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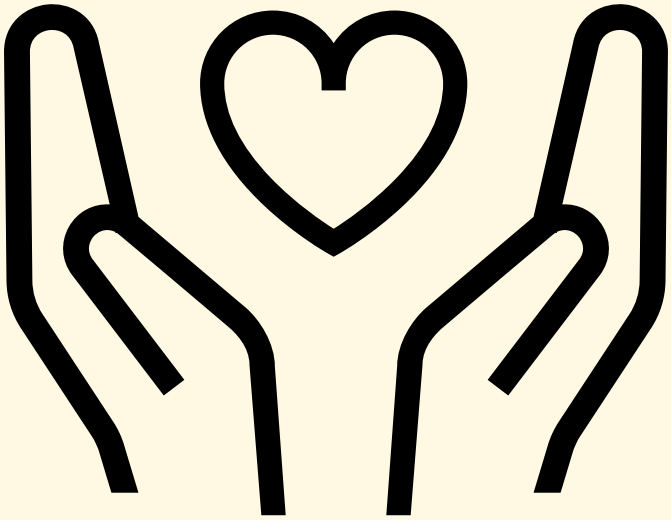

ik kies zelf

Policy Terms and Conditions

Ik kies zelf van a.s.r. ‘Vrije Keuze‘

Version 2025

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1. Definitions

Pharmacy
Pharmacy includes regular pharmacies, Internet pharmacies, chains of pharmacies, hospital pharmacies, outpatient pharmacies and dispensing general practitioners.

Dispensing practitioner
The dispensing general practitioner or an established pharmacist registered in the register of established pharmacists, or a pharmacist who is assisted by registered pharmacists in their practice. The term dispensing practitioner shall also include legal entities that provide care through pharmacists that are registered in the foregoing register.

Company doctor
A doctor who acts on behalf of the employer or the employer's Occupational Health and Safety Service. This doctor must be registered as a company doctor in the registry of the Royal Dutch Medical Association that was instituted by the Board of Registration of Doctors of Social Medicine (Sociaal-Geneeskundigen Registratie Commissie, SGRC).

Treatment plan or care plan
A treatment plan or care plan consists of, among other things, a description of:
- the patient's prior history;
- the complaints;
- results of examinations carried out previously;
- the – probable – diagnosis;
- the proposed treatment: purpose, nature, frequency and duration of the treatment, the healthcare providers involved and whether or not the patient is to be hospitalised.

Pelvic physiotherapist
A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg, BIG) and who is also registered as a pelvic physiotherapist in the Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie).

Special dentistry
Special dentistry is dental treatment provided to specific groups of patients which, on account of the level of difficulty of the treatment or specific circumstances, cannot be provided by a conventional dentist.

Centre for special dental treatment
A centre for the provision of dental care in special cases requiring treatment by a team and/or specialist expertise.

Centre for genetic counselling
An institution which holds a licence under the terms of the Special Medical Procedures Act (Wet op de bijzondere medische verrichtingen) for clinical genetic testing and the provision of genetic counselling.

Non-assignment clause
Under a non-assignment clause, the healthcare provider is not permitted to submit an invoice to the health insurance provider on behalf of the insured party. Instead, the insured party itself pays the invoice amount to the healthcare provider and claims the costs from the insurance company.

Infant welfare centre physician
A physician who is registered as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten, RGS) or who is registered as a health and society physician (arts Maatschappij en Gezondheid) in the Specialists Register maintained by the Royal Dutch Medical Association (Nederlandsche Maatschappij tot bevordering der Geneeskunst, KNMG) and established by the RGS, and who works as such in Youth Healthcare.

Emergency mental healthcare
Treatment for a patient who requires emergency mental care. This care is provided by a psychiatric care provider who works for a 24-hour emergency service. It is also referred to as emergency treatment. Emergency situations are situations where emergency assistance is required within 24 hours, for example in cases of imminent suicide.

Day treatment
Admission for less than 24 hours.

DTC Care Product
A DTC (Diagnosis-Treatment Combination) Care Product describes the full path of specialist medical care using an expense claim code laid down by the Dutch Healthcare Authority (NZa). This covers the patient's care need, the type of care provided, the diagnosis and the treatment.

The DTC Care Product commences on the date of the first care activity. This can be a consultation (in person or by telephone) with a specialist or an examination. The DTC is concluded in accordance with the applicable regulations.

Dietician
A dietician who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and is also registered as a dietician in the Quality Register for Allied Health Professions (Kwaliteitsregister Paramedici).

DSM
The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a classification system for psychiatric disorders. It contains cluster descriptions of such disorders based on symptoms.

Primary care admission
A temporary stay that is necessary on medical grounds in relation to medical care as generally provided by general practitioners.

Occupational therapist
An occupational therapist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists and is also registered as an occupational therapist in the Quality Register for Allied Health Professions.

EU and EEA States
In addition to the Netherlands, this shall mean the following countries within the European Union: Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek), Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovenia, Slovakia, Spain and Sweden.

Switzerland has been given equal status under the relevant treaty provisions.
The EEA States (states that are party to the Agreement on the European Economic Area) are Iceland, Liechtenstein, and Norway.

Pharmaceutical care
The supply of medicine and dietary preparations and/or advice and guidance as provided by dispensing practitioners in the interests of medication assessment and responsible use, designated as such under or pursuant to the Healthcare Insurance Decree (Besluit Zorgverzekeringen), with due observance of the Pharmaceutical Care Regulations stipulated by us.

Fraud
To deliberately commit or attempt to commit forgery of documents, deceit, to prejudice creditors or entitled parties and/or commit embezzlement with respect to the conclusion and/or performance of a health insurance or other insurance contract, aimed at acquiring a payment or reimbursement or the performance of services to which there is no entitlement, or acquiring insurance cover under false pretences.

Physiotherapist
A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered in Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie). A remedial masseur as referred to in Section 108 of the Individual Health Care Professions Act is also deemed to be a physiotherapist.

Birth centre
An institution for primary obstetric care (also known as a birth hotel or delivery centre), located in a hospital, which is able to provide acute obstetric care. New mothers will be able to stay at such an institution for childbirth and during their maternity period.

Contracted care
The care that, in accordance with the Healthcare Insurance Act (Zorgverzekeringswet, Zvw), we are obliged to provide, or to reimburse the costs of, by virtue of an agreement entered into between us and the healthcare provider.

Medical care for specific patient groups (gzsp)
Medical care for specific patient groups (gzsp) is a set of types of care for vulnerable insured parties who still live at home and exhibit (highly) complex medical issues. In most cases, geriatric specialists and physicians for the intellectually disabled are the coordinating treatment providers in these types of care.

Medicine
A substance or combination of substances intended to be administered or used or presented in order to:
- cure or prevent an illness, defect, wound or pain in a person;
- establish a medical diagnosis for a person; or
- recover, improve or otherwise modify functions in a person.

Geriatric physiotherapist
A physiotherapist who is registered as such in accordance with the terms and conditions as referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a geriatric physiotherapist in Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie).

Geriatric rehabilitation
Geriatric rehabilitation is meant for vulnerable elderly people following treatment in hospital, for example in connection with a stroke or a fracture. This type of rehabilitation is geared to the elderly patient's individual recovery potential and training speed, and also takes account of other, existing conditions (if applicable). The purpose of geriatric rehabilitation is to help elderly patients return to their home environment.

Healthcare psychologist
A healthcare psychologist who is registered in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act.

Mental healthcare institution
An institution entitled to provide mental healthcare in connection with a psychiatric disorder, which may or may not include a stay at the institution. The healthcare institution must be accredited under Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorgaanbieders, Wtza). Based on the mental healthcare National Quality Charter for Mental Healthcare, a distinction is made between independent practices and institutions.

Handicap
Physical or mental incapacity caused by a disorder or disability to function normally.

Skin therapist
A skin therapist who is registered in the Quality Register for Allied Health Professions and also satisfies the requirements as stated in the Decree governing educational requirements and the discipline of skin therapists (Besluit opleidingseisen en deskundigheidsgebied huidtherapeut).

General practitioner
A doctor who is registered as a general practitioner in the register of accredited general practitioner established by the Commission for the Registration of Medical Specialists of the Royal Dutch Medical Association.

Provision of medical aids
A provision to meet the need for medical aids and dressing materials designated by a ministerial regulation with due observance of the 'Vrije Keuze' Medical Aids Regulations (Reglement Hulpmiddelen Vrije Keuze) laid down by us regarding the requirements for consent, period of use and quantity.

Attempt at in vitro fertilisation
Care according to the in vitro fertilisation method, which involves:
- stimulating the maturation of ova in the body of the female by means of hormone treatment;
- follicular aspiration;
- fertilising the ova and growing embryos in the laboratory;
- implanting one or two embryos in the womb, one or more times, in order to instigate pregnancy.

Youth healthcare physician
A physician who is registered as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (RGS) or who is registered as a Health and Society physician in the Specialists Register maintained by the Royal Dutch Medical Association and established by the RGS, and who works as such in Youth Healthcare.

Dental surgeon
A dental specialist who is registered in the specialists register maintained by the Commission for the Registration of Dental Specialists (Registratiecommissie Tandheelkundig Specialismen, RTS])

Multidisciplinary care
Multidisciplinary care is provided to people with chronic conditions such as diabetes, COPD and those with an increased risk of developing cardiovascular diseases. The general practitioner provides this care in consultation with other healthcare providers.

Paediatric physiotherapist
A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg, BIG) and who is also registered as a paediatric physiotherapist in the Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie).

Clinical psychologist
A clinical psychologist is a healthcare psychologist who, after attaining a university degree in psychology and thereafter the degree in healthcare psychology, has successfully completed the three-year university degree programme in clinical psychology. A clinical psychologist diagnoses and treats more complex and severe psychiatric disorders.

Maternity care agency
An institution that offers obstetric care and/or maternity care and meets the requirements laid down by law. This is understood to include maternity centres.

Maternity hotel
An institution that provides inpatient maternity care and is accredited as such in accordance with regulations laid down by or pursuant to the law, as well as any institution recognised as such by us.

Maternity care
The care provided by a maternity care provider affiliated with a hospital, maternity centre or maternity hotel that provides the care generally provided by maternity nurses.

Laboratory tests
Tests carried out by a laboratory, which are permitted in accordance with regulations laid down by or pursuant to the law.

National Quality Charter for Mental Healthcare
The National Quality Charter for Mental Healthcare (Landelijk Kwaliteitsstatuut GGZ) is a field standard in which mental healthcare providers must set out how they have arranged the quality and accountability of medical mental healthcare, which is registered as a professional standard in the public register for quality standards, measuring instruments and information standards of the National Health Care Institute and applies to all mental healthcare providers.

It is mandatory for mental healthcare providers to have a Quality Charter. As of 1 January 2022, the Natural Quality Standard for Mental Healthcare serves as the basis for this. This means that healthcare providers must base their Quality standard on the National Quality Standard for Mental Healthcare.

Speech therapist
A speech therapist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists and is also registered as a speech therapist in the Quality Register for Allied Health Professions.

Authorisation
The written consent that we provide you with in response to a request for care from a care provider. The authorisation confirms that:
- the requested care falls under your health insurance cover;
- you can reasonably be deemed to depend on such care;
- you are entitled to full or partial compensation of the costs of such care in accordance with the policy conditions, which states the requirements for compensation specific to the type of care involved.

Manual therapist
A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg, BIG) and who is also registered as a manual therapist in the Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie).

Secondary medical specialists providing mental healthcare
Secondary medical specialists working under the responsibility of the coordinating treatment provider and whose profession is listed in the the list of mental healthcare professions (ZPM) Occupational Table GGZ and Field Standard Occupations in Medical Mental Health and Forensic Care.

Medical adviser
A medical adviser can be a consultant physiotherapist, a consulting nurse or a medical consultant. The medical consultant must be registered as a Health and Society physician (arts Maatschappij en Gezondheid) in the Specialists Register established by the Commission for the Registration of Medical Specialists (Registratiecommissie Geneeskundig Specialisten, RGS) or as a Policy and Advice physician (arts Beleid en Advies KNMG) in the Profile Register established by the Royal Dutch Medical Association (KNMG) and must be employed as such with a health insurance company. The medical consultant can be found in the BIG register under the profession of physician, with or without a statement of the specialist area.

Medical specialist
A physician who is registered as a medical specialist in the Specialists Register established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical Association.

Dental hygienist
A dental hygienist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists.

NZa
The Dutch Healthcare Authority (Nederlandse Zorgautoriteit, NZa) which is responsible for the regulation, supervision and implementation of healthcare.

Oedema therapist
A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as an oedema therapist in the Individual Physiotherapy Register (Individueel Register Fysiotherapie) maintained by the Physiotherapy Quality House (Kwaliteitshuis Fysiotherapie).

Cesar/Mensendieck remedial therapist
A Cesar/Mensendieck remedial therapist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists, and is also registered as a remedial therapist in the Quality Register for Allied Health Professions.

Turnover cap
In order to control healthcare costs and keep premiums as affordable as possible, we apply a turnover cap to some contracted care providers. This means that we have made agreements with these healthcare providers on a maximum amount that may be claimed per calendar year.

Admission
Admission in a hospital or rehabilitation centre for 24 hours or longer in the event that and insofar as, on medical grounds, nursing, examinations and treatment can only be offered in a hospital or rehabilitation centre, while uninterrupted treatment by a medical specialist is necessary.

Orthodontist
A dental specialist who is registered in the specialists register maintained by the Commission for the Registration of Dental Specialists.

General remedial educationalist
A general remedial educationalist (orthopedagoog-generalist) who is registered in the BIG register and also registered as such in the General Remedial Educationalists Register of the Association of Educationalists in the Netherlands (Nederlandse Vereniging van Pedagogen en Onderwijskundigen, NVO). A general remedial educationalist has attained a Master's degree in educational studies, psychology or health sciences, as part of which they acquired clinical skills and completed a clinical internship, and thereafter successfully completed the required two-year dual post-Master's degree programme.

Orthoptist
An orthoptist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists and is also registered as an orthoptist in the Quality Register for Allied Health Professions.

Chiropodist
A chiropodist who is registered with the endorsement for diabetes, rheumatism or medical pedicure in the Quality Register for Pedicures (KRP) or has a registration with Stipezo in the P-R register level A or B see https://www.stipezo.nl/register), or a medical pedicurist who is registered in the Kabiz Medical Foot Care Providers (KMV) quality register.

Physician's assistant
A physician assistant (PA) is a BIG-registered medical care professional with a college master's degree. A PA may independently examine, diagnose, treat and supervise patients. The PA does this in a partnership with a medical specialist, geriatrics specialist, doctor for the mentally handicapped or general practitioner.

Podiatrist
A podiatrist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists and is also registered as a podiatrist in the Quality Register for Allied Health Professions.

Mental healthcare sector privacy statement
A statement signed by the insured party and the healthcare provider, which ensures that the invoice contains no details that could be used to disclose the diagnosis.

Private clinic
A treatment centre in the Netherlands without accreditation under the Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorgaanbieders, Wtza) or a treatment centre abroad where treatments are carried out that are not reimbursed by the health insurance(s) that are part of the social system in the country concerned.

Psychiatrist
A physician registered as a psychiatrist in the Specialists Register established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical Association.

Psychotherapist
A psychotherapist who is registered in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act.

Coordinating treatment provider for medical care for specific patient groups (gzsp)
The gzsp coordinating treatment provider is a healthcare provider who is responsible for implementing the care and treatment plan in a multidisciplinary context. This means that he or she in should have the medical expertise required to identify the insured party's care needs and describe them in the treatment plan, in collaboration with other healthcare providers. If required, the coordinating treatment provider should also be able to adjust the treatment plan in response to changes in the insured party's care needs.

Coordinating treatment provider for mental healthcare
A coordinating treatment provider is the care provider managing the care process as described in the National Quality Charter for Mental Healthcare, the 2023 field agreements and the Dutch Healthcare Authority regulations.

Rehabilitation
Examination, advice and treatment of a specialist medical, paramedical, behavioural science or rehabilitative nature. This type of care is provided by a multidisciplinary team of experts led by a medical specialist affiliated with a rehabilitation centre accredited in accordance with regulations laid down by or pursuant to the law.

Rehabilitation institution
An institution authorised to provide inpatient or outpatient rehabilitation care. The healthcare institution must be accredited under the Care Institutions (Accreditation) Act (Wet toelating zorginstellingen, WTZi).

Second opinion
Requesting an assessment regarding a diagnosis and/or proposed treatment provided by a physician or medical specialist from a second, independent physician or medical specialist operating in the same specialist area/ professional field as the physician initially consulted. In the case of district nursing, a second opinion concerns the reassessment of the current indication by a second, independent district nurse.

SOS International
This organisation provides 24/7 assistance to insured parties in the event of urgent care. Medical travel assistance can be requested via https://sosinternational.nl/op-reis-en-hulp-nodig/. You will receive a response within 15 minutes.

Geriatric specialist
A doctor who is registered as a geriatric specialist in the register of recognised geriatric specialists established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical Association.

Emergency care
Care that cannot be foreseen, arising from an acute illness or accident for which immediate medical care is required that cannot reasonably be postponed.

Dentist
A dentist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act.

Prosthodontist
A prosthodontist who has been trained in accordance with the Decree governing educational requirements and the discipline of prosthodontics (Besluit opleidingseisen en deskundigheidsgebied tandprotheticus).

You/your
The insured party, policyholder and/or insured party. The name of this person is stated on the policy schedule.

V&VN
V&VN Dutch Nurses' Association (Verpleegkundigen en Verzorgenden Nederland), the association of care professionals in the Netherlands.

Treaty country
A country that is not part of the European Union, an EEA Member State or Switzerland, with which the Netherlands has a treaty on social security in which regulations on the provision of medical care have been included. These are the following countries: Australia (only for a temporary stay), Bosnia and Herzegovina, Macedonia, Montenegro, Serbia, Tunisia, Turkey and the United Kingdom.

Obstetrician
An obstetrician who is registered as such in accordance with the requirements referred to in Section 3 of the Individual Health Care Professions Act.

Nursing specialist in mental healthcare
A nursing specialist in mental healthcare who is registered as such in one of the five statutory registers for nurses in accordance with Section 14 of the Individual Healthcare Professions Act.

Nurse
A nurse who is registered as such in accordance with the requirements referred to in Section 3 of the Individual Health Care Professions Act.

Nursing and other care
Nursing and other care focuses on your physical health and on improving your self-reliance within your own residential and living environment.

Addiction specialist
This is a doctor who works at an institution for addiction treatment or mental healthcare. An addiction specialist provides guidance and treatment for people with an addiction.

Referral
The recommendation of a healthcare provider to an insured party to be admitted for treatment or for treatment to be continued by another healthcare provider. A referral must be issued prior to the treatment. The referral must at least state: the name, address and date of birth of the insured party, the name, job title, AGB code (administrative code assigned to healthcare professionals in the Netherlands) and stamp of the practice and/or signature of the referring party, the date of issue, the reason for the referral and any other relevant details. A referral letter remains valid for a period of one year (nine months in the case of mental healthcare) after the date of issue and must comply with the national laws and regulations.

Insured party
Any person who is designated as such in the healthcare policy, the policy endorsement or in the certificate of registration.

Policyholder
A person who has entered into the insurance contract with us.

Waiting list mediation
If the healthcare provider has longer waiting times than the nationwide level, please contact us for waiting list mediation assistance. In such a case, you will always be referred to a different healthcare provider.

Wet BIG
Individual Healthcare Professions Act (Wet op de Beroepen in de Individuele Gezondheidszorg, Wet BIG).

We/us/our
ASR Basis Ziektekostenverzekeringen N.V.

District nurse
A nurse or nursing specialist who has attained the required degree at HBO level as per the Dutch Qualifications Framework (NLQF): Bachelor's in Nursing, level 5 or 6 (under Sections 3.1 and 14 of the Individual Healthcare Professions Act / NLQF version 4.0).

Wlz
The Long-Term Care Act (Wet langdurige zorg, Wlz).

Wmo
The Social Support Act (Wet maatschappelijke ondersteuning, Wmo).

Wtza
The Dutch Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorgaanbieders).
Pursuant to the Wtza, which came into force on 1 January 2022, healthcare providers are subject to a notification requirement, a licensing requirement and an internal supervision requirement.

Independent treatment centre (zelfstandig behandelcentrum, ZBC)
A centre for specialist medical care (examination and treatment) as referred to in the Care Institutions (Accreditation) Act (Wet toelating zorginstellingen, WTZi) or which is accredited under the Long-Term Care Act (Wlz).

Hospital
An institution for nursing, examining and treating sick people as referred to in the Care Institutions (Accreditation) Act (WTZi).

Sensory impairment care
Sensory impairment care comprises multidisciplinary care for people with a visual, auditory or communication impairment arising from a developmental language disorder and focuses on learning to deal with, removing or compensating for the impairment to enable the individual to function as independently as possible.

Healthcare provider
An institution or a care provider working solo, with WTZa accreditation.

Care Performance Model(ZPM) Occupational chart GGZ
The occupational structure in the GGZ issued by the Dutch Healthcare Authority listing those professions that are qualified and competent to fulfil a role in the (individual diagnosis-oriented) treatment of clients in the GGZ. It is also enriched by the field standard Professions in medical mental health and forensic care, which provides further clarification on which professions qualify for which tasks and responsibilities.

Care programme (mental healthcare)
A care programme comprises all care provided to a patient within scope of the Healthcare Insurance Act (Zorgverzekeringswet, Zvw) (irrespective of the diagnosis, setting or type of care). The care takes place in a setting that is determined on the basis of the patient's care need. The start date is the date of the first care performance. A care programme ends once the healthcare provider and/or patient concludes the treatment (within scope of the Health Insurance Act (Zvw)). In addition, a care programme may be concluded due to the transfer to the Long-Term Care Act (Wlz). A care programme is automatically concluded when no care performance (i.e., consultation) has been provided within a period of 365 calendar days. This also applies to a chronic care need that may involve long intervals between contacts, in which case the care programme is likewise concluded when no consultation has been provided within a period of 365 calendar days.

Care provider
A natural person who provides care in a professional capacity.

Health insurance company/health insurance provider
ASR Basis Ziektekostenverzekeringen N.V.

Zvw-pgb
Personal budget (persoonsgebonden budget, pgb) under the Healthcare Insurance Act (Zorgverzekeringswet, Zvw).

2. Basis of the insurance

This basic insurance policy can be taken out by or on behalf of:
- any person who is subject to compulsory health insurance in the Netherlands;
- any such persons residing abroad.

This insurance contract is a Combination insurance policy (Combinatieverzekering) and is based on:
- the Healthcare Insurance Act (Zorgverzekeringswet) and accompanying notes;
- the Healthcare Insurance Decree (Besluit zorgverzekering) and accompanying notes;
- the Healthcare Insurance Regulations (Regeling zorgverzekering) and accompanying notes;
- the (digital) application form completed by the policyholder or his or her representative;

The insurance contract is stated on the policy schedule, which is sent annually to the policyholder.
We will also send you a (digital) health insurance card. Either the policy schedule or the health insurance card must be shown to the healthcare provider when requesting healthcare services, after which you will be entitled to reimbursement of healthcare costs under the Healthcare Insurance Act.

Either you or the healthcare provider can claim these healthcare costs from us, which we will reimburse subject to the conditions outlined in Article 3 below. You must pay any excesses or statutory personal contributions yourself.

These policy terms and conditions outline your policy cover entitlements. The extent of basic insurance cover is determined by the government. The relevant legislation states inter alia that the content and scope of your entitlement to care is determined by the current state of scientific research and current practice. If there is no such benchmark, the definition of 'prudent and appropriate care and services' in the relevant specialist area shall apply. You are only entitled to reimbursement of care if you can be reasonably considered to be dependent on the type and scope of care you have received.

We cannot conclude any basic insurance contract with you if the address you have provided does not appear in the Personal Records Database (Basisregistratie Personen) or if it differs from the address under which you are registered in the database. This rule does not apply if:
- you have presented a payslip or employer statement which states that the person to be insured works and pays income tax in the Netherlands or on the continental shelf (see Section 1.1.1 Long-Term Care Act (Wlz)). The statement or payslip must state when the person to be insured commenced employment, and the statement must not be more than one month old;
- you have submitted a declaration from the Social Insurance Bank stating that the person to be insured is insured under the Wlz;
- you cannot reasonably be held at fault for the discrepancy regarding the address in the Personal Records Database.

Receive correspondence on paper
We communicate with you digitally. Would you like tot receive a correspondence document on paper? Then you can submit a request to our customer service. In this way you will still receive your correspondence document on paper. Your request only applies to the correspondence document you request. You will receive all future correspondence digitally again in the usual way.

3. Entitlement to (reimbursement of the costs of) care

Reimbursement
The treatment and/or supply date as stated on the invoice is decisive in order to determine whether you qualify for reimbursement of care. In other words, the invoice date is not decisive. If a particular treatment is claimed in the form of a Diagnosis-Treatment Combination (DTC), your entitlement to reimbursement of care depends on the date on which the DTC commenced (the date of the first care activity). You will not qualify for reimbursement unless you were insured with us on that date.

Choice of healthcare provider
This basic insurance policy entitles you to reimbursement of the costs of care. You are entirely free to select the care provider of your choice. You can make use of:
- care provided by a care provider that has entered into a contract with us (contracted care);
- care provided by a care provider that has not entered into a contract with us (non-contracted care). For GGZ (Art. 18.12) and Nursing & Care (Art. 18.27) a maximum reimbursement of 90% of the average rate contracted by us applies. You pay the bill first yourself and then declare it to us.

Reimbursement of contracted care
If you opt for care with a contracted healthcare provider, we will reimburse your healthcare costs at the rates we have agreed on with the relevant provider. We will pay the healthcare provider directly, and you will not receive an invoice. You will normally pay any statutory patient contribution to the healthcare provider directly. If this is not the case, we will claim this payment from you by direct debit. In addition to agreements on rates and claim procedures, our contract with the healthcare provider will also include agreements regarding suitability and quality of care, and the conditions under which it may be provided.

To find contracted healthcare providers, please visit https://zorgzoeker.asr.nl.

Reimbursement of non-contracted care

Statutory maximum rate
If you consult a healthcare provider in the Netherlands with whom we have not concluded a contract and a statutory maximum rate applies, we will fully reimburse your treatment up to a maximum of this statutory maximum rate. In such cases, healthcare providers may not charge rates higher than the statutory maximum.

Exceptions are:
- GGZ (specialist and basic).
  We will reimburse your treatment up to a maximum of 90% of the average contracted rate. You pay the invoice first yourself and then declare it to us.
- Nursing and care
  We reimburse your treatment up to 90% of the average contracted rate. You pay the invoice first yourself and then declare it to us.

Our maximum rates can be found at www.asr.nl/verzekeringen/zorgverzekering/maximale-vergoedingen.

Free rates
If you consult a healthcare provider with whom we have not concluded a contract and no statutory maximum rate applies, we will reimburse your treatment at prevailing market rates. In accordance with the law, this is understood to include the costs deemed reasonably appropriate given the current market conditions in the Netherlands.
If a healthcare provider charges amounts higher than those deemed reasonably appropriate given the current market conditions in the Netherlands, you will therefore have to pay for the remaining amount yourself. For GGZ and V&V there is a maximum reimbursement of 90% of the average contracted rate.

Learn more about reimbursement for non-contracted care at: www.asr.nl/verzekeringen/zorgverzekering/Combinatiepolis

For nursing and other care under the Healthcare Insurance Act Personal Budget Scheme (Zvw-pgb), the maximum rates will apply as stated in the Zvw-pgb Regulations under the 2025 'Vrije Keuze' policy.

The 2025 'Vrije Keuze' Zvw-pgb Regulations are available on www.asr.nl/verzekeringen/zorgverzekering/documenten.

Obstacle
If the cost of your care exceeds the maximum reimbursement, you must pay the rest yourself. This may hinder you from receiving care from the non-contracted health care provider of your choice. If this obstacle is insurmountable for you, you may be eligible for a higher reimbursement. You can submit a request for this. For more information, visit www.asr.nl/verzekeringen/zorgverzekering/maximale-vergoedingen.

Additional conditions governing non-contracted care
We can only accept original invoices for processing that contain all the relevant information. The information that is required is determined by the NZa and specified in the current policy rules, which are available on https://puc.overheid.nl/nza.

We also only reimburse care that has actually been provided. If you have received an invoice from your healthcare provider, but the care has not been provided, we will not reimburse it.

The invoice must show what healthcare costs the healthcare provider is charging you for. If you received the bill from the healthcare provider, it is your own responsibility to ensure that the healthcare provider is paid in time.

You can only transfer your entitlement to reimbursement to a non-contracted care provider if either you or the relevant healthcare provider uses a deed of assignment to that end, which must comply with our rules, which rules can be consulted at www.asr.nl/verzekeringen/zorgverzekering/documenten. This does not apply to:
- audiological care (Article 18.1);
- dialysis (Article 18.3);
- genetic testing and counselling (Article 18.6);
- pharmaceutical care (Article 18.8);

- provision of medical aids (Article 18.14);
- mechanical ventilation (Article 18.17);
- specialist medical care (excluding mental healthcare) (Article 18.18);
- organ transplants (Article 18.21);
- rehabilitation (Article 18.23);
- thrombosis service (Article 18.25);
- nursing and other care (Article 18.27);

The care referred to in the above-mentioned articles is subject to a non-assignment clause.
Under a non-assignment clause, the healthcare provider is not permitted to submit an invoice to us on your behalf. You must pay the invoice to the healthcare provider yourself and then submit the invoice to us yourself.

Emergency care (including emergency care abroad)

In the event that you need emergency care abroad, you must notify us of this care as soon as possible. In the case of emergency care abroad, you should do so via SOS International. You can call them on +31 (0)20 651 51 51. No referral is required for this type of care.

Crucial care guaranteed

In some cases, healthcare institutions may reach their turnover cap during the course of the year as a result of financial agreements between them and us. In such cases, crucial care is guaranteed, i.e. ambulance care, emergency assistance, acute maternity services and emergency mental healthcare. In the case of care needs for which you are already receiving treatment from the healthcare institution, this will depend on the agreements we have made with the healthcare institution.

Waiting list mediation

If the waiting times at the healthcare provider exceed the maximum agreed nationwide, please contact us. We will be able to offer waiting list mediation services. Any referral will always be made to another healthcare provider.

Overpayment

Sometimes, we may pay you or the healthcare provider or institution more than the amount you are entitled to under the insurance contract. In such cases, you (the policyholder) must pay the difference back to us, which we will claim via direct debit. By entering into this insurance contract, you (the policyholder) have granted us authorisation to do so.

Authorisation policy

A number of reimbursement types are subject to an authorisation policy, which means that you (or your healthcare provider on your behalf) must submit an application to obtain our permission prior to the treatment. If we grant the necessary permission, you will receive an authorisation in writing.

This applies to:
- extending staying in a primary care institution following three months of hospitalisation (Article 18.5);
- certain medicines (Article 18.8);
- non-contracted mental healthcare treatment at a Mental Healthcare (GGZ) institution (Article 18.12);
- non-contracted mental healthcare diagnostics at a mental healthcare institution that take more than 300 minutes (Article 18.12);
- consecutive stays of more than 365 days in a clinical mental healthcare institution (Article 18.12);
- non-contracted medical aids (Article 18.14), as well as certain contracted medical aids ('Vrije Keuze' Medical Aids Regulations);
- plastic surgery treatment (Article 18.18);
- specific types of dental surgery (Articles 18.19 and 18.20); see the limitative list of dental surgery authorisations;
- certain treatments within oral care (Articles 18.19 and 18.20);
- rehabilitation at non-contracted independent treatment centres (Article 18.23);
- non-contracted nursing and other care (Article 18.27);
- personal budget for nursing and other care (Zvw-pgb) (Article 18.27); for details, see the 2025 'Vrije Keuze' Regulations;
- if you travel abroad to receive care there.

The authorisation will state its period of validity. If the authorisation states a period that exceeds the term of the insurance, your new health insurer will take over the authorisation according to their own conditions and rates.

For more details about the backgrounds to this policy and the limitative list of dental surgery authorisations, please go to www.asr.nl/verzekeringen/zorgverzekering/documenten.

DTC Care Product (Diagnosis-Treatment Combination)
In order to determine the voluntary excess, the DTC Care Product will be apportioned to the year in which the DTC Care Product was opened. This means that the compulsory excess in 2024 will be charged to the 'old' insurer if you switch in 2025.

Example:
If your first contact with the specialist was in 2024, the specialist opens a DTC Care Product and the treatment or operation is performed or continues into 2025, the reimbursement conditions and the compulsory/voluntary excess of 2024 will apply. If the specialist opens a new follow-up DTC Care Product in 2025, the follow-up product will be subject to the reimbursement conditions and the compulsory and/or voluntary excess of 2025.

Abroad
Different reimbursement regulations apply to healthcare costs incurred in another country. These are listed in Article 18.2 Abroad.

4. Premium

As the policyholder or contracting party, you must pay a premium for your basic insurance. Even if the premium is paid by a third party within the framework of a group scheme, the policy holder remains liable to pay the premium at all times. In the event of non-payment by the third party, the premium may therefore be claimed from the policyholder without delay.

You do not need to pay insurance premiums for insured parties turning 18 until the first day of the month following their birthday.

The premium is equal to the premium base minus any discounts resulting from a voluntarily chosen excess or participation in a group insurance contract.

5. Compulsory excess

Compulsory excess amount
If you are 18 years of age or older, you must pay a compulsory policy excess of €385 per calendar year. The costs of care will be payable by you up to this amount.

The following applies to mental healthcare as of 2022: the excess is calculated and charged on a monthly basis. If your treatment started in 2024 and continues into 2025, you may be faced with an excess bill for 2024 and 2025.

When does the compulsory excess apply?
Compulsory excess applies to all forms of healthcare in these policy terms and conditions, except:
- visits to your general practitioner. However, medicines prescribed by your general practitioner or laboratory tests ordered as part of the care from your general practitioner do fall under the excess;
- the costs of Combined Lifestyle Intervention;
- the costs of obstetric care and maternity care;
- the costs of nursing and other care;
- the costs of preventive foot care;

- the costs of follow-up checks for donors;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- medical costs of a living donor that are associated with the donation and incurred after 13 weeks following the donation;
- the costs of multidisciplinary care in the case of diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);
- medical aids provided on loan or rented based on a loan arrangement;
- the cost of an exploratory interview requested by the physician;
- the costs of cross-domain and cross-sector collaboration;
- the costs of multidisciplinary primary care that includes general practitioner care;
- the costs of non-invasive prenatal test and structural ultrasound examination in the second trimester;
- personal contributions (except for medicines) or private payments. The personal contribution and personal payment are not deducted from the excess;
- quit-smoking guidance and nicotine replacement products and medicines as part of the quit-smoking guidance;

The following applies to the cost of medicines:
- The costs of most preferred drugs are partially (35%) offset against the compulsory deductible. The costs of a number of preferred medicines are not offset against the deductible excess at all. The list of preferred medicines (see the list on https://www.asr.nl/verzekeringen/zorgverzekering/medicijnen/voorkeursbeleid) shows which medicines are preferred and whether the costs of these medicines are not set off against the obligatory deductible excess or are set off in part (35%).
- The costs of other medicines are fully offset against your deductible.
- The costs of care provided by the pharmacy (such as costs of delivery or a counseling session) fall entirely under the compulsory deductible, even if the pharmacy supplies preferred medicines.

Only the costs that we reimburse under this basic insurance policy count towards the compulsory excess. Amounts that are at your own expense (such as the personal contribution), therefore do not count towards it.
Costs are first deducted from the compulsory excess, and then from any voluntarily chosen excess.
If we reimburse your care costs to your care provider or healthcare provider directly, we will charge you the payable obligatory excess amount separately.

Calculation of compulsory excess for a mid-year contract date
If the basic insurance does not start or end on 1 January, we will calculate the compulsory excess as follows:

$$\text{Compulsory excess} \times \frac{\text{length of basic insurance in days}}{\text{no. of days in the relevant calendar year}}$$

DTC Care Product (Diagnosis-Treatment Combination)
In order to determine the compulsory excess, the DTC Care Product will be apportioned to the year in which it was the DTC Care Product was opened. This means that the compulsory excess in 2024 will be charged to the 'old' insurer if you switch in 2025.

Example:
If your first contact with the specialist was in 2024, the specialist opens a DTC Care Product and the treatment or operation is performed or continues into 2025, the reimbursement conditions and the compulsory/voluntary excess of 2024 will apply. If the specialist opens a new follow-up DTC Care Product in 2025, the follow-up product will be subject to the reimbursement conditions and the compulsory and/or voluntary excess of 2025.

6. Voluntary excess

Voluntary excess amount
The default voluntary excess amount is €0.
If you are aged 18 or over, you can elect to pay a voluntary excess of €100, €200, €300, €400 or €500 per calendar year. This will result in a reduced premium, and the discount will be noted in your policy schedule.
The following applies to mental healthcare as of 2022: the excess is calculated and charged on a monthly basis. If your treatment started in 2021 and continues into 2022, you may be faced with an excess bill for 2021 and 2022.

When does the voluntary excess apply?
The voluntary excess applies to all forms of healthcare in these policy terms and conditions, except:
- visits to your general practitioner. However, medicines prescribed by your general practitioner or laboratory tests ordered as part of the care from your general practitioner do fall under the excess;
- the costs of Combined Lifestyle Intervention;
- the costs of obstetric care and maternity care;
- the costs of nursing and other care;
- the costs of preventive foot care;
- the costs of follow-up donor checks;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- medical costs of a living donor that are associated with the donation and incurred after 13 weeks following the donation;
- the costs of multidisciplinary care in the case of diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);
- medical aids provided on loan or rented based on a loan arrangement;
- the cost of an exploratory interview requested by the physician;
- the costs of cross-domain and cross-sector collaboration;
- the costs of multidisciplinary primary care that includes general practitioner care;
- the costs of non-invasive prenatal test and structural ultrasound examination in the second trimester;
- personal contributions (except for medicines) or private payments;
- quit-smoking guidance and nicotine replacement products and medicines as part of the quit-smoking guidance;

The following applies to the cost of medicines:
- The costs of most preferred drugs are partially (35%) offset against the voluntary deductible excess. The costs of some preferred medicines are not offset against the excess at all. The list of preferred medicines (see the list on https://www.asr.nl/verzekeringen/zorgverzekering/medicijnen/voorkeursbeleid) shows which medicines are preferred and whether the costs of these medicines are not deducted from the voluntary deductible excess or are deducted in part (35%).
- The costs of other medicines are fully offset against your deductible.
- The costs of care provided by the pharmacy (such as costs of delivery or a counseling session) fall entirely under the voluntary deductible excess, even if the pharmacy supplies preferred medicines.

Costs are first deducted from the compulsory excess, and then from any voluntarily chosen excess.
If we reimburse your care costs to your care provider or healthcare provider directly, we will charge you the payable obligatory excess amount separately.

Calculation of voluntary excess for a mid-year contract date
If your basic insurance does not start or end on 1 January, we will calculate your voluntary excess as follows:

$$\text{Voluntary excess} \times \frac{\text{length of basic insurance in days}}{\text{no. of days in the relevant calendar year}}$$

If the basic insurance does not start on 1 January and you had a basic insurance policy with us with a different voluntary excess immediately preceding it, then the total voluntary excess will be calculated as follows:
- First, we take the total voluntary excess amount x no. of days the voluntary excess was applicable during the preceding period and for the period after it was changed.
- These two amounts will be summed together and divided by the total number of days in the calendar year.
- The result will be rounded to whole euros.

DTC Care Product (Diagnosis-Treatment Combination)
In order to determine the voluntary excess, the DTC Care Product will be apportioned to the year in which the DTC Care Product was opened. This means that the compulsory excess in 2024 will be charged to the 'old' insurer if you switch in 2025.

Example:
If your first contact with the specialist was in 2024, the specialist opens a DTC Care Product and the treatment or operation is performed or continues into 2025, In that case, the reimbursement conditions and the compulsory (and/or voluntary) excess from 2024 will apply. If the specialist opens a new follow-up DTC Care Product in 2025, the follow-up DTC Care Product is subject to the reimbursement conditions and the compulsory and/or voluntary excess of 2025.

7. Privacy

Registration of personal details
When you apply to us for insurance or financial services, we will ask you to provide your personal details. These will be used for:
- entering into and performing contracts with you;
- informing you of relevant products and offering them to you;
- ensuring the security and integrity of the financial sector;
- statistical analyses;
- relationship management;
- fulfilling statutory requirements.

We are highly committed to protecting your personal information, and your medical details in particular. We therefore treat your information with the utmost care. Whenever we use your personal details, we are bound to strict legislation and the Code of Conduct governing the Processing of Personal Details by the Insurance Industry (Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars).

For further information, see the privacy statement at www.asrnederland.nl/privacyverklaring.

In order to pursue a responsible acceptance policy, we are entitled to view your details as included in the Central Information System Foundation (Stichting CIS) in The Hague. Organisations affiliated with this foundation may also exchange information with each other, for the purposes of risk management and combating fraud. The CIS privacy regulations apply to all data exchange via CIS.

For further information, visit www.stichtingcis.nl.

Citizen Service Number
We are required by law to record your Citizen Service Number (Burgerservicenummer, BSN) in our records. Your care provider or healthcare provider is required by law to use your BSN in all forms of communication, as are other service providers offering care under the Healthcare Insurance Act. We also use your BSN when communicating with these parties.

Notification
Whenever we send you (the policyholder) a message to your last known address, or to the address of the person mediating your insurance, we are entitled to assume that the message has reached you (i.e. the policyholder).

8 Obligations of the policyholder/insured party

Insured parties and policyholders are obliged to:
- identify themselves using a driver's licence, passport or Dutch identity card when utilising healthcare services in a hospital or outpatients' department;
- ask the treatment provider or medical specialist to inform our medical adviser of the reason for your being admitted, upon request;
- cooperate fully with us in obtaining the information we need, with due observance of privacy legislation;
- inform us within 30 days in the event of your detainment. You must also inform us within 30 days of the cessation of your detainment;
- submit original invoices to us within three years of the date of treatment. The details on the invoices must allow us to determine whether you are entitled to a reimbursement, and the amount. Computer-generated invoices must be authenticated by the healthcare provider. Neither a payment overview, nor a quote, order confirmation, proof of advance payment or advance invoice count as an invoice.

If you act contrary to our interests by failing to meet these obligations, your right to reimbursement will be void and we may reclaim the costs from you.

9. Recourse

Insured parties and policyholders are obliged to:
- provide us with information and lend their cooperation with regard to seeking recourse against a liable third party;
- contact us before reaching a settlement with a third party, or a party acting for or on behalf of the third party – including the health insurer of the third party – in relation to the damage suffered by him or her.
- Under no circumstances are you permitted to reach a settlement with a third party or their representative without obtaining our prior written consent. This includes issuing notice of discharge (stating that a debt has been paid) that impinges upon our rights.

If you fail to meet these obligations wholly or in part, you will be liable to compensate us for the damages suffered.

In the event that you must pay the compulsory and/or voluntary excess for medical assistance as a result of an accident for which another party is to blame, you will have to personally recover this sum from that party.

10. Fraud

Duty of cooperation
Under the Healthcare Insurance Act (Zorgverzekeringswet) and the Incidents Warning System for Financial Institutions Protocol (Protocol Incidentenwaarschuwingssysteem Financiële Instellingen), for the purposes of fraud investigation we are allowed to monitor the content of your insurance application, your personal data in our systems, and your claims and requests for authorization. Under the Healthcare Insurance Regulations, health insurance providers are obliged to conduct material checks and fraud investigations in accordance with the requirements in the Regulations. You are obliged to cooperate in this regard. If you refuse to cooperate, we will be unable to acknowledge your statements and will be required to draw unilateral conclusions.

Personal data
For the purposes of fraud investigation, we will register your personal data as well as those of any accessories or co-perpetrators in our Incident Register. The Incident Register is lodged with the Dutch Data Protection Authority, and is administered by the Healthcare Security Team.

Healthcare insurers actively collaborate on fraud management
The Healthcare Insurance Act, the Long-Term Care Act and the Health Care (Market Regulation) Act authorise health insurance providers to exchange information among themselves for monitoring and fraud management purposes. We also share certain indications with sector partners to combat fraud, such as the Dutch Healthcare Authority (NZa), NLA and the Fiscal Intelligence and Investigation Service (FIOD), with due observance of Article 06.01 of the General Data Protection Regulation (GDPR). This information exchange may take place directly, or via the Association of Dutch Health Insurers. The GDPR sets out the way in which personal data may be processed.

Lapsed right to claims
No claims will be paid out while fraud investigation is underway. If the investigation reveals proof of full or partial fraud, you will no longer be entitled to reimbursement for any healthcare costs. This means we will either reject and refuse to pay the relevant claim(s) or recall the payment(s) already issued. Cases of partial fraud will void the right to compensation for the entire claim, including the portion in which no fraud was involved. We will also charge investigation costs in accordance with Section 6:96 of the Dutch Civil Code.

Sanctions
If you and any accessories/co-perpetrators are found guilty of fraud, we are entitled to:
- issue an official warning;
- place an internal alert;
- terminate your health/other insurance with immediate effect; This means we will:
  - refuse to grant you a new Basic Insurance policy for a five-year period. Other health insurance providers will be obliged to accept your application for Basic Insurance;
  - refuse to grant you any supplementary or other insurance policies from a.s.r. insurers for a period of eight years;
- discontinue your contractual relationship and terminate all current insurances with the brands of a.s.r. and its authorisations;
- register your personal data in the External Referral Register maintained by the Central Information System Foundation (Stichting CIS);
- register your personal data with the Insurance Fraud Bureau (Centrum Bestrijding Verzekeringsfraude) of the Dutch Association of Insurers (Verbond van Verzekeraars);
- institute criminal proceedings by submitting a report to the police or other investigative body;
- reclaim healthcare and other costs involved in fraud.

11. Unlawful registration

If it transpires that you were not obliged to obtain health insurance, the basic insurance will become void with retroactive effect from the moment the insurance obligation ended.

If we draw up basic insurance for you based on the Central Administration Office (CAK) Regulations for the Non-insured, and it later transpires that you were insured elsewhere, our basic insurance will become void with retroactive effect.

In such a case, you must demonstrate to us and the CAK that you were insured elsewhere. You will have two weeks to do so, counting from the day the CAK informed you of this. The CAK implements regulations at the behest of the government.

12. Payment of premium and payment arrears

Payment of premium

You are obliged to pay the premium and the contributions arising from Dutch or international statutory regulations or provisions to us in advance. We have agreed with you that you will do so on a monthly or annual basis. You can only pay by direct debit. In case of monthly payment, we will debit the amount payable from your account every month around the same date. If the policy is backdated when drawn up, the outstanding premium will be collected as a lump sum within 30 days. The amount of the premium is shown on the policy schedule issued to you.

If your insurance changes during the course of a month, we will recalculate your premium. If you have paid too much, we will reimburse the difference to you. If you have paid too little, we will charge you the additional amount. If you make a payment without stating the a.s.r. payment reference, we will decide to which outstanding amount the payment will be credited.

You are not permitted to use your existing credit with us to pay outstanding amounts.

If you have opted for annual payments and we have not received your payment within the designated 30-day payment period, we will convert your policy to a monthly payment plan and you will no longer be entitled to any discount.

If an insured party dies, we will recalculate the premium starting from the day following death.

Payment reminders

If you (the policyholder) fail to pay any statutory personal contributions or other costs on time, we will send you a written reminder asking you to pay within 14 days of the date on the reminder.

Premium payment arrears

If you are two monthly premium payments in arrears, we will offer you a premium payment plan.
If your payment arrears amount to four monthly premiums, we will inform you that, should your arrears reach six monthly premiums, we will refer your case to the Central Administration Office (CAK) in connection with the levying of a premium under administrative law.

If your payment arrears amount to six monthly premiums or more, we will report the matter to the CAK and to you, the policyholder. From that point on, the Central Administration Office will collect the premium under administrative law from you, the policyholder, and you will no longer pay any nominal premiums to us.

In such cases, the statutory regulations concerning 'The consequences of non-payment of the premium and the premium under administrative law' (Sections 18a through 18g of the Healthcare Insurance Act) apply.

We are entitled to settle any payment arrears against sums that we still owe to you. This settlement will also apply to any payment arrears in respect of your policy excess and any personal contributions. If you have opted for a voluntary excess of €100, €200, €300, €400 or €500 per calendar year, that option will lapse as of the next 1 January.

Suspension in the event of detention

If you are detained, you must notify us within 30 days. We will suspend your policy for the duration of your detention, and you will not need to pay any premiums. You must also inform us within 30 days of the cessation of your detention; we will then reinstate your policy starting from your date of discharge.

13. Claims

Claims paid directly

We have the right to pay claims that have been submitted to us by the healthcare provider directly to the healthcare provider. You are entitled to an itemised statement of the amounts paid. We will not pay the healthcare provider directly if the latter is subject to a statutory sanctions regime.

Amounts owed

Contracted care providers claim the costs of the care provided directly to us. We pay the full invoice amount to the care provider. You do not have to do anything yourself.

Sometimes a claim is not eligible for full reimbursement, e.g. due to an outstanding excess amount or a limited reimbursement scheme. You must pay the excess or payment amount(s) exceeding the reimbursement scheme back to us.

General claim

We will notify you of any amounts to be repaid by you; you will have to repay such amounts by the deadline stated in the notification. It is not permitted to settle an outstanding amount with any amount we owe to you.

14. Notification of relevant events

Changes to your personal situation

As a policy holder or insured person, you are obliged to provide us with information that may be significant for the correct implementation of the insurance within 30 days. By this we mean anyway:

- if your obligation to take out insurance ends;
- if your accountnumber/IBAN changes;
- if you are going to stay abroad for a long period of time
- if you move;
- if you are detained on the basis of a court decision;
- when your detention ends.

Birth

It is important to also report the birth of a child to us quickly. If the birth is reported to us within 4 months, we can insure your child retroactively to the day of birth. All healthcare costs incurred in the meantime will then be covered by the insurance. If the birth of a child is not reported to us until after 4 months, the insurance will commence on the day on which we receive the notification. If the child has already incurred healthcare costs, these will remain borne by the parents.

18 years and over

If you (the insured party) turn 18, we ask that you choose your voluntary excess amount at least two weeks prior to your birthday. Please inform us of your decision in writing, or via Mijn a.s.r.. If we have not heard from you by your birthday, we will send you a policy without any voluntary excess amount. The policy will come into effect on the first day of the month following your 18th birthday.

Reimbursement of care costs via the local authority

There may be a degree of overlap between the care for which you are reimbursed by your local authority under the Social Support Act (Wet maatschappelijke ondersteuning, Wmo) and the care for which you are reimbursed by us under the Healthcare Insurance Act (Zorgverzekeringswet, Zvw). If, as a result, you are reimbursed twice for the same care, you are obliged to contact us about the matter.

15. Revision of premium or conditions

Annual amendment
We are entitled to amend your premium and/or policy conditions every year, effective 1 January.

What if the premium and/or terms and conditions change in the interim?
It is in everybody's interest for us to be able to meet (and continue to meet) our financial obligations in the future. For this reason, in exceptional cases, we may introduce interim changes to your premiums and/or terms and conditions if they cannot wait until the annual renewal date (e.g. if we are required by law to do so). 'Exceptional cases' also include the threat or existence of circumstances that may result in solvency dropping to below the statutory minimum if the changes are not implemented. Adverse developments in the interest and investment market or lower-than-expected operating results do not constitute exceptional cases.

We will notify you of any changes
A revision of the premium base will take effect no sooner than seven weeks after the date upon which the policyholder was notified to this effect. Before we change anything, you will receive a message from us containing information on the changes. Complaints regarding the implementation of the change will be subject to the customary complaints procedure (see Article 17).

16. Commencement and end of the insurance

Commencement of your basic insurance
The basic insurance will commence on the date stated as the date of commencement on the policy schedule. If you switch to us from your old insurer at the end of the year or before 1 February of the following year (if you have terminated your previous insurance), the start date will be 1 January of the new year.

In other cases, we will insure you with retroactive effect:
- if you apply for basic insurance with us within four months of becoming obliged to obtain health insurance (e.g. birth of a child, or moving to the Netherlands from abroad). In such cases, the commencement date will be the date on which the insurance obligation came into force;
- if you apply for basic insurance with us within one month of terminating your basic insurance with another insurer. In such cases, the commencement date will be the day after the termination date of your old basic insurance.

If you apply for basic insurance in situations other than those described above, the basic insurance will commence on the date we receive the completed application from you, the policyholder. The commencement date will be listed on your policy schedule. If, at the time of application, you are still insured with another insurer and you specify a later preferred commencement date on your application, the basic insurance will commence on the later specified date.

Right of withdrawal
The policyholder has 14 days after submitting an application for basic health insurance during which he or she may withdraw the application.

Termination of your basic insurance by notice of termination

Switching at the end of the year
Policyholders may give notice to terminate their basic health insurance up until 31 December, effective 1 January of the following year. If you do not terminate your basic insurance, we will automatically extend it by one year at a time.

You (the policyholder) may terminate the insurance policy in the following ways:
- in writing, no later than 31 December;
- by making use of the transfer system prior to 31 December.

If you take out basic health insurance with us by no later than 31 December, effective the following year, we will terminate your basic insurance with your previous health insurance provider for you.

Should you accidentally turn out to be insured with two insurers, the insurers will organise matters among themselves so that you remain insured with one insurer only.

Interim termination
Termination during the course of a calendar year is only possible in the following cases:
- You (the policyholder) have insured someone other than yourself, who is insured under a separate basic insurance policy. In such cases, however, you must provide us with proof of registration for the new insurance policy. If we receive the termination notice prior to the commencement date of the new basic insurance, the basic insurance will terminate on the day the insured party receives new basic insurance. In other cases, the termination date will be the first day of the second calendar month following the day on which you (the policyholder) submitted notice of termination.
- Changes to the premium base or policy conditions adversely affect you. In such cases, the basic insurance will terminate on the day on which the changes to your premium or conditions enter into force. You have 30 days from receiving notice of the changes in which to submit written notice of termination. This reason for termination will not apply if the premium or conditions change as the result of a statutory provision.
- You (the policyholder) have a group insurance policy with us and start work with another employer who offers different group basic insurance. You may cancel the old basic insurance up to 30 days after commencing your new employment contract. Your new group insurance will start on the day you commence employment with the new employer if it is the first day of the month; otherwise, it will start on the first day of the following month. Your old group insurance will end on the same day. All rights to discounts and other entitlements under the group policy will cease to apply upon termination of participation in the group insurance.
- You recently turned 18 and wish to transfer to a different insurance company.
- The Dutch Healthcare Authority has informed you that we have failed to meet the provisions of Section 15f of the Processing of Personal Data in Healthcare (Additional Provisions) Act (Wet aanvullende bepalingen verwerking persoonsgegevens in de zorg). In that case, we need to have received your notice of termination within six weeks of the Dutch Healthcare Authority's notification.

These termination options do not apply:
- during the period in which you (the policyholder) have failed to pay the premiums and any collection costs owed by the set deadline (see Article 12), unless we confirm your termination within two weeks;
- during the first 12 months of the insurance contract, if you are insured under the Central Administration Office (CAK) Regulations for the Non-insured.

Termination of your basic insurance by operation of law
We will terminate your basic insurance effective the day following the day on which:
- we can no longer offer basic insurance because our permit to do so has been modified or withdrawn. We will notify you at least two months in advance of any such case;
- the insured party dies. We must be notified of the death of the insured party within 30 days of the date of death;
- the obligation to obtain health insurance expires for persons no longer insured under the Long-Term Care Act, or if you enter military service. You must inform us of the above as soon as possible.
- In the above cases, we will notify you as soon as possible of the termination date of the basic insurance, and the reasons why.

Termination of insurance upon withdrawal of the insurance product
We are entitled to terminate the insurance unilaterally if we decide to withdraw the insurance product concerned from the market or to no longer offer it.

17. Reconsideration and complaints

This agreement is governed by Dutch law.

Request for reconsideration
In the event that you do not agree with a decision made by us, you may request that we reconsider it. To do so, upload your request for reconsideration https://www.asr.nl/service/zorgverzekering-upload. Alternatively, you may send a letter to a.s.r., attn. Medical Care Department, PO Box 2072, 3500 HB Utrecht (the Netherlands). In your request, please explain clearly why you disagree with the decision.
When you submit the request, also include additional documents and/or arguments that can support this.
In all cases, please clearly state that your correspondence concerns a request for reconsideration.

If you have a question, you may call us on +31 (0)30 699 79 30.

SKGZ
If we fail to respond to your request for reconsideration within four weeks or have indicated the intention to adhere to our decision, you may turn to the Dutch Health Insurance Industry Complaints and Disputes Authority (SKGZ). The SKGZ offers mediation services in order to solve problems. If mediation fails to produce satisfactory results, the Disputes Board of the SKGZ may issue a binding decision. You can also bring your request for reconsideration before the competent court.

Complaints
If you have a complaint, please use the complaints form on Mijn a.s.r. Alternatively, you may call us on +31 (0)30 699 79 30 or send a letter to a.s.r. Klachtenservice, Postbus 2072, 3500 HB Utrecht.

If you are dissatisfied with the way your complaint was handled, please submit it to the SKGZ.

You may also bring your complaint before the competent court.

Complaints about standard forms
If you find our forms too complicated or superfluous, you may submit a complaint to the NZa, who will issue a binding opinion on the matter.

18 Medical care

18.1 Audiological care

Audiological care focuses on the prevention, examination and treatment of hearing disorders. It is a type of specialist medical care.

We pay for care provided by audiological centres, which offer the following care services:
- conducting hearing tests;
- advising you on the purchase of hearing aids;
- giving you information on the use of the hearing aid;
- offering psychosocial care if required by your hearing impairment;
- diagnostic assistance in the case of speech and language impediments for your child.

For specialist medical care you need a referral from a referring specialist.

18.2 Abroad

Submitting an invoice and medical report
To enable us to determine the correct reimbursement amount, please ensure that we are provided with a medical report or discharge letter from the attending physician that shows what care was provided. The discharge letter and the invoice must be submitted in one of the following languages: Dutch, German, English, French or Spanish. If the invoice and the invoice have not been provided in one of these languages, it is your responsibility to provide a translation produced by a certified translator. If and for as long as the discharge letter and the invoice are not made out in one of those languages or no translation by a certified translator is provided, the invoice will not be processed. The right to reimbursement will be void after three years.

Emergency care
In the case of emergency care abroad, you must ensure that SOS International is contacted immediately. In such a case, the SOS International physician will act on behalf of our medical adviser.

SOS International can be contacted on +31 (0)20 651 51 51 (this number is also listed on your health insurance card) or via https://sosinternational.nl/op-reis-en-hulp-nodig/.

In the case of non-emergency care abroad, you are entitled to (the reimbursement of) a single room.

Requesting non-emergency care in advance
For non-emergency care abroad, you will need our prior permission. to find out if – and if so, to what amount – you are eligible for reimbursement. We reimburse the costs up to prevailing market rates.

If you live in the Netherlands and receive healthcare abroad
We provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted healthcare provider in the Netherlands.
We will reimburse no more than the costs at the prevailing Dutch market rates. For GGZ and V&V there is a maximum reimbursement of 90% of the average contracted rate.

For more information on reimbursement of non-contracted care, please visit https://www.asr.nl/verzekeringen/zorgverzekering/combinatiepolis.

Residing or staying in an EU/EEA country or treaty country other than the Netherlands In this case, you have the following options:
- we will pay the costs of your care in accordance with the statutory regulations of that country pursuant to the provisions of the EU Social Insurance Regulation or the treaty concerned; or
- we provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted healthcare provider in the Netherlands.

If you live in another EU/EEA country or treaty country and are temporarily residing in the Netherlands or in another EU/EEA country or treaty country, In this case, you have the following options:
- We will pay the costs of your care in accordance with the statutory regulations of the country where you receive your care pursuant to the provisions of the EU Social Insurance Regulation or the treaty concerned; or
- we provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted healthcare provider in the Netherlands.

If you live or reside in a country that is not an EU/EEA country or treaty country:
We provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands.

European Health Insurance Card (EHIC)
The EHIC can be found on your health insurance card. If you go on holiday to an EU/EEA country or Switzerland, you will be entitled to necessary medical care in the destination country. You can also use the EHIC in Australia for necessary medical care services. You may only use this EHIC if you are insured with a.s.r. If you use the EHIC with the knowledge that it is no longer valid, or if you should know that it is no longer valid, the costs of your care will be for your own account.

For more information about the use of your EHIC, go to www.hetCAK.nl/regelingen/buitenland.

Payment
We will pay your claim in euros according to the exchange rate applicable at the moment when your claim is accepted for processing. We apply the exchange rates listed on www.oanda.com. Payment will be issued to the account number (IBAN) of the policyholder listed in our records.

18.3 Dialysis

We reimburse the following dialysis centre costs:
- dialysis;
- specialist medical care that is necessary and consists of:
  - tests, treatment and nursing care associated with dialysis;
  - medicines necessary for treatment;
  - psychosocial support for you and those assisting with performing the dialysis.

If the dialysis takes place at your home, you are entitled to:
- the costs of training by the dialysis centre for those performing or assisting with the home dialysis;
- the loan, regular monitoring and maintenance (including replacement) of the dialysis equipment and accessories;
- chemicals and fluids required for performing the dialysis;
- other consumer items reasonably required in order to carry out the home dialysis (e.g. a dialysis chair);
- any reasonable modifications in or around the home, including those necessary to return the home to its original state, if not provided for under other statutory provisions;
- any other reasonable costs (e.g. electricity and water) directly associated with the home dialysis, if not covered by other statutory provisions;
- he required expert assistance provided by the dialysis centre for the dialysis.

Please note that you will need our prior permission for any adjustments to your home and for restoring your home to its original state.

18.4 Dietetics

Dietetics is the provision of information about eating habits and food for a medical purpose. Dieticians will provide advice on your eating pattern in order to promote your physical health.

Reimbursement
We will reimburse a maximum of three hours of treatment per calendar year. This treatment must involve care generally provided by dieticians and must have a medical purpose.

When you go to a non-contracted dietician, you require a statement by a general practitioner, dentist, infant welfare centre physician, company doctor, youth healthcare physician or medical specialist.

Dietetics within the framework of gzsp
If you receive care within the framework of medical care for specific patient groups (gzsp), that care must be provided in accordance with the conditions set out in Article 18.11.

18.5 Primary care admission (ELV)

It is possible that due to the type of care you need, you cannot live at home for a period of time. In such a case, you may be temporarily admitted to a primary care institution, in consultation with your general practitioner, medical specialist, geriatric specialist or emergency department doctor. The purpose of such admission is for you to recover sufficiently to return to your own home environment, or to bridge the period until the care you need can be provided in your home environment. You can also decide to spend the last phase of your life in a primary care institution.

Primary care admission focuses on recovery and return to your home environment or relates to palliative terminal care, in cases where life expectancy is an average of three months or less. During a primary care admission, it may become clear that a return home is not medically justified. In such case, it is advisable to request an indication under the Long-term Care Act (Wlz), as care at home cannot be safeguarded. The care that you receive during primary care admission is a medical necessity in relation to care as generally provided by general practitioners.

During a primary care admission, you will be monitored or have care close by you at all times, which is accompanied by nursing and care (in accordance with Section 2.12 of the Healthcare Insurance Decree) and may be accompanied by psychological care (in accordance with Section 2.4 of the Healthcare Insurance Decree) or paramedical care that relates to the indication for primary care admission. The indication for a primary care admission must be issued by a general practitioner, medical specialist, emergency department doctor or geriatric specialist.
This professional will establish the need for medical care and the medical grounds for a stay at an institution, using the most recent version of the primary care assessment instrument.

You are not eligible for primary care admission if you have a medical indication for:
- respite care under the Social Support Act;
- admission under the Long-Term Care Act;
- admission related to maternity care (maternity hotel).

Care provided and claimed under primary care admission cannot also be declared separately with other services.

Maximum admission period

Because of the temporary nature of primary care admission, we will reimburse such a stay for a maximum period of 90 consecutive days. If you require primary care admission for longer than 90 consecutive days, then you must request an extension no more than two weeks before the end of the 90-day period. To do so, your healthcare provider, in consultation with you, must submit an application form for authorisation of an extension of the primary care admission by a maximum period of 90 days. If, following your discharge, you are re-admitted to a primary care healthcare provider within two weeks, the interruption will not count towards the maximum stay and the two admission periods will count as one.

You can find the authorisation form on www.asr.nl/verzekeringen/zorgverzekering/documenten.

Quality requirements for primary care admission providers

All providers must meet the following minimum criteria:
- The care supplied by the provider must be in line with the latest professional requirements and standards.
- Nurses must be available 24 hours a day, 7 days a week. A nurse with higher professional education qualifications (or higher) will have primary responsibility and will act as your primary point of contact.
- Upon admission and discharge, the healthcare provider makes arrangements with the primary care physician and the hospital regarding the transfer of medical records and medical policies.

In the case of palliative terminal care, the following conditions apply for the healthcare provider:
- Nurses with a level of competence of 4 or 5 who are qualified and competent to provide palliative care (as described in the palliative care nurse competency description of the Dutch Nurses' Association (V&VN)) must be available 24/7.
- The care provided must be in accordance with the Palliative Care NL Quality Framework and the guidelines for palliative care of the Netherlands Comprehensive Cancer Organisation (Integraal Kankercentrum Nederland, IKNL) (www.pallialine.nl).

- The healthcare provider must be affiliated with the regional Palliative Care Network (Netwerk Palliatieve Zorg, NPZ).
- The healthcare provider must work in accordance with the Palliative Care Module (Zorgmodule Palliatieve Zorg) 1.0 and the Care Pathway for the dying patient (Zorgpad Stervensfase).
- The healthcare provider must cooperate with the regional team or use a Palliative Care Support Team (Team Ondersteuning Palliatieve Zorg, TOPZ).
- The healthcare provider must be able to demonstrate that it uses the guidelines of the National Primary Care Collaboration Agreement (Landelijke Eerstelijns Samenwerkings Afspraak, LESA) and the regional transmural agreements (regionale transmurale afspraken, RTA) in the area of palliative care (if these exist in the work area).

18.6 Genetic testing and counselling

Genetic testing involves examining whether a congenital disorder or defect is hereditary. It is a type of specialist medical care.

We reimburse this care if you have a referral from a medical specialist.
This care comprises:
- conducting research into hereditary diseases by means of:
  - genealogical research;
  - chromosome research;
  - biomedical diagnostics;
  - ultrasound testing;
  - DNA testing;
- genetic counselling and the necessary psychosocial support.

We also reimburse tests for other persons if this is necessary for the recommendation to be issued to you. This also includes potential counselling for these other persons.

You need a referral from a referring specialist for specialist medical care.

18.7 Occupational therapy

Occupational therapy helps you find practical solutions in your environment if performing daily activities becomes problematic for you due to a physical, mental, sensory or emotional disorder. You can also ask your occupational therapist for advice on the use of aids, or how to apply for them.

We reimburse a maximum of ten treatment hours per calendar year for consultation, instruction, training or treatment by an occupational therapist, either at the specialist's practice or at your home. This treatment must comprise the care generally provided by occupational therapists, for the purposes of promoting or restoring your self-reliance and ability to care for yourself.

Occupational therapy within the framework of gzsp

If you receive care within the framework of medical care for specific patient groups (gzsp), that care must be provided in accordance with the conditions set out in Article 18.11.

18.8 Pharmaceutical care

Pharmaceutical care relates to the use of drugs or medicines, as well as the supply of such drugs or medicines and providing advice and guidance on how to use them. Medicines come in a wide variety of forms, such as tablets, drinks, injections, etc. Medicines are substances that have a specific – ideally curative – effect on the body.

Reimbursement

Entitlement to reimbursement of the costs of pharmaceutical care concerns:

- the supply of medicine and advice as provided by dispensing practitioners (pharmacists and dispensing general practitioners) for the purpose of medication assessment and responsible use;
- reimbursement of:
  - registered medicines from Appendices 1 and 2 to the Healthcare Insurance Regulations (Regeling Zorgverzekering) as designated by us, and medicines that are equivalent or practically equivalent to any non-designated registered medicine listed in Appendix 3A of those Regulations. For more information about medicines designated by us and the relevant conditions, we refer to our Pharmaceutical Care Regulations and our website; go to www.asr.nl/verzekeringen/zorgverzekering/medicijnen;
  - other medicines, provided they relate to rational pharmacotherapy as follows:
    - medicines prepared by or on assignment of a dispensing practitioner in a private pharmacy on a small scale and made available (in accordance with Section 40(3a) of the Medicines Act);
    - medicines brought into commercial circulation in accordance with established regulations and prepared by a manufacturer at the request of a doctor in the Netherlands. The medicines must be intended for use by individual patients of the doctor in question, and must have been prepared under the doctor's supervision according to his or her specifications (in accordance with Section 40(3)(c) of the Medicines Act(Geneesmiddelenwet));
    - medicines that were brought into commercial circulation in another Member State or a third country, have been imported or otherwise brought into the Netherlands at the doctor's request and are intended for a patient who is suffering from an illness that does not have a higher incidence in the Netherlands than 1 in 150,000 inhabitants (in accordance with Section 40(3)(c) of the Medicines Act);
  - polymeric, oligomeric, monomeric and modular dietary preparations in compliance with Section 1 of Appendix 2 to the Healthcare Insurance Regulations. They should furthermore comply with the provisions in Article 2.3 of the 'Vrije Keuze' Pharmaceutical Care Regulations.

Appendices 1 through 3A of the Healthcare Insurance Regulations may be amended during the course of the year by the Ministry of Health, Welfare and Sport (VWS).

Appendices 1 through 3A of the Healthcare Insurance Regulations can be consulted on https://wetten.overheid.nl/BWBR0018715

The 'Vrije Keuze' Pharmaceutical Care Regulations are available on www.asr.nl/verzekeringen/zorgverzekering/documenten.

The cost of most preferred drugs is partially (35%) offset against the deductible. The costs of a number of preferred medicines are not offset against the excess at all. The list of preferred medicines (see the list on https://www.asr.nl/verzekeringen/zorgverzekering/medicijnen/voorkeursbeleid) shows which medicines are preferred and whether the costs of these medicines are not or partially (35)% offset against the deductible. The costs of other medicines are fully offset against your deductible.

Details about the personal contribution can be found in Article 2.1 of the 'Vrije Keuze' Pharmaceutical Care Regulations and on https://www.asr.nl/verzekeringen/zorgverzekering/eigen-risico.

We reimburse the supply of medicines by dispensing practitioners. In addition to the supply of medicines, we also reimburse the medicines described above. A statutory personal contribution of up to €250 applies to specific medicines (but not to their supply). The Minister of Health, Welfare and Sport determines to which medicines this contribution applies. These medicines are listed in Appendix 1a to the Healthcare Insurance Regulations

We also reimburse the costs of consultation and support services as generally provided by dispensing practitioners.

Advice and assistance includes the following:
- the provision of medicines exclusively available on prescription;
- explanation of the new medicine and how it should be used.

The costs of care provided by the pharmacy (such as costs of delivery or a counseling session) are fully covered by the mandatory deductible, even if the pharmacy provides preferred drugs.

Polymeric, oligomeric, monomeric and modular dietary preparations must be supplied by a dispensing practitioner or a specialised supplier of medical aids.

Prescribing doctor
Unless otherwise agreed with your healthcare provider, the medicines supplied must be prescribed by:
- a general practitioner;
- a company doctor;
- a youth healthcare physician;
- a medical specialist;
- a dentist;
- a dental specialist;
- an obstetrician;
- a nursing specialist;
- a physician's assistant;
- a geriatric specialist;
- a physician for the intellectually disabled.

The supply must be carried out under the supervision of a dispensing practitioner.

We do not reimburse:
- pharmaceutical care which the minister has decided does not qualify as insured care or which the minister has made subject to certain conditions that have not been met;
- medicines for travel-related risk of illness;
- medicines for examination or experimental use;
- medicines for which an application for market authorisation has been submitted to the Medicines Evaluation Board (College ter Beoordeling van Geneesmiddelen, CBG) or that are still undergoing clinical tests and which, in accordance with conditions established by a Ministerial Regulation, have been made available for compassionate use;
- personal contribution(s) for medicines up to €250;
- personal contribution(s) for medicines that fall under the excess;
- medicines that are equivalent or practically equivalent to any registered medicine that is not listed in the medicine reimbursement system (geneesmiddelenvergoedingssysteem, GVS), with the exception of pharmacists' medicines listed in Appendix 3A of the Healthcare Insurance Regulations;
- homeopathic and anthroposophical products and medicines;
- nutritional supplements and vitamins not registered as medicines;
- other costs (i.e. administrative or shipping costs).

Pharmaceutical Care Regulations
The 'Vrije Keuze' Pharmaceutical Care Regulations contain further conditions concerning the eligibility assessment of pharmaceutical care. These include:
- approval conditions;
- supply quantities;
- specific medicine-related provisions;
- reimbursement of medicines.

The 'Vrije Keuze' Pharmaceutical Care Regulations are available on www.asr.nl/verzekeringen/zorgverzekering/documenten.

18.9 Physiotherapy and remedial therapy

Physiotherapy and remedial therapy are types of treatment aimed at improving the way you move and your posture when you have physical complaints.

General

This treatment must comprise the care generally provided by physiotherapists and remedial therapists. Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a statement from a general practitioner or medical specialist stating that there is a medical necessity for the treatment at home or in an institution. This only applies if you go to a non-contracted physiotherapist or remedial therapist.

Physiotherapy within the framework of gzsp

If you receive care within the framework of medical care for specific patient groups (gzsp), that care must be provided in accordance with the conditions set out in Article 18.11.

Parties under the age of 18

Physiotherapy and remedial therapy are reimbursed as follows:

- If your condition is listed in Appendix 1 of the Healthcare Insurance Decree:
  - You must be treated by a (paediatric) physiotherapist, Mensendieck/Cesar remedial therapist, pelvic physiotherapist or oedema therapist. You require a statement from a general practitioner, a company doctor or a medical specialist that states for which diagnosis you are receiving treatment. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist;
- If your condition is not listed in Appendix 1 of the Healthcare Insurance Decree:
  - A maximum of nine treatments per indication per calendar year will be covered. You must be treated by a (paediatric) physiotherapist, manual therapist, pelvic physiotherapist, Mensendieck/Cesar remedial therapist or oedema therapist. Oedema therapy and scar therapy may also be provided by a skin therapist;
  - If the outcomes are not satisfactory, a maximum of nine additional treatments per indication per calendar year will be covered. You require a statement from a doctor or medical specialist stating the medical necessity for 9 additional treatments. This only applies if you go to a non-contracted physiotherapist or remedial therapist.

Appendix 1 of the Healthcare Insurance Decree can be found on www.asr.nl/verzekeringen/zorgverzekering/documenten.

Parties aged 18 or older

Physiotherapy and remedial therapy are reimbursed as follows:

- If your condition is listed in Appendix 1 of the Healthcare Insurance Decree:
  - the necessary treatment starting from the 21st treatment. You must be treated by a physiotherapist, manual therapist, Mensendieck/Cesar remedial therapist, pelvic physiotherapist, oedema therapist or geriatric physiotherapist. You require a statement from a general practitioner, a company doctor or a medical specialist. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist;
- up to 9 pelvic therapy treatments for urinary incontinence. You must be treated by a pelvic therapist. You require a statement from a general practitioner, a company doctor or a medical specialist;
- up to the first 37 treatments for a medical diagnosis of intermittent claudication (stage-2 claudicatio intermittens) during a maximum period of 12 months;
- up to 12 remedial therapy sessions for arthrosis of the hip or knee over a period of up to 12 months;
- supervised exercise therapy for COPD if there is stage II or higher of the GOLD Classification for spirometry. You will need a statement from a general practitioner, occupational physician or medical specialist;
- long-term personalized supervised active exercise therapy for rheumatoid arthritis when this causes you severe functional limitations. You will be treated for this by a physio- or exercise therapist. You need a statement from a general practitioner, company doctor or medical specialist for this;
- fall preventive exercise intervention for people who, after a fall risk assessment, show that there is a high risk of falling and who, as a result of underlying somatic and/or psychological problems, require guidance at the level of a physiotherapist or exercise therapist. This care includes a maximum of one fall-preventing exercise intervention every 12 months. To be reimbursed for a fall-preventive exercise intervention, you need a statement from your GP or medical specialist showing that you have a high risk of falling based on the fall risk assessment and that you require guidance from an exercise or physiotherapist.

Appendix 1 of the Healthcare Insurance Decree can be consulted at www.asr.nl/verzekeringen/zorgverzekering/documenten.

18.10 Combined Lifestyle Intervention (GLI)

Combined Lifestyle Intervention consists of advice and guidance on nutrition, exercise and behaviour for patients with moderately elevated weight-related health risks. The objective of the care is to achieve a healthier lifestyle for the patient.

Reimbursement

You are only entitled to compensation from the GLI programs recognized by the RIVM.

You are eligible for a GLI if you
- Have a BMI between 25 and 30, in combination with a large abdominal size. For women this is 88 cm or more. For men that is 102 cm or more.
- Have a BMI from 25 and are more at risk for an overweight disease, such as cardiovascular disease or type 2 diabetes.
- Have a BMI from 30. You are then obese.

We also impose the following conditions for reimbursement of the GLI:
- you have been referred by your GP, medical specialist or company doctor;
- the GLI healthcare provider must at least be included with the lifestyle coach endorsement in the register of the Dutch Lifestyle Coaches Professional Association (BLCN) or the Central Quality Register (CKR); or the sub-register of the Physiotherapy Quality Mark foundation; or, in the case of dieticians or exercise therapists, the Paramedics quality register;
- a care provider of the GLI coordinates the care process and acts as the first point of contact for the insured person;
- the care provider works with an effective GLI program that is registered as such with the RIVM's Healthy Living Centre and that has been designated as insured care by Zorgverzekeraars Nederland.

18.11 Medical care for specific patient groups (gzsp)

Medical care for specific patient groups (gzsp) is a set of types of care for vulnerable insured parties who still live at home and exhibit (highly) complex medical issues. In most cases, geriatric specialists and physicians for the intellectually disabled are the coordinating treatment providers in these types of care.

The gzsp care needs of insured parties are various and may concern physical, psychological and/or behavioural issues. For insured parties with complex issues or multiple disorders, it is important for the care to be well-coordinated and coherent. This is why gzsp always involves a coordinating treatment provider. This is usually the geriatric specialist or the physician for the intellectually disabled, but in some situations a behavioural scientist may take on this role.

Referral

You have a referral from:
- your general practitioner or paediatrician;
  for people with a severe behavioural disorder and slight intellectual disability, a referral may also be made by a physician for the intellectually disabled.

We do not reimburse gzsp if:
- the treatment goals have been achieved or if there are no more treatment goals;
- an indication for the Long-Term Care Act has been issued;
- you no longer live at home.

Transport within the framework of gzsp

We reimburse the costs of transport from and to group day treatment, subject to the conditions set out in Article 18.28.

18.12 Medical or curative mental healthcare (GGZ)

Mental healthcare is the diagnosis and treatment of a complex psychiatric disorder for the purpose of restoring or improving your mental health. For some psychiatric treatments, you may be admitted to a psychiatric clinic or a psychiatric ward of a general hospital.

General

If you are aged 18 or over, you are entitled to the costs of mental healthcare for the (online) treatment of, as well as for recovery from or prevention of exacerbation of mental health problems arising from a DSM-classified disorder. This must be understood to mean diagnostics (determining the disorder) and treatment of mental disorders, or consultation from outside the mental health system. It concerns care as described by or pursuant to the Health Insurance Act.

The following applies to mental healthcare: the excess is calculated and charged on a monthly basis. If a mental health care provider is consulted by a professional outside the mental health care system, for example by a primary care physician for an exploratory consultation, no excess is deducted.

If you choose a non-contracted provider

If you go to a non-contracted healthcare provider for Specialized mental health care, we will reimburse up to a maximum of 90% of the average contracted rate. This may mean that you pay part of the invoice yourself.

Please note: for 'Additional conditions for non-contracted healthcare', see Article 3 (Reimbursement of healthcare).

Our maximum rates can be found on www.asr.nl/verzekeringen/zorgverzekering/maximale-vergoedingen. Contracted healthcare providers can be found at https://zorgzoeker.asr.nl.

Referral

You will require a referral from your general practitioner, medical specialist, company doctor, street doctor (if you have no GP) or a referral from your coordinating treatment provider in accordance with the referral arrangements for mental healthcare (Verwijsafspraken Geestelijke gezondheidszorg).

A referral letter is not required for emergency mental healthcare; however, a referral is required for any treatment that commences after the emergency situation has passed.

Healthcare provider

Quality Charter

- The care provider offers care in accordance with its own Quality Charter registered as such with www.ggzkwaliteitsstatuut.nl. You are only entitled to reimbursement of the costs of care supplied by care providers with a Quality Charter that satisfies the criteria of the most recently applicable mental healthcare National Quality Charter Model.

Coordinating treatment provider

- The coordinating treatment provider who provides the indication and coordinates the care, as indicated and designated in the most recently applicable National Quality Charter for Mental Healthcare (Landelijk Kwaliteits-statuut GGZ) , bears final responsibility for the care.
- Not every professional group is allowed to act as a coordinating treatment provider in every case. The LKS indicates which coordinating treatment provider may/can be deployed in which setting. See: Mental Health Care National Quality Statute | Healthcare Insight.
- If you commence treatment under the Youth Act (Jeugdwet) and turn 18 while treatment is still ongoing, you may continue to receive care from the general remedial educationalist, post-master remedial educationalist or paediatric/youth psychologist as part of the mental healthcare provisions. This only applies to treatments that are started prior to the patient's 18th birthday and completed after their 18th birthday. The mental healthcare performance must be opened consecutively following the patient's 18th birthday and will remain valid for a period of one year after that.

Mental healthcare without admission
We will reimburse a period of admission in a mental healthcare institution, psychiatric hospital or psychiatric ward of a hospital for a period of up to 1,095 days. The care provided must be specialised psychiatric treatment, and admission must be necessary for the treatment.

The following rules apply to calculating the 1,095 days:
An interruption of no longer than 30 days is not viewed as an interruption, and these days will not be counted towards the 1,095 days. Interruptions exceeding 30 days will reset the count at 0.
Entitlement to the above care may still exist after a period of 1,095 days under the Long-Term Care Act.

Mental healthcare within scope of the Long-term Care Act
There are three situations in which an insured party can be provided with mental healthcare with the costs being chargeable under the Long-term Care Act:
- if (entirely or partly) on account of a psychiatric disorder, the insured party satisfies the admission criteria under the Long-term Care Act, mental healthcare provided in the context of residential care featuring treatment is also chargeable under the Long-term Care Act (as of 1 January 2021);
- If the treatment of the psychiatric disorder is an integral part of the specific treatment provided in the context of residential care featuring treatment;
- if a patient has been admitted to a psychiatric institution and the continuation of this residential care is necessary for the treatment of the disorder after 1,095 days (three years); this is known as continued residential care.

Authorisation requirements

For non-contracted mental healthcare institutions:
We have concluded agreements with the majority of institutions. However, if you wish to attend a non-contracted mental healthcare institution, either you or your practitioner on your behalf must request our authorisation prior to commencing treatment to prevent high own costs. For each care programme, admission or combination thereof, a separate authorisation request form must be submitted.
This also applies to care programmes provided abroad that are covered by the insurance.

For long-term admission
If you are admitted to a mental healthcare institution, psychiatric hospital or psychiatric ward of a hospital for longer than 365 consecutive days, you, or your practitioner on your behalf, must apply to us for authorisation. This must be applied for in advance, and at least three months before the end of the year. We use the nationally agreed 'Mental Healthcare Checklist' for this. This is used to assess whether, after 365 days, it is still a medically necessary stay or whether continuation within long-term care or the social domain is to be applied.

In order to be able to issue authorisation, we need to receive a completed Mental Healthcare Authorisation Form from you or your practitioner, for instructions, see our website:
https://www.asr.nl/verzekeringen/zorgverzekering/machtiging-aanvragen.

We will treat your claim confidentially; please send it to our medical adviser:
https://www.asr.nl/verzekeringen/zorgverzekering/machtiging-aanvragen.

Privacy statement
If you do not want data to be shared with us that can be traced back to the diagnosis, you and your practitioner can complete a GGZ privacy statement. This should be present no later than the first consultation and is valid for the entire care process.
The care provider ensures that the privacy statement is included in its records.

Among other things, we do not reimburse:
- help with complaints such as gloominess that cannot (yet) be considered a psychological disorder (e.g. depression);
- help with work and relationship problems (such as overstrain and burnout);
- psychosocial help and coaching;
- help with learning and developmental disorders;
- help with adjustment disorders;

- driving test;
- intelligence testing;
- diagnostics without the desire for treatment or counseling;
- therapies that do not meet the state of science and practice as stated in the ZN circular "Therapies GGZ";
- costs of care provided abroad that are not directly related to treatment, such as travel and accommodation costs (see article 18.2).

An overview of mental healthcare therapies that do/do not reflect the latest developments in science and practice can be found at www.asr.nl/verzekeringen/zorgverzekering/documenten.

18.13 General practitioner

Your general practitioner is the first person to turn to if you have any questions about your health. Outside regular office hours, please contact your local after-hours clinic.

We reimburse medical care provided by a general practitioner, or by a care provider acting under his or her responsibility. This treatment must comprise the care generally provided by general practitioners. We also reimburse costs for X-rays and laboratory tests requested by a general practitioner.

Primary diagnostics

We reimburse MRI scans requested by the general practitioner when this is included in the treatment guidelines for general practitioners (the NHG standards). A GP may deviate from these NHG standards if there is good justification for doing so. In such cases, the GP must explain why the results of an MRI scan are important for policy.

18.14 Provision of medical aids

Medical aids are made to help you deal with a physical problem. There are all sorts of medical aids, for a wide variety of medical conditions. Examples include a hearing aid, a prosthetic arm or leg, test strips for diabetics or dressing materials.

We reimburse the costs of medical aids and dressings, subject to the further requirements and conditions of reimbursement listed in the 'Vrije Keuze' Medical Aids Regulations. These regulations also specify whether the aids are given or loaned to you, and form part of this insurance policy.

The 'Vrije Keuze' Medical Aids Regulations can be found on www.asr.nl/verzekeringen/zorgverzekering/documenten.

Authorisation

The Medical Aids Regulations state for each of the aids listed whether you require our authorisation. We may set additional requirements for authorisation.

Usage costs

The usage costs of a medical aid must be paid by you, unless stated otherwise in the Medical Aids Regulations. Examples of usage costs include energy consumption and batteries.

Suitability

The medical aid must be necessary, suitable and not unnecessarily costly or complicated. We will assess whether this applies to your medical aid.

Dressings

Dressings will only be reimbursed if you have a serious condition requiring the long-term use of dressings.

Aids on loan

If we provide you with a medical aid on loan, we may check whether you really require it. If it transpires that you no longer need it, we may claim it back from you.

We do not reimburse:

- aids and dressings that are also covered under the Long-Term care Act or the Social Support Act.

18.15 Chain approach for overweight or obese children

The national 'Chain approach for overweight and obese children' model ensures that appropriate support and care is provided for children who are overweight or obese. This involves care services being provided by multiple care providers from different domains, such as by the general physician in consultation with a dietician. This is known as a chain approach. Under the approach, one of the care providers is the designated point of contact. This care provider is referred to as the central care provider (centrale zorgverlener, CZV). The Combined Lifestyle Intervention for children is also part of the chain approach for children.

We reimburse:
- a comprehensive intake and analysis of the problem performed by the COD who then draws up a plan of action. If a GLI is included in the plan of action, the COD will provide further guidance and coordination for up to 3.5 years. You are entitled to reimbursement for this care only if there is a moderately increased weight-related health risk (GGR).
- a Combined Lifestyle Intervention for children provided by a children's lifestyle coach when you get a referral from the central care provider.

Conditions:
- Children up to age 18 are entitled to a GLI based on this article. Are you 16 or 17 years old? Then you are also entitled to the GLI for adults from article 18.10 when the primary care physician deems this care appropriate for you. Care under this article and 18.10 cannot occur at the same time
- You need a referral from a general practitioner, medical specialist, youth healthcare physician or youth healthcare nurse to a central care provider stating that there is a moderately increased (or higher) (GGR).
- The central care provider must meet the applicable national expertise profile (degree in social care or paramedical or medical degree at HBO+ level) and competence profile and the associated registration requirements as set out in the 'Chain approach for care and support for overweight and obese children' (Ketenaanpak zorg en ondersteuning voor kinderen met overgewicht en obesitas) of the National Health Care Institute dated 27 January 2021. The central care provider must be able to demonstrate that he/she has successfully completed the supplementary accredited central care provider training programme.
- The Combined Lifestyle Intervention must be performed by a children's lifestyle coach with an HBO degree. This care provider must have at least the level of expertise required of a children's lifestyle coach with an HBO degree and meet the applicable national competence profile (still to be drawn up) and the associated registration requirements.
- The Combined Lifestyle Intervention for children will be reimbursed provided that the RIVM and Zorgverzekeraars Nederland has found in the accreditation process that the efficacy of the Combined Lifestyle Intervention programme is sufficient.

You are not entitled to:
- counseling to address a social issue or actual exercise coaching (exercising under the supervision of a central care provider of lifestyle coach).

18.16 Speech therapy

A speech therapist helps you diagnose and treat disorders in the functioning of your mouth organs. Such disorders may concern your breathing, voice, speech, language or hearing. Speech therapists also provide advice and information if you are the patient or a person caring for a patient.

We reimburse treatment by speech therapists. The treatment is expected to result in the improvement or recovery of speech or speech ability. This treatment must involve care generally provided by speech therapists and must have a medical purpose.

When you go to a non-contracted speech therapist, this requires a statement from your doctor, dentist or remedial educationalist stating the indication for speech therapy. Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a referral from your general practitioner or specialist stating the medical necessity for the treatment at a location other than at the practice.

Individual sessions in the treatment of aphasia, preverbal speech therapy, stuttering, the Hanen programme for parents, and the integrative anti-stuttering programme are provided by a qualified speech therapist trained for that purpose. The speech therapist must be listed in the register relevant to that specialisation maintained by the Netherlands Association for Speech Therapy and Phoniatrics.

Speech therapy treatment does not include the treatment of dyslexia or developmental language disorders in relation to a dialect or a foreign language.

Speech therapy within the framework of gzsp
If you receive care within the framework of medical care for specific patient groups (gzsp), that care must be provided in accordance with the conditions set out in Article 18.11.

18.17 Mechanical ventilation

We will reimburse ventilation at home and the associated specialist medical care if provided at or under the supervision of a ventilation centre. If you are ventilated at home under the supervision of a ventilation centre:
- the ventilation centre will provide the equipment required for each treatment in a ready-to-use state;
- the ventilation centre will provide the specialist medical care and pharmaceutical care associated with the mechanical ventilation.

In the event of mechanical ventilation at home, you are entitled to an allowance for electricity costs. For more information, please visit our website.

You need a referral from a referring specialist for specialist medical care.

18.18 Specialist medical care (excluding mental healthcare)

Specialist medical care is provided by a medical specialist affiliated with a hospital, independent treatment centre or specialist institution. A medical specialist is a doctor who completed a specialist medical programme following his or her basic training and is registered as such. There are approximately 30 different medical specialities in the Netherlands, such as surgery, cardiology and neurology.

Referrals for specialist medical care
To qualify for reimbursement of the costs of these types of care, you need a referral from a general practitioner, medical specialist, physician for the intellectually disabled, geriatric specialist, youth healthcare physician, company doctor, emergency department doctor, physician's assistant or nursing specialist. This does not apply to emergency care. For specialist medical care in relation to pregnancy and/or childbirth, the referral can also be made by an obstetrician. The obstetrician may refer the newly born baby to a paediatrician (for the first ten days following childbirth) or ENT specialist. Your entitlement to oral care provided by a dental surgeon is subject to the provisions of Articles 18.19 and 18.20. A referral from a dentist, orthodontist or prosthodontist is sufficient in such cases.

Dentists of a centre for special dental treatment may also refer you to a neurologist, anaesthesiologist (outpatient pain relief clinic) or ENT specialist. A referral to an ophthalmologist may also be issued by an optometrist or an orthoptist. A triage hearing specialist or clinical audiology physicist may refer a patient to a clinical audiology physicist and an ENT specialist. A clinical audiology physicist may likewise refer patients to the ENT specialist, as well to other specialists. In the case of infectious diseases, a Municipal Health Service (GGD) doctor may also refer patients. The referring specialist must be registered in the BIG register; however, prosthodontists, triage hearing specialists, clinical audiology physicists and optometrists are exempted from this requirement.

Admission to hospital
We will cover your stay in the lowest class of a hospital or an independent treatment centre (ZBC) for an uninterrupted period of up to 1,095 days. Your stay there must be medically necessary as described in this article or in Articles 18.19 and 18.20 (Oral care).

The following rules apply to calculating the 1095 days:
An interruption of no longer than 30 days is not viewed as an interruption, and these days will not be counted towards the 1095 days. Interruptions exceeding 30 days will reset the count at 0. If you are interrupting your admission for weekend or holiday leave, these days will be counted as part of the calculation. We also reimburse necessary treatment-related nursing, paramedic care, medicines, medical aids and dressings during the period of admission.

Lodging costs in the event of CAR-T
You are entitled to a compensation for accommodation costs after CAR-T cell therapy in the 3rd and 4th week after treatment, if the travel time to the hospital is longer than 60 minutes. The reimbursement of accommodation costs amounts to a maximum of €91 per night. In the 1st and 2nd week of treatment you will stay in the expert hospital.

Non-clinical specialist medical care
We reimburse specialist medical day treatment and out-patient treatment provided in or by an institute recognised as a hospital or an independent treatment centre (ZBC). We also reimburse the necessary nursing (day admission), medicines, medical aids and dressings.

IVF (in vitro fertilisation attempts) or ICSI (intracytoplasmic sperm injection)
If an IVF or ICSI treatment involves sperm or egg donation, the conditions relevant to IVF as set out in this article will apply. We do not reimburse the costs of the sperm or egg donation (nor the treatment of the donor).

As a woman, you are entitled to this care up to age 43, provided there is an indication for this. You are entitled to 3 IVF or ICSI attempts for each intended non-interrupted pregnancy. Treatments must take place in a hospital with the proper licence to provide such treatment. We also reimburse the necessary medicines. We draw a distinction between two different forms of non-interrupted pregnancy:
- physiological pregnancy: a spontaneous or other pregnancy lasting at least twelve weeks counted from the first day of the last menstrual cycle;
- pregnancy after an IVF or ICSI treatment lasting at least ten weeks from the follicular aspiration after the non-frozen embryo has been returned to the womb, or at least nine weeks and three days after the frozen embryo has been returned to the womb.

Attempts do not count unless follicular aspiration (the collection of ova) has been successfully carried out.
The reinsertion of the/all embryo(s) obtained during an attempt (whether or not these have been frozen in the meantime) forms part of the attempt in which the embryos were obtained, provided there is no instance of a non-interrupted pregnancy. A new attempt following a non-interrupted pregnancy (either spontaneous or following IVF) counts as a new first attempt.

When a frozen embryo is returned to the womb, this will never qualify as a new IVF attempt. This means that, even after an uninterrupted pregnancy, reinsertion of a frozen embryo in the womb will not count as a new IVF attempt. An IVF attempt that commenced before you reached the age of 43 may be completed.

We do not reinmburse:
- treatments and medicines for which there are no medical grounds;
- treatments or medicines for the fourth or any subsequent IVF attempts for each intended pregnancy. Prior to this, three attempts must have concluded between the initial successful follicular aspiration and an instance of a non-interrupted pregnancy;
- the first and second IVF attempt up to age 38 if more than one embryo is returned to the womb;
- fertility-related care commencing at age 43 or over.

Other fertility treatments
You are entitled to medical care as referred to in this article (specialist medical care) for other fertility treatments: gynaecological or urological treatments and surgery to enhance fertility. This care also includes artificial insemination (with your own sperm or donor sperm) and intra-uterine insemination. The costs of the sperm donation itself or reversing a sterilisation are not reimbursed. Again, the woman must be younger than 43. We do not reimburse the costs of treatments and medicines for which there are no medical grounds.

Treatments of a plastic surgical nature

We reimburse plastic surgery treatments for the correction of:

- abnormalities in appearance that are linked to demonstrable functional abnormalities in the body;
- deformations resulting from illness, accident or medical intervention;
- weakened or loosened eyelids that are the result of a congenital abnormality or a chronic condition that was present at birth, or if an acquired weakness or loosening severely reduces your field of vision;
- the implantation or replacement of a breast prosthesis following a full or partial mastectomy or in the event of stunted breast growth (agenesis/aplasia of the breast) in women, or to address a comparable situation in diagnosed transsexuality (male-to-female transgender persons);
- the following congenital malformations:
  - cleft lip, jaw and palate;
  - malformations of the facial bones;
  - benign tumours of the blood vessels, lymph vessels or connective tissue;
  - birthmarks;
  - malformations of the urinary tract and sexual organs;
- primary sexual characteristics where transsexuality has been diagnosed.

For these treatments, you need our prior written permission. We will assess your claim using the Guide for the Assessment of Plastic Surgery Treatment (Werkwijzer beoordeling behandelingen van plastisch chirurgische aard). The assessment of some cases may require photographs and/or a signed statement from you. If you fail to provide them, no written consent can be issued and the treatment will not be reimbursed.

This type of care may also be provided by medical specialists other than a plastic surgeon. In that case, these conditions will also apply to such other medical specialist.

The Guide for the Assessment of Plastic Surgery Treatment can be viewed at www.asr.nl/verzekeringen/zorgverzekering/documenten.

The types of care not eligible for reimbursement include the following:

- liposuction of the stomach;
- the surgical removal of a breast prosthesis without medical grounds.

Transgender care

Diagnostics and treatment must be performed in accordance with the international standards of care for the treatment and counselling of transgender people of the World Professional Association for Transgender Health (WPATH) (formerly known as the Harry Benjamin International Gender Dysphoria Association, HBIGDA) and by a multidisciplinary gender care team in a centre or recognised network specialised in the protocol-based treatment of transgender people. Depilation must be performed by a certified skin therapist for transgender care who is included in the list of the Dutch Association of Skin Therapists (NVH). You do not require permission for the first 10 epilation treatments in the face. If you need more epilation treatments after that, you are required to request permission for reimbursement. We will then assess whether you still meet the conditions for reimbursement.

Second opinion

We reimburse requesting an assessment regarding a diagnosis or proposed treatment provided by a physician from a second, independent physician operating in the same field as the physician initially consulted. You must return with the second opinion to your initial treatment provider. This person is authorised to direct the course of the treatment.

You need a referral from a referring specialist for specialist medical care.

Provisional authorisation and promising care
The Minister of Health, Welfare and Sport has made some forms of care provisionally admissible under basic insurance. These forms of care qualify for reimbursement if the Minister's conditions are met, as listed in Section 2.2. of the Healthcare Insurance Regulations. This involves care whose effectiveness is still in doubt, or that has not yet been proven. This means that the full list of provisionally admitted treatments may change in the course of the year. As of 2020 new provisionally authorised types of care qualify for reimbursement pursuant to the grant scheme for 'promising care'.

An updated version of the Healthcare Insurance Regulations can be consulted at https://www.wetten.overheid.nl/zoeken.

18.19 Oral care for insured parties under age 18

Oral care involves treatment by a dentist, dental surgeon, prosthodontist, dental surgeon, orthodontist or oral hygienist, including those that work in a centre for special dental treatment. For any child who has teeth in their mouth, it is important for optimal oral health to see the dentist regularly (usually from age 1 ½ to 2 years). Your child is entitled to reimbursement of nearly all types of care provided by a dentist to children. The costs of these types of care are exempted from the compulsory excess.

Dental treatment for insured parties under age 18
You are entitled to the reimbursement of the following types of care:
- one annual check-up (periodic preventive dental examinations), or multiple check-ups per year if dentally required;
- incidental consultations;
- tartar removal*;
- fluoride application starting from the emergence of the first permanent tooth, up to twice per year and multiple times per year if dentally required;
- sealing of grooves and pits in teeth and molars*;
- gum (periodontal) treatment;
- anaesthetic;
- root-canal (endodontic) treatment;
- fillings (restoration of dental elements using plastic materials)*;
- treatment for problems with the jaw joint (gnathological treatment);
- removable prosthetics (e.g. dentures or plates);
- crowns, bridges and implants to replace one or more missing permanent incisors or canines which have failed to develop or which are absent due to an accident. This entitlement lasts until the age of 22 for incisors or canines that failed to develop entirely, or that were lost due to an accident before your 18th birthday. The need for this must have been established prior to your 18th birthday;
- Surgical dental care, except for the placement of dental implants;
- On x-ray examination, except for x-ray examination for orthodontic assistance.
- Oral care includes for insured persons under twenty-three years of age in cases other than the periodic preventive dental examination, occasional dental consultation or the removal of tartar, dental replacement assistance with non-plastic materials as well as the fitting of dental implants, if it concerns the replacement of one or more missing, permanent incisor or canine teeth that have not been constructed at all, or because the absence of that tooth or those teeth is the direct result of an accident, and if the need for this care has been established before the insured has reached the age of eighteen.

* Above a certain number of minutes/elements/fillings, prior approval is required. See below:

Treatments for insured parties under age 18 for which permission is required
- Implants require our prior permission. A statement of the grounds for the treatment and a treatment plan drawn up by a dentist must be submitted along with your application.
- The dentist should contact us for an authorisation to produce a dental overview X-ray (performance code X21).
- If you depend on oral care provided by a dental surgeon, you will need a letter of referral from a general practitioner, medical specialist, dentist, prosthodontist or orthodontist. For some types of treatment, the dental surgeon must first submit a request for authorisation. The dental surgeon knows to which types of treatment this rule applies.

- For an autotransplant (H38/H39), prior permission is required.
- Anaesthesia.
- Preventive information (code M01 and/or M02) if you need more than 1 hour of preventive information per year.
- Dental cleaning (M03) if you need more than 30 minutes of dental cleaning per day and/or need more than 1.5 hours of dental cleaning per year.
- Sealing (V30/V35): applying sealant to baby teeth and/or applying sealant to more than 8 permanent teeth per year.
- Fillings (code V71 through 74, code V81 through 95): placing more than 6 fillings per day and/or placing more than 10 fillings per year.

Explanation: when a healthcare provider requests permission for a treatment, he or she will do so on your behalf. A year means 365 consecutive days starting from the date of treatment.

We do not reimburse:
- Missed appointments.
- Grinding of deciduous teeth/ non-restorative treatment of caries in deciduous teeth (M05)
- Treatment of white spots (M80 + M81)
- Mouthguard e.g. (individually) fitted mouthguards for the purpose of sports activities. (M61)
- Soft grinding plate (M61, also not claimable as G69)
- External bleaching of teeth and/or molars (E97 + E98)
- Myofunctional equipment and related consultations (G74 and G76)
- Comprehensive examination for the purpose of establishing, recording and providing treatment plan to the patient (C012)
- Orthodontics, including associated x-rays
- Crowns, bridges, inlays and implants
- Inspection reports
- Cosmetic oral care (K001, K002, K003, K004)
- Dental statement
- (R90) partially completed work
- Help with snoring
- Help with sleep problems
- Therapeutic injection of botox

A list of procedures (plus codes) and rates is available on www.allesoverhetgebit.nl.

Special dental treatment for insured parties under age 18
This concerns oral care for people who cannot obtain the care they need from a regular dentist. and must entail the dental care necessary:
- due to a serious developmental disorder, growth disorder or acquired defect of the dental, jaw and mouth system such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- due to a non-dental physical or mental disorder such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- if, without this care, medical treatment would have a demonstrably insufficient result and, without this other care, you would be unable to retain or attain a dental function that is equivalent to that which you would have had if the condition had not presented.

Orthodontics
Entitlement to orthodontic assistance is possible in case of a very serious development or growth disorder of the tooth-jaw-mouth system, whereby co-diagnosis or co-treatment of surgical dental assistance of a specialist nature. This is subject to individual assessment.

Treatments for insured parties under age 18 for which permission is required
- All forms of special dental surgery require our prior permission. Your healthcare provider's request must be accompanied by a justification from a general practitioner, medical specialist, dentist, dental surgeon or orthodontist.
- If you attend a centre for special dental treatment for oral care, you require our prior permission.

Explanation: when a healthcare provider requests permission for a treatment, he or she will do so on your behalf.

Attributable damage dentures or prosthetic device.
The insured is obliged to take good care of the dentures or prosthetic device provided/purchased to him/her. If due to culpable negligence damage occurs through injudicious use or neglect or there is loss of the dentures or prosthetic provision, there is no entitlement to provision/compensation of replacement, modification or repair of the provision. A request for replacement of the dentures or prosthetic device must be justified by the insured or the requesting health care provider.

18.20 Oral treatment for insured parties from age 18

Oral care involves treatment by a dentist, dental surgeon, prosthodontist, dental surgeon, orthodontist, oral hygienist, including those that work in a centre for special dental treatment.

Personal contribution – Adults
You may receive care that is subject to a statutory personal contribution. In that case, you should first pay your personal contribution. The remaining amount will then count towards your compulsory excess and voluntary excess. Below you can read when a statutory personal contribution is payable.

Dental treatment for insured parties from age 18
You are entitled to the costs of the following types of care:
- surgical dental treatment by a dental surgeon and the accompanying X-rays, with the exception of periodontal surgery, the insertion of a dental implant and the extraction of teeth or molars without any complications;
- full removable dentures (or emergency dentures) or removable replacement dentures for the upper and/or lower jaw. This is subject to a statutory personal contribution of 25%;
- removable dentures for the lower jaw (the mesostructure (bar, pressure buttons or magnets) and the removable dentures). This is subject to a statutory personal contribution of 10%;
- removable dentures for the upper jaw (the mesostructure (bar, pressure buttons or magnets) and the removable dentures). This is subject to a statutory personal contribution of 8%;
- removable dentures for the one jaw and artificial dentures for the other, manufactured simultaneously (code J50). This is subject to a personal contribution of 17%;
- repairs and filling a full set of artificial dentures / removable dentures. This is subject to a statutory personal contribution of 10%.

Treatments for insured parties from age 18 for which permission is required
- If you depend on oral care provided by a dental surgeon, you will need a letter of referral from a general practitioner, medical specialist, dentist, prosthodontist or orthodontist. For some types of treatment, the dental surgeon must first submit a request for authorisation. The dental surgeon knows to which types of treatment this rule applies.

Explanation: when a healthcare provider requests permission for a treatment, he or she will do so on your behalf.

A list of procedures (plus codes) and rates is available on www.allesoverhetgebit.nl.

More information regarding fully removable dentures and/or click dentures can be found at www.kunstgebit.nl

We do not reimburse:
- Missed appointments
- (R90) partially completed work

Dental treatment for insured parties from age 18
This concerns oral care for people who cannot obtain the care they need from a regular dentist. and must entail the dental care necessary:
- due to a serious developmental disorder, growth disorder or acquired defect of the dental, jaw and mouth system such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- due to a non-dental physical or mental disorder such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- if, without this care, medical treatment would have a demonstrably insufficient result and, without this other care, you would be unable to retain or attain a dental function that is equivalent to that which you would have had if the condition had not presented.

Implant for the purpose of attaching removable dentures
You are entitled to the costs of dental implants in cases of a severely shrunken toothless jaw and where the implant is for the purposes of attaching removable dentures. You should also have a severe functional disorder.

We do not reimburse:
- Missed appointments
- (R90) partially completed work

Orthodontics
Entitlement to orthodontic assistance is possible in case of a very serious development or growth disorder of the tooth-jaw-mouth system, whereby co-diagnosis or co-treatment of surgical dental assistance of a specialist nature. An individual assessment will take place.

Treatments for insured parties from age 18 for which permission is required
- All forms of special dental surgery require our prior consent. Your healthcare provider's request must be accompanied by a justification from a general practitioner, medical specialist, dentist, dental surgeon or orthodontist.
- The replacement of full dentures (or removable dentures) within five years requires our prior permission. Your healthcare provider will be able to submit a request for such treatment.
- For a 'supplement for a very severely shrunken jaw' (code P044), prior permission is required.
- If you attend a centre for special dental treatment for oral care, you require our prior consent.

Explanation: when a care provider requests permission for a treatment, he or she will do so on your behalf.

Attributable damage dentures or prosthetic device.
The insured is obliged to take good care of the dentures or prosthetic device provided/purchased to him/her. If due to culpable negligence damage occurs through injudicious use or neglect or there is loss of the dentures or prosthetic provision, there is no entitlement to provision/compensation of replacement, modification or repair of the provision. A request for replacement of the dentures or prosthetic device must be justified by the insured or the requesting health care provider.

18.21 Organ transplants

A transplant involves the full or partial replacement of a poorly functioning or non-functioning organ or tissue by that of a donor. Examples of organs and tissues that can be transplanted include the heart, skin, lungs, kidneys, pancreas, liver, bone and bone marrow.

As the recipient of the organ, you qualify for reimbursement of the costs of:
- the transplant of tissues and organs;
- the specialist medical care related to selecting the donor (the person donating the organ/tissue to you) and the surgical removal of the transplant material from the donor;
- the examination, preservation, removal and transportation of the post-mortal transplant material in connection with the transplantation.
- As the donor of the organ, you qualify for reimbursement of the costs of:
- the care related to the donor's admission, for selection and/or removal of the transplant material. The costs of this care for the donor will be reimbursed up to 13 weeks after the admission period. A maximum period of six months applies to liver donors;
- the transport within the Netherlands that a donor who is uninsured in the Netherlands requires for:
  - selection, admission to and discharge from a hospital;
  - care for up to 13 weeks (or 6 months for liver donors) following admission for transplant purposes.

This transport is reimbursed at the lowest-class rates for public transport. If, for medical reasons, this transport must take place by taxi or using the donor's private vehicle, then we will reimburse the associated costs. If the donor lives abroad and has no insurance in the Netherlands, we will reimburse travel costs to and from the Netherlands in cases of kidney, liver or bone-marrow transplants for insured parties in the Netherlands.

We will also reimburse the donor's transplant-related costs if they are connected to the donor's residence abroad. If the donor does have basic insurance in the Netherlands, the costs of this transport will be paid by the donor's basic insurance. If the donor is also an insured party under this basic insurance policy, the costs may be claimed against this basic insurance policy.

The transplant must be performed:
- in an EU Member State;
- in a state that is a party to the Agreement on the European Economic Area;
- in another state, if the donor resides in that state and is the spouse, registered partner or a blood relative in the first, second or third degree of the insured party.

We do not reimburse:
- accommodation expenses of the donor in the Netherlands;
- any lost income of the donor.

If you are the donor yourself, the recipient's healthcare insurance will reimburse the costs under the same conditions. We reimburse the costs of your (the donor's) annual follow-up medical check-ups from 13 weeks (or from 6 months for liver donors) following admission for transplant purposes. These medical follow-up check-ups and medical costs arising from the donation fall outside of your excess.

Medical costs incurred in connection with the donation by a living donor within 13 weeks (or 26 weeks for liver transplants) are reimbursed by the healthcare insurer of the receiving patient.

18.22 Preventive foot care

Preventive foot care is aimed at preventing foot ulcers and amputations; it includes treatments, foot check-ups, the physical examination of feet, education and advice.

You are entitled to foot care if you have an increased risk of foot ulcers, due to the loss of protective sensation in your feet, or if you have reduced blood circulation in your feet, vulnerable skin, or increased skin pressure due to diabetes mellitus, provided the care is preventive in nature. You need a referral to a podiatrist from your general practitioner, physician or geriatric specialist (nursing home doctor), who will determine your classification and any other medical risks. The podiatrist will then consult with you to draw up an individual treatment plan. The aspects of care that you are entitled to are set out in the 'Prevention of Diabetic Foot Ulcers Care Module'. The type of foot care you receive will depend on your care profile, which will fall into one of the following categories:

- annual foot check-up, consisting of case history, physical examination and a risk assessment. This examination may be performed by a medical chiropodist, a certified diabetic foot care chiropodist, a podiatrist or a podiatrist who specialises in diabetes cases.
- preventive foot care to protect against the development of wounds in the case of high-risk feet without local increased pressure, high-risk feet with local increased pressure or very high-risk feet, consisting of:
  - more frequent targeted examination of the feet including the resulting diagnostics and treatment of skin and nail problems and abnormalities in the shape and position of the feet;
  - treatment of risk factors in the case of a high risk or very high risk of ulcers;
  - education and initiating changes in your lifestyle conducive to your treatment;
  - advising on proper footwear.

The foot care must be performed by, or under the supervision of, a podiatrist or a diabetes-specialised podiatrist. The podiatrist may subcontract certain aspects of care to a medical chiropodist, a certified diabetic foot care chiropodist or a registered podologist. This foot care will be claimed from us by the podiatrist at a uniform rate per care class.

Foot care at home

You are entitled to foot care provided at your home if you have high-risk feet, medical reasons prevent you from travelling to the healthcare provider and there is no informal carer to transport you to the healthcare provider.

We do not reimburse:

- the removal of calluses for cosmetic or grooming purposes;
- general nail care, such as the precision-cutting of nails to prevent ingrown toenails.

More information on preventive foot care can be found at https://www.asr.nl/verzekeringen/zorgverzekering/documenten under Zorgmodule Preventie Diabetische Voetulcera.

18.23 Rehabilitation

Specialist medical rehabilitation is meant for people who suffer an impairment associated with a disorder that results from an accident, medical intervention, serious illness or congenital disorder. The patient is treated by a multidisciplinary team led by a rehabilitation specialist with the aim of helping him or her overcome or cope with the impairment.

Geriatric rehabilitation is meant for (mostly) elderly people following treatment in hospital, for example in connection with a stroke or a fracture. This type of rehabilitation is geared to the elderly patient's individual recovery potential and training speed, and also takes account of other, existing conditions (if applicable). The purpose of the rehabilitation is to enable elderly persons to return to their homes.

Specialist medical rehabilitation
We reimburse the costs of rehabilitation if:
- the rehabilitation focuses on improving or preventing problems in a person's daily life and social functioning following an accident, surgery or serious illness;
- the care is provided by a multidisciplinary team led by a medical specialist or rehabilitation specialist affiliated with a healthcare facility accredited by law;
- efforts are made to help you function as independently as possible in line with your disability;

There is an indication for specialist medical rehabilitation if the rehabilitation specialist has determined that:
- it is a musculoskeletal disorder, neurological disorder or other disease, associated with problems of spinal, trunk or limb movement; or noncongenital brain injury (NAH), associated with problems of movement, cognitive problems, speech or swallowing problems or a combination thereof;
- based on scientific evidence and professional knowledge and experience, it may be assumed that interdisciplinary medical specialist rehabilitation is the most effective treatment to prevent, reduce or overcome these impediments or limitations and that the patient can fully or partially fulfil their role in the family, at school or work, in leisure activities, etc;
- the patient is (or will in the foreseeable future be) capable of learning, training and actively participating in rehabilitation treatment that can achieve pre-agreed results;
  or:
- specific rehabilitation medical interventions can be expected to prevent, reduce or eliminate specific symptoms (e.g. spasticity) and/or secondary effects (e.g. pressure ulcers) of the disease or condition.

Specialist medical rehabilitation may take place:
- via part-time or day treatment (non-clinical);
- through an inpatient stay of several days (inpatient situation), where significantly better results can be expected than with part-time or day treatment.

You need a referral from a referring specialist for specialist medical care.

Geriatric rehabilitation
Geriatric rehabilitation includes integrated and multidisciplinary rehabilitation care as specialists in geriatrics tend to provide in connection with frailty and complex multimorbidity with the goal of restoring or improving the insured's functioning and participation in society.

We reimburse geriatric rehabilitative care if:
- the geriatric assessment of whether you need geriatric rehabilitative care is performed by a clinical geriatrician, geriatric internist or geriatric specialist; and
- before the specialist medical treatment, you did not stay at an institution designated under the Long-Term Care Act to be treated there. This is because in that case, the treatment will be reimbursed under the Long-Term Care Act;
- Or
- if you are referred from the home to geriatric rehabilitation care without prior medical specialist care, in certain cases the geriatric specialist may conduct a geriatric assessment. A condition for an indication for access to geriatric rehabilitation is then the determination of medical stability. With acute conditions, the geriatric specialist will always contact the treating medical specialist or, in case of doubt, a medical specialist is consulted to determine medical stability.

Indication from a geriatric specialist

- A geriatric specialist can issue an indication for geriatric rehabilitation care from the hospital, the primary care institution or the home situation.
- If a geriatric specialist is the primary care provider in the primary care institution, the geriatric specialist will map out your care requirements during the stay. For this reason, performing an examination for access to geriatric rehabilitation care is not reimbursed separately if a claim for elv high complex is also submitted. Also, an examination for access to geriatric rehabilitation care will not be reimbursed separately if it is already clear at the start of the elv admission that a subsequent rehabilitation program will be started. This is the case, for example, if, after surgery on a joint or after a bone fracture, you are not allowed to actively load immediately and are awaiting your rehabilitation program. The assessment has then already taken place in the hospital.

Authorisation requirement for specialist medical rehabilitation care at a non-contracted independent treatment centre

We have concluded agreements with numerous institutions. However, if you wish to attend a non-contracted independent treatment centre, either you or your healthcare provider on your behalf must request our authorisation prior to commencing treatment. In order for us to issue the authorisation, we need to receive the following:

- a referral from a general practitioner, company doctor or medical specialist;
- in the case of hospitalisation: the clinical indication for hospitalisation in accordance with the established guidelines of the Dutch Association of Rehabilitation Specialists (Nederlandse vereniging van Revalidatieartsen, VRA);
- the proposed treatment plan. This should state:
  - the indication, including substantiation thereof;
  - the treatment goals of the proposed treatments;
  - the interventions that will be offered within the proposed treatment;
  - the previous treatments that have taken place;
  - the diagnosis code;
- the DTC expense claim code and the performance code.

We will treat your claim confidentially; please send it to our medical adviser:
By uploading the document at: www.asr.nl/verzekeringen/zorgverzekering/machtiging-aanvragen
Or by mail to:
a.s.r.
Attn.: Mental Healthcare (MSZ) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

18.24 Quitting smoking

We reimburse a maximum of one programme to support quitting smoking per calendar year. The quit-smoking guidance must comprise medical care intended to help you stop smoking. If necessary, the quit-smoking guidance can be combined with a treatment based on nicotine replacement products or medicines.

The medicines must have been prescribed by the doctor, addiction specialist, medical specialist, obstetrician or nursing specialist providing the treatment. Nicotine replacements or medicines can be obtained from a contracted nationwide healthcare provider by means of a 'quit-smoking' request form completed by the treatment provider, or, if prescribed by your general practitioner, with an 'SMR' (= quitting smoking) code on the prescription.

You can find contracted nationwide healthcare providers at https://zorgzoeker.asr.nl.

Quit-smoking guidance and nicotine replacement products and medicines as part of the quit-smoking guidance are exempted from the excess.

The healthcare providers providing quit-smoking guidance apply the '2022 Tobacco Addiction and addendum' care standard and CBO Dutch Institute for Healthcare Improvement guideline 'Tobacco Addiction Treatment and Quit-Smoking Support, revised version, 2016'.

You may take part in a quit-smoking programme with:
- a general practitioner;
- a medical specialist;
- an addiction specialist;
- an obstetrician;
- a clinical psychologist;
- all other healthcare providers listed in the Quit-Smoking Quality Register (Kwaliteitsregister Stoppen met Roken).

The Quit-Smoking Quality Register can be consulted at https://www.kabiz.nl/raadplegenregister/default.aspx

18.25 Thrombosis Service

Thrombosis is a clot in a vein or artery. Patients can use anti-coagulants prophylactically (preventatively, because they have a high risk of developing thrombosis) or therapeutically (to treat existing thrombosis). The Thrombosis Service monitors patients using specific anticoagulants and provides advice.

We reimburse care provided by the Thrombosis Service.

This care consists of:
- the regular collection of blood samples;
- performance of laboratory tests to determine the clotting time of your blood;
- training in the use of the equipment that measures your clotting time, and help with the measurements themselves;
- use of equipment and accessories capable of determining your blood's clotting time if you have attended the training mentioned above;
- advice on the dosage of the medicines that affect your clotting ability.

You need a referral from a referring specialist for specialist medical care.

18.26 Obstetric care and maternity care

An obstetrician guides and monitors women during pregnancy and childbirth. A maternity nurse assists the obstetrician or doctor during childbirth. Maternity nurses also help to provide care for the mother and child after childbirth, usually for a week.

You and your child are entitled to obstetric care and maternity care.

The obstetric care may be provided by an obstetrician, general practitioner or medical specialist. Here, maternity care is defined as: care provided by a maternity nurse. The maternity nurse is affiliated with either:
- a hospital;
- a maternity care agency;
- a birth centre;
- a maternity hotel;
- is independent.

The maternity nurse cares for you and your newborn child and any other children who belong to the family and are at home. Household chores are also included in the entitlement. The following situations can be identified:

Childbirth and postpartum care in a hospital on medical grounds
We reimburse specialist medical care and admission to hospital for you and your child if you are required to give birth in a hospital for medical reasons. The care will commence on the day of the childbirth. You do not pay a co-payment on this.

Childbirth and postpartum care in a hospital or birth centre without medical grounds
We reimburse nursing and maternity care for you and your child in the absence of medical grounds.
The care will commence on the day of the childbirth.

You do have to pay a co-payment for admission to the hospital or birth center. For each day of admission, a co-payment of € 21.50 applies to you (the mother). A personal contribution of € 21.50 also applies to your child. We deduct this amount of € 43 from the maximum reimbursement per day of admission of € 152 for you and the maximum reimbursement of € 152 for your child. If the hospital or birth center charges a higher amount € 304.00 (€ 152.00 for you and € 152.00 for your child) - € 43.00 = € 261.00, that amount is for your own account.

We will calculate the number of admission days based on a statement issued by the hospital, birth centre or maternity care agency that is concerned with providing additional maternity care after discharge from the hospital.

Explanation:
A birth in an outpatients' department counts as one day of hospitalisation.

Maternity care in a maternity hotel
We reimburse maternity care in a maternity hotel for you and your child after childbirth in a hospital or maternity hotel. A personal contribution of €5,40 per hour applies to maternity care. This is waived if the maternity care takes place at the request of a.s.r. in the maternity hotel. The hotel costs remain at your own expense.

Maternity care at home after childbirth in a birth centre, maternity hotel or hospital
If you receive maternity care at home following childbirth in a birth centre, hospital or maternity hotel, we will deduct the number of admission days from the maximum number of maternity care days that we reimburse childbirth and maternity care at home, as described below. We will calculate the number of days of hospitalisation based on a statement issued by the maternity hotel or maternity care agency that is concerned with providing additional maternity care after discharge from the birth centre, maternity hotel or hospital

Childbirth and postpartum care at home
We reimburse obstetric care (including prior and aftercare) at home.

We also reimburse:
- registration, intake (once-only, unless there are compelling reasons to decide otherwise) and childbirth assistance as established by the National Maternity Care Guidelines (Landelijk Indicatie Protocol);
- 24 up to 80 hours of maternity care. The actual number of hours of maternity care depends on your needs (as a mother) and those of the child, and will be determined on the basis of the National Indication Assessment Protocol for Maternity Care (Landelijk Indicatieprotocol Kraamzorg). This protocol assumes a maximum of 10 days of maternity care. This means that almost everyone receives maternity care up to a maximum of 10 days after delivery. You may by law receive maternity care for a maximum of 6 weeks after the birth. Only if a vulnerable situation arises because the mother and/or child has not been able to receive sufficient maternity care within 10 days after delivery, is this a reason to provide maternity care after the 10th day. This only concerns exceptions based on justified deviation from the National Indication Protocol. In all cases, care must be provided continuously. A personal contribution of €5.40 per hour applies to maternity care.

Find the contracted or non-contracted maternity agency and maternity care of your choice via https://zorgzoeker.asr.nl.

Obstetric care during pregnancy
You are entitled to obstetric care during pregnancy to promote good health for mother and child.
Obstetric care during pregnancy includes the following ultrasound scans:
a. general term echo
b. specific diagnosis ultrasounds:
   - biometrics, assessing the child's growth
   - ultrasound due to blood loss
   - guidance ultrasound when turning the unborn child from the breech position to the cephalic position from the outside
   - ultrasound to determine the position of the child
   - ultrasound to check the placenta
   - ultrasound due to reduced vitality

The specific diagnosis ultrasounds are performed exclusively on medical indication.

Prenatal screening
We reimburse prenatal screening, comprising:
- non-invasive prenatal test (NIPT): free of charge for you. You are only entitled to reimbursement under your insurance if there are medical grounds for the NIPT, in which case it is not subject to the excess.
- invasive diagnostics: only if your medical history or current medical status reveals a high risk of having a baby with Down syndrome, Edwards syndrome or Patau syndrome, or if the NIPT established a significant risk of a chromosomal abnormality. This concerns chorionic villus sampling and an amniotic fluid puncture.

Consultation child wish or contraception question
We reimburse a consultation with an obstetrician if you have a desire to have children or a question about contraception. This concerns the care described in the NHG guidelines 'preconception care' or 'contraception' provided by an obstetrician, provided she is qualified and competent to provide this care. The midwife provides this care in collaboration with the family doctor.

Entitlement to I the costs of UD placement by an obstetrician
We reimburse the cost of placing an IUD (Intra-Uterine Device; IUD) by a general practitioner, in the hospital or by an obstetrician. The deductible does not apply to the placement of an IUD by the general practitioner and obstetrician. The deductible does apply to the cost of an IUD only under limited conditions. Specifically for the Levosert, the conditions apply as described in Article 18.8 Pharmaceutical care. Here you will find an explanation of preferred medicines. You must obtain an IUD from the pharmacy by prescription. The deductible also applies in the case of hospital placement.

18.27 Nursing and other care

Nursing and other care focuses on your physical health and on improving your self-reliance within your own residential and living environment.

Nursing and other care
We reimburse nursing and other care as generally provided by nurses, provided that such care:
- relates to the need for medical care or a high risk of such a need;
- is not already covered under the Social Support Act (Wet maatschappelijk ondersteuning, Wmo), the Long-term Care Act (Wet langdurige zorg, Wlz) or the Youth Act (Jeugdwet);
- does not coincide with admission.

For more information about reimbursement, visit www.asr.nl/verzekeringen/zorgverzekering/wijkverpleging.

Qualifications
To determine how much care you require, a district nurse with a degree at HBO level (high professional education) will make a diagnosis and will create a care plan on the basis thereof. There are a number of requirements for such a diagnosis and for the care plan.

The medical indication for nursing and other care (both care services in kind and Zvw-pgb):
- is provided by a nurse or district nurse with an HBO degree who is registered in the BIG register. For children up to age 18, the medical indication must be provided by a nurse with an HBO degree specialised in care for children. You may also consult a district nurse with an HBO degree who holds the KIWA certification mark for self-employed persons in the healthcare sector;
- is determined in accordance with the 'Standards for establishing indications for organising nursing and other care in the residential environment' (Normenkader voor het indiceren en organiseren van verpleging en verzorging in de eigen omgeving) of the Dutch Nurses' Association (V&VN);
- in addition, in the case of care given to those under the age of 18, the medical indication for this is established as per the 'Guideline for Indication Assessment Process in Child Care (Handreiking Indicatieproces Kindzorg, HIK) and the HBO-educated paediatric nurse has completed the HIK training.
- in the case of non-contracted care, the HBO-educated district nurse who establishes that there is an indication for this care must be affiliated with a network or social district team.

The district nurses who establish that there is an indication for care preferably update the status of their further training via the Dutch Nurses' Association (V&VN) Quality Register.

The district nurse determines your care needs based on the principle: self if possible, at home if possible and digitally if possible. This means that the district nurse determines how you can meet your care needs as much as possible "yourself," possibly with the help of aids, technologies and your own network, and records this in the indication.

Based on the established medical indication, the HBO-educated district nurse registered in the BIG register will draw up an up-to-date and dynamic care plan in consultation with you, the patient. This means that the care plan will be regularly evaluated and adjusted in cases where the care needs may change to address the relevant situation. The HBO-educated district nurse registered in the BIG register will be responsible for that care plan. The care plan at minimum contains information on the nature (care functions and activities), scope, duration and objectives of the healthcare provided and the desired outcome.

The HBO-educated district nurse records in writing that the care plan has been discussed with you or with your (legal) representative and that the care plan has been consented to. If a major change regarding the nature and/or objectives of the care is implemented in the care plan, it must be clearly stated in the care plan that this change has been discussed with you or with your (legal) representative and that this change has been consented to. In the case of non-contracted healthcare providers, the care plan must be signed by you or by your (legal) representative upon commencement of the care and whenever major changes are made to the care. The care is provided by qualified professionals. In the case of non-contracted healthcare providers, the deployment of level 2 care providers is not permitted. In addition, in the case of both contracted and non-contracted care given to those under the age of 18, this care must be provided by a paediatric nurse.

If you opt for a non-contracted care provider, you will declare the bills of the non-contracted care provider yourself. It is not possible that the non-contracted care provider declares the bill to us on your behalf (this is possible with contracted care). We reimburse the care provided in accordance with the terms and conditions set by us. We will only pay if you have permission from us for the reimbursement of the care in question.

We reimburse up to 90% of the average contracted rate. This may mean that if the bill is higher than the rate reimbursed by us, you will have to pay part of the bill yourself. The maximum rates can be found on our website. If you want to make sure that you do not incur any additional costs, we advise you to go to a contracted healthcare provider. We have contracted care providers in all regions. You can find out whether a care provider is contracted at https://zorgzoeker.asr.nl.

In exceptional situations we may also be unable to find a suitable care provider in the short term. In that case it is possible, after permission from us, to make use of a non-contracted care provider against full compensation (maximum NZa rate) of the care for a bridging period of up to 12 weeks. You can then use this period to search for and transfer to a contracted care provider. If you remain with the non-contracted care provider after these 12 weeks, the reimbursement will revert to 90% of the average contracted rate.

Please note: for 'Extra conditions for non-contracted care', see Article 3 (Reimbursement of care).

Requesting permission for reimbursement of non-contracted nursing and other care
You can apply for permission for reimbursement of non-contracted care by means of the form 'machtigingsaanvraag niet-gecontracteerde wijkverpleging'.

When requesting the authorisation from us, please submit the following information with the form:
- the indication and the care plan (drawn up in accordance with the conditions listed above);
- a copy of the degree certificate of the district nurse who holds at least an HBO degree and who is registered in the BIG register and who has established the indication for the care;
- and, in the case of palliative terminal care, the indication and the care plan must state the details of what the HBO-educated district nurse discussed with the general practitioner and relatives regarding the required care during the last phase of life and how this is going to be implemented, along with a substantiation of the care that will be provided and in which the possibilities of support from other facilities (e.g., municipality or own network) are included. It must also be evident from indication that the HBO-educated district nurse has informed the insured party and the insured party's next of kin about the option of passing away in a hospice or an institution for primary care admission.

We will subsequently assess the effectiveness and legitimacy of your application.

We will assess the effectiveness, for example, by comparing your indication with similar indications and determining the extent to which it is in line with your care needs. If we believe any particular care to be ineffective and/or not legit, we will contact the district nurse who provided the indication. If that contact does not change our view regarding the effectiveness and/or legitimacy, we will not authorise the care concerned. As a result, the care awarded may be less than the number of hours indicated. We will always explain our reasons for deviating from the indication. We may also decide to request that the indication be reassessed.

This means that we request a second, independent district nurse to reassess the current indication. The first district nurse will retain the authority with regard to the indication. Following the reassessment by the second district nurse, the second nurse's opinion/advice must be submitted to the first district nurse. After the two nurses have consulted with each other (peer review), the first nurse will assess whether the reassessment should result in an adjustment of the indication. Any adjustment of the indication must be substantiated by the first district nurse. We will then reassess the effectiveness and legitimacy of this new indication and issue an authorisation if our assessment is positive. You yourself may also request a reassessment of the indication (this is then referred to as a second opinion), but you will need our approval for such a step.

We do not reimburse:
- care under the nursing and other care heading that is delivered by a non-contracted healthcare provider or a care provider who is also a family member in the first or second degree of the patient. The Zvw-pgb is available for this purpose, in accordance with the 2025 'Vrije Keuze' Zvw-pgb Regulations.

Personal budget for nursing and other care (Zvw-pgb)
If you wish to purchase nursing and other care services yourself, you may request a personal budget for nursing and care (Zvw-pgb) with us. The eligible target groups and applicable terms and conditions are outlined in the 'Vrije Keuze' Zwv-pgb Regulations, which form part of this insurance policy.

The 2025 'Vrije Keuze' Zvw-pgb Regulations are available on www.asr.nl/verzekeringen/zorgverzekering/documenten.

Care for children with complex care needs
We will reimburse nursing and other care for children up to the age of 18 where the care needs relate to the need for medical care or a high risk of medical care. If the care does not focus on the care needs, but rather on supporting and teaching skills that should lead to increasing the self-reliance of the child, the then care will be reimbursed under the Youth Act (Jeugdwet).

Day care nursing and stays in childcare homes
You are entitled to day care nursing and a stay in a childcare home if you are under age 18 and you depend on intensive childcare. You also require permanent supervision or constant availability of care that involves one or more specific nursing activities. In order to qualify for day care nursing or stays in child care homes, you must have a referral from a medical specialist. Day care nursing and stays in child care homes do not qualify for reimbursement from a personal budget for nursing and care.

Palliative terminal care
In the last phase of life, the HBO-educated district nurse and your general practitioner will generally discuss your situation and see whether you need any more care now that your last phase of life has begun. The HBO-educated district nurse will discuss the types of care required with you and your relatives, as well as the potential role of others, such as informal care providers, your own network and/or volunteers. You and your relatives will also be informed about the option of passing away in a hospice or an institution for primary care admission, and the HBO-educated district nurse will let you know when staying at home would not be a responsible choice. The HBO-educated district nurse is required to record the care needs and the conclusions of consultations with the general practitioner and your relatives regarding the start of the last phase of life in the care dossier. This must be done in such a manner that the information concerned can be retrieved and consulted by the health insurer. As regards the personal budget for nursing and other care (Zvw-pgb), you must provide a statement from your attending physician from which it can be inferred that your estimated life expectancy is less than three months.

The following conditions apply for healthcare providers that provide palliative terminal care to you:
- Nurses with a level of competence of 4 or 5 who are qualified and competent to provide palliative care (as described in the palliative care nurse competency description of the Dutch Nurses' Association (V&VN)) must be available 24/7.
- The care provided must be in accordance with the Palliative Care NL Quality Framework and the guidelines for palliative care of the Netherlands Comprehensive Cancer Organisation (Integraal Kankercentrum Nederland, IKNL) (palliaweb.nl/richtlijnen-palliatieve-zorg).
- The healthcare provider must work in accordance with the Palliative Care Module (Zorgmodule Palliatieve Zorg) 1.0 and the Care Pathway for the dying patient (Zorgpad Stervensfase).
- The healthcare provider must deploy VPTZ volunteers (Vrijwilligers Palliatieve Terminale Zorg). They offer support, peace of mind and concrete help in the last phase of life.

18.28 Patient transport

Ambulance transport covers both emergency transport (usually via 112) and pre-ordered transport. During ambulance transport, care is provided by nurses and drivers who have had special training for this purpose.

With certain indications, you can use patient transport (by public transport, taxi or your own car).

Ambulance transport
We reimburse transport by ambulance in the Netherlands on medical grounds if other transport (public transport, taxi or private vehicle) is not considered safe for medical reasons. The maximum distance covered is 200 kilometres, unless we give permission to travel a longer distance.

The ambulance travel must be:
- to a healthcare provider at which you receive care that is covered by this policy, whether in full or in part;
- to an institution where your admission will be paid for under the Long-Term Care Act;
- from an institution designated under the Long-Term Care Act to a healthcare provider where you will be undergoing an examination or treatment, the costs of which are covered under the Long-Term Care Act, whether in full or in part;
- from an institution designated under the Long-Term Care Act to a healthcare provider for the purpose of measuring and fitting a prosthesis, the costs of which are covered under the Long-Term Care Act, whether in full or in part;
- if you are under age 18: to a healthcare provider for mental healthcare treatment;
- from the above-mentioned healthcare providers to your home, or to another home if the required care cannot reasonably be provided at your own home.

We do not reimburse:
- transport for attending an outpatients' clinic for half a day at an institution designated under the Long-Term Care Act.

Patient transport (public transport, taxi or your own car)
We reimburse transport to and from the healthcare providers listed above under 'Ambulance transport' by taxi, lowest-class public transport or your own vehicle up to a maximum of 200 kilometres if:
- you require kidney dialysis. We also reimburse transport costs for consultations, (follow-up) check-ups and (blood) testing;
- you must undergo oncological treatments involving chemotherapy, immunotherapy or radiotherapy. We also reimburse transport costs for consultations, (follow-up) check-ups and (blood) testing;
- you are temporarily wheelchair-bound and require transport to and from a healthcare provider where you receive care that is covered under this policy;
- you are temporarily visually impaired and cannot travel unaccompanied, and therefore require transport to and from a healthcare provider where you receive care that is covered under this policy;
- you are under 18 years of age and receive care under your nursing and care entitlements with complex somatic problems or physical disability (as part of intensive paediatric care), provided the transport is to and from a nursing day care centre and is required on medical grounds;
- transport for an attendant, if you require one or are aged under 16; the kilometres driven by an attendant will be reimbursed only if the insured party requiring support from an attendant was present in the means of transport at the time;
- you require treatment within the context of geriatric rehabilitative care;
- you require group day treatment within the context of medical care for specific patient groups as referred to in Article 18.11.

If you need taxi transport for one of the above indications, you do not need prior permission.

Using your own transport or public transport requires our prior permission. For this, we require a statement from your attending physician.

If we issue approval, we may set additional criteria for the mode of transport. We may also permit transport to a healthcare provider covering more than 200 kilometres.

In order to claim transport by taxi, please contact Transvision. They will then arrange the taxi transport for you.

Via VITA mobility, you can make an online reservation with Transvision directly. Transvision can be contacted on 0900-33 33 33 0 (€0.15 per minute).

Patient transport hardship clause (by public transport, taxi or private vehicle)
If you do not meet the criteria as referred to above under 'Patient transport (public transport, taxi or your own car)', you may still be entitled to reimbursement for seated patient transport under the hardship clause if you require transport for a prolonged period of time due to illness or a medical condition. To find out whether you qualify for reimbursement, you can make a calculation yourself via this link: www.zorginstituutnederland.nl/Verzekerde+zorg/hardheidsclausule-bij-vervoer-zvw.

This is subject to the condition that we reimburse the care for which the transport is meant from the basic insurance. You require our prior permission. To apply for permission, send in the application form, which is available on www.asr.nl/verzekeringen/zorgverzekering/zittend-ziekenvervoer.

Lodging instead of transport
If you need transport to a healthcare provider on at least three consecutive days and you are entitled to transport in accordance with the above terms and conditions for 'patient transport (public transport, taxi or private vehicle)', you can apply for reimbursement of lodging costs instead of transport costs. We will reimburse your lodging costs if lodging can reasonably be expected to be less burdensome for you than being transported on three consecutive days. The maximum reimbursement for lodging costs is €91 per night. You also qualify for reimbursement of the cost of travel to the lodging address and back to your home address. If you opt for lodging instead of transport, we will not reimburse the costs of transport between your lodging address and the address of your care provider. You can submit an application for reimbursement of lodging costs via www.asr.nl/verzekeringen/zorgverzekering/ziekenvervoer. When claiming lodging costs, make sure to also submit the invoice of the stay concerned.

We will not reimburse your lodging costs if we do not have the invoice. You are not required to pay a personal contribution towards the lodging costs. You do however pay a personal contribution for the journey to the lodging address and back again.

Personal contribution
For patient transport (by public transport, taxi or your own car) a statutory personal contribution of €126 per calendar year applies.

The personal contribution does not apply to:
- transport from one institution where you have been admitted to another institution where you will be admitted to undergo specialised tests or treatment that is/are not available at the first institution. The costs of both admissions must be covered by your basic insurance policy or under the Long-term Care Act;
- transport that involves a round trip from an institution where you have been admitted to a person or institution to undergo specialised tests or treatment that is/are not available at the first institution, provided the tests or treatment is/are covered by this basic insurance and the admission is covered by this insurance or under the Long-Term Care Act;
- transport that involves a round trip from an institution where you have been admitted to a person or institution to undergo dental treatment that is not available at the first institution, provided both the treatment and the admission are covered under the Long-Term Care Act;
- the lodging costs if you have opted for 'lodging instead of transport'.

Kilometre allowance for private vehicle use
The allowance for use of your own vehicle is €0.40 per kilometre via the fastest common route. The distance is calculated using the Google Maps journey planner.

Other means of transport
If patient transport is not possible by ambulance, taxi, car or public transport, we may issue approval to use other means of transport. You must request this from us in advance.

18.29 Sensory impairment care (ZG-care)

Sensory impairment care is a type of treatment you receive if you are deaf or hearing-impaired, blind or vision-impaired or if you have serious speech and/or language problems due to a developmental language disorder. Multiple medical specialists (multidisciplinary care) are involved in the treatment.

General
We reimburse multidisciplinary care (i.e. care involving various specialists) for:
- hearing impairments (you are deaf or hearing-impaired);
- visual impairments (you are blind or vision-impaired);
- communication impairments (you have a serious speech and/or language impediment) resulting from a developmental language disorder and you are not more than 23 years old;

The care provided comprises:
- diagnostic examinations;
- interventions aimed at psychologically learning to cope with a disability;
- interventions to resolve or compensate for the impairment and thus increase your level of self-reliance;
- admission in combination with out-patient sensory impairment care.

In addition to treatment of the person with a sensory impairment, the cover also includes direct and indirect, system-oriented 'co-treatment' of parents/carers, children and adults in contact with the person with the sensory impairment. These persons learn skills that will benefit the person with the disability. In cases of 'co-treatment', all costs fall under the insurance of the person with the sensory impairment.

Criteria for medical indication
- You must meet one of the following criteria for a medical indication: a hearing impairment determined on the basis of the guidelines issued by the Federation of Dutch Audiological Centres (Nederlandse Federatie van Audiologische Centra, FENAC);
- a visual impairment determined on the basis of the guidelines issued by the Netherlands Ophthalmological Society (Nederlands Oogheelkundig Gezelschap, NOG);
- a communication impairment arising from a developmental language disorder as determined in the FENAC guidelines. A communication impairment arising from a developmental language disorder exists if the disorder can be traced back to neurobiological and/or neuropsychological factors. A further condition is that the developmental language disorder must be primary; in other words, other problems (psychiatric, physiological or neurological) are subordinate to the developmental language disorder;
- any combination of the above impairments.

Referral
- Sensory impairment care for hearing and/or communication impairments requires a referral from a clinical physicist in audiology at an audiological centre or from a medical specialist based on diagnostic data demonstrating that you satisfy the inclusion criteria for the performance of the sensory impairment care to be insured (see Section 2.5(d) of the Health Insurance Decree).
- For visual impairment care, you require a referral from a medical specialist on the grounds of the evidence-based NOG guideline on Viral diseases, rehabilitation and referral.
- If an audiological clinical physicist, ophthalmologist or medical specialist has already confirmed your sensory impairment in the past and you develop a sensory impairment-related care need, without the sensory impairment itself having changed, you may also be referred by a general practitioner or youth care doctor. Visually impaired insured parties who have a straightforward rehabilitation demand (in line with Care Programme 11) do not need a new referral.

Medical responsibility
The care provider must ensure ultimate medical responsibility as described below.

For auditory and/or communication impairments:
A healthcare psychologist who is registered under the Individual Healthcare Professions Act (BIG) must always retain ultimate responsibility for the care provided and the care plan. Where the patient is a child or young person up to the age of 23, this responsibility may also fall to a general remedial educationalist. If other disciplines are involved in the care, these activities must be limited to the care as described in Section 2.5(a) of the Healthcare Insurance Decree, and the requirements and conditions placed on sensory impairment care in that decree.

For visual impairments:
An ophthalmologist or healthcare psychologist who is registered under the Individual Healthcare Professions Act must always retain ultimate responsibility for the care provided and the care plan. If other disciplines are involved in the care, these activities must be limited to the care as described in Section 2.5(a) of the Healthcare Insurance Decree, and the requirements and conditions placed on sensory impairment care in that decree.

The Health Insurance Decree can be found via https://www.wetten.overheid.nl/zoeken.

We do not reimburse:
- aspects of care that are related to supporting social functioning;
- complex, long-term and life-encompassing support to deaf-and-blind adults and adults with prelingual deafness (those who acquired a hearing impairment prior to the age of three years);
- care for insured parties in connection with a communication impairment arising from a developmental language disorder aged 23 or over.

19. Exclusions

We do not reimburse:
- care that is covered under the Long-Term Care Act (Wlz), the Youth Act (Jeudgwet), the Social Support Act (Wmo) or other statutory provision(s);
- personal contributions you pay under the Long-Term Care Act or the Social Support Act;
- pre-employment medical examinations and other examinations (for example for a driving or pilot's licence), certificates and vaccinations, unless the Healthcare Insurance Regulations specify otherwise;
- treatments in private clinics;
- flu vaccinations;
- alternative medicine/treatment;
- treatments against snoring with uvuloplasty;
- treatments aimed at the sterilisation of the insured party (man or woman);
- treatments aimed at reversing the sterilisation of the insured (man or woman);
- treatments aimed at the circumcision of the insured party, unless medically necessary;
- treatment of plagiocephaly and brachycephaly without craniosynostosis with a redression helmet;
- medicines for travel-related risk of illness;
- a maternity package, surgical cotton wool or sterile hydrophilic gauze for obstetric care;
- costs for failure to attend an appointment with a healthcare provider;
- costs of consultations, treatments, medicines or medical aids that are granted, prescribed or provided by an insured party for him or herself or within a family by a family member for an insured party, unless we have given consent for this;
- damage caused by or arising from armed conflict, civil war, rebellion, domestic unrest, rioting or mutiny as defined in Section 3.38 of the Financial Supervision Act (Wet op het financieel toezicht, Wft);
- care resulting from one or more terrorist acts, if the total damage to be claimed in a calendar year as a result of such acts from non-life or life insurers, or insurers of funeral expenses and benefits in kind, to which the Financial Supervision Act applies, is expected by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade N.V., NHT) to be higher than the maximum amount that this company has reinsured for a calendar year. In such cases, you will only be reimbursed a certain percentage, which will be the same for all insured parties and determined by the NHT. Under Sections 33 and 55 of the Healthcare Insurance Act, the government may decide to issue an additional contribution to health insurers and their insured parties in the event of a disaster, such as terrorist acts.

Terrorism clause

Under this insurance, any damage or loss due to terrorist acts is covered by the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade N.V., NHT).

The text of the terrorism cover clause is available from us upon request.

Contact details

Ik kies zelf van a.s.r.
www.asr.nl/verzekeringen/zorgverzekering/ikkieszelf

SOS International
BV Nederlandse Hulpverleningsorganisatie SOS International
Telephone: 31 (0)20 651 51 51
Email: info@sosinternational.nl

These terms and conditions are a translation of the Dutch terms and conditions and are subject to possible translation errors. No rights may be derived from this translation. The conditions in Dutch are leading in the operation of this insurance.

a.s.r.
Archimedeslaan 10
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