not have the medical appliance. You must always request permission from us in advance for a spare medical appliance.

List of medical appliances

Type of medical appliance		Health Basic	Health Premium
Medical appliances for diabetes	Blood sampling device	•	•
	Lancets for blood sampling	•	•
	Blood glucose meter	•	•
	Real Time Glucose Monitor (rt-CGM) with consumables/accessories	•	•
	Flash Glucose Monitor (FGM) with consumables/accessories	•	•
	Test strips	•	•
	Insulin pens	•	•
	Ketone test strips with accessories	•	•
	Insulin pumps with consumables/accessories	•	•
Medical appliances for urinary and bowel incontinence	Urine drainage bags	•	•
	Catheters	•	•
	Rectal irrigation system	•	•
	Stoma pouches and support products	•	•
	Protective pads/sheets	•	•
	Incontinence products	•	•
Medical appliances for thrombosis		•	•
Medical appliances for vascular conditions	Ort.O.Mate	•	•
	Compression therapy aids	•	•
Compression stockings/sleeves		•	•
Medical appliances to help with feeding	Feeding tube with consumables/accessories	•	•
	Feeding pump with consumables/accessories	•	•
Infusion pump for medications		•	•
Syringes and injection pens to self-administer medicine		•	•
Orthoses		•	•
Prostheses	Prostheses for arms and hands, shoulders, hips and the pelvis	•	•
	Prostheses for legs and feet	•	•
	Stump socks	•	•
	Liner	•	•
	Voice prostheses	•	•
	Ocular prostheses, scleral shell prostheses and scleral lenses without visual correction	•	•
	Facial prostheses (including nose and ears)	•	•
Dressings	Bandage contact lenses (without vision correction)	•	•
	Dressings	•	•
Medical appliances for respiratory conditions	Spacers/valved holding chambers and accessories	•	•
	Nebulisers and accessories	•	•
	Positive expiratory pressure (PEP) device	•	•
	Mucus suction aspirator	•	•
	Tracheal cannula with stoma filter/protector	•	•
	Airway clearance device	•	•
	Sleep position trainer (STP)	•	•
Oxygen therapy equipment		•	•
CPAP machine			•
MRA			•
Medical appliances for problems with movement	Foot-propelled ‘trippelstoel’ chairs		•
	Gait trainer or seated scooter		•
	Adapted table or adapted chair		•
	Stand aids, dynamic seating and bed orthosis		•

Type of medical appliance		Health Basic	Health Premium
Short-term loan of medical appliances for problems with movement	Wheelchair		•
	Elevated leg rest		•
	Threshold/bridge ramps		•
	Transfer board, turntable and lift systems		•
	Pressure relief ring		•
	Toilet seat riser, commode chair, portable shower chair and bath board		•
	Adapted bed (and accessories)		•
Orthopaedic footwear and orthotics for footwear	Orthopaedic/semi-orthopaedic footwear		•
	Second pair of orthopaedic/semi-orthopaedic footwear		•
	Orthotics for footwear		•
	Orthopaedic modifications to regular footwear		•
Medical appliances for speech disorders			•
Hearing aids and tinnitus maskers	Hearing aids		•
	Ear domes/moulds		•
	Tinnitus masker		•
	Simple assistive listening devices		•
Breast prostheses			•
Wig			•
Lenses for glasses and contact lenses with a medical indication			•
Contraceptive devices			•
Medical appliances for pain management (TENS)			•

Medical appliances for diabetes

When you have diabetes, your body is unable to properly control the blood glucose (sugar) level. This occurs when it produces too little or no insulin, or when the body fails to respond to the insulin it produces. There is help, however, in the form of medical appliances you can use to measure your blood glucose level, and ones to administer the insulin needed.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover medical appliances for diabetes if one of the following situations applies to you:
- you have type 1 diabetes and are being treated with insulin
- you have type 2 diabetes and the medicines you are taking are no longer working well enough and, as a result, your doctor is considering putting you on insulin

If you are entitled to medical appliances for diabetes, and if you cannot handle the standard medical appliances for diabetes due to an impairment, we cover the costs of specially adapted medical appliances for diabetes.

Whom to contact
- supplier of medical appliances for diabetes

What is not covered
- replacement batteries or replacement charger

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Blood sampling device Lancing device to prick your finger to get a sample of blood you can use to measure your blood glucose level.	Attending doctor or diabetes specialist nurse	Yes	2 years
Lancets for blood sampling* These are medical appliances you place in the lancing device to prick your finger to get a drop of blood you can use to measure the level of glucose in your blood.	Attending doctor or diabetes specialist nurse	Yes	No
Blood glucose meter This is a medical appliance used to measure the concentration of glucose in a blood sample.	Attending doctor or diabetes specialist nurse	Yes	3 years
Real Time Glucose Monitor (rt-CGM) with consumables/ accessories Medical appliance used to measure blood glucose levels via a sensor inserted under the skin.	Medical specialist	Yes	We determine this on the basis of the manufacturer's user guide
Flash Glucose Monitor (FGM) with consumables/accessories Medical appliance used to regularly measure blood glucose levels via a sensor inserted under the skin of the upper arm.	Attending doctor	Yes	3 years
Test strips* These are little strips of plastic onto which the blood is placed, after which the strip is placed into the blood glucose meter.	Attending doctor or diabetes specialist nurse	Yes	No
Ketone test strips with accessories** Strips used to measure blood ketones.	Attending doctor or diabetes specialist nurse	Yes	No
Insulin pens*** This is an injection pen to self-administer insulin.	Attending doctor or diabetes specialist nurse	Yes	3 years
Insulin pump with accessories This small device, which is attached to your body by a narrow tube called a cannula, gives your body regular small doses of insulin.	Medical specialist or diabetes specialist nurse	Yes	4 years

*** In some cases, you are given a maximum quantity**
For certain medical appliances, you will receive a limited quantity, which is expected to last you for a certain period of time. If you need more than this maximum quantity, you will need to ask our permission for this in advance.

If you have diabetes, we reimburse at most the costs of:
1. 100 test strips/lancets once only if the medicines you are taking seem to be no longer working well enough and you may have to start using insulin
2. 100 test strips/lancets per 3 months if you need an insulin injection 1-2 times per day
3. 400 test strips/lancets per 3 months if you need 3 or more insulin injections per day or use an insulin pump
4. 400 test strips during pregnancy for women diagnosed with gestational diabetes

**We reimburse the costs of a maximum of 40 ketone test strips per year.

***You are entitled to 1 spare insulin pen.

Medical appliances for urinary and bowel incontinence

These are medical appliances for when, due to an illness, ailment or treatment, you have limited or no control over your bladder or bowel, or are unable to urinate or defecate in the normal manner.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover medical appliances that can help a person suffering from urinary or bowel incontinence. Appliances include catheters, drainage bags, rectal irrigation systems and stoma pouches and support products. We also cover absorbent and washable incontinence products. These medical appliances are specified below.

If you have a stoma, we also cover the costs of medical appliances you can use to protect your skin, as well as the products specified below, as long as these are needed for your stoma.

Absorbent and washable incontinence products are only covered if you meet the following conditions:

- for children aged 3 or 4: due to an illness or ailment, it is not expected that they will be potty-trained
- for children aged 5 or older, and for adults: the child or adult has long-term incontinence due to an illness or ailment. This is deemed to be the case if:
  - bowel incontinence has been a problem for more than 2 weeks; urinary incontinence has been a problem for more than 2 months
  - it has become clear that the illness or ailment causing the urinary or bowel incontinence will not heal/ resolve itself, or that the incontinence cannot be resolved by pelvic floor or bladder training

The continence care nurse will decide during the initial talk with your supplier which incontinence products you need and the quantity needed. We will cover that quantity.

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Urine drainage bags Medical appliance to collect urine when using an indwelling catheter.	Attending doctor, stoma/continence care nurse specialist	Yes	No
Urinary catheter A narrow, flexible tube used to empty the bladder and direct the urine to the drainage bag.	Attending doctor, stoma/continence care nurse specialist	Yes	No
Rectal irrigation system The medical appliance is used to irrigate (rinse) the bowels with lukewarm water.	Attending doctor, stoma/continence care nurse specialist	Yes	No
Stoma pouches and support products* Aids for taking care of a stoma**.**	Attending doctor or specialist stoma care nurse	Yes	No
Protective pads/sheets These are pads or sheets to protect your bed, chair and wheelchair from blood, exudate (seepage), urine or bowel matter.	Attending doctor or stoma/ continence care nurse specialist, with a statement specifying the need	Yes	No
Incontinence products Absorbent or washable materials that can be used for urinary or bowel incontinence. These products can be either disposable or washable.	Attending doctor, physician assistant, specialist nurse, urology-continence-stoma care nurse or continence care nurse	Yes	No

*** Maximum quantity for stoma pouches and support products**
You are entitled to reimbursement for a maximum quantity (as shown below). If you will be using more of these items than the stated maximum quantity, make sure you get our prior permission.

1-piece colostomy pouch	max. 4 pouches per day
2-piece colostomy pouch	max. 4 base plates per day / max. 4 pouches per day
1-piece stoma plug	max. 4 plugs per day
2-piece stoma plug	max. 1 base plate and 4 plugs per day
1-piece ileostomy pouch	max. 2 pouches per day
2-piece ileostomy pouch	max. 4 base plates per week / max. 2 pouches per day
1-piece urostomy pouch	max. 2 pouches per day
2-piece urostomy pouch	max. 4 base plates per week / max. 2 pouches per day
continence stoma (adhesive dressing and catheters)	2 to 6 per day, depending on prescription
irrigation system sets	1st year: max. 2 sets, after that max. 1 set per year
irrigation pump	max. 1 irrigation pump per year, max. 1 irrigation sleeve per day, and after each irrigation max. 2 stoma plasters or colostomy pouches

Whom to contact
- supplier of medical appliances for urinary and bowel incontinence

What is not covered
- cleaning supplies and deodorants (e.g. air fresheners)
- products that protect your skin if you do not have a stoma
- clothing, with the exception of fixation pants (net pants)
- bed-wetting alarm
- waterproof/incontinence mattress
- incontinence products if the need for these is short term, like after an operation or pregnancy, or when needed for nocturnal bedwetting

Medical appliances for thrombosis

Thrombosis is when a blood vessel is blocked by a blood clot. Such a clot can have serious consequences, such as blocking a vein in your leg, or dislodging and obstructing blood vessels in the lungs (causing a pulmonary embolism) or vessels in the heart (causing a heart attack) or in the brain (causing a stroke). Checking the time it takes the blood to coagulate (clot) can help reduce the risk. Self-monitoring devices (also called point-of-care coagulometers or INR test meters), can be used to test how fast the blood clots. These determine the International Normalized Ratio (INR) level (how fast blood clots), and if the results are not what they should be, the dosage of the anticoagulant can be adjusted.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover the costs of a self-monitoring device if you meet the following 2 conditions:
1. you have an illness or ailment that poses an increased risk of thrombosis
2. you make long-term use of blood thinning medication, or you are unable to visit the thrombosis service due to your work

We also cover the accessories and consumables for the self-monitoring device, like test strips, a lancing device with lancets, and the quality control solution.

If you have your INR levels (blood clotting time) tested by the thrombosis service, or if they have given you a self-monitoring device to test your INR levels at home, the Medical specialist coverage will apply. The thrombosis service teaches you how to use the self-monitoring device, provides guidance on the measurements and advises you on the use of anticoagulant medicines.

Whom to contact
- supplier of an INR self-testing device

What you have to do yourself

You must have a prescription
You get the prescription for the self-monitoring device from the attending doctor.

You must seek our permission first
We only cover the costs of the self-monitoring device and the related accessories/consumables if you have obtained permission from us in advance.

Medical appliances for vascular conditions

Your veins and arteries carry your blood to all parts of your body: the arteries bring oxygenated blood from the heart to all your organs and tissues, while the veins return the blood to the heart, after much of the waste has been filtered along the way. Lymphatic vessels carry ‘lymph’, a fluid that picks up toxins from the tissues and delivers these to the lymph nodes to be destroyed. This keeps these toxins out of the blood stream.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

However, sometimes the veins and lymphatic vessels do not work effectively and you need the help of certain medical appliances. We cover the costs of the medical appliances listed below if you meet the following 2 conditions:

1. the veins or lymphatic vessels are unable to transport blood or lymph fluid as well as needed
2. you need a medical appliance over the long term to address the problem

Whom to contact

- supplier of medical appliances for vascular conditions

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Ort.O.Mate This electric medical appliance allows a compression stocking wearer to take these off unassisted.	Attending doctor	Yes	No
Compression therapy aids These are medical appliances to treat lymphoedema.	Attending doctor + report with a treatment plan written by the physiotherapist	Yes	No

Compression stockings/sleeves

Since a compression stocking or compression sleeve places extra pressure on all or part of your leg or arm, it helps your body carry the blood or lymph away from your legs and arms. This can prevent thrombosis or oedema, for example, or help alleviate the symptoms of rheumatoid arthritis. Compression stockings and sleeves are available in 4 compression classes. Class 1 stockings/sleeves offer light support, while class 4 stockings/sleeves place a lot more pressure on your leg or arm and are therefore suitable for treating serious ailments.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We only cover compression stockings or compression sleeves in class 2 or higher. These are also called ‘therapeutic elastic garments’. You must satisfy the following 2 conditions:
- the veins or lymphatic vessels in your arms or legs are unable to transport blood or lymph fluid as well as needed on their own
- to address this problem, you need compression class 2, 3 or 4 compression stocking(s) or sleeve(s) on an ongoing basis

You are entitled to 2 pairs or 2 items per year.

If you are unable to put the stockings on and take them off on your own, we also cover a simple donning and doffing aid to help you with this.
The expected minimum service life of this donning and doffing aid is 2 years.

Whom to contact
- supplier of compression stockings, compression sleeves and donning and doffing aids

What is not covered
- support stockings to be worn after varicose vein surgery

What you have to do yourself

You must have a prescription
You get the prescription for the compression stockings, compression sleeves and/or donning and doffing aids from the attending doctor. You can also get the prescription for the donning and doffing aid from your physiotherapist or occupational therapist.

You must seek our permission first
We only cover the costs of the compression stockings/sleeves if you have obtained permission for this from us in advance.

Medical appliances to help with feeding

It can happen that you are unable to eat normally or need additional nutrition. A feeding tube delivers nutrients directly into the gastrointestinal tract, and sometimes a feeding pump is also required for this.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover a feeding tube for delivering nutrients directly into the gastrointestinal tract (together with the accessories/consumables) as long as this tube is inserted somewhere other than in a hospital *and* if you meet the following conditions:
- you have an illness or ailment affecting your stomach or intestines, as a result of which you cannot eat normal food, and
- you need a feeding tube to ensure that you get sufficient nutrition

If a feeding pump is required to regulate your feeding tube, we cover this and the related accessories, like clamps and a stand/frame.

An infusion pump and tube that deliver nutrients directly into the bloodstream come under the Medical specialist coverage.

Whom to contact
- supplier of feeding tubes, feeding pumps and infusion pumps

What is not covered
- replacement batteries or replacement charger

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Handige downloads’, or call us on +31 (0)30 639 62 22

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Feeding tube with consumables/accessories A narrow tube through which tube feed (liquid nourishment) is administered.	Attending doctor or dietitian	Yes	No
Feeding pump with consumables/accessories Medical appliance that pumps the tube feed through the feeding tube.	Attending doctor or dietitian	Yes	No

Infusion pump for medications

An infusion pump is an external medical appliance that delivers medications directly into your bloodstream. These are commonly used in hospitals, but can be used in a home setting as well.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover the costs of the external, ambulatory (portable) infusion pump if you meet the following 3 conditions:
1. you need to self-administer a medicine directly into your bloodstream at home
2. you need this medicine on an ongoing basis
3. we cover that medicine. You can see which medicines are covered in the Medicines section

We also cover the accessories and consumables for the infusion pump, like cannulae (connecting tubes), adhesive tape, disinfectants and needles.

Whom to contact
- supplier of infusion pumps

What is not covered
- replacement batteries

What you have to do yourself

You must have a prescription
For the infusion pump, you need a prescription from the attending medical specialist.

You must seek our permission first
We only cover the costs of an infusion pump for administering medicine if you have obtained permission from us in advance.

Syringes and injection pens to self-administer medicine

The syringes and injection pens are medical appliances used to inject medicine directly into the body.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover the costs of syringes and injection pens and the related products if you have an ailment for which you need to receive medicine by injection on an ongoing basis. This must be an ailment other than diabetes.

If you have a serious motor impairment or cannot see (well enough) and if you cannot handle a regular syringe or injection pen as a result, we cover, instead, the costs of specially adapted syringes or injection pens.

Whom to contact
- supplier of syringes and injection pens

What you have to do yourself

You must have a prescription
You get the prescription for the syringes or injection pens from the attending doctor.

You must seek our permission first
We only cover the costs of these medical appliances if you have obtained permission from us in advance.

Orthoses

An orthosis is an external medical appliance that you wear to correct your body position or the abnormal movement of your joints or spine. This could be a support corset, splint or a brace for example.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

If you have a motor impairment, i.e. a serious medical condition that limits the movement of a body part and/or adversely affects your posture, like a deformed spine, paralysis, a bone fracture or an injury to a tendon for example, and if you need an orthosis to correct this, we cover the orthosis if you need to use this on a permanent basis. So an orthosis that you only need temporarily is not covered.

The expected minimum service life of an orthosis is 2 years.

Whom to contact
- supplier of orthoses

What is not covered
- simple orthoses, like arch supports
- orthoses that you only use while playing sports

What you have to do yourself

You must have a prescription
For the orthosis, you need a prescription from the medical specialist. The attending doctor also writes the prescription for a replacement orthosis.

You must seek our permission first
We only cover the costs of an orthosis if you have obtained permission from us in advance.

Prostheses

A prosthesis is an external medical appliance used to replace or cover a part of your body.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover prostheses intended to replace:
- arms and hands, legs and feet, shoulders, hips and the pelvis
- vocal cords

If your prosthesis requires a liner or stump sock, we cover the costs of these.

We also cover prostheses intended to **replace** or cover:
- the eye; this includes scleral shell prostheses and scleral lenses without visual correction
- the face, including nose and ears

Whom to contact
- supplier of prostheses

What is not covered
- dental prostheses

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Prostheses for arms and hands, shoulders, hips and the pelvis These are artificial body parts that fully or partially restore the normal functions of your arms and hands, shoulders, hips or pelvis.	Medical specialist	Yes	3 years
Prostheses for legs and feet These are artificial body parts that fully or partially restore the normal functions of your legs and/or feet.	Medical specialist	Yes	3 years (18 or older) 2 years (under the age of 18)
Stump socks* Stump socks are placed over the stump of the residual limb, making it more comfortable to wear a prosthesis. They protect the skin from the pressure and reduce the friction from the movement of the prosthesis.	Attending doctor	No	No
Liner A liner works as a cushion between the skin and the inside of the socket.	Medical specialist	Yes	1 year
Voice prosthesis This is a medical appliance that enables you to speak again after your larynx has been removed.	Medical specialist	No	No
Ocular prostheses, scleral shell prostheses and scleral lenses without visual correction These are medical appliances that replace a missing eye or cover the front of the eyeball.	Ophthalmologist	No	1 year (for scleral lenses without vision correction)
Facial prostheses (including nose and ears) These are medical appliances that fully or partially replace or cover your face, nose and/or ears.	Medical specialist	Yes	5 years

*** Maximum number of stump socks**
You are entitled to a maximum of 6 stump socks per calendar year.

Dressings

Dressings come in all shapes and sizes, from simple gauze, cotton wool, plasters and tape to tubular bandages, mesh bandages, crepe bandages and bandage contact lenses (without vision correction).

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover these dressings if you have one of the following ailments:
- a complex wound, or a high risk of developing such
- a chronic skin condition
- serious scarring if this concerns a demonstrable physical disorder or disfigurement

A complex wound is one for which the healing process is not progressing normally due to an illness or ailment. Other factors may also play a role, i.e.:
- you cannot properly care for the wound due to your social situation
- your health-care provider does not have the expertise or skill required to properly care for the wound
- your health-care facility is not doing enough in terms of wound management and your wound is not being properly treated as a result

We also cover bandage contact lenses to protect your eye.

Whom to contact
- supplier of dressings

What is not covered
- dressings for short-term use
- dressings that are comparable to over-the-counter dressings or dressings that are only used during treatment in a hospital. You can see which dressings these are on the list of dressings[1]. You will find this document on our website, or you can call our Service Centre

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Bandage contact lenses (without vision correction) This is a contact lens that, rather than correcting your vision, protects your eye.	Ophthalmologist	Yes	No
Dressings Medical appliance to cover (dress) a wound, for example.	Attending doctor, specialist nurse, or wound care nurse	Yes	No

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Handige downloads’, or call us on +31 (0)30 639 62 22

Medical appliances for respiratory conditions

There are various medical appliances that can help you when you have difficulty breathing, like spacers/valved holding chambers used for administering medication you need to inhale, or devices that suction mucus to clear your airways.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover external medical appliances that address or alleviate respiratory problems, as stated below. We also cover the substances that these medical appliances administer.

Whom to contact

- supplier of medical appliances for respiratory conditions

Chronic respiratory support comes under the Medical specialist coverage. The coverage you are reading about now does not apply to this.

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Spacers/valved holding chambers and accessories Medical appliances for inhalation of medicines.	Attending doctor or respiratory nurse	No	No
Nebulisers and accessories These are medical appliances that allow medicine in aerosol form to be suspended longer making it easier to inhale.	Attending doctor or respiratory nurse	Yes	No
Positive expiratory pressure (PEP) device Medical appliance to help you cough up phlegm.	Pulmonologist or paediatrician	No	No
Mucus suction aspirator Medical appliance to remove mucus from the mouth or throat.	Medical specialist	No	No
Tracheal cannula with stoma filter/protector A tracheal cannula is a tube inserted through a hole in the throat to the windpipe, and a stoma filter/protector keeps the windpipe from drying out as quickly.	Medical specialist	No	No
Airway clearance device Medical appliance to help loosen mucus from the lungs by means of vibrations.	Attending doctor	No	No
Sleep position trainer (STP) This is a medical appliance you can use if you have mild sleep apnoea and tend to sleep on your back. Once you turn on to your back, the SPT gives a gentle vibration to ‘remind’ you to change your sleeping position.	Pulmonologist, ENT doctor or neurologist	Yes	No

Oxygen therapy equipment

You use oxygen therapy equipment for when you need help getting enough oxygen.

Coverage under each health-care plan

Health Basic	100%
Health Premium	100%

What is covered

We cover oxygen therapy equipment that addresses or alleviates respiratory problems. There are various types of oxygen therapy equipment:

- oxygen concentrators, which are intended for home use, take in air and concentrate the oxygen from it. Portable oxygen concentrators are also available for use outside the home
- oxygen cylinders hold pressurised oxygen, making them portable and easy to take with you
- systems that hold liquid oxygen (LOX) in a main oxygen tank that is decanted into a portable vacuum flask. Oxygen from the LOX system can be used both at home and when away from home

You do not get to decide which oxygen therapy system to use. The attending doctor and the supplier determine this based on your needs.

We also cover the substances that this oxygen therapy equipment administers, like oxygen, for example, and other substances that are certified in accordance with the *Wet op de medische hulpmiddelen* [Medical Appliances Act].

If your oxygen therapy system uses electricity, we reimburse €0.06 per hour of use of the oxygen therapy system. The supplier of the medical appliance must keep a record of all hours of use.

Chronic respiratory support (use of mechanical ventilation) comes under the Medical specialist coverage.

Whom to contact

- supplier of oxygen therapy equipment

What you have to do yourself

You must have a prescription
You get the prescription for the oxygen therapy equipment from the attending doctor.

You must request our permission first
We only cover the costs of oxygen therapy equipment if you have obtained permission for this from us in advance.

CPAP machine

CPAP stands for continuous positive airway pressure. A CPAP machine is used to treat sleep apnoea, a sleep disorder that causes you to stop breathing repeatedly and for more than 10 seconds while asleep. This can be caused by your tongue obstructing your airway, for instance, or your brain failing to give enough signals to inhale. A CPAP machine blows continuously pressurised air through a mask down your throat, keeping your airways open while you sleep or giving you a signal to breathe.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers a CPAP machine if you have moderate to severe sleep apnoea and have had a trial period with the device with positive results.

The expected minimum service life of a CPAP machine is 5 years.

Whom to contact
- supplier of CPAP devices

What is not covered
- medical appliances for chronic respiratory support
- medical appliances that are only intended to reduce snoring
- a CPAP machine if you use an MRA

What you have to do yourself

You must have a prescription
You get the prescription for the CPAP machine from the pulmonologist, ENT doctor or neurologist.

You must seek our permission first
We only cover the costs of a CPAP machine if you have obtained permission from us in advance.

MRA

An MRA (mandibular repositioning appliance) is used to treat sleep apnoea, a sleep disorder that causes you to stop breathing repeatedly and for more than 10 seconds while asleep. This occurs, for example, when the tongue and soft palate relax during sleep and obstruct the airway. An MRA pushes the lower jaw forward, keeping the airway unobstructed while you sleep.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers an MRA if you are being treated for mild to moderate sleep apnoea or if a CPAP machine does not work for you.

The expected minimum service life of this medical appliance is 5 years.

Whom to contact
- supplier of MRAs
- dentist recognised by the *Nederlandse Vereniging voor Tandheelkundige Slaapgeneeskunde* [Dutch Association of Dental Sleep Disorder Specialists] (NVTS)
- dental surgeon
- orthodontist

What is not covered
- medical appliances that are only intended to reduce snoring

What you have to do yourself

You must have a prescription
You get the prescription for the MRA from the pulmonologist or ENT doctor.

You must seek our permission first
We only cover the costs of an MRA if you have obtained permission from us in advance.

Medical appliances for problems with movement

If you have a motor impairment, i.e. a serious medical condition that limits the movement of a body part and/or adversely affects your posture, and if it is necessary to correct the effects of this condition, an orthosis may help. These are used to help with spinal deformities, for example, or foot problems, paralysis, bone fractures and injury to tendons. However, an orthosis may not help sufficiently, or at all.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers the medical appliances listed below if you have problems with movement, *and* if an orthosis does not help your condition (or not adequately) *and*, due to your ailment, you are restricted in 1 of the activities listed below:

- walking
- use of your hand and arm
- changing your position or remaining in a particular position (your body posture)
- using a device for communication

Health Premium will cover the costs of medical appliances listed in the table below to correct or improve this.

Whom to contact

- supplier of medical appliances for problems with movement

What is not covered

- medical appliances for tasks in the home, like adapted kitchen utensils for example
- simple medical appliances to help you eat and drink
- simple medical appliances to help you walk
- a riser-recliner chair to help you get up off the chair more easily, with no further medical function

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Foot-propelled 'trippelstoel' chairs Because this agile chair on wheels glides smoothly across the floor, you can move about easily while having your hands free to do what you need to do or while carrying something along.	Attending doctor + written recommendation from occupational therapist	Yes	No
Gait trainer or seated scooter These are medical appliances that can help you when you can no longer walk more than a short distance outdoors.	Attending doctor + written recommendation from occupational therapist	Yes	No
Adapted table or adapted chair A table that is height-adjustable for use by wheelchair users. An adapted chair is one you use when sitting normally is no longer possible.	Attending doctor + written recommendation from occupational therapist	Yes	5 years
Stand aids, dynamic seating and bed orthosis These are medical appliances that help you correct your posture or get into a comfortable position.	Medical specialist For replacement: attending doctor	Yes	No

Short-term loan of medical appliances for problems with movement

If you have a motor impairment, i.e. a serious medical condition that limits the movement of a body part and/or adversely affects your posture, this could make it difficult for you to wash yourself, go to the toilet, move from one surface to another or get around.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers the costs of the medical appliances listed below to correct or improve a limitation you face, but only if you need the medical appliance temporarily. We call this ‘short-term loan’, with a ‘short term’ being no more than 26 weeks. This term can be extended, however, if your personal situation so requires.

If you need the medical appliance permanently or for a longer period of time, you can request it through your local council.

Whom to contact
- supplier of medical appliances on short-term loan

What is not covered
- medical appliances for tasks in the home, like adapted kitchen utensils for example
- simple medical appliances to help you eat and drink
- simple walking aids to help you walk
- a riser-recliner chair to help you get up off the chair more easily, with no further medical function

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Wheelchair This medical appliance helps you get around when you cannot walk (or cannot walk very well) for a while.	Attending doctor	No	No
Elevated leg rest This medical appliance can be mounted to a wheelchair to support a leg cast.	Attending doctor	No	No
Threshold/bridge ramps These are medical appliances that provide safe access over elevated thresholds and other obstacles.	Attending doctor	No	No
Transfer board, turntable and lift systems These are medical appliances that help you move from one surface to another, like from a wheelchair to your bed or car seat for example.	Attending doctor or district nurse	No	No
Pressure relief ring This is a medical appliance that relieves pain when you are sitting.	Attending doctor	No	No
Toilet seat riser, commode chair, portable shower chair and bath board These are medical appliances that help you use the toilet, shower and bath.	Attending doctor or district nurse	No	No
Adapted bed (including accessories) This is a specially adapted bed for use when a regular bed would make nursing and caring very difficult, or make it hard for you to continue to live independently.	Attending doctor, wound care nurse or district nurse	Yes	No

Orthopaedic footwear and orthotics for footwear

Orthopaedic footwear is footwear custom-made for your feet. Semi-orthopaedic footwear concerns taking existing footwear and adapting this in such a way that it solves your foot problems. You are entitled to orthopaedic or semi-orthopaedic footwear if you are unable to wear regular (‘off-the-rack’) footwear. You may not need orthopaedic footwear as such. Regular (‘off-the-rack’) footwear that has undergone orthopaedic adjustments may suffice, or possibly orthotics for footwear.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

If you have a motor impairment, i.e. a serious medical condition that limits the movement of a body part and/or adversely affects your posture, and if you need orthopaedic footwear or orthotics for footwear on a permanent basis to correct this, Health Premium will reimburse the costs of the footwear or orthotics described below. So orthopaedic/semi-orthopaedic footwear or orthotics that you need temporarily are not covered.

Whom to contact

- supplier of orthopaedic/semi-orthopaedic footwear and orthotics for footwear

What is not covered

- regular footwear (‘off-the-rack’)
- orthopaedic/semi-orthopaedic footwear or orthotics for footwear you only use while playing sports

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Orthopaedic/semi-orthopaedic footwear This is adapted footwear for you to wear when you are not able to wear regular (off-the-rack) footwear.	Medical specialist	Yes	18 months (16 or older) 6 months (under 16 years)
Second pair of orthopaedic/ semi-orthopaedic footwear* This is an extra pair of orthopaedic/ semi-orthopaedic footwear.	Attending doctor	Yes	18 months (16 or older) 6 months (under 16 years)
Orthotics for footwear These are orthopaedic inserts that you wear inside regular (‘off-the-rack’) footwear.	Medical specialist	Yes	No
Orthopaedic modifications to regular footwear** This is off-the-rack footwear that has undergone orthopaedic modifications.	Medical specialist	Yes	No

*** Second pair of orthopaedic/semi-orthopaedic footwear**
You may request a spare pair after you have had the original pair of orthopaedic/semi-orthopaedic footwear for 3 months.

**** Maximum number of orthopaedic modifications to regular footwear**
You may have up to 2 pairs of footwear orthopaedically modified per year.

Medical appliances for speech disorders

There are various medical appliances that can help you when you have little or no clear speech, like an alphabet board or symbol board, a computer program, or a text telephone, for example.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium only covers external medical appliances for speech disorders if you meet the following 3 conditions:
1. you have a serious speech or language disorder
2. you have little or no clear speech as a result
3. you need a medical appliance to help you deal with this

Whom to contact
- supplier of medical appliances for speech disorders

What is not covered
- phones, tablets, laptops and computers on which a program aimed at helping those with a speech disorder has been installed
- medical appliances to help with stuttering

What you have to do yourself

You must have a prescription
You get the prescription for the medical appliance for speech disorders from the attending doctor.

You must seek our permission first
We only cover the costs of these medical appliances if you have obtained permission from us in advance.

Hearing aids and tinnitus maskers

There are various hearing and listening aids that can help you when you have difficulty hearing, like hearing aids, tinnitus maskers and simple assistive listening devices.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Hearing aid, tinnitus masker: up to €600 per ear Replacement ear domes/moulds: 100%

What is covered

If you have serious hearing loss or serious tinnitus, Health Premium covers the costs of a hearing aid or tinnitus masker for up to €600 per ear. We consider serious hearing loss to be a loss of 35dB (dB is decibel) or more, based on an average of your hearing ability at the frequencies of 1,000Hz, 2,000Hz and 4,000Hz (Hz is Hertz), as measured by your audiologist.

Health Premium covers the full costs of replacement ear domes/moulds that form part of the hearing aid or tinnitus masker.

If you are entitled to a hearing aid, but would prefer to have a simple ‘assistive listening device’, Health Premium will reimburse the costs of this device, instead of a hearing aid, up to a maximum of €600.

Hearing and listening aids of which all or a part are surgically implanted come under the Medical specialist coverage.

Whom to contact
- audiologist

What you have to do yourself

	Prescription Health-care provider you need a prescription from	**Permission** Do you need our prior permission?	**Expected service life** Does an expected minimum service life apply?
Hearing aids Medical appliances that help you hear better.	ENT doctor or audiological centre No prescription is required in the case of age-related hearing impairment*	Yes	5 years
Ear domes/moulds An ear dome or ear mould is the bit of the hearing aid that you wear inside your ear.	ENT doctor or audiological centre	Yes	24 months (16 or older) 6 months (under 16 years)
Tinnitus masker This medical appliance generates and emits a sound ('white noise') that helps mask the perceived sound (such as ringing) in your ear(s).	ENT doctor or audiological centre	Yes	5 years
Simple assistive listening devices If you are not yet ready (or are unable) to wear a hearing aid, these relatively simple devices can help you follow a conversation.	ENT doctor or audiological centre	Yes	No

* Age-related hearing impairment refers to when you are 67 or older and are hard of hearing.

Breast prostheses

A breast prosthesis is an artificial breast that replaces a breast (or part of a breast) that is missing.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

We cover an external breast prosthesis if all or part of your mammary gland is missing, because it has been removed during surgery for example.

The expected minimum service life of a breast prosthesis is 1 year.

Whom to contact
- supplier of breast prostheses

What is not covered
- bras, adhesive strips or closure strips for a breast prosthesis

Breast implants placed by a surgeon are covered under the Medical specialist section.

What you have to do yourself

You must have a prescription
You get the prescription for the breast prosthesis from the attending doctor or nursing specialist.

Our permission is required for replacement within 1 year
If you need to have your breast prosthesis replaced before the expected minimum service life of 1 year has passed, you will need to ask our permission for this in advance.

Wig

A wig is a replacement for your natural hair and can be made of human or animal hair or synthetic fibre.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Maximum of €1,000

What is covered

Health Premium covers a wig if you have gone partially or entirely bald as the result of a medical treatment or ailment.

The expected minimum service life of a wig is 1 year.

Whom to contact
- wig supplier

What is not covered
- hairpieces like toupees for classic male pattern baldness
- regular headwear like hats, caps and bandanas
- care and maintenance of the wig

What you have to do yourself

You must have a prescription
You get the prescription for the wig from the attending doctor or oncology nurse.

You must request our permission first
We only cover the costs of a wig if you have obtained permission for this from us in advance.

Lenses for glasses and contact lenses with a medical indication

Many people are long-sighted or short-sighted and wear glasses or contact lenses every day to correct their vision. We do not provide cover for these. This is different, however, if the lenses for glasses or contact lenses are required as a result of an accident, illness or ailment, in which case we say there is a medical indication (i.e. medical grounds) for the prescription.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium reimburses the costs of lenses if 1 of the following situations applies to you:
- your vision needs to be corrected due to a medical ailment or trauma, and contact lenses work better for you than glasses in helping to make your vision clearer or improve the quality of your vision
- you are younger than 18 and you have degenerative myopia (a form of short-sightedness), with at least -6.00

The Health Premium plan covers the costs of **lenses for glasses** or **filter lenses if you are younger than 18** and 1 of the following situations applies to you:
- we would reimburse the costs of contact lenses because you have a medical indication, but you prefer glasses
- either 1 or both of your eyes have been operated on to address a problem with the lens(es)
- due to your long-sightedness, your eyes turn inward as you try to focus (accommodative esotropia)

Whom to contact
- supplier of lenses for glasses, filter lenses and contact lenses

What is not covered
- frames for glasses

What you have to do yourself

You must have a prescription
You must have a prescription from your ophthalmologist for the lenses for glasses, filter lenses or contact lenses.

You must seek our permission first
We only cover the costs of the lenses for glasses or filter lenses and contact lenses if you have obtained permission from us in advance.

Contraceptive devices

A diaphragm and the copper intrauterine device (IUD) are medical appliances intended to prevent pregnancy.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers the costs of a copper intrauterine device (IUD) and a diaphragm.

Whom to contact
You can pick up a diaphragm or a copper IUD from a:
- pharmacy
- dispensing practice

You have a copper IUD inserted or removed by a:
- general practitioner
- midwife
- gynaecologist

Please note: if you go to a gynaecologist for this procedure, the copper IUD is part of the treatment, and you do not purchase it yourself.

What you have to do yourself

No prescription needed
You can get the contraceptive devices without a doctor's prescription from your local pharmacy or a dispensing practice.

You must have a referral in advance for the gynaecologist
Before you see a gynaecologist, you need a referral from your general practitioner or midwife. The health care is covered under Medical specialist coverage in this case.

Medical appliances for pain management (TENS)

TENS stands for transcutaneous electrical nerve stimulation. A TENS device delivers small electrical impulses to the affected part of your body in order to reduce pain.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	100%

What is covered

Health Premium covers a TENS device if you meet the following 3 conditions:
1. you have non-stop pain
2. the pain cannot be treated any other way
3. the TENS device proved to be effective for you during a trial period

We also cover the accessories and consumables for the TENS device, like electrodes (pads), electrode gel, adhesives, leads and a carry pouch.

Whom to contact
- supplier of TENS devices

What is not covered
- replacement batteries

What you have to do yourself

You must have a prescription
For the TENS device, you need a prescription from the attending doctor or medical specialist.

You must seek our permission first
We only cover the costs of a TENS device if you have obtained permission from us in advance.

Oral and dental
Coverage

Dental surgery
Dental health care after an accident
General dental health care
Orthodontics up to the age of 18

ONVZ

Dental surgery

For specialist dental health care, you go to an oral and maxillofacial surgeon, sometimes abbreviated as OMS or OMFS. This specialist is usually referred to as a dental surgeon, which is the term we will use in the following.

A dental surgeon is not classified as a medical specialist in the Netherlands, and, accordingly, the care provided by a dental surgeon does not come under Medical specialist coverage, but rather under the coverage you are reading about now.

The dental surgeon works at a hospital or independent treatment centre. You cannot go to the dental surgeon directly: you always need a referral. You get this referral from the dentist, for instance if you have a difficult-to-remove wisdom tooth, or from the orthodontist, if you have jaw problems. Your general practitioner or a medical specialist could also refer you.

Coverage under each health-care plan

Health Basic	100% A maximum of 1 year applies to admissions
Health Premium	100% A maximum of 1 year applies to admissions

What is covered

Health Basic and Health Premium cover the costs of specialist dental surgery. We also reimburse the X-ray examinations needed for this. If you need to be admitted, we reimburse the costs of your hospitalisation, for up to 1 year, under the Hospital admission coverage.

Whom to contact
- dental surgeon

What is not covered
- surgery on the gums (periodontal surgery)
- the pulling of teeth or molars if the dentist is able to do this
- dental surgery relating to the insertion of implants and dental prostheses

What you have to do yourself

You need to have a referral first
Before you go to the dental surgeon, you must have a referral from your dentist, orthodontist, general practitioner or medical specialist. No referral is needed in acute cases.

Sometimes you need permission from us in advance
We will only cover treatments specified on the *limitatieve lijst machtigingen kaakchirurgie*[1] (exhaustive list of authorisations for dental surgery) where we have given our prior permission. Your dental surgeon will generally seek our permission for you. You will find this list on our website, or you can call our Service Centre.

Dental health care after an accident

You may need to see a dentist because your teeth have been damaged in an accident, during a fall from your bike for example.

Coverage under each health-care plan

Health Basic	€5,000 Maximum of 1 accident per calendar year
Health Premium	€5,000 Maximum of 1 accident per calendar year

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Toestemming voor zorg’, or call us on +31 (0)30 639 62 22

What is covered

If your teeth have been damaged as the result of an accident, we will reimburse the costs of dental treatment, no more than once per calendar year, up to a maximum of €5,000. This also covers equipment and technical costs, for a crown or prosthesis, for instance.

In the context of this coverage, by accident we mean a sudden, external violent impact on your body, outside your control, that has caused medically demonstrable physical injury.

The accident must have occurred while you were insured under the Health Basic or Health Premium plan, and you must have received the treatment within 1 year of the accident.

Whom to contact
- dentist
- dental hygienist
- prosthodontist

What is not covered
- general anaesthetic
- treatment of damage to your teeth caused by a circumstance where you should have been able to suspect in advance that such damage could possibly occur, for example, biting on a hard object, opening a bottle with your teeth, or not wearing a mouthguard while engaged in sports where this should be worn
- treatment of damage to your teeth caused or made worse by eating

You must seek our permission first
We only reimburse the costs of dental health care following an accident if we have given permission in advance. For emergency treatment, you can also request permission retrospectively. In order to assess your request, we need a written explanation from your health-care provider. This must be accompanied by a treatment plan, X-rays and a quotation.

General dental health care

Dental health care concerns prevention and maintenance work on your teeth, like providing dental check-ups, making X-rays, filling cavities and cleaning your teeth.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Up to a maximum of €300 per calendar year

What is covered

Health Premium reimburses the costs of general dental health care for up to €300 per calendar year.

Whom to contact
- dentist
- dental hygienist

What is not covered
- general anaesthetic
- MRA (mandibular repositioning appliance)
- gum shield
- equipment and technical costs for care that is not covered
- dentures
- implants
- external bleaching
- facings
- treatment of white spots

Orthodontics up to the age of 18

If you have difficulty biting and chewing because your teeth and molars are not well aligned or because of some abnormality in your jaw, you have what we call a ‘functional abnormality’. This can often be fixed with orthodontics. Orthodontics involves improving the position of the teeth using braces.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Up to a maximum of €500 per calendar year

What is covered

Health Premium covers the costs of orthodontics up to the age of 18, up to a maximum of €500 per calendar year.

Whom to contact
- dentist
- orthodontist

What is not covered
- orthodontics mainly for aesthetic purposes

Psychological health care
Coverage

General basic mental health care
Specialist mental health care

ONVZ

General basic mental health care

If you have psychological problems, your general practitioner or corporate doctor will be your first port of call. A general practitioner can help you with minor psychological conditions, like if you are feeling down, tense or lonely. The general practitioner may talk with you in order to assess, among other things, whether he or she will be able to provide suitable treatment, and may possibly recommend online treatment programmes as well. If your doctor suspects you have a psychological disorder, he or she will refer you for general basic mental health care *(generalistische basis-ggz*), which is how we refer to first-line support from a psychologist or psychotherapist, or, in the event of serious complaints, for specialist mental health care (*gespecialiseerde GGZ*).

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	In specific cases: A maximum of 1 general basic mental health-care package per 12-month period, or A maximum of 8 consultations per calendar year, with a maximum of €100 per consultation

What is covered

The coverage you are reading about now applies to general basic mental health care. The treatment usually consists of consultations with a health psychologist or psychotherapist. Treatment over the internet is another possibility where you can opt to have the care provided in your own language.

Health Premium reimburses the costs of general basic mental health care if your doctor suspects that you have a psychological disorder or this has already been ascertained. We cover the costs of a maximum of 1 general basic mental health-care package per 12-month period, or a maximum of 8 consultations per calendar year, up to a maximum of €100 per consultation.

Whom to contact
- health psychologist
- clinical psychologist
- psychotherapist
- clinical neuropsychologist
- psychiatrist

What is not covered
- treatment of relationship problems
- treatment of eating disorders
- treatment of addictions
- treatment of somatic symptom disorders
- treatment of fear of flying
- treatment of learning disorders, such as dyslexia
- admission

What you have to do yourself

You need to have a referral first
Before consulting the health-care provider, you need a referral from your general practitioner, the corporate doctor or an A&E (Accident & Emergency) doctor. No referral is needed in acute cases.

If you are receiving specialist mental health-care treatment, your treatment coordinator can also refer you to general basic mental health care. You will not need to go to your general practitioner to get the referral.

Good to know

A psychological disorder according to the DSM
Mental health care is covered under the Health Premium plan, but only in cases of a psychological disorder, or where your health-care provider suspects this to be the case. All psychological disorders are described in the ‘Diagnostic and Statistical Manual of Mental Disorders’, DSM. This is an international standard for categorising psychological disorders. DSM-5 is the version currently in use.

In the event of a waiting list, please contact the *ZorgConsulent*
You can ask our *ZorgConsulent* advisers to help reduce the waiting time on your behalf. The *ZorgConsulent* advisers can also help with other types of health-care mediation.

Specialist mental health care

For serious psychological problems, you receive a referral for specialist mental health care. The treatment usually consists of consultations with a psychiatrist or psychotherapist for instance. If necessary, you will be admitted to a mental health-care centre or the psychiatric ward of a general hospital (called a *Psychiatrische Afdeling Algemeen Ziekenhuis* or PAAZ in Dutch).

Coverage under each health-care plan

Health Basic	100%, in specific cases A maximum of 1 year applies to admissions
Health Premium	100%, in specific cases A maximum of 1 year applies to admissions

What is covered

Health Basic and Health Premium cover the costs of specialist mental health care, but only in the case of certain indications. If you need to be admitted to hospital for a good treatment result for the covered indication, we reimburse the costs of admission, too, for a period of no longer than 1 year, along with any nursing and other care, allied health care, medicines and medical appliances and dressings that may be required. If organised daytime activities are provided during the admission, we also cover the costs of these daytime activities and the required transport.

If you are first admitted to hospital and then to a mental health-care centre (or vice versa), we will reimburse the costs of up to 1 year for your stay at both combined.

Whom to contact
Mental health-care centre, psychiatric ward of a general hospital or an independent health-care provider, where the treatment coordinator is a:
- clinical psychologist
- psychotherapist
- clinical neuropsychologist
- psychiatrist
- health psychologist

What is not covered
- treatment of problems that can be treated in the general basic mental health-care system
- treatment of relationship problems
- treatment of work-related problems
- treatment of eating disorders
- treatment of addictions
- treatment of somatic symptom disorders, i.e. a disorder that manifests as physical symptoms but with no identifiable physical cause
- treatment of fear of flying
- treatment of learning disorders, such as dyslexia

What you have to do yourself

You need to have a referral first
Before consulting the health-care provider, you need a specific referral from your general practitioner, a medical specialist or an A&E (Accident & Emergency) doctor. This means that the general practitioner or medical specialist believes that the specialist mental health care is the most appropriate form of treatment. No referral is needed in acute cases.

If you are receiving general basic mental health care treatment, your practitioner can refer you for specialist mental health care. You will not need to go to your general practitioner to get the referral.

Good to know

A psychological disorder according to the DSM
Specialist mental health care is covered under the Health Basic and Health Premium plans, but only in cases of a psychological disorder, or where your health-care provider suspects this to be the case. All psychological disorders are described in the 'Diagnostic and Statistical Manual of Mental Disorders', DSM. This is an international standard for categorising psychological disorders. DSM-5 is the version currently in use.

Your invoice may list a diagnosis
If you do not want this information to appear, you can sign a privacy statement together with your practitioner and send it to us. Your health-care provider knows how this works. Any invoice must then be accompanied by a statement from your health-care provider, saying that this does not involve a treatment not covered by Health Basic or Health Premium. You can see which treatments are not covered under 'What is not covered'.

We will cover up to 1 continuous year of admission
In the event of the period of admission being interrupted, we will treat the admission as continuous, providing the interruption is for no more than 30 days. If the interruption is for a holiday or weekend leave, any such leave will count towards the 1-year total.

In the event of a waiting list, please contact the *ZorgConsulent*
You can ask our *ZorgConsulent* advisers to help reduce the waiting time on your behalf. The *ZorgConsulent* advisers can also help with other types of health-care mediation.

Transportation
Coverage

Medical transportation by ambulance
Repatriation in the event of death in the Netherlands
Other medical transportation

ONVZ

Medical transportation by ambulance

Medical transportation by ambulance is medically necessary transportation in an ambulance vehicle. This often involves emergency transportation in the event of an accident or heart attack, for instance, but the ambulance can also be used in non-emergency situations. For instance, to transfer you from a hospital to a nursing home if you must remain lying down while being transported.

Coverage under each health-care plan

Health Basic	100%, up to 200 kilometres
Health Premium	100%, up to 200 kilometres

What is covered

We cover transportation by ambulance over distances of up to 200 kilometres (one-way) within the Netherlands if the use of public transport, a taxi or a private car would be medically irresponsible. In certain situations, such as an accident, we also cover transport by helicopter/air ambulance.

In all these situations, we also cover transport back to your home or, if you cannot get the care you need at home, to the place where you will be looked after.

If you cannot travel on your own, but do not need transport by ambulance, Health Premium may cover other medical transportation in some cases. This comes under Other medical transportation rather than the coverage you are reading about now.

What you have to do yourself

You must request permission for journeys of further than 200 kilometres or using a different mode of transport
If, in a non-emergency situation, you need to be transported further than 200 kilometres, or a different mode of transport must be used, we may give permission for this in special cases. You or your attending doctor must request the permission in advance. No advance permission is required in emergency situations.

Repatriation in the event of death in the Netherlands

Coverage under each health-care plan

Health Basic	Repatriation of physical remains to your country of nationality through the *Zorgassistance* emergency centre
Health Premium	Repatriation of physical remains to your country of nationality through the *Zorgassistance* emergency centre

What is covered

If an insured person dies while in the Netherlands, we reimburse the costs of transporting the physical remains to the insured person's country of nationality, though only if this is arranged through our *Zorgassistance* emergency centre.

What needs to be done by the next of kin

Partner or next of kin must contact *Zorgassistance*
Your partner or next of kin must contact our *Zorgassistance* emergency centre before incurring any costs. Our *Zorgassistance* emergency centre is always available on +31 (0)88 668 97 67.

Other medical transportation

If there is a medical reason why you cannot travel to the hospital or health-care provider for treatment yourself, because you need a wheelchair to get around, for example, or you are visually impaired, you may be entitled to reimbursement of your transportation costs. In such cases, you are entitled to what we call ‘other medical transportation’. This is transportation to a hospital to get medical tests or medical treatment in cases where you cannot, on medical grounds, get there by using public transport.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• transportation by taxi: 100% • with private transportation: €0.27 per km

What is covered

Health Premium covers other medical transportation if this is to a hospital in the Netherlands where you will be receiving health care covered by the Health Premium plan.

Health Premium also covers transport back to your home, or, if you cannot (yet) be at home independently, to the place where you will be looked after.

The coverage is for other medical transportation over distances of up to 200 kilometres (one-way). If you have received permission from us for treatment that is more than 200 kilometres away, we will also cover the further distance.

Health Premium also covers transportation of a companion to accompany a child who is under the age of 16, and older than that, if assistance is required. If 2 companions are needed, we only reimburse the costs if we have given permission in advance.

Health Premium covers:
- car (private transportation): €0.27 per kilometre
- transportation by taxi: full coverage

Transportation by taxi
If you opt to travel by taxi, make it easy for yourself and choose the service offered by Transvision. Transvision arranges the taxi transportation for you and invoices us directly for the costs. Your doctor must fill in part 1 of the application form for other medical transportation[1] in advance. You will find this form on our website. We can request the completed statement from you. You can call Transvision between 8.30am and 5pm Monday to Friday, on 0900 333 33 30.

What is not covered
- parking charges and other additional costs
- the costs of transportation of a companion if you are not travelling at the same time, for example if you are admitted and the companion travels home alone

What you have to do yourself

You must seek our permission first
We only reimburse the costs of other medical transportation if you have obtained our permission in advance, which you request using the application form for other medical transportation[1]. You can also use this form to request permission for transportation over a distance greater than 200 kilometres, transportation using a different mode of transport or transportation with a companion/an extra companion. You will find this form on our website, or you can call our Service Centre.

Good to know

Car transportation is based on the optimum route
We calculate the number of kilometres using the Routenet route planner. We only reimburse the kilometres actually travelled by you.

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Handige downloads’, or call us on +31 (0)30 639 62 22

Claim expenses using the claim form for other medical transportation
If you want to claim the costs of medical transportation, Claim expenses using the claim form for other medical transportation[1]. The form tells you what documents you need to send. You will find this form on our website, or you can call our Service Centre.

[1] www.onvz.nl: click ‘Snel regelen’ and then ‘Handige downloads’, or call us on +31 (0)30 639 62 22

Other therapies
Coverage

Other therapies

ONVZ

Other therapies

You may have a complaint that the general practitioner cannot treat, but for which you do not need to go to the hospital. In that case, the general practitioner will refer you to a different health-care provider, like a physiotherapist or dietitian, for example. These health-care providers may even work in the same health-care centre as your general practitioner. You can visit these health-care providers without a referral from the general practitioner too.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Up to a maximum of €2,000 per calendar year

What is covered

Health Premium covers the other therapies list below. All listed therapies and treatment are covered up to a combined maximum of €2,000 per calendar year.

Physiotherapy, Cesar and Mensendieck remedial therapy
If you have physical symptoms whenever you move or that are caused by your posture, a physiotherapist or a remedial therapist can find out what the problem is and treat and support you as you recover. The recovery process will often include exercises for you to do, which will also serve to prevent recurrence of symptoms. You can do these exercises either at home or at a gym.

You can visit a general or specialist physiotherapist, manual therapist or Cesar/Mensendieck remedial therapist.

Foot specialist treatment and podiatry/chiropody
If you have general foot pain or physical problems due to abnormal foot posture or the way you walk, you can go to a foot specialist, *registerpodoloog* [registered podiatrist/chiropodist], or *podoposturaal therapeut* [podopostural therapist] for help. Such a specialist will examine your feet and treat your symptoms. If necessary, you will be fitted with podiatric arch supports, orthoses, or nail braces.

The registered podiatrist/chiropodist or podopostural therapist must be registered in the *KABIZ* (Quality registration and accreditation for health-care professionals) quality register.

Chiropractic therapy and osteopathy
You can visit a chiropractor with full membership of one of the following professional organisations:

CCA	*Christelijke Chiropractie Associatie* [Christian Chiropractic Association]
DCF	Dutch Chiropractic Federation
NCA	*Nederlandse Chiropractoren Associatie* [Dutch Association of Chiropractors]
SCN	*Stichting Chiropractie Nederland* [Dutch Chiropractic Foundation]
SNRC	*Stichting Nationaal Register van Chiropractoren* [National Register of Chiropractors Foundation]

You can visit an osteopath with full membership of one of the following professional organisations:

NOF	*Nederlandse Osteopathie Federatie* [Dutch Osteopathy Federation]
NRO	*Nederlands Register voor Osteopathie* [Dutch Osteopathy Register]
NVO	*Nederlandse Vereniging Osteopathie* [Dutch Association of Osteopathy]

Occupational therapy
If you have trouble doing your daily activities due to physical or psychological problems, an occupational therapist can help you get back to an independent lifestyle as much as possible.

Together with the occupational therapist, you will work on making those things you struggle with possible again. The occupational therapist will give advice, instructions, training, or treatment to help you achieve your goals.

You can visit an occupational therapist.

Speech therapy
The speech therapist deals with problems with the voice, speaking and swallowing in both children and adults. Stuttering is a common example of this kind of problem. Other problems include often being hoarse or swallowing the wrong way, or being unable to pronounce certain words or sounds. The care provided by a speech therapist is called speech therapy.

You can visit a speech therapist.

Dietetics
Are you overweight, or perhaps underweight, as the result of illness, an eating disorder or food allergies? Or do you have other symptoms relating to nutrition, such as intestinal problems, high blood pressure or high cholesterol? A dietitian provides information and advice on nutrition, diet and eating habits. We call this dietetics.

You can visit a dietitian.

Acupuncture
Acupuncture is a form of traditional Chinese medicine used to treat a range of complaints, like pain, allergies or stress symptoms, for example.

You can visit an acupuncturist with full membership of one of the following professional organisations:

NVA	*Nederlandse Vereniging voor Acupunctuur* [Dutch Acupuncture Association]
NAAV	*Nederlandse Artsen Acupunctuur Vereniging* [Dutch Association of Doctor-Acupuncturists]
ZHONG	*Nederlandse Vereniging van Traditionele Chinese Geneeskunde* [Dutch Association for Traditional Chinese Medicine]
NWP	*Nederlandse werkgroep Praktizijns in de natuurlijke geneeskunst* [Dutch Natural Medicine Workgroup]
NBCG YI	*Nederlandse Beroepsvereniging Chinese Geneeswijzen YI* [Dutch Chinese Traditional Medicine Professional Association]

What is not covered
- pregnancy fitness classes
- sports massage
- work-related/recreational therapy
- treatment of language problems caused by a dialect or because you have a different native language
- treatment of dyslexia
- treatment to support education
- music therapy

Health care abroad and travel

Coverage

Emergency medical assistance abroad
Repatriation

ONVZ

Emergency medical assistance abroad

If you urgently need health care abroad (outside of the Netherlands), for instance after an accident or due to sudden illness, this is known as emergency medical assistance abroad. This is health care that you must receive immediately, which could not have been foreseen when you departed on your trip, and which also cannot wait until you are back in the Netherlands.

Coverage under each health-care plan

Health Basic	100%, up to the statutory or prevailing market rate in the country where the treatment takes place
Health Premium	100%, up to the statutory or prevailing market rate in the country where the treatment takes place

What is covered

We cover emergency medical assistance abroad if you are abroad for no more than 180 consecutive days and the need for the health care could not have been foreseen when you departed on your trip. By 'emergency medical assistance', we mean health care that must be provided immediately and that cannot wait until you are back in the Netherlands.

We will only reimburse the costs of health care up to the prevailing market amount in the country where treatment is taking place, i.e. the rate charged by the health-care provider may not be unreasonably high when compared to the amount charged by other health-care providers in the country where the treatment takes place.

Arrangements for pregnancy and childbirth
Medical complications in your pregnancy or the childbirth can arise if you travel abroad while pregnant. We reimburse the costs of health care required to treat these complications as long as the complications could not have been anticipated. We regard the regular care involved in pregnancy and childbirth to be scheduled health care, i.e. you could have anticipated it when you set out on your trip abroad, meaning you cannot make use of the coverage you are reading about now for such care.

Furthermore, we do not provide coverage if:
- you are pregnant when you start out on your trip abroad and you have an increased health risk or obstetric risk factor at that time
- you are pregnant and travel to the tropics, to malaria or yellow fever risk areas and/or to areas with an increased risk of infection with the Zika virus
- you travel by plane after your 36th week of pregnancy

What is not covered
- emergency medical assistance if you go abroad for a period of more than 180 days

What you have to do yourself

Always contact the *Zorgassistance* emergency centre
If you urgently need health care abroad, you must contact our *Zorgassistance* emergency centre as soon as possible. Not doing this may have consequences for the reimbursement of costs. You can also contact us for advice on medical care.

Our *Zorgassistance* emergency centre is always available on +31 (0)88 668 97 67. We will reimburse telephone costs incurred when calling our emergency centre from abroad.

Medical details
You give permission to the medical adviser at our *Zorgassistance* emergency centre to transfer information to our medical adviser. This might be information relating to the treatment, for instance.

Requirements for health-care providers
For health care in a country outside the Netherlands as well, the health-care provider must be on the registers used by the government. If there is no such register in the country in question, the health-care provider must be on the register of the recognised professional organisation, if there is one. The health care provided must be considered common practice within the profession.

Repatriation

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	• repatriation in the event of serious illness or injury • repatriation of physical remains Through *Zorgassistance* emergency centre

What is covered

If you are travelling outside the Netherlands and sustain serious injury in an accident or become seriously ill, Health Premium covers the costs of your repatriation to the Netherlands, where this is medically required, with the prescribed medical supervision. Your repatriation is organised through our *Zorgassistance* emergency centre. This coverage only applies to a stay outside the Netherlands of no more than 180 days.

In the event of your death during a trip outside the Netherlands, where the trip lasted no more than 180 days, we will reimburse the costs of transporting your physical remains to the Netherlands or your country of nationality. Our *Zorgassistance* emergency centre will arrange the transportation of the physical remains.

What is not covered

- repatriation if you go abroad for a period of more than 180 days

What you have to do yourself

Repatriation through our *Zorgassistance* emergency centre
If you urgently need health care abroad, you must contact our *Zorgassistance* emergency centre as soon as possible. Not doing this may have consequences for the reimbursement of costs. Our emergency centre will determine whether repatriation is needed and, if so, will make the arrangements for this.

Our *Zorgassistance* emergency centre is always available on +31 (0)88 668 97 67. Health Premium reimburses the telephone costs incurred when calling our emergency centre from abroad.

Medical details
You give permission to the medical adviser at our *Zorgassistance* emergency centre to transfer information to our medical adviser. This might be information relating to your repatriation, for instance.

Third-party claims for injury
Coverage

Aid for third-party claims for injury

ONVZ

Aid for third-party claims for injury

The regular coverage provided by Health Premium applies to injuries incurred during an accident too. However, you may not be reimbursed for all costs in all cases. You may have to pay an excess or personal contribution, for example, or perhaps you have lost wages. You may also feel that you are entitled to compensation for pain and suffering.

Coverage under each health-care plan

Health Basic	No coverage
Health Premium	Up to a maximum of €12,500 per accident

What is covered

After an accident, you can use your legal expenses insurance of course, but if you do not have this, Health Premium offers an aid for third-party claims service to help you get reimbursed for your out-of-pocket expenses and lost wages and receive compensation for pain and suffering. This applies only to an accident that occurs in the Netherlands during the term of your Health Premium policy. A lawyer or claims representative engaged by us then tries to recover your loss from the person who is liable for your loss or from that person's insurer. Health Premium covers the costs of the aid for third-party claims service that we arrange for you, up to a maximum of €12,500 per accident. The costs of court proceedings also come under this coverage.

The *Verhaalsbijstand-service* [Aid for third-party claims service] rules[1] explain what this service entails and the conditions that apply. However, the rules concerning the places in which you can ask for help from the aid for third-party claims service do not apply. You can only use this service in the event of an accident that occurs in the Netherlands.

What is not covered
- other costs you incur outside the scope of the aid for third-party claims service
- contrary to the provisions of the aid for third-party claims service rules, Health Premium does not cover aid for third-party claims involving work-related illnesses

Questions
Simply call our *Verhaalszaken* (third-party claims) department on +31 (0)30 639 62 64, or send an email. We'd be happy to help.

What you have to do yourself

If any medical costs are the result of an accident, let us know
This will enable us to can see whether another party is liable for the costs incurred. Tick the '*ongeval*' (accident) box when you make a claim, or send us a completed third-party claim questionnaire[1] if you know that a hospital or other health-care provider will be billing us for the costs directly. You will find this form on our website, or you can call our Service Centre.

[1] www.onvz.nl: click 'Snel regelen' and then 'Handige downloads', or call us on +31 (0)30 639 62 22

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