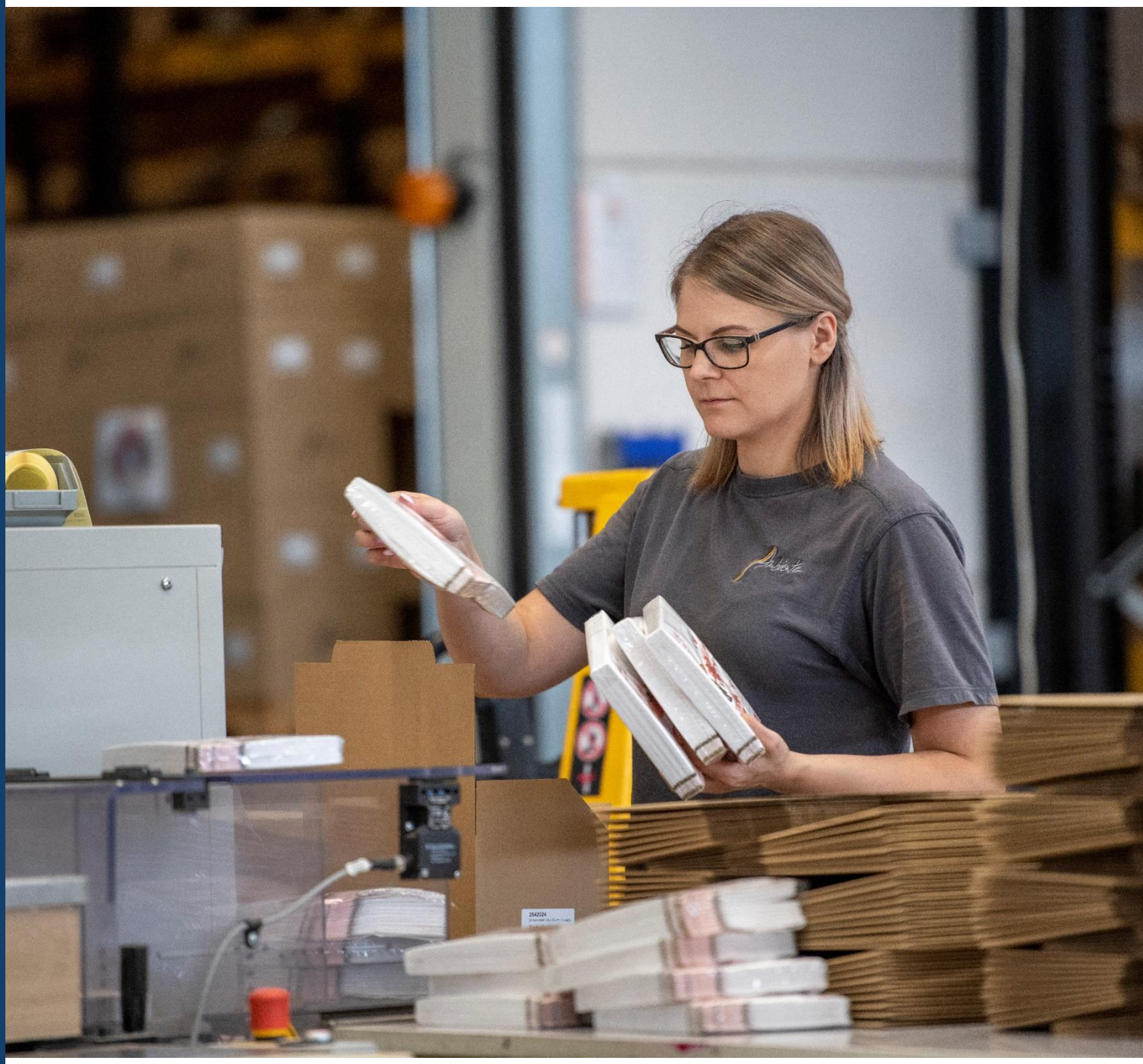
POLICY CONDITIONS

FLEXPOLIS NO RISK I, II AND III

2024



HollandZorg

Contents

Contact and service

All information about your health insurance can be found in these policy conditions. However, you may still have questions. You can find many answers to your questions online, at www.hollandzorg.com. If this still does not answer your questions, please contact us using one of the methods below:

Online: You can put your question to us using the contact form on our website (www.hollandzorg.com/contact).

Customer Service: +31 (0)570 687 123 (lines are open Monday to Friday, from 8 am to 6 pm)

Care advice: +31 (0)570 687 123 (for waiting period mediation and care advice)

Emergency centre: +31 (0)570 687 112 (standard rate/for emergency care abroad) The emergency centre is reachable 7 days a week and 24 hours a day. Alternatively, you can send an e-mail to the emergency centre at alarmcentrale@hollandzorg.nl.

Postal address: HollandZorg, Postbus 166, 7400 AD Deventer

Care Finder

Our Care Finder is an easy tool to help you find a care provider near you. In addition, you can instantly see whether and for which treatments we have made agreements with this care provider. Go to: www.hollandzorg.com/careprovider.

HollandZorg has concluded contracts with many care providers. These care providers can submit the invoice directly to us. You do not need to do anything. However, you can always view all invoices and account in My HollandZorg at https://mijn.hollandzorg.com/.

Claiming online

Have you received an invoice from a care provider directed at you? You can claim the invoice online via My HollandZorg (https://mijn.hollandzorg.com/). For this you need to log in using your DigiD. You fill in the online claim form and take a clear photo of the original invoices. You can upload the photo(s) and send them together with the online claim form. You will receive an e-mail to confirm we received your claim. You can view your claims via My HollandZorg.

The HollandZorg Claims app now makes claiming your healthcare costs even easier. You enter your details, take a picture of the invoice and submit it with a single mouse-click. The app is available for both Android and iPhone. You can download the claims app from the App Store (iOS) and the Play Store (Android). In most cases, we will pay the claim within five working days.

Excess

Each public healthcare insurance has an excess. This is the amount for care that you need to pay yourself. Every insured party aged 18 or older has an excess.

Compulsory excess
Each year, the government determines the amount of the compulsory excess. In 2024, the amount is € 385. This means that, in the year 2024, you will never pay more than this amount as compulsory excess.

Voluntary excess
In addition to compulsory excess, we distinguish voluntary excess. If you opt for this when taking out the insurance, you will receive a discount on the healthcare premium. The higher the voluntary excess, the higher the discount. However, this also means you have to pay a higher amount yourself if you use care that is subject to excess. The maximum amount of voluntary excess that you can choose is € 500. The voluntary excess is in addition to the compulsory excess. If you opt for the maximum voluntary excess amount, you will pay a maximum of €885 for the year 2024 (compulsory + voluntary).

Voluntary excess exceptions
Not all care provided through public healthcare insurance is subject to excess.

The exceptions can be found on our website and in Articles 5 and 6 of the Specific provisions for the public healthcare insurance. As a health insurer, we too can decide whether to exclude certain care from excess. These exclusions can be found in the 'Designated care not subject to excess' scheme on our website.

Paying excess

1. We receive an invoice from your care provider. We check whether excess applies. If so, we will invoice you the amount due.

2. You receive an invoice from your care provider directed at you. You can claim this amount from us. We deduct the excess from the payment and transfer the reimbursement to the bank account number (IBAN) of the policyholder.

3. A statutory personal contribution applies to the healthcare or medical expenses (see glossary). The personal contribution is first deducted from the total amount. The remaining amount counts towards the compulsory excess and then towards the voluntary excess. How this works in practice is shown in the calculation examples.

Example 1: compulsory excess

In 2024, you spend € 400 on hospital care. The compulsory excess is € 385. This is the amount you pay yourself. We will reimburse the payable amount that remains. So the reimbursement is € 15 (€ 400 - € 385). You have now paid the full amount of the compulsory excess for 2024. We will no longer deduct compulsory excess on new healthcare costs for the year 2024.

Example 2: compulsory excess

In 2024, you spend € 85 on medicines via the chemist. The full amount of € 85 is subject to compulsory excess. These costs are payable by you. You will not be reimbursed under the public healthcare insurance. For the year 2024, your remaining compulsory excess is € 300 (€ 385 - € 85).

Example 3: statutory personal contribution and compulsory excess

In 2024, you spend € 200 on patient transport. The statutory personal contribution for transport is € 113 per calendar year. These costs are payable by you. The amount that remains after that is € 89 (€ 200 - € 113). This amount is subject to the compulsory excess of € 385. These costs are payable by you too. For the year 2024, your remaining compulsory excess is € 298 (€ 385 - € 87).

Sending documents

In our policy conditions, we refer to regulations and lists that can be found on our website (www.hollandzorg.com/conditions) Such as the List of alternative care providers or the Pharmacy Regulations. All documents available online can also be sent, on request.

General provisions

In the general provisions you will find rules that apply to your insurance. For example, about cancellations, premium payments and the way in which you can submit a complaint.

1. General

- These general provisions apply to your public healthcare insurance and also to your supplementary insurance and dental insurance. Which insurances you have taken out is stated on your policy.
- By the term 'insurance' as stated below, we mean the public healthcare insurance, the supplementary insurance and/or the dental insurance.
- The policyholder is the person who has concluded the insurance with us. The insured is the person whose medical expenses are insured. Often, the policyholder and the insured are one and the same person. In these terms and conditions, 'you' means the insured, unless stated otherwise.
- The insurance contract consists of your policy, these policy terms conditions and all associated regulations and other appendices thereto.

2. Invoices and payments

2.1 What year do the healthcare costs relate to?

The costs of care are allocated to the calendar year in which you received the care. If you received the care in two successive calendar years but the care has been charged as a single sum, the care is allocated to the calendar year in which the care started. The date on which you were treated, a medicine was issued or a medical aid supplied determines the reimbursement and excess. The invoice date or the date on which payment was made is not relevant in this respect.

Example: you are operated on in November of year A, but you receive the invoice for this in January of year B. In that case, the excess and reimbursement apply to year A and not year B.

The costs of a DBC care product (Diagnosis Treatment Combination) apply to the calendar year in which the DBC product was opened. Therefore, in the event of a DBC care product that was opened in year A and closed in year B, you will be reimbursed in accordance with Year A. The excess also applies to Year A.

2.2. How do I submit an invoice?

We often pay the care provider directly. Sometimes you may receive an invoice directed to you. For example, if you use the services of a non-contracted care provider.

Submitting the invoice online:

- You can do so in My HollandZorg or with the claims app.
- We may ask you to submit the original invoice after all. If we do not receive the original invoice, the right to reimbursement of that invoice lapses. In that case, we may claim back any money reimbursed incorrectly.
- You must keep the original invoice for up to two years after submission.

Submitting the invoice by post:

- This must be the original invoice.
- The invoice will not be returned to you. We can provide you with a certified copy of the invoice, on request.

An invoice must meet the following conditions:

• It must in any case state the name, address and profession of the care provider, invoice date, date on which the care was provided and a description of that care and name and date of birth of the insured party.

• The invoice must be drawn up in Dutch, German, English, French, Polish, Spanish or Turkish. If the invoice is drawn up in a different language, you must include a sworn translation of the invoice. We do not reimburse the costs of the translation. If you do not provide a sworn translation, we may refuse to process the invoice.

• In the event of healthcare costs incurred abroad, you must enclose a completed and signed foreign claim form (available for download at www.hollandzorg.com/forms).

• In the event of a healthcare insurance personal budget (Zvw-pgb) invoice, you must send a completed and signed healthcare insurance personal budget claim form (available for download at www.hollandzorg.com/forms).

• The invoice must be clearly legible.

• The invoice must comply with the statutory requirements applicable to the care provider for claiming that care.

2.3 Until when can I submit an invoice?

Care-related invoices must be submitted within 12 months of the end of the calendar year in which you received the care. This means the treatment or delivery date and not the date on which the invoice was issued. If the care is described as DBC or a DBC care product, you must submit the invoice within 12 months of the moment the DBC or the DBC care product is terminated.

If you submit an invoice after 12 months, we may decide to reimburse the invoice partially or not at all. In that case, the additional costs for administrative processing will be payable by you. Invoices submitted three years after the treatment or delivery or the date on which the DBC or DBC care product is terminated are never eligible for reimbursement.

We may ask you for additional information in order to verify that the care you claim meets the policy conditions.

2.4 Can I transfer a claim?

You are not permitted to transfer any (future) claims against us to any third party (i.e. another natural person or legal entity). The transfer of a claim is called assignment. This ban on assignment of a claim must be interpreted as a stipulation with property-law effect as referred to in Article 3:83, paragraph 2, of the Netherlands Civil Code.

You are not permitted to assign any third party (another natural person or legal entity) to collect any claim against us (by mandate, for example). If you do, we are not obliged to pay. Payment of the claim to you will in that case also constitute a valid discharge (the invoice has been duly paid).

2.5. When do we pay?

We will pay an invoice submitted to us within five working days of receipt. This is based on the assumption that all conditions for (partial) reimbursement have been met. The processing time will be longer if the invoice is incomplete or if more time is needed to check whether the care meets the policy conditions. You can view your claims via My HollandZorg.

Alternatively, we are entitled to pay the costs of care directly to the care provider who provided the care. Your entitlement to reimbursement is nullified by that payment.

If we reimburse more to a care provider than we are obliged to under the insurance, we may charge you (insured party/policyholder) for the excess paid. In that case, you (insured party/policyholder) must pay us the amount paid in excess.

We pay the costs of care and other amounts payable to you (insured party/policyholder) by transferring the money into the policyholder's IBAN which we have in our records. Your entitlement to reimbursement is nullified by the payment to the policyholder.

We can set off the reimbursement of costs for care and other amounts payable to you (insured party/policyholder) against premiums, interest, costs or other amounts owed to us.

We deduct the statutory personal contribution from the reimbursement for the costs of care which falls under the public healthcare insurance, unless the statutory personal contribution has already been settled with the care provider. If an excess applies, we will also deduct the excess from the reimbursement. Finally, we will deduct any other amounts that remain payable by you from the reimbursement.

We reimburse the costs of care in Euros. We use the exchange rate applicable on the date on which the care was provided, where possible.

2.6 How do we process your payments?

You (insured party/policyholder) can pay our invoices via:

- Direct debit
- iDEAL from My HollandZorg
- Internet banking
- Transfer form from your bank.

If you (insured party/policyholder) pay an invoice via Internet banking or a transfer form from your bank, you (insured party/policyholder) must always state the payment reference given on the invoice. We will then process the payment on the relevant outstanding account.

If you (insured party/policyholder) fail to state a payment reference, or the payment reference is not or no longer known to us as an outstanding claim, we will process your payment at our discretion for any other outstanding claims. If there are no outstanding claims, we will refund the amount to you (insured party/policyholder).

3. Taking out and terminating insurances

3.1. How do I take out an insurance policy?

You (policyholder) can apply for insurance online at https://application.hollandzorg/situation. You can also submit a request via an agent with whom we have made arrangements about brokering our insurances.

The public healthcare insurance commences on the day on which we receive the application. We will send the policyholder and the person to be insured confirmation of receipt of the request, stating the date of receipt.

If we are unable to establish whether or not the person to be insured is obliged to take out public healthcare insurance, we will ask you (policyholder) for additional information. In that case, the public healthcare insurance commences on the day that we receive the additional information and that information demonstrates the obligation to take out insurance. We will send you (policyholder) and the person to be insured a confirmation of receipt for the additional information, stating the date on which we received it.

If the public healthcare insurance commences within four months of the obligation to take out healthcare insurance coming into force, the public healthcare insurance will be backdated to the date on which the obligation to take out healthcare insurance arose.

If, on the day of the request, the person to be insured already has a health insurance contract, the public healthcare insurance will commence on the later date on which you (policyholder) wish the public healthcare insurance to commence.

If the public healthcare insurance commences within a month of an earlier health insurance contract being terminated through cancellation as of 1 January of a calendar year or due to changes to the conditions subject to application of Article 7:940, paragraph 4 of the Netherlands Civil Code, the public healthcare insurance will be backdated to the day on which the earlier health insurance contract was terminated.

You (insured party/policyholder) will be issued policy documents as soon as possible after the insurance is taken out and subsequently at the start of each new calendar year. If you (insured party/policyholder) believe the policy is incorrect, you must report this to us within one month of receiving the policy. If we do not receive any notification from you within a month, we assume the details are correct.

3.2. How long do I take out the insurance for?

The insurance is taken out for one calendar year. If the insurance commences during the course of a calendar year, it is concluded for the remaining part of that calendar year.

The public healthcare insurance is tacitly renewed for one calendar year on 1 January of each calendar year, unless it is terminated prematurely in the sense of these policy conditions.

If the public healthcare insurance will end or has ended, we will notify you (insured party/policyholder) of that fact as soon as possible, stating the reason and the date on which the insurance will end or has ended.

3.3. What happens if I change my mind?

You (policyholder) can change your mind after having taken out the insurance. You can cancel within 14 days of receipt of the first policy documents. The insurance is then deemed not to have commenced. We will refund any premium paid. And you (insured party/policyholder) are obliged to repay any healthcare costs paid by us.

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

• via the contact form at www.hollandzorg.com.

• via My HollandZorg (https://my.hollanzorg.com)

• in writing, to: HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

NOTE: verbal cancellations or cancelling via social media is not accepted.

3.4. When does the insurance end?

The insurance terminates automatically on the day following that on which:

• our licence entitling us to provide healthcare insurance terminates. In that case, we will inform you (policyholder) of the termination date and reason no later than two months before termination of the insurance.

• you pass away. The insured party or your heirs are obliged to notify us of your death promptly.

• your obligation to take out insurance ends. You (insured/policyholder) must inform us of that fact as soon as possible. If you were not subject to compulsory health insurance, we will terminate the public healthcare insurance and, if applicable, the supplementary insurance, from the moment that your public healthcare insurance came into force. We will set off the premium that has been paid against the care that has been reimbursed. The difference is either paid out or charged.

The public healthcare insurance also terminates on the day following that on which you, as a result of changes to our territory, reside outside our territory.

3.5. How can I cancel the insurance?

- You (policyholder) can cancel the insurance on or before 31 December of any year with effect from 1 January of the following calendar year.
- You (policyholder) can cancel the public healthcare insurance of another person you have insured and who will be insured under a different health insurance. If we receive the notice of cancellation before the commencement date of the other health insurance, the public healthcare insurance of that other person terminates on the commencement date of the other health insurance. In other cases, the public healthcare insurance of that other person ends on the first day of the second calendar month following the day on which you (policyholder) cancelled the policy.
- You (policyholder) may cancel the public healthcare insurance within six weeks of receiving notification from the Dutch Healthcare Authority that we have received an order or an administrative penalty has been imposed upon us because we breached the law by accessing your data by means of an electronic exchange system. The public healthcare insurance will then end on the first day of the second calendar month following the day on which you (policyholder) have cancelled.

- You (policyholder) can cancel the insurance if we change the policy conditions to your (insured party/policyholder) disadvantage. This does not apply if the change is the direct result of a change to a statutory regulation. We must receive the notice of cancellation before the effective date of the change, or within one month of us having announced the change. The insurance terminates on the day on which the change takes effect.
- You (policyholder) can cancel the insurance if your participation in a group scheme ends through termination of your employment, and you (policyholder) take out new health insurance and participate in a group scheme through your new job immediately after that. This also applies to members of your family. We must receive the notice of cancellation within 30 days of termination of employment. If we receive the notice of cancellation before the starting date of the new health insurance, the public healthcare insurance ends on the starting date of the new health insurance. This is usually the day of commencement at your new employer if this is the first day of the calendar month, otherwise it will be the first day of the month after commencement of employment. In other cases, the insurance ends on the first day of the second calendar month following the day on which you (policyholder) have cancelled.

The stated cancellation options do not apply to the public healthcare insurance if the premium and collection costs owed have not been paid and we have demanded payment from you (the policyholder) for the premium owed. This does not apply if we have suspended (temporarily discontinued) the cover of the public healthcare insurance or if we have confirmed the cancellation to you (the policyholder) within two weeks.

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

• via the contact form at www.hollandzorg.com.

• via My HollandZorg (https://my.hollanzorg.com)

• in writing, to: HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

NOTE: verbal cancellations or cancelling via social media is not accepted.

If you (policyholder) ask us to provide insurance, we at the same time deem that request as a notice of termination of any other live, similar insurance contracts held with us.

If you (insured party/policyholder) ask another health insurer to provide insurance for you, we at the same time deem that request from that other health insurer as a notice of termination of any other live, similar insurance contracts held with us, from the moment that we receive a copy of that request. We call this the cancellation service.

3.6. How does it work if I'm insured through the CAK?

If you are insured through the Central Administrative Office for Exceptional Medical Insurance (CAK) within the framework of measures against the uninsured, you can still cancel (terminate) the public healthcare insurance. This must be done within two weeks of the date on which the CAK has notified you that you are insured with us. In addition, you must demonstrate that you have been given another health insurance in the three-month period from the date of dispatch by the CAK of the second administrative penalty on account of being uninsured and the instruction to take out insurance (or arrange for insurance to be taken out on your behalf) under the public health insurance scheme.

If you are insured through the Central Administrative Office for Exceptional Medical Insurance (CAK) within the framework of measures against the uninsured, you cannot cancel the public healthcare insurance during the first 12 months. During that period, the cancellation options under article 3.5 of these general provisions do not apply.

If you are insured through the Central Administrative Office for Exceptional Medical Insurance (CAK) within the framework of measures against the uninsured, we can terminate (cancel) the public healthcare insurance on account of an error if, in retrospect, it transpires that you were not obliged to take out insurance. In that case, the public healthcare insurance is deemed not to have commenced.

3.7. When may we cancel or suspend the insurance?

We can cancel or dissolve the insurance, or suspend (temporarily discontinue) cover of the insurance:

• if you (policyholder) have failed to pay the premium or other amounts you (policyholder) owe us in a timely fashion. This only applies if you (policyholder), after a written reminder stating the consequences of non-payment, continue to be in default of payment within the applicable term. Cancellations or dissolutions on account of non-payment will not be backdated. A suspension on account of non-payment ends on the day after that on which we have received the outstanding amount, including interest and costs.

• if you (insured party/policyholder) fail to give us any information or paperwork, or if you give us incomplete or incorrect information or paperwork that is important for the execution of the public healthcare insurance, which is or may be of detriment to us.

• if you (insured party/policyholder) have intentionally misled us or if we would not have concluded any insurance if we had been aware of the true state of affairs.

• if you (insured party/policyholder) seriously misbehave towards us or our employees.

In all cases, we will provide you (insured party/policyholder) with proof of termination of the insurance. Upon termination of the public healthcare insurance, we will send you proof of termination stating the details which we are required to provide under the Healthcare Insurance Act.

3.8. What happens to my insurance if I'm detained?

The cover and obligation to pay premiums under the public healthcare insurance are suspended (temporarily discontinued) during the time you are detained. We cannot cancel or dissolve your public healthcare insurance as long as you are in detention. Do not forget to state the starting and end dates of your detention. The starting date must be reported within one month of the detention commencing. The end date must be reported within one month of the detention ending. The report can be submitted by presenting a statement of detention from your penitentiary:

• via the contact form at www.hollandzorg.com; or

• by post to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

If you are detained abroad, you must send us a statement from the Minister of Foreign Affairs or a statement from the Dutch probation service in evidence of your incarceration.

4. Premium

4.1. How is the premium made up?

The premium that you (the policyholder) must pay is the premium calculation basis less any discount. You (the policyholder) can be granted a discount if you (the policyholder) opt for voluntary excess. The premium calculation basis, any discount and the premium that you (policyholder) must pay can be found on the policy.

The premium calculation basis is shown in the Premium Appendix to these policy conditions.

If the insurance does not come into force on the first day of a month, the premium will be calculated in proportion to the number of insured days in that month.

Example: your insurance comes into force on 13 March 2024. In that case, you pay premium for 18 days (31-13) for the month of March, instead of the amount for the entire month. That amount is the monthly premium divided by 31 and then multiplied by 18.

It is possible that, pursuant to a law or treaty, we are obliged to pay a tax or other levy, in the Netherlands or abroad, in connection with your insurance. In any such case we may charge this amount in the form of a surcharge in addition to your premium. You (policyholder) must then pay the surcharge to us. If a surcharge applies, this will be specified in the policy.

4.2. When do I pay the premium?

You (the policyholder) must pay the premium in advance. Your payment must be made before the first day of the period to which the premium relates. We decide whether you can pay per month, per six months or per year, and which form of payment is possible. If you (insured party/policyholder) do not pay the premium or other amounts to be paid to us on time, we may charge you statutory interest, collection costs and administration costs.

You (insured party/policyholder) are not entitled to set off the premium or other amounts payable to us against any amounts that you (insured party/policyholder) are yet to receive from us. Nor are you (insured party/policyholder) permitted to suspend payments if you (insured party/policyholder) feel that we owe you (insured party/policyholder) an amount of money.

In the event of the death of the insured party, any premium paid relating to the period after the date of death will be refunded.

5. Important rules

5.1. Who are the insurances for?

The insurances are intended for all persons living in the Netherlands or abroad and who are obliged to take out health insurance.

The insurance is governed by the laws of the Netherlands.

5.2. What information requirements do I have to meet?

You (insured party/policyholder) are obliged:

• to prove your identity when receiving care in a hospital or outpatients' department by means of a driver's licence, passport, Dutch identity card or an aliens document (proof of ID as referred to in the Compulsory Identification Act (Wet op de identificatieplicht)).

• to ask the care provider treating you to notify the medical advisor of the reason for treatment if the medical advisor requests such notification.

• to cooperate with our medical advisor or employees in obtaining all the information they need to check the execution of the public healthcare insurance.

• to immediately inform us of all facts and circumstances that could be of importance to the correct execution of the insurance, including moving house, births, deaths and changes in IBAN number, divorce or end of a group participation. Or circumstances that have led or could lead to the termination of your insurance.

NOTE: if you (insured party/policyholder) fail to meet the information requirements set out in this article and the other policy conditions, you are not entitled to (reimbursement of the costs of) the care if this is detrimental to our interests.

5.3 How we notify you

Our notifications to you (insured party/policyholder) apply only if we have confirmed them in writing or, with your permission, by e-mail. When using the most recent residential address or e-mail address we hold on record, we assume that the notification will have reached you.

If you (insured party/policyholder) send us an e-mail, we may assume you authorise us to respond to that by e-mail.

If you (insured party/policyholder) have given us your authorisation to send notifications electronically, you (insured party/policyholder) are entitled to withdraw that authorisation. You can do so as follows:

• You (insured party/policyholder) can send a written request to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

• Via the contact form at www.hollandzorg.com.

5.4. What do I do if someone else is liable for the healthcare costs?

You may at times require care due to the actions of someone else, e.g. as a result of an accident. That person may be liable to pay the costs of the care you consequently need.

If someone else may be liable to pay the costs of care provided to you, you are obliged to notify us of that fact. You can do so as follows:

• by calling (0570) 68 74 84

• in writing, to: HollandZorg, Verhaal, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

• by e-mail to verhaal@hollandzorg.nl

• by completing the accident claim form at www.hollandzorg.com/forms. On our website, you will immediately be given a rough indication of whether it is possible for you or us to recover the damages.

You are obliged to provide us with the information we need to recover the costs of the care given to you from that other person.

You are not permitted to make arrangements with another person or the liability insurer of that other person which prejudice or may prejudice our chances of recovering the healthcare costs. This does not apply if you have received our prior written authorisation. If our chances of recovering the healthcare costs are prejudiced as a result of your actions or omissions, we may hold you liable for the damage incurred by us and corresponding costs.

5.5. What limits to liability apply?

We are not liable for damage or losses you (insured party/policyholder) suffer as a result of the actions or omissions of a care provider who has or should have provided you with care.

Any liability on our part for damage or losses suffered as the result of our own shortcomings in the execution of the public healthcare insurance is limited to the amount of the costs that would have been borne by us in the event of the correct execution of the public healthcare insurance.

5.6. How do we handle your personal data?

We record the personal data and execution data we receive from you (insured party/policyholder) in our administration.

We use this data for the following purposes:

• to conclude and execute the insurance policy

• to increase our customer portfolio and provide information about our products

• conducting research into the quality of care as perceived by you

• to comply with the statutory obligations

• monitoring the safety and integrity of the financial sector, including preventing and combating fraud

• exercising the right of recourse, including exchanging data with the non-life insurer of the liable person and with your travel insurer in the event of concurrence of cover abroad

• scientific and statistical analyses

The processing of personal data is governed by our privacy statement. You (insured party/policyholder) can view and download this at www.hollandzorg.com/conditions.

In relation to a responsible acceptance, risk and fraud policy, we can access your data at Stichting CIS, Bordewijklaan 2, 2591 XR The Hague, c/o Postbus 124, 3700 AC Zeist. The objective of processing personal data at Stichting CIS is to manage risks for insurers and prevent fraud. More information about this and the Stichting CIS privacy regulations is available at www.stichtingcis.nl.

If relevant arrangements have been made with your care provider, the latter can consult your address details and policy details we have registered through the national Internet portal VECOZO

(Veilige Communicatie in de Zorg). This is necessary for the care provider in order to claim the costs of the care provided to you directly from us.

In some cases, your personal data may need additional protection, for instance because you are staying at a shelter. If you believe you need that additional protection, please tell us by calling (0570) 68 74 84. If we feel your notification is justified, we will take additional measures to protect your personal data.

5.7. How do we act in case of fraud?

If we suspect fraud, we will conduct an investigation to determine whether fraud has occurred.

In the event of confirmed fraud:

• we can have your (insured party/policyholder) data included in the Internal Reference Register (IVR) or the External Reference Register (EVR). The IVR and EVR are used by financial institutions to assess the integrity of insured parties and other customers. The IVR can only be consulted by us. The EVR can also be consulted by other financial institutions. Consultation runs via the central database of Stichting CIS. This will be done in accordance with the rules of the Protocol Incident Warning system for Financial Institutions. You (insured party/policyholder) can view and download this protocol at www.hollandzorg.com/conditions.

• we can file a report with the police.

• we may recover the investigation costs we incurred in identifying and proving the fraud committed by you (insured party/policyholder).

• we may terminate the insurance contract.

• we can recover the collection costs from you (insured party/policyholder).

• you will not be entitled to a reimbursement of the care costs and we can demand that any compensations paid, including the costs incurred to do so, are paid back.

5.8. How do I become a member of the cooperative?

If you (insured party/policyholder) have taken out an insurance policy or are insured by virtue of an insurance policy, your request will also count as a request to become a member of Coöperatie Salland U.A. This does not apply if you (insured party/policyholder) have told us of your wish to opt out of this provision. The members' council of Coöperatie Salland UA talks directly with the board of Salland Zorgverzekeraar, it contributes ideas about a variety of subjects and makes decisions on important matters. The member's council is elected from among the members. Membership ceases upon death, cancellation or member disqualification. Membership is deemed to have been cancelled at the moment that you (insured party/policyholder) have ended your last remaining insurance with us.

5.9. What restrictions apply in case of exceptional circumstances?

You are not entitled to (reimbursement of the costs of) care in the event of fraud, abuse or improper use of your insurance. This also applies if you attempt to mislead us by submitting false statements or withholding facts or circumstances from us that could be important for assessing the costs or the entitlement to reimbursement.

You are not entitled to (reimbursement of the costs of) care if the injury is caused by, occurred during or ensues from armed conflict, civil war, uprising, domestic riots, revolt and mutiny as

referred to in Article 3:38 of the Financial Supervision Act (Wet op het financieel toezicht). For the definitions of these terms, please refer to the text filed by the Netherlands Association of Insurers (Verbond van Verzekeraars in Nederland) on 2 November 1981 at the Registry of the District Court in The Hague.

If the Minister of Finance makes use of the authority set out in Article 18b, paragraph 1 of the Emergency Act on Financial Transactions (Noodwet financieel verkeer) and the need for care has come about due to any of the terrorist acts referred to in that act, you are entitled only to one or more services as long as the costs thereof are no higher than determined by the Minister of Finance. If the injury is caused by terrorism, the cover is limited to the amount of payment we receive subject to the claim to compensation from the Dutch Terrorism Risk Reinsurance Company (Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade). A description of the definitions and the Terrorism Cover Clause Sheet can be viewed at www.hollandzorg.com/conditions. If we receive an additional contribution by virtue of Article 33 of the Healthcare Insurance Act (Zorgverzekeringswet) or Article 3.23 of the Healthcare Insurance Decree (Besluit zorgverzekering), you are also entitled to the additional reimbursement by virtue of these regulations.

5.10. Can we change the policy conditions?

We can change the policy conditions with effect from a date to be set by us. A change to the premium calculation basis for the public healthcare insurance will come into force no earlier than seven weeks after the date on which we have informed you (policyholder) of that change.

5.11. What is the process for requesting and granting authorisation?

In some cases you need authorisation from us for the right to care or the reimbursement thereof. In that case, receiving the care is subject to our written authorisation. This is to prevent problems afterwards. The policy conditions specify, per type of care, whether or not you need written authorisation from us.

When assessing the request for authorisation we will gauge whether the care complies with the policy conditions, whether the care is the most appropriate in your situation and whether the care provider meets our quality requirements. In that case, you will know in advance if and how much reimbursement you will receive for the care. If we grant our authorisation, it is valid for one year, counting from the date on which the written authorisation is granted. This authorisation may be valid for a shorter or longer period of time, if we explicitly mentioned that fact when we granted the authorisation.

The request for authorisation must always state your name and address as well as the name, address and profession of the care provider. Any additional information the request must state is set out per care form in the specific conditions for the public healthcare insurance and supplementary insurance.

You can e-mail a request for authorisation to our medical advisor at: toestemming@hollandzorg.nl. Alternatively, send your request for authorisation to:

- HollandZorg
  Medisch adviseur
  Antwoordnummer 30
  7400 VB Deventer
  (no stamp required).

If your care provider submits the application on your behalf, your care provider may only provide us with personal data about your health, provided you have given the care provider explicit permission to do so.

We may invite you to explain your request in person during office hours.

It is possible that you need care under the public healthcare insurance that requires authorisation and that you have already received the authorisation for that care or the reimbursement thereof from your previous health insurer. In that case, the authorisation applicable to the period issued by your previous health insurer is continued. This authorisation will entitle you to the care or to the reimbursement of the costs of the care in accordance with the rules in our policy conditions. Sending us that authorisation at toestemming@hollandzorg.nl or to the address above suffices. If your previous health insurer did not specify a period, the authorisation remains valid for a maximum of one year of the date the authorisation was granted by your previous health insurer.

You are not entitled to care which was authorised by your previous health insurer if the care or the costs of the care the authorisation relates to is or are no longer insured.

5.12. Referral or prescription

The right to care or the reimbursement thereof will often be subject to a referral or prescription. The policy conditions state, per type of care, whether or not you need a referral or prescription. These conditions also state which care provider may be the referrer or prescriber. The referral or prescription will remain valid for a period of nine months from the day the referral or prescription was issued. The validity may be longer or shorter, provided this is expressly stated in the policy conditions in relation to the type of care concerned. If the care did not commence within the validity period, then the right to care or the reimbursement thereof will be subject to a new referral or prescription.

The referrer or prescriber must be expert in the discipline to which the referral or prescription relates.

If you received a referral or prescription in the period during which you were still insured with another medical insurer, you do not have to ask for the referral or prescription again, unless the term of validity has expired.

5.13. How can I submit a complaint?

If you (insured party/policyholder) disagree with a decision made by us within the framework of the public healthcare insurance, you (insured party/policyholder) can ask us to reconsider such a decision. You (insured party/policyholder) must submit your request within six weeks of receiving our decision. You can do so as follows:

• You can submit requests electronically by using the complaints form at www.hollandzorg.com/complaint.

• written request must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

If we do not respond to your request within six weeks or if you are not happy with our response,

you can present the dispute to the Healthcare Insurance Complaints and Disputes Foundation (Stichting Klachten en Geschillen Zorgverzekeringen - SKGZ), Postbus 291, 3700 AG Zeist, www.skgz.nl. This does not apply if you already presented the dispute to a civil court. The SKGZ acts

in accordance with its own regulations. The SKGZ Ombudsman acts as the mediator in the dispute. If mediation is impossible or yields no satisfactory result, the SKGZ Disputes Committee can issue a binding recommendation. For more information, visit www.skgz.nl.

You (insured party/policyholder) are entitled to submit a dispute with us to the civil court at any time.

If you (policyholder) took out the insurance online, you (policyholder) can also send your complaint to the European ODR platform. The ODR platform can be reached at ec.europa.eu/consumers/odr. The platform must then forward your complaint to the SKGZ.

If you (insured party/policyholder) feel that a form we use is too complicated or unnecessary, you (insured party/policyholder) may ask us to review that form. You can do so as follows:

• Electronically by using the complaints form at www.hollandzorg.com/complaint.

• A written request must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

You (insured party/policyholder) can also submit complaints about the form we use to the Dutch Healthcare Authority (Nederlandse Zorgautoriteit). The Dutch Healthcare Authority will issue a binding recommendation. For more information, visit www.nza.nl.

Public healthcare insurance

Specific provisions for public healthcare insurance

The public healthcare insurance is subject to the following conditions:

• the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the supplementary insurance;

• the arrangements set out in this chapter, Specific provisions for the public healthcare insurance;

• the list of terms;

• all appendices referred to in the applicable terms and conditions.

Grounds and reasons for refusal

1. What is the basis for the public healthcare insurance?

The public healthcare insurance is based on the Healthcare Insurance Act (Zorgverzekeringswet), the Healthcare Insurance Decree (Besluit zorgverzekering) and the Healthcare Insurance Regulations (Regeling zorgverzekering). The public healthcare insurance is further based on the information provided by you (policyholder) during the application and on agreements in connection with any group scheme you participate in.

The public healthcare insurance should be interpreted and applied in accordance with the Healthcare Insurance Act (Zorgverzekeringswet), the Healthcare Insurance Decree (Besluit zorgverzekering) and the Healthcare Insurance Regulations (Regeling zorgverzekering) and the corresponding explanation.

If a provision in the policy conditions fully or partly contradicts a provision of the Healthcare Insurance Act, the Healthcare Insurance Decree or the Healthcare Insurance Regulations or the explanation, that provision or that part of the provision in the policy conditions does not apply. The provision in the Healthcare Insurance Act, the Healthcare Insurance Decree or the Healthcare Insurance Regulations applies instead.

The same applies if the Healthcare Insurance Decree or the Healthcare Insurance Regulations are amended in the course of the year. Should any such amendment change cause there to be a difference with the policy conditions of the public healthcare insurance, then the provisions of the amended Healthcare Insurance Decree or the Healthcare Insurance Regulations will apply.

All ministerial regulations or other appendices referred to in these policy conditions form part of the public healthcare insurance.

2. When can we refuse you?

As a health insurer, we have an acceptance obligation if you (the policyholder) want to take out public healthcare insurance. We do not take into account a person's age, gender or health situation. In certain situations we are not obliged to offer the public healthcare insurance:

- You are not obliged to insure under the public health insurance scheme.
- You are already insured under the public health insurance scheme.
- We cancelled your previous public healthcare insurance in the five years preceding the request to conclude the new public healthcare insurance on account of non-payment of premiums or deliberate deception by you (insured party/policyholder).

- The address of the person to be insured stated on the application for the public healthcare insurance is not recorded in the Key Register of Persons (BRP) or differs from the address of the person in the BRP. This provision does not apply if the person insured can do nothing about the discrepancy. It also does not apply if you (policyholder) submit the following to us with the application for the public healthcare insurance:
    - a statement from the Social Security Bank (SVB) which shows that the insured person is insured under the Long-Term Care Act (Wlz); or
    - An employer's statement or a wage slip, both no older than one month, showing that the person to be insured is liable to pay Dutch income tax.

Premium

3. When are premium payments waived?

You (policyholder) must pay us premiums for the public healthcare insurance, except in the following cases:

• You (policyholder) do not have to pay premiums for an insured party who is under 18. Premium payments start on the first day of the calendar month following the calendar month in which the insured party turned 18.

Example: The insured party turns 18 on 10 September. In that case, you (the policyholder) start paying premiums for the health insurance from 1 October of that year.

• you (policyholder) do not have to pay us premiums during the period that you (policyholder) have to pay the Central Administrative Office for Exceptional Medical Insurance (CAK) an administrative premium. In that case, you will have premium arrears of more than six months.

4. What happens if you get behind on your payments?

4.1 If you are in arrears of payment of less than two months of premium, we can cancel the public healthcare insurance with due observance of Article 3.7 of the General Provisions.

4.2 No later than 10 working days after our records indicate payment arrears of two monthly premiums for public healthcare insurance, we will contact you (the policyholder) to agree on a payment arrangement. The payment arrangement consists of:

• agreements about paying the next premium instalments;
• agreements about paying off your debts (including interest and collection costs) relating to the public healthcare insurance and the instalments for settlement;
• our commitment that we will not terminate or suspend (temporarily discontinue) the public healthcare insurance during the term of the payment arrangement due to these debts relating to the public healthcare insurance. This promise lapses if you (the policyholder) fail to comply with the aforesaid arrangements concerning the payment of new instalments or debts, including interest and collection costs.

4.3 Our payment arrangement proposal further includes the following option. If you (policyholder) took out the public healthcare insurance for another party, you can cancel the public healthcare insurance of that other party with effect from the date on which the repayment arrangement commences. The conditions for this are:

• The insured party has taken out alternative health insurance on or before the day on which the payment arrangement takes effect; and,

• If the insured party has taken out the health insurance with us (public healthcare insurance), this party must authorise us to automatically collect future premiums each month or instruct a party from whom the insured party receives periodic payments (e.g. the employer) to pay us the amount of the future premiums on behalf of the insured party and to deduct this from the payments made to the insured party. In that case, we will send a copy of our proposal to the insured party.

4.4 With the payment arrangement proposal, we will send you (policyholder) a letter stating that you (policyholder) have four weeks to accept the proposal. It will further state the consequences if you (policyholder) were to reject the proposed payment arrangement and the premium arrears (excluding interest and collection costs) have risen to six or more monthly premium payments. We will also remind you (policyholder) of the option of debt counselling.

4.5 If you have payment arrears of less than four months' premium and no payment arrangement is made after a payment arrears of two months, we can dissolve the public healthcare insurance.

4.6 Do you (the policyholder) have premium arrears, excluding interest and collection costs, of at least four monthly premiums? In that case, we will notify you (the policyholder) as soon as possible about our intention to report to the CAK if the debt (excluding interest and collection costs) has risen to an amount of at least six monthly premiums. We will refrain from making the report if you (insured party/policyholder) have objected to the payments arrears within four weeks of having received the notification.

4.7 If you (insured party/policyholder) have objected to the premium arrears in time, but we maintain our position, we will report you to the CAK if your arrears, excluding interest and collection costs, have increased to an amount of six monthly premiums or more. We will refrain from making the notification if you (insured party/policyholder), within four weeks of having been notified by us, have submitted a dispute in respect of the premium arrears to SKGZ, Postbus 291, 3700 AG Zeist, www.skgz.nl, or to the civil court.

4.8 If the payment arrangement takes effect when the premium arrears, excluding interest and collection costs, have increased to an amount of four monthly premiums, we will not report to the CAK as long as future premiums are paid.

4.9 Once the premium debt, exclusive of interest and collection costs, has risen to an amount of six monthly premiums or more, we will notify the Central Administrative Office for Exceptional Medical Insurance (CAK) and you (insured party/policyholder) accordingly. As part of that notification, we will include the personal details required by the CAK for the execution of Article 34a of the Health Insurance Act (Zorgverzekeringswet). We will further state that we have acted in accordance with the procedure referred to in 4.6 to 4.9. We do not report to the CAK:

• if the premium arrears have been disputed within the period referred to in 4.6, but we have not yet responded.
• for a period of four weeks as referred to in 4.7.
• if a dispute in respect of the premium arrears has been submitted to the SKGZ or the civil court within the period referred to in 4.7 and no final and irreversible decision has yet been made.
• if you (policyholder) have applied to a debt counsellor as referred to in Article 48 of the Consumer Credit Act, such as a municipal authority or municipal credit institution and demonstrate that, within that framework, a written agreement has been concluded in order to service your debt.
• if your address is not shown in the Key Register of Persons (BRP) or if the address we have for you in our records does not correspond with your address in the BRP. This does not apply if the

discrepancy is the result of the exceptional situations described in Article 2, bullet point four of the Specific Provisions for Public Healthcare Insurance.

4.10 We will immediately notify the Central Administrative Office for Exceptional Medical Insurance (CAK) and you (insured party/policyholder) of the date on which:
• the debts by virtue of the public healthcare insurance have been repaid or cancelled.
• the debt management scheme for natural persons referred to in the Bankruptcy Act is declared applicable.
• the written agreement referred to under 4.9, point four, has been concluded or a debt settlement has been agreed in which at least you (policyholder) and we are participants.

NOTE: as long as your premium payments are in arrears, you cannot change insurer. That is stipulated by law. As part of the implementation of this law, health insurers exchange data about people with premium arrears.

Excess

5. When does the compulsory excess apply?

If you are eighteen or older, you are subject to a compulsory excess. The extent of this compulsory excess is included in the Premium Appendix to these policy conditions.

The following are excluded from the compulsory excess:
• the costs of obstetric care and maternity care
• the NIPT
• the cost of general practitioner care The compulsory excess does, however, include the costs of examinations that the general practitioner has performed by others and that are charged separately, such as laboratory tests and blood tests
• the costs of registering with a general practitioner
• the costs of other medical (GP) care
• the costs of preventive foot care
• the costs of integrated care (multidisciplinary primary care including general practitioner care)
• the costs of care for nursing without in-patient care (district nursing)
• the costs of a combined lifestyle intervention
• if you are the donor, the costs of care, accommodation and transport relating to the admission for the selection and removal of the transplant material, as described in the article on transplant care in these policy conditions.
• the costs of medicinal care or aids designated by us and the costs of care provided to you by a care provider appointed by us in that regard. These are listed in the overview 'Designated care not subject to excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.
• the costs of care provided to you if you have followed a programme, designated by us, for diabetes, depression, cardiovascular diseases, COPD, obesity, dementia, thrombosis care, incontinence care or giving up smoking. In that case, the costs must relate to the disease for which you followed that programme. The programmes designated by us are listed in the overview 'Designated Care Not Subject to Excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.

6. When does the voluntary excess apply?

It is not possible to opt for a voluntary excess for the year 2024. If we do offer this option, you (policyholder) can opt for a voluntary excess for insured parties aged 18 or older. The higher the voluntary excess, the lower the premium. Depending on what we offer, you (policyholder) can opt for no voluntary excess or voluntary excess of € 100, € 200, € 300, € 400 or € 500 per calendar year. The Premium Appendix to these policy conditions states which premium corresponds to which level of voluntary excess. The selected voluntary excess is stated on the policy document.

NOTE: carefully consider whether your preferred option is wise depending on your situation. If something unexpected happens, the costs can be high.

If an insured turns 18, we will calculate the premium for the public healthcare insurance of that insured without voluntary excess. This does not apply if you (policyholder) have opted for a voluntary excess for that insured party before this time. In that case, we calculate the premium on the basis of that voluntary excess.

The following are excluded from the voluntary excess:
• the costs of registering with a general practitioner or with a GP surgery
• the NIPT
• the cost of general practitioner care. The excess does, however, include the costs of examinations that the general practitioner has performed by others and that are charged separately, such as laboratory tests
• the costs of other medical (GP) care
• the costs of integrated care (multidisciplinary primary care including general practitioner care)
• the costs of medicinal care or aids designated by us and the costs of care provided to you by a care provider appointed by us in that regard. These are listed in the overview 'Designated care not subject to excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.
• the costs of obstetric care and maternity care
• the costs of preventive foot care
• the costs of a combined lifestyle intervention
• if you are the donor, the costs of care, accommodation and transport relating to the admission for the selection and removal of the transplant material, as described in the article on transplant care in these policy conditions.
• the costs of nursing without in-patient care (district nursing)

We may decide to stop offering one or more of the voluntary excesses. If you (policyholder) have taken out public healthcare insurance with voluntary excess of this kind, you can opt for public healthcare insurance with a lower voluntary excess or without voluntary excess.

7. Which rules are applicable to compulsory and voluntary excess?

Per calendar year, the costs of care remain payable by you until the extent of the compulsory and possible voluntary excess in that calendar year is reached.

Statutory personal contributions and other costs of care that remain payable by you (e.g. maternity care and certain medicines) do not count when establishing whether the limit of the excess has been reached, unless the Minister has stipulated otherwise.

If we have paid the costs of care to a care provider directly, without deducting the compulsory excess or any voluntary excess from that payment, you (insured party/policyholder) must pay us this excess.

Healthcare costs are initially charged against the compulsory excess. The healthcare costs are then charged against any voluntary excess.

Does your public healthcare insurance come into force after 1 January? Or does it end in the course of the calendar year? In that case, we will calculate your compulsory and voluntary excess on the basis of how many days you will be insured in that calendar year. The calculated amount is rounded off to whole Euros.

It may be that you (policyholder) have taken out public healthcare insurance with a voluntary excess, and that the amount of the voluntary excess changes during the course of the calendar year. The eventual amount of the voluntary excess for that calendar year is then determined as follows: the amount of each of the voluntary excesses is determined in proportion to the number of days insured in the year to which that voluntary excess relates. The excesses determined are added up together and divided by the total number of days insured in that calendar year. The calculated amount is rounded off to whole Euros.

Example: You receive GP assistance for an amount of € 60. You receive an invoice of € 675 for admission to hospital. In addition to the compulsory excess of € 385 you have opted for voluntary excess of € 200.

GP assistance is not subject to any excess. The costs of € 60 will therefore be fully reimbursed. Hospital costs, however, are subject to excess.

First you pay the compulsory excess of € 385. The remaining amount of the hospital invoice is € 290 (€ 675 - € 385). You pay the voluntary excess of € 200 for this. We will reimburse the payable amount that remains. So the reimbursement is € 90 (€ 290 - € 200).

You have now paid the full amount of the compulsory and voluntary excess for 2024. In the event of additional healthcare costs, no further excess will be payable for the year 2024.

Insurance cover general

8. Which services are insured?

You are entitled to:

• the care (non-monetary) described further down in the policy conditions of the public health insurance, with the exception of physiotherapy, occupational therapy and speech therapy;
• reimbursement of the costs of physiotherapy, occupational therapy and speech therapy (restitution) described further down in the policy conditions of the public health insurance. Whenever the general clauses (the clauses that do not form part of the section Cover per type of care) in these policy conditions refer to 'reimbursement of the costs of care', for these types of care this should be read as 'entitlement to care';
• provision of information and mediation in order to obtain care, if you ask us to do so. You can do so at www.hollandzorg.com/conditions. You can also contact our Care Advice Line on +31 (0)570 687 123.

In principle, you need to use the care provided by contracted care providers. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

If the care provided by a contracted care provider is not available, not available in time or only at a great distance from your place of residence or temporary place of residence abroad, you are still entitled to reimbursement of the costs of care from a non-contracted care provider. The same applies if you opt for care provided by a non-contracted care provider for another reason. The extent of the reimbursement is described further down in the policy conditions.

NOTE: if you use a non-contracted care provider, we will reimburse no more than the rates according to the list of rates for non-contracted care. The rates list can be viewed and downloaded at *www.hollandzorg.com/rates*. *If the rates of the non-contracted provider are higher than our maximum rates, the difference will be payable by you.* Contracted care providers are listed at *www.hollandzorg.com/careprovider*. *You can also contact our Care Advice Line on +31 (0)570 687 123.*

The content and scope of the care are partially determined by the state of the art and practice. In the absence of such a benchmark, it is determined by what is regarded as responsible and adequate care in the relevant discipline.

You are only entitled to care, if you may reasonably be regarded as being dependent on that care in terms of content and scope. The care to be provided should be effective and not unnecessarily expensive or unnecessarily complicated.

If a guideline/care standard/quality standard has been established for healthcare, you are entitled to (reimbursement of the costs of) the care, if the care has been provided according to that standard. The current care standards can be viewed and downloaded at www.zorginzicht.nl/kwaliteitsinstrumenten. If your care provider deviates from the guideline/care standard/quality standard, you are still entitled to (reimbursement of the costs of) the care if your care provider demonstrates that deviation from this is medically necessary in your case and your care provider justifies this in your medical file.

The policy conditions state per type of care whether a statutory personal contribution applies. The statutory personal contribution exists in addition to the compulsory and, if applicable, voluntary excess.

9. Which restrictions apply in case of concurrence with other provisions?

You are not entitled to the care if you are entitled to that care or reimbursement of the cost thereof by law or pursuant to other legal provisions. The law and other legal provisions include the Youth Act, Social Support Act 2015, municipal provisions in relation to these acts and the Long-Term Care Act.

The same applies if you do not want to exercise the right to care or the reimbursement of costs of the care by virtue of that act or the legal provision.

Cover and reimbursement in the Netherlands

10. What is the cover in the Netherlands?

You are entitled to care in the Netherlands if:

• all conditions in connection with that care have been met before you receive that care. In addition to the general terms and conditions, many types of care are also subject to specific conditions, such as the need for a referral, a prescription or our prior written authorisation before you receive the

care. The policy conditions refer to the general terms and conditions in the chapters General Provisions and Specific Provisions for the public healthcare insurance. The specific conditions that apply to a particular type of care are stated per type of care; and
• the care provider who provides the care to you has been appointed by us. The policy conditions stipulate which care providers they are per type of care. It is often a group of care providers with a particular licence, registration or training. In some cases it is a specific care provider. You may still receive care from a care provider not appointed by us:
- if we have given our written authorisation before you receive the care; or
- if a care provider provides the care under the responsibility of the coordinating practitioner/practitioner in charge that has been appointed by us and the care is charged by the coordinating practitioner/practitioner in charge or the institution the coordinating practitioner/practitioner in charge works for. Specific conditions may be stipulated per type of care which a secondary practitioner must meet; and
- you receive the care at a location which may be regarded as customary, given the nature of the care and the circumstances.

11. What is the amount of the reimbursement for healthcare in the Netherlands?

You are entitled to care provided by a contracted care provider in the Netherlands, subject to a maximum of the rate we have agreed with that care provider. In some cases, the agreement between us and the care provider ends the moment you receive care from that care provider. In that case, you are entitled to reimbursement of the costs of the remaining care to be provided by this care provider subject to a maximum of the competitive rate which applies for that care in the Netherlands (the competitive Dutch rate).

Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

You are entitled to reimbursement of the costs of care provided by a non-contracted care provider in the Netherlands:

a. if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non-contracted care. The rates list can be viewed and downloaded at www.hollandzorg.com/rates.
b. if we do not apply a maximum rate for that care, subject to a maximum of the competitive rate which applies to that care in the Netherlands (the competitive Dutch rate);

The reimbursement referred to under (a) does not apply if the contracted care provider cannot provide the care, cannot provide it in time or only at a great distance from your place of residence. In that case, you are entitled to the reimbursement referred to under (b).

Cover and reimbursement abroad

12. What is the cover abroad?

You are entitled to care abroad if:
• all conditions in connection with that care have been met before you receive that care. The right to care abroad is subject to the same conditions as those for the right to that care in the Netherlands. This includes having a referral or a prescription or our prior written authorisation. The policy conditions refer to the general terms and conditions in the chapters General Provisions and Specific Provisions for the public healthcare insurance. The specific conditions that apply to a particular type

of care are stated per type of care; and
• you have written authorisation from us, before you receive the care in case of in-patient care of at least one night. This does not apply if the care in question is medically necessary care. In this context, medically necessary care is taken to mean unforeseen care that cannot be postponed until after returning to the Netherlands; and
• the care provider holds qualifications under the laws of the country where the care provider has his business address, that are equal to the qualifications that apply to care providers we appoint in the Netherlands. In many cases, care providers abroad have received different training to care providers in the Netherlands. Qualifications that comply with the recognised professional qualifications within the meaning of the General EU Professional Qualifications (Recognition) Act suffice in most cases.

Are you staying abroad and do you need medical care? Please contact our emergency centre if you require emergency care. Our emergency centre will help you find care. They can also give you information about the reimbursement of the care. You can reach the emergency centre in one of the following ways:
- by telephone: +31 (0)570 68 71 12
- by e-mail: alarmcentrale@hollandzorg.nl
The emergency centre can be contacted 24 hours a day, 7 days a week.

13. How is the amount of reimbursement abroad determined?

If you reside or are temporarily staying in an EU, EEA or Treaty country other than the Netherlands (including temporary stays for planned care), you are entitled, for care provided by a non-contracted care provider in that country or another EU, EEA or Treaty country, at your discretion:

a. to reimbursement of the costs of the care you would have received from us if this care was provided by a non-contracted care provider in the Netherlands. In practice, this means:
I) if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non-contracted care. The rates list can be viewed and downloaded at www.hollandzorg.com/rates.
ii) if we do not apply a maximum rate for that care, subject to a maximum of the competitive rate which applies to that care in the Netherlands (the competitive Dutch rate).

b. to care or reimbursement of the costs of care in accordance with the statutory regulations of the social healthcare insurance of that country, if that applies to you by virtue of the provisions of the applicable European social security regulations or the relevant treaty.

The reimbursement referred to under i) does not apply if the contracted care provider cannot provide the care, cannot provide it in time or only at a great distance from your place of residence or your temporary place of residence abroad. In that case, you are entitled to the reimbursement referred to under ii) or (b).

If you reside or are temporarily staying in an EU, EEA or Treaty country other than the Netherlands (including temporary stays for planned care), you are entitled, for care provided by a contracted care provider in that country or another EU, EEA or Treaty country, at your discretion:

a. to care provided by a contracted care provider, up to the maximum of the rate we have agreed with that care provider. In some cases, the agreement between us and the care provider ends the moment you receive care from that care provider. In that case, you are entitled to reimbursement of the costs of the remaining care to be provided by this care provider up to the maximum of the competitive rate which applies for that care in the Netherlands.

b. to care or reimbursement of the costs of care in accordance with the statutory regulations of the social healthcare insurance of that country, by virtue of the provisions of the applicable European social security regulations or the relevant treaty.

PLEASE NOTE! Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

If you reside or are temporarily staying in a country that is not an EU, EEA or Treaty country, including a temporary stay for planned care, you are entitled to reimbursement of the costs of care in that country:

a. if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non-contracted care. The rates list can be viewed and downloaded at www.hollandzorg.com/rates.
b. if we do not apply a maximum rate for that care, subject to a maximum of the competitive Dutch rate.

The reimbursement referred to under (a) does not apply if the contracted care provider cannot provide the care, cannot provide it in time or only at a great distance from your place of residence or your temporary place of residence abroad. In that case, you are entitled to the reimbursement referred to under (b).

We reimburse the costs of care in Euros. We use the exchange rate applicable on the date on which the care was provided, where possible.

The submission of invoices for care provided abroad is subject to the conditions contained in article 2 of the General Provisions. For instance, the invoice must be drawn up in Dutch, English, French, German, Polish, Spanish or Turkish and contain a description of the care provided. If the invoice is drawn up in a different language, you must also enclose a sworn translation of the invoice. Without this translation we may decide not to process the invoice. An invoice for care provided abroad must be accompanied by a fully completed and signed Foreign Claim Form. The Foreign Claim Form can be downloaded at www.hollandzorg.com/forms.

NOTE: as regards healthcare abroad, the conditions and exclusions are the same as those that apply to healthcare in the Netherlands. For example, is a referral needed? You will need one abroad as well.

Turnover limits and volume agreements

14. Are there consequences due to turnover limits and volume agreements?

We enter into agreements with care providers about the costs and quality of the care. We often make agreements about the maximum reimbursement per year (turnover limit). In principle, we do not enter into agreements about the volume of care a care provider has to provide (volume agreement).

We do our best to ensure that you are not affected by agreements about a turnover limit. You can still use the care providers, even if the turnover limit is reached.

Unfortunately, it cannot be ruled out that there will never be any consequences. If a care provider no longer wants to treat you (for the rest of the year) after the turnover limit has been reached, we will help you find an alternative care provider who can provide the care to you.

In the exceptional case of possible consequences, we will state on our website which care providers they are, as well as the possible consequences. You can find this information at www.hollandzorg.com.

Cover per care type

Birth care

Maternity care

You are entitled to maternity care. Maternity care is care such as maternity carers generally provide to mother and child in connection with childbirth. The right to maternity care applies for a maximum of six days, counting from the day of delivery. The maternity carer assists during the delivery (partum assistance), takes care of you and the baby during the maternity period and gives advice. The number of hours of maternity care are established by your care provider in consultation with and under the final responsibility of the obstetrician. The 'National Maternity Care Indication Protocol' is leading in this. The number of hours and days partly depend on the family composition and the presence of informal care (family and friends). The protocol can be viewed and downloaded at www.hollandzorg.com/conditions.

Provided there are medical grounds to do so during your delivery, you are entitled to admission and obstetric and specialist medical care in a hospital from the day of the delivery. In that case, maternity care will be included in that admission. The number of remaining days/hours of maternity care to which you are still entitled after admission is determined on the basis of the number of days you were admitted.

What do I need to keep in mind?
The following care providers are permitted to provide maternity care:
- a maternity carer
- a hospital
- a birth centre
- a maternity hotel
- an integral birth care organisation contracted by us for this purpose.

Is there a statutory personal contribution?
Yes, maternity care at home is subject to a statutory personal contribution of € 5.10 per hour. As regards maternity care without medical grounds in an institution (hospital, birth centre or maternity hotel), the statutory personal contribution is € 20 per day for the mother and € 20 per day for the baby, plus that part of the institution's rate per day higher than € 143.

Example 1
You have given birth and received 49 hours of maternity care at home. In that case, your personal contribution is 49 x 5.10 = € 249.90.

Example 2
You have given birth and stayed in a birth centre for six days, without medical grounds. The daily rate of this institution is € 145 per day. In that case, you pay (20+ 20) x 6 = € 240 plus (145 - 143) x 6 = € 12. So your total personal contribution is € 252.

Are the costs deducted from the compulsory and voluntary excess?
No

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The

maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Prenatal screening

You are entitled to prenatal screening. Prenatal screening comprises care usually provided by obstetricians and medical specialists and consists of tests that can determine whether your unborn child has an increased risk of a congenital chromosomal or structural abnormality. You decide if you want to have these tests done.

Prenatal screening consists of:
- counselling (explanations about prenatal screening for congenital defects when you are pregnant);
- the NIPT, if there are medical grounds to do so;
- invasive diagnostics, (chorionic villus sampling or amniocentesis), if there are medical grounds to do so. Medical grounds are also deemed to exist if an NIPT reveals a reasonable risk of the child developing Down syndrome or Edwards or Patau syndrome.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- an obstetrician
- a general practitioner
- a hospital
- a sonographer

Prenatal screening may only be provided if the care provider:
- is licensed under the Population Screening Act; or
- has a cooperation agreement with a regional centre licensed under the Population Screening Act.

Is a referral needed?
Yes, prenatal screening in a hospital requires a referral from a general practitioner or midwife before the start of the care. If the obstetric care is provided by a medical specialist, no referral is required for prenatal screening in a hospital.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No.

The following *are* included in the excess:
- the costs of diagnostic follow-up examinations, if applicable.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website, under obstetric care. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Obstetric care without medical grounds

You are entitled to obstetric care without medical grounds. Obstetric care without medical grounds is care such as obstetricians generally provide.

If there is no increased risk to your health or that of your baby during pregnancy or delivery, you are entitled to obstetric care without medical grounds. Provided there are no medical grounds dictating otherwise, you are free to choose where you want to give birth. You can choose to give birth at home or in a birth centre or hospital. In most cases, the obstetric care is provided by your own midwife or general practitioner.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- an obstetrician
- a general practitioner
- a hospital
- a birth centre
- an integral birth care organisation contracted by us for this purpose.

Is a referral needed?
No

Is there a statutory personal contribution?
Yes, if you give birth in a birth centre or use a delivery room in a hospital. In that case, the personal contribution is € 20 per day for the mother and € 20 per day for the baby plus that part of the rate of the birth centre or hospital for the use of the delivery room per day higher than € 143.

Example
You have given birth and stayed in a birth centre for six days, without medical grounds. The daily rate of this institution is € 145 per day. In that case, you pay (20 + 20) x 6 = € 240 plus (145 - 143) x 6 = € 12. So your total personal contribution is € 252.

Are the costs deducted from the compulsory and voluntary excess?
No.

The following *are* included in the excess:
- the cost of laboratory testing at the request of an obstetric care provider
- indirect costs, such as medicines and transport costs.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website, under obstetric care. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Obstetric care with medical grounds

You are entitled to obstetric care and admission in a hospital for this, if there are medical grounds to do so. Obstetric care with medical grounds is care such as obstetricians and medical specialists generally provide.

If there is an increased risk to your health or that of your baby during pregnancy or delivery, medical grounds are deemed to exist. In that case, the obstetric care in a hospital is provided by a gynaecologist or an obstetrician from the hospital.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- a hospital
- an integral birth care organisation contracted by us for this purpose

Is a referral needed?
Yes, for obstetric care with medical grounds in a hospital, you need a referral from a general practitioner, medical specialist, nursing specialist, obstetrician or physician assistant before the start of the care.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No.

The following *are* included in the excess:
- the cost of laboratory testing at the request of an obstetric care provider
- indirect costs, such as medicines and transport costs.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website, under specialist medical care. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Medical mental healthcare

Medical mental healthcare

You are entitled to mental healthcare (GGZ) and admission if you are 18 or older. Medical mental healthcare includes diagnosis and treatment of mild to (highly) complex psychological issues or chronic conditions such as medical specialists (psychiatrists) clinical psychologists generally provide.

The care is aimed at the recovery or preventing the deterioration of a psychological disorder. Your need for care determines what care programme is used. A care programme can consist of various components, such as intake, diagnostics, individual consultations, group consultations or admission. A care programme can be offered both physically and online. A treatment plan, as part of your care programme, will be discussed with you and subsequently determined by your care provider.

Medical mental healthcare up to the age of 18 falls under the Youth Act. For this you can contact the municipality.

Medical mental healthcare does not include:
- treatment of post-traumatic disorders. This is taken to mean ongoing psychological symptoms impeding your everyday functioning at home or work following a traumatic event or change (a stressful situation).
- help in the event of work and relationship issues, such as being overstressed or burnout
- help in the event of learning disabilities
- indicated prevention in the case of depression, panic and anxiety disorders and problematic alcohol abuse, which falls under general practitioner care.

Your treatment must comply with the state of the art and practice. Go to www.hollandzorg.com/conditions for more information about which treatments meet the current state of the art and practice and in which situation they may be applied by your care provider.

Admission to a mental health institution
Admission includes stays 24 hours or longer during an uninterrupted period of no more than 1,095 days, for which there is a medical need in connection with medical care.

An interruption of the admission for a maximum period of thirty days is not regarded as an interruption to the uninterrupted period. The duration of the interruption does not count in the calculation of the 1095 days, except in the event of weekend and holiday leave. Interruptions for weekend and holiday leave are included in the calculation of the 1095 days.

Do you need to stay in hospital for more than 1095 days in connection with your treatment? You can request an indication of medical grounds under the Long-term Care Act, in consultation with your care provider.

Field agreements
Nationally, field agreements for mental healthcare are established by representatives of the government, healthcare providers, health insurers and patients. The care provider must provide the care in accordance with nationally established field agreements. You can view and download the nationally determined field agreements at www.zorgprestatiemodel.nl.

What do I need to keep in mind?
The following care providers can provide medical mental healthcare as the coordinating practitioner:
- a healthcare or clinical psychologist, clinical neuropsychologist, psychotherapist, psychiatrist, specialist mental health nurse, a specialist or clinical geriatrics doctor, addiction specialist, remedial educationalist-generalist, physician assistant, social psychiatric nurse clinical geriatrics.

A psychiatric hospital is authorised to offer admission.

Transitional arrangement
Medical mental healthcare up to the age of 18 falls under the Youth Act. This involves other coordinating practitioners as those prescribed by your health insurance. If treatment needs to continue with this coordinating practitioner even after your 18th birthday, the care provider may continue the treatment for a maximum of 365 days (one year) after your 18th birthday. This must be a coordinating practitioner with a post-master's registration in the register of Stichting kwaliteitsregister Jeugd (SKJ) or the BIG register (usually a remedial educationalist or care provider registered as an NIP-certified paediatric and adolescent psychologist in the association register of the Netherlands Institute of Psychologists). In that case, this care provider does not need to prescribe to a certain Quality Charter. Continuation of treatment should aim at closure or transfer.

Quality Charter
The healthcare provider must have a Quality Charter, based on the GGZ National Quality Charter that is included in the Register of Quality Standards and Measuring Instruments of the National Health Care Institute and must comply with the quality charter.

In the quality charter, the care provider must indicate how the quality standards are given form and content. The quality charter of the care provider also states who is responsible for the indication and/or coordination of the care. This is the coordinating practitioner.

We make agreements with contracted care providers about the quality and deployment of the coordinating practitioner. In the case of non-contracted care, when submitting the invoice, we check, among other things, whether the deployment of the coordinating practitioner has been provided in accordance with the quality charter. We may request additional information for this. Based on this information we decide on the reimbursement of the costs of care.

Is a referral needed?
Yes, from a general practitioner, medical specialist, coordinating practitioner (in case of a referral), a company doctor or a doctor affiliated to Nederlandse Straatdokters Groep:
- at the start of the care programme
- upon re-registration if the care programme was completed more than 365 days ago.

The referral must comply with the 'Referral Agreements on Mental Health Care' as established by the Ministry of Health, Welfare and Sport. You can then view them at www.hollandzorg.com/conditions.

No referral is needed:
- in the event of unforeseen care that cannot reasonably be postponed (urgent mental healthcare).
- in the case of forced care under the Mandatory Mental Healthcare Act.
- if the care is a direct continuation of care to you from a judicial programme, care provided to you by the same care provider after the end of the Wlz indication or care provided to you under the Youth Act.
- in the event of a re-registration within one year of completing a previous care programme.
- follow-up after start of treatment within acute mental healthcare (mental healthcare provided to you in a crisis situation where it is suspected that you have an acute psychiatric disorder).
- in the event of a referral between mental health care providers.
-
Your referral is valid for a maximum of 9 months (275 days). This means that your treatment must start within 9 months of the referral being issued.

Is prior written authorisation required?
You must obtain our written authorisation, prior to you receiving the care:
- for medical mental healthcare by a non-contracted care provider in combination with admission.
- for care in the setting of highly specialist mental healthcare with a non-contracted care provider.
One of the requirements for authorisation is that we come to a written agreement with your care provider for the provision of the healthcare. If the application is not submitted by your care provider on your behalf but by yourself or another representative, we need your explicit permission to contact your care provider in order to reach written agreement about the provision of the care.

Most care providers that are allowed to act as coordinating practitioners are registered with the national authorisation portal. Your care provider can request digital authorisation via this portal. Your care provider will receive an answer from us to your request via the authorisation portal.

If you visit a care provider who is not registered with the national authorisation portal or if you go abroad for treatment, you must request and obtain authorisation from us to be entitled to care before the start of treatment. Each time you apply for care, you will need to send us a copy of a report from the attending coordinating practitioner with the medical diagnosis/diagnoses, a description of the current problem and the medical need for the requested care.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Pharmaceutical care

Medicinal care

You are entitled to medicinal care. Medicinal care (pharmaceutical care) consists of the dispensing (by the chemist) of the medicines and dietary preparations listed below. Medicinal care also includes the advice and support which dispensing chemists generally provide for the medication assessment and responsible use of prescribed medicines.

You are entitled to these medicines and dietary preparations:

1. the following registered medicines contained in Appendices 1 and 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering).

    a. the preferred medicine on the Preferred Medicines List. You can view the Preferred Medicines List at www.hollandzorg.com/conditions. We can change the Preferred Medicines List monthly. You can view the up-to-date list on a month-by-month basis at www.hollandzorg.com/conditions. We can also send you the list on request.

    We refer to the designation of preferred medicines as preference policy. For a number of groups of mutually replaceable medicines, we have allocated a preferred medicine. If you are entitled to a preferred medicine, you are not entitled to another medicine, unless in the event of a 'medical need' or a 'logistical need' (more about this under points c and d below).

    b. the mutually replaceable medicines from the groups of mutually replaceable medicines in which no preferred medicine is designated. If there is a choice between several mutually replaceable medicines within a group, you are entitled to:
        - the cheapest medicine within that group. The cheapest medicine is the medicine with the lowest pharmacy purchase price (AIP) according to the G-Standard of Z-Index B.V. You can request the cheapest medicine and its price from our customer service department via the contact form on our website www.hollandzorg.com/conditions or by calling +31 (0)570 687 123. Or from your chemist;
        - the medicine that is a maximum of 3% more expensive than the cheapest medicine from that group.

    This does not apply in the event of a 'medical need' or a 'logistical need' (more about this under points c and d below).

c. In derogation from a and b above, you are entitled to the prescribed medicine if there is a medical need ('MN'). This does not apply if there is a 'logistical need' (more about this under point d below).

   A medical need is deemed to exist when it would be medically irresponsible for you to use the preferred medicine or the medicine selected by the chemist. Your prescriber may only note 'medical need' on the prescription if he can substantiate that need. The chemist assesses the existence of a medical need. If in doubt, the chemist will contact the prescriber for consultation and coordination about the medical need. In the event of a medical necessity, you will not receive the (preferred) medicine. In that case, you are entitled to an alternative medicine that you need on the basis of care-related criteria. The pharmacist and prescriber can discuss this between them.

d. In derogation from a, b and c above, you are entitled to the medicine selected by the pharmacist if there is a logistical need ('LN').

   You have a logistical need if the (preferred) medicine is not available in the Netherlands for a prolonged period of time and no other (preferred) medicine has been allocated. In the event of a logistical need, your chemist will decide which other medicine he will dispense, on the basis of the active ingredient and associated explanation prescribed by the prescriber.

e. all non-mutually replaceable medicines.

Appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) states additional conditions for the listed medicines for the provision of that medicine. You are only entitled to those medicines if you meet these conditions.

2. the following non-registered medicines in case of rational pharmacotherapy:

   a. chemist's preparations, unless they are chemist's preparations that are (virtually) equivalent to a registered medicine not included in appendix 1 of the Healthcare Insurance Regulations (Regeling zorgverzekering), with the exception of chemist's preparations that:
      - are (virtually) equal to registered UR medicines (prescription medicines only) with regard to which no decision has been made about the qualification within the meaning of Article 2.8, paragraph 1, subparagraph a of the Health Insurance Decree (Besluit zorgverzekering), according to Appendices 1 and 3 to this regulation;
      - are (virtually) equal to a registered UR medicine that is listed in Appendix 3, section A of the Healthcare Insurance Regulations (Regeling zorgverzekering), provided the criteria given are met.
   b. medicines which, following prior authorisation of the Public Health Supervisory Service and in accordance with rules to be stipulated ministerial regulation, are delivered following an order placed at the initiative of a doctor and which are intended for your use under his supervision, if:

- these medicines have been prepared in the Netherlands by a manufacturer with a licence for preparing medicines pursuant to the Medicines Act (Geneesmiddelenwet), and prepared in accordance with the specifications of that doctor; or
- these medicines are sold in another EU country or in a third country, and are imported into Dutch territory, if you suffer from an illness suffered by no more than 1 in 150,000 inhabitants in the Netherlands;
- these medicines are sold in another EU country or in a third country and are imported into Dutch territory as a replacement medicine on account of a shortage of medicines;

c. medicines for which a marketing authorisation has been granted by the Medicines Evaluation Board (MEB) for public health reasons, as a replacement medicine due to a shortage of medicines. The condition is that those medicines are not available in the Netherlands, but are in another EU country.

3. the dietary preparations as referred to in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering). You are only entitled to the dietary preparations referred to in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) if the relevant conditions contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) have been met.

4. the following over-the-counter medicines and gastric acid inhibitors:
    a. laxatives, calcium tablets, medicines for allergies, medicines for diarrhoea, medicines to empty the stomach and artificial tears as referred to in Appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering). You are only entitled to these over-the-counter medicines if the relevant conditions contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) have been met.
    b. gastric acid inhibitors as referred to in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering). You are only entitled to these gastric acid inhibitors if the relevant conditions contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) have been met.

Medicinal care does not include:

- medicines to prevent travel sickness;
- medicines for research (medicines as defined in article 40, paragraph 3, subparagraph b of the Medicines Act (Geneesmiddelenwet));
- medicines that are (virtually) equivalent to a registered medicine not included in appendix 1 of the Healthcare Insurance Regulations (Regeling zorgverzekering);
- medicines that are still being used for clinical testing and which are made available for distressing cases (medicines as defined in article 40, paragraph 3, subparagraph b of the Medicines Act (Geneesmiddelenwet));
- medicines you receive within the framework of an admission or medical specialist treatment, provided they are (deemed to form) part of that admission or treatment. In that case, those medicines form part of that care.

Appendices 1 and 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) can be viewed and downloaded at www.hollandzorg.com/conditions.

How long do we reimburse medicines?
We do not issue medicines in unlimited quantities. Per dispensing (by the chemist), you are entitled to medicines for a period of:
- a maximum of twelve months, if it concerns the contraceptive pill (oral contraceptives).
- a minimum of three and a maximum of twelve months, if you have a chronic condition and you have been using the medicine for at least six months and you have properly adjusted to that medicine. In derogation from this, the dispensing of benzodiazepines, hypnotic drugs and anxiolytic drugs is subject to a maximum period of one month. The prescriber determines whether it concerns a chronic condition.
- a maximum of one course or one month, in the case of antibiotics or chemotherapy to combat acute conditions.
- a maximum of 15 days or the smallest supply packaging for a medicine that is new to you
- a maximum of one month in all other cases.

What do I need to keep in mind?
- Dispensing chemists and dispensing general practitioners can provide this type of care.
- Dietary preparations may also be supplied by suppliers of dietary preparations.
- You need a prescription. A physician (which also includes a GP, a medical specialist, a doctor for the mentally disabled, a sports doctor, a specialist geriatrics doctor, a nursing specialist, A&E doctor), an orthodontist, a dentist, an obstetrician and a physician assistant may issue a prescription for most medicines. This is subject to the condition that the prescribed medicine is related to the care that the prescribing party generally provides.
- Separate rules apply to the medicines contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering). The care providers that can issue prescriptions for these medicines are listed in the Pharmacy Regulations (Reglement Farmacie). You can view and download the Pharmacy Regulations at www.hollandzorg.com/conditions.

Authorisation or dispensing chemist's instruction
In order for you to be entitled to some medicines contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering), you must have received our written authorisation before receiving the care. You must enclose a copy of the prescription with your request.

For the right to other medicines contained in appendix 2, the dispensing chemist or dispensing general practitioner must determine that right on the basis of a doctor's note or dispensing chemist's instruction.

The Pharmacy Regulations specify the medicines for which authorisation or a doctor's note or chemist's instruction is required. You can view and download the Pharmacy Regulations at www.hollandzorg.com/conditions.

Authorisation for (resold) chemist's preparations
Chemist's preparations are non-registered preparations prepared in one dispensing chemist and sold on to another dispensing chemist. The reimbursement of certain chemist's preparations, designated by us, is subject to our written authorisation before you receive the care. The chemist's preparations for which authorisation is required are listed in the overview 'Reimbursement for chemist's preparations'. This overview can be viewed and downloaded at www.hollandzorg.com/conditions.

When applying for care you will need to send us a copy of the prescription and a report from the attending physician including the medical diagnosis/diagnoses, a description of the current problem and the proposed treatment plan.

Is there a statutory personal contribution?
Yes, if the medicine is classified into a group of interchangeable medicines and the purchase price is higher than the reimbursement limit. A statutory personal contribution is also due when a medicine is prepared from a medicine for which a statutory personal contribution is due. The Healthcare Insurance Regulations (Regeling zorgverzekering) stipulate how the personal contribution is calculated. In the year 2024, the extent of your statutory personal contribution will be a maximum of €250 per calendar year. If your public healthcare insurance does not commence or end on 1 January of a calendar year, the compulsory voluntary contribution for your public healthcare insurance for that calendar year is set lower, in proportion to the number of days insured. The calculated amount is rounded off to whole Euros.

Example: your public healthcare insurance comes into force on 15 June. In that case, the statutory personal contribution for the remainder of the calendar year is € 136.98. The calculation is (€ 250 : 365 days) x 200 days. This amount is rounded to € 137.

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

No compulsory excess applies to contraceptives and the dispensing thereof as referred to in appendix 2 of the Health Insurance Regulations. Nor does compulsory excess exist for a medication assessment, as included in and under the conditions of the overview 'Designated care not subject to excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.

No compulsory or voluntary excess applies to preferred medicines allocated by us as included in and under the conditions of the overview 'Designated care not subject to excess'. The costs of dispensing, the counselling consultation for a preference medicine and inhaler instruction do fall under the compulsory excess.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

General practitioner care

General practitioner care

You are entitled to general practitioner care. General practitioner care is care such as general practitioners generally provide. This does not include tests that the general practitioner has asked others to perform and that are charged separately, such as laboratory tests.

What do I need to keep in mind?
General practitioners are entitled to provide this type of care.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No. The costs of medicines or (laboratory) testing in a hospital or an independent laboratory at the request of the general practitioner *do* count towards the compulsory and possibly voluntary excess.

Integrated care

You are entitled to integrated care. Integrated care means that a group of care providers works together surrounding a specific condition, in which your general practitioner remains your point of contact. Integrated care is available to people aged 18 and older suffering from Diabetes Mellitus type 2, COPD, asthma or with an increased risk of cardiovascular disease.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- a contracted care group. Contracted care groups are listed atwww.hollandzorg.com/carefinder. You can also contact our Care Advice Line on +31(0)570 687 123
- a care provider appointed by us for providing general practitioner care, preventive foot care and dietetic care, each for the relevant part of the integrated care.

Is a referral needed?
Yes, from a general practitioner or a medical specialist for those parts of the integrated care not provided by the general practitioner himself.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No, the compulsory and, if applicable, voluntary excess *do* include the costs of any (laboratory) testing in a hospital or independent laboratory at the request of a general practitioner.

Medical aids

Medical aids

You are entitled to medical aids (care in kind). Medical aids concerns functioning aids and dressings designated in the Medical Devices Regulations (Reglement Hulpmiddelen). The regulations also stipulate the scope of the care and whether you become the owner of the medical aids or are given them on loan. Other conditions for the right to care and the use of the medical aids are also contained in the regulations. You can view and download the Medical Aids Regulation (Reglement Hulpmiddelen) at www.hollandzorg.com/conditions.

The cover for medical aids does not include:
- medical aids and dressings you receive as part of an admission or medical specialist treatment if they form or are deemed to form part of that admission or treatment. In that case, those medical aids form part of that care. In case of transmural care at home, the aids and the required accessories (which form part of those aids) are included in the specialist medical care. In this situation, dressings *do* fall under the medical aids.
- medical aids and dressings you are entitled to pursuant to the Long-Term Care Act (Wlz), the Social Support Act (Wet maatschappelijke ondersteuning), the Work and Income (Capacity for Work) Act (Wet inkomen naar arbeidsvermogen (WIA).
- the costs of normal use of medical aids such as energy consumption and batteries, unless stipulated otherwise in these policy conditions.

What do I need to keep in mind?
- In principle, you must use the care provided by contracted care providers. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123. You can also opt for care provided by a non-contracted care provider.

The Medical Devices Regulations (Reglement hulpmiddelen) set out which care providers can provide the care in that case.
- You need a prescription in order to qualify for medical aids. The Medical Devices Regulations (Reglement hulpmiddelen) outline, per category of medical aids, which care provider can issue the prescription.

Is prior written authorisation required?
The Medical Devices Regulations (Reglement hulpmiddelen) set out in which cases you need our written authorisation before you receive the care, and which conditions the request must meet.

Is there a statutory personal contribution?
Yes, for some aids. The personal contribution is set out in the Medical Aids Regulation. Some medical aids are subject to a statutory maximum reimbursement. The statutory personal contribution also includes the costs that exceed that statutory maximum reimbursement and which therefore remain payable by you.

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older. This does not apply to medical aids you are given on loan, with the exception of the consumables or usage costs associated with those medical aids.

Do I have to pay extra for non-contracted care?
If the medical aids are available from a contracted care provider in time, but you buy or hire the medical aid or dressing from a non-contracted care provider, the reimbursement is subject to a maximum. In that case, we will reimburse up to a maximum of 75% of the costs we would incur if you would have received the care from a contracted care provider. In that case, we also reimburse a maximum of 75% of any repair costs in connection with the medical aid.

The costs of a medical aid that we would normally give on loan are in that case reimbursed per calendar year. In that case, we will reimburse a maximum of 75% of the costs. The reimbursement is in proportion to the number of days you are entitled to that care and actually have the medical aid at your disposal in that calendar year. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Oral care and orthodontics in exceptional cases

Oral care

You are entitled to oral care. Oral care is care such as dentists generally provide.

All ages
You are entitled to oral care if:
- you suffer from a serious development disorder, growth disorder or deformation in the dental and oral system. The disorder or deformation must be of such a serious nature, that without that care you are unable to retain or acquire dental function equal to that which you would have had if the disorder or deformation had not occurred. In that case, the care also includes fitting dental implants if you have a severely atrophied, toothless jaw and the implant is necessary to secure removable prostheses. The care may not include fitting dental implants if your jaw has been toothless for a long time and the functional complaints are not related to the seriously atrophied jaw.
- you suffer from a non-dental physical or mental disorder. The disorder must be of such a nature, that without that care you are unable to retain or acquire dental function equal to that which you would have had if the disorder had not occurred.

- medical treatment will demonstrably fail to have an adequate result without that oral care and without that other care you cannot retain or acquire dental function equal to that which you would have had if such disorder had not been present.

Younger than 18

If the insured party is younger than 18, the insured party, in addition to all-ages oral care, is also entitled to:
- periodic preventive dental check-up once a year. The insured party is only entitled to more times per year if required from a dental point of view.
- occasional dental examination
- plaque removal
- a maximum of two fluoride treatments per year from the moment that the adult teeth emerge. The insured party is only entitled to more times a year if desirable from a dental point of view.
- application of a protective coating to the biting surfaces of molars (sealing)
- treatment of the tissues supporting the teeth, such as gums (periodontal treatment)
- local anaesthetic
- treatment of the dental nerve (endodontic treatment)
- fillings (restoration of the dental elements with plastic materials)
- bite correction (gnathological treatment)
- removable prostheses
- dental surgery with the exception of fitting dental implants
- X-rays, with the exception of X-rays for orthodontic care.

18 or older

If you are aged 18 or older, you are, in addition to all-age oral care, entitled to:
- dental surgery of a specialist nature and the associated X-rays, with the exception of periodontal surgery, dental implants and uncomplicated extractions.
- removable full prostheses for the upper or lower jaw, whether or not fitted to dental implants. A removable full prosthesis secured on dental implants includes fitting the fixed part of the superstructure (the click system).

Younger than 23

If you are younger than 23 and the care does not fall under the heading of Oral Care for 'all ages', you are entitled to dental replacement care involving non-plastic materials and the fitting of dental implants. This only applies if this serves to replace one or more permanent incisors or canines which were either never developed or missing as a direct result of an accident. This is subject to the condition that the necessity of the care is established before you reached the age of 18.

What do I need to keep in mind?

- A dentist, whether or not affiliated to a centre for special dentistry or a youth dental care institution, is permitted to provide this type of care.
- A dental hygienist, whether or not affiliated to a centre for special dentistry or a youth dental care institution, may provide the care insofar as it concerns care that dental hygienists tend to provide.
- A dental surgeon may provide surgical dental assistance of a specialist nature. A hospital is authorised to offer admission.
- A prosthodontist is authorised to measure, make and fit removable (full) prostheses for the upper or lower jaw, whether or not fitted to dental implants.

Is prior written authorisation required?

A number of forms of oral care are subject to our written authorisation before you receive the care.

They are:
- gnathologic care if the insured is under 18.
- making an overall jaw image if the insured is under 18.
- a third or fourth fluoride treatment in a year from the moment the adult teeth emerge when the insured party is under 18.
- placing an autograft.
- dental replacement care involving non-plastic materials if you are under 23.
- the care as described under the heading 'All ages'.
- treatment under general anaesthetic.
- placing dental implants.
- surgical dental care of a specialist nature if the treatment is on the 'Exhaustive List of Authorisations for Dental Surgery'. This list can be viewed and downloaded at www.hollandzorg.com/conditions.
- replacing a full dental prosthesis for the upper or lower jaw, whether or not to be placed on dental implants, within five years of the placement of the previous full dental prosthesis.

- care provided by a centre for special dentistry.

Most oral care providers are registered with the national authorisation portal. Your oral care provider can request digital authorisation via this portal. Your oral care provider will receive an answer from us to your request via the authorisation portal. If you visit an oral care provider who is not registered with the national authorisation portal or if you travel abroad for treatment, you must request and obtain authorisation from us to be entitled to reimbursement before the start of treatment. Requests for care must be accompanied by a written, substantiated treatment plan stating the medical diagnosis/diagnoses and the performance codes, plus X-rays and any models made of the teeth.

Is a referral needed?
Yes, in the following cases:
- For care provided in a centre for special dentistry, you need a referral from a general practitioner, dentist, dental surgeon or orthodontist. The referring dentist, dental surgeon or orthodontist may not be affiliated to a centre for special dentistry.
- You need a referral from a dentist, dental surgeon or orthodontist for the measuring, making and fitting of removable (full) prostheses on dental implants by a prosthodontist.
- For the care provided by a dental surgeon plus the required admission, you need a referral from a general practitioner, dentist, orthodontist or other dental surgeon.

Is there a statutory personal contribution?
Yes, in the following cases:
- for care that falls under the heading 'All ages', if the relevant care is not directly related to specialist dental care. In that case, the extent of the statutory personal contribution is the maximum amount that the care provider would have charged if there was no right to reimbursement of the costs under the heading 'All ages'. This means that you are in fact entitled to a reimbursement of only the additional costs associated with that type of care.
- For a removable full dental prosthesis for the upper or lower jaw, if you are 18 or older and the care does not fall under the heading 'All ages'. In that case, the statutory personal contribution amounts to 25% of the costs of that dental prosthesis. Contrary to the above, the statutory personal contribution for a removable full dental prosthesis secured on dental implants amounts to:
a. 10% of the costs of that dental prosthesis, if it is a denture for the lower jaw.
b. 8% of the costs of that dental prosthesis, if it is a denture for the upper jaw.
- For repairs or rebasing of a removable full dental prosthesis. In that case, the statutory personal contribution amounts to 10% of the costs of the repair or rebasing.

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
No, unless the invoice exceeds the competitive Dutch rate. An exception to this is care provided by a dental surgeon. Do you wish to use the care from a dental surgeon in a hospital or an independent treatment centre (ZBC) with which we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. We apply a maximum reimbursement for dental surgery provided by a non-contracted hospital or ZBC. The maximum reimbursements can be found on the rates lists for non-contracted care on our website, under specialist medical care. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Orthodontics in special cases

You are entitled to orthodontics if you have a serious development or growth disorder of the dental and oral system. Orthodontia is care of an orthodontic nature such as dentists generally provide. The treatment must be necessary in order for you to retain or acquire dental function equal to that if the disorder had not been present. The disorder or deformation must be of such a nature that additional diagnosis or additional treatment from disciplines other than oral care (multidisciplinary treatment) is required.

What do I need to keep in mind?
An orthodontist, whether or not affiliated to a centre for special dentistry, is permitted to provide this type of care.

Is a referral needed?
Yes, from a general practitioner, dentist, dental surgeon or orthodontist.

Is prior written authorisation required?
You must obtain our written authorisation, prior to you receiving the care.

Most oral care providers are registered with the national authorisation portal. Your oral care provider can request digital authorisation via this portal. Your oral care provider will receive an answer from us to your request via the authorisation portal.

If you visit an oral care provider who is not registered with the national authorisation portal or if you go abroad for treatment, you must request and obtain authorisation from us to be entitled to care before the start of treatment. Requests for care must be accompanied by a written, substantiated treatment plan stating the medical diagnosis/diagnoses and the performance codes, plus X-rays and any models made of the teeth.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
No, unless the invoice exceeds the competitive Dutch rate.

Other care

Medical care for specific patient groups

You are entitled to medical care for specific groups of patients. This is general medical care for specific patient groups under or pursuant to the Healthcare Insurance Act (Zorgverzekeringswet). This concerns care for vulnerable groups living at home, for example vulnerable elderly people, people with chronically progressive degenerative diseases, people with non-congenital brain damage and people with a mental impairment aged 18 and older.

This can involve diagnostics, consultations, specific consultation with your attending physician and implementation or management of the treatment plan. This care focuses on improving independent living, preventing the limitations from worsening and learning to live with the (progressive) limitations.

You are not eligible for this type of care if you have a Wlz indication or if you qualify for one.

This medical care for specific patient groups does not include care that is part of other types of care such as first-line in-patient stays and geriatric rehabilitation care.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- a specialist geriatrics doctor
- a doctor for the mentally disabled
- healthcare psychologists
- clinical psychologists;
- NIP-certified paediatrics and adolescent psychologists
- remedial educationalists

Is a referral needed?
Yes, from a general practitioner or medical specialist.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Other medical care (e.g. GP care)

You are entitled to other medical care (e.g. GP care). Other medical (GP) care includes:
- medical care within the framework of individual care for tuberculosis and infectious diseases
- cow's milk allergy test (Double-blind Placebo-Controlled Food Challenge Test).

Other medical (GP) care does not cover preventive foot care. The cover thereof is set out elsewhere in these policy conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- for medical care within the framework of individual care for tuberculosis and infectious diseases: a qualified and nationally registered doctor, the criteria of which are determined by the Board of KNMG's Board of Registration's Medical Specialists.

- for cow's milk allergy test: a care provider contracted by us for this purpose. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

Is a referral needed?
Yes, from a general practitioner, medical specialist, nursing specialist or physician assistant.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No

Preventive foot care

You are entitled to preventive foot care as generally provided by general practitioners or medical specialists if you have an increased risk of developing foot ulcers due to loss of protective sensitivity of the feet, reduced blood circulation in the feet, fragile skin or increased pressure on the skin due to illness or medical treatment.

Preventive foot care comprises the total package of examinations and treatments in care profiles 1 to 4, as laid down in the 2019 'Prevention of Diabetic Foot Ulcers Care Module' (*Zorgmodule Preventie Diabetische Voetulcera*). An individual treatment plan determines the number of treatments you will receive.

When your feet are examined, the Sims classification is used in order to express the risk of the feet being affected. Foot care is subdivided into the care profiles according to the Sims classification and several other factors. Your general practitioner or podiatrist determines your care profile. The preventive foot care comprises:
- annual foot check (screening), consisting of case history, examination and risk inventory.
- frequent specific foot examinations, the ensuing diagnosis and treatment of skin and nail problems and deviations in the foot shape and position and the treatment of risk factors. To qualify, you must have a moderately increased (Sims Classification 1) or increased risk (Sims Classification 2 and 3) of inflammation, artery problems and loss of sensation in your feet.
- information and encouragement to modify your lifestyle as part of the treatment.
- advice on suitable shoes.

NOTE: treatments for cosmetic or nurturing reasons only, such as removing calluses and clipping toenails, are not covered under preventive foot care.

Preventive foot care can be part of integrated care or specialist medical care (general). The conditions for the right to integrated care or specialist medical care (general) are set out in the article on these forms of care. You are not entitled to preventive foot care on the grounds of this article if you already receive preventive foot care on the grounds of the article on integrated care or (general) medical specialised care.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
For Sims classification 1 (care profile 1):
- a general practitioner
- a podiatrist
- a chiropodist

For Sims classifications 2 and 3 (care profiles 2 to 4):
- a general practitioner
- a podiatrist

A chiropodist may independently perform the annual foot examination for Sims classification 1 (care profile 1). A chiropodist may provide care for Sims classifications 2 and 3 (care profile 2 and higher) if requested by the podiatrist. In that case, the podiatrist acts as the medical specialist who is ultimately responsible and the podiatrist will invoice the care.

Is a referral needed?
Yes, from a general practitioner, medical specialist, nursing specialist or physician assistant in order to receive foot care from a chiropodist or a podiatrist. If a non-contracted care provider provides the care, you must include a copy of the referral when you submit the first invoice.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. We apply a maximum reimbursement for preventive foot care provided by a non-contracted podiatrist. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Paramedical care

Physiotherapy and remedial therapy

You are entitled to reimbursement of the costs of physiotherapy and remedial therapy. Physiotherapy is care such as physiotherapists generally provide. Remedial therapy is care such as remedial therapists generally provide. The conditions that you must meet in order to be eligible for the reimbursement are set out below.

18 or older

If you are 18 or older, you are entitled to a reimbursement of the costs of:

- physiotherapy and remedial therapy for a disorder on a list stipulated by the Minister (Appendix 1 to the Health Insurance Decree (Besluit zorgverzekering)), the 'List of chronic disorders that qualify for physiotherapy and remedial therapy'. The right starts after the 21st treatment. This means that you have to pay for the first 20 treatments for conditions on the 'List of chronic disorders that qualify for physiotherapy and remedial therapy' or to take out additional insurance for this. Some conditions on the list are subject to a maximum treatment term. In that case, you are entitled to a reimbursement of the costs of the care until the end of the maximum term.
- pelvic physiotherapy in connection with incontinence, subject to a maximum of 9 treatments (once-only).

- walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication). In that case, you will be entitled to reimbursement of the costs of only 37 treatments for a maximum of 12 months.
- remedial therapy under the supervision of a physiotherapist or remedial therapist for osteoarthritis in your hip or knee joint. In that case, you will be entitled to reimbursement of the costs of only the first 12 treatments for a maximum of 12 months.
- remedial therapy under the supervision of a physiotherapist or remedial therapist for COPD, if it concerns stage II or higher of the GOLD Classification for spirometry. In that case, you are entitled to reimbursement of the costs of:
  - In the event of class A of the GOLD Classification for symptoms and risk of exacerbations (worsening of or increase in symptoms): no more than the first 5 treatments for a maximum of 12 months
  - In the event of class B of the GOLD Classification of symptoms and risk of exacerbations (worsening of or increase in symptoms) in combination with a moderate burden of disease or sufficient physical capacity (class B1): no more than the first 27 treatments for a maximum of 12 months after the start of treatment and a maximum of 3 treatments per 12 months in the following years.
  in the event of class B of the GOLD Classification for symptoms and risk of exacerbations (worsening of or an increase in symptoms) in combination with a high burden of disease and limited physical capacity (class B2) or in the event of class C or class D of the GOLD Classification for symptoms and risk of exacerbations (worsening of or an increase in symptoms): no more than the first 70 treatments during a maximum of 12 after the start of treatment and a maximum of 52 treatments per 12 months in the following years.
- conditionally permitted physiotherapy and remedial therapy as referred to in Article 2.2 of the Health Insurance Regulations under the associated conditions, insofar as it concerns responsible care. An up-to-date version can be found on the ‘List of conditionally permitted care’ at www.hollandzorg.com/conditions.

Younger than 18

If the insured party is younger than 18, the insured party is entitled to reimbursement of the costs of:

- physiotherapy and remedial therapy for a disorder on a list stipulated by the Minister (Appendix 1 to the Health Insurance Decree (Besluit zorgverzekering)), the 'List of chronic disorders that qualify for physiotherapy and remedial therapy'. The right starts after the first treatment. Some conditions on the list are subject to a maximum treatment term. In that case, the insured is entitled to a reimbursement of the costs of the care until the end of the maximum term.

- physiotherapy and remedial therapy which are not on the ‘List of chronic disorders that qualify for physiotherapy and remedial therapy’. In those cases, the insured party is entitled to a reimbursement of the costs of a maximum of the first 9 treatments per calendar year. If those treatments do not yield sufficient result, the insured party is entitled to reimbursement of the costs of a maximum of 9 additional treatments for the same condition.

The insured party is only entitled to reimbursement of the costs of children's physiotherapy and paediatric remedial therapy if the insured party is younger than 18.

The List of chronic disorders that qualify for physiotherapy and remedial therapy can be viewed at www.hollandzorg.com/conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- general physiotherapy: a physiotherapist
- pelvic physiotherapy: a pelvic physiotherapist
- geriatric physiotherapy: a geriatric physiotherapist
- paediatric physiotherapy: a paediatric physiotherapist
- scar treatment: a physiotherapist and skin therapist
- manual therapy: a manual therapist
- oedema therapy and lymph drainage: an oedema therapist and skin therapist
- general remedial therapy: a remedial therapist
- geriatric remedial therapy: a geriatric remedial therapist
- paediatric remedial therapy: a paediatric remedial therapist
- walking therapy supervised by a physiotherapist or remedial therapist for peripheral arterial disease in stage 2 Fontaine (intermittent claudication or display legs): a physiotherapist or remedial therapist affiliated to the Chronisch ZorgNet national network. These care providers can be found in the Chronisch ZorgNet care finder at www.chronischzorgnet.nl/nl/zorgzoeker. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation to Chronisch ZorgNet is not compulsory if the provision of care started before 1 January 2018.
- physiotherapy and remedial therapy in the event of Parkinson's disease: a physiotherapist or remedial therapist affiliated to the national ParkinsonNet network. These care providers can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl/#/. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.

NOTE: manual therapy treatments E.S. (Egg Shell) / Van der Bijl method and orthomanual medicine are not covered under physiotherapy and remedial therapy. These treatments may be covered under alternative treatments.

Is a referral needed?
Yes, from a general practitioner, medical specialist, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, dentist, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP):

- for treatment of a complaint on the List of chronic disorders that qualify for physiotherapy and remedial therapy.
- for treatment by a pelvic physiotherapist in connection with urine incontinence.
- for walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication).
- for remedial therapy under the supervision of a physiotherapist or remedial therapist for osteoarthritis in your hip or knee joint.
- for remedial therapy under the supervision of a physiotherapist or remedial therapist for COPD, if it concerns stage II or higher of the GOLD Classification for spirometry.

If you go to a non-contracted care provider, you must include a copy of the referral when you submit the first invoice. In order to be entitled to reimbursement of the costs of healthcare by a non-contracted provider for treatment of a condition listed on the List of chronic disorders that qualify for physiotherapy and remedial therapy (www.hollandzorg.com/conditions), you must also enclose a statement from the care provider when submitting the first invoice stating how much physiotherapy or remedial therapy you have already received for the same condition.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older. With the exception of compulsory excess for remedial therapy under the supervision of a physiotherapist or remedial therapist in the event of osteoarthritis in your hip or knee joint, as included in and under the conditions of the overview 'Designated care not subject to excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Occupational therapy

You are entitled to a reimbursement of the costs of occupational therapy such as occupational therapists generally provide, subject to a maximum of ten hours of treatment per year. Occupational therapy helps you improve your self-reliance and self-care. You will receive advice, instructions, training or treatment to be able to perform general daily or work-related activities again and to function as independently as possible in your private or working situation. The care further includes conditionally permitted physiotherapy as referred to in Article 2.2 of the Health Insurance Regulations under the associated conditions, insofar as it concerns responsible care. An up-to-date version can be found on the 'List of conditionally permitted care' at www.hollandzorg.com/conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- occupational therapy in the event of Parkinson's disease: an occupational therapist affiliated to the national ParkinsonNet network. These occupational therapists can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl/#/. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other occupational therapy: an occupational therapist

Is a referral needed?
Yes, from a general practitioner, medical specialist, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP).

This does not apply to care provided by a contracted care provider who has successfully completed the Direct Accessibility course. In that case, no referral is required. Care providers who have successfully completed the Direct Access course are listed at www.kwaliteitsregisterparamedici.nl and have 'DT' status. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

NOTE: if a referral is required, you must enclose a copy of the referral when submitting the first invoice.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Dietetics

You are entitled to dietetic care such as dieticians generally provide, subject to a maximum of three hours of treatment per year. You can go to a dietician for information about nutrition and eating habits, provided this serves a medical purpose. The care also consists of treatment aimed at eliminating, reducing or compensating for food-affected or related illnesses or symptoms.

The care further includes conditionally permitted dietetic care as referred to in Article 2.2 of the Health Insurance Regulations under the associated conditions, insofar as it concerns responsible care. An up-to-date version can be found on the 'List of conditionally permitted care' at www.hollandzorg.com/conditions.

You are not entitled to dietetic care if you already receive this care within the framework of integrated care or combined lifestyle intervention for the same condition, without an additional need for care based on a separate, specific indication.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- dietetic care in the event of Parkinson's disease: a dietician affiliated to the national ParkinsonNet network. These dieticians can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl/#/. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other dietetic care: a dietician.

Is a referral needed?
Yes, from a general practitioner, medical specialist, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, dentist, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP).

This does not apply to care provided by a contracted care provider who has successfully completed the Direct Accessibility course. In that case, no referral is required. Care providers who have successfully completed the Direct Access course are listed at www.kwaliteitsregisterparamedici.nl and have 'DT' status. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

NOTE: if a referral is required, you must enclose a copy of the referral when submitting the first invoice.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Speech therapy

You are entitled to reimbursement of the costs of speech therapy. Speech therapy is care such as speech therapists generally provide. The care must serve a medical purpose and the treatment must be expected to restore or improve speech function or the ability to speak. The care further includes stutter therapy and conditionally permitted speech therapy as referred to in Article 2.2 of the Health Insurance Regulations under the associated conditions, insofar as it concerns responsible care. An up-to-date version can be found on the 'List of conditionally permitted care' at www.hollandzorg.com/conditions.

This type of care does not include:

- treatment of language development disorders related to dialect or another native language
- the treatment of a language deficiency in Dutch and/or a foreign language, in the event of multilingualism
- treatment of dyslexia

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- preverbal speech therapy: a speech therapist who is listed in the NVLF Preverbal speech therapy sub-register
- Aphasia therapy: a speech therapist who is listed in the NVLF Aphasia register
- the Hanen parent programme It Takes Two to Talk (*Praten Doe je Met z'n Tweeën* = PDMT): a speech therapist listed in the NVLF PDMT Hanen parent programme sub-register
- the Hanen parent programme More than Words (*Meer Dan Woorden* = MDW): a speech therapist listed in the NVLF MDW Hanen parent programme sub-register
- individual stutter therapy: a speech therapist who is listed in the NVLF Stutter therapy sub-register
- integrated stutter care: a speech therapist or stutter therapist listed in the NVLF integrated stutter care sub-register
- speech therapy in the event of Parkinson's disease: a speech therapist affiliated to the national ParkinsonNet network. These speech therapists can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl/#/. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other speech therapy: a speech therapist

Is a referral needed?
Yes, from a general practitioner, medical specialist, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, dentist, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP).

This does not apply to care provided by a contracted care provider who has successfully completed the Direct Accessibility course. In that case, no referral is required.

Care providers who have successfully completed the Direct Access course are listed at www.kwaliteitsregisterparamedici.nl and have 'DT' status. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123. If a referral is required, you must enclose a copy of the referral when submitting the invoice.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Prevention

Combined lifestyle intervention (GLI) for adults

You are entitled to a combined lifestyle intervention (GLI) if you are 18 or older and there is a moderately increased weight-related health risk in accordance with the indication criteria in the NHG guidelines for Obesity and the Obesity Care Standard. The reimbursement for GLI for insured parties up to the age of 18 can be found under the heading 'Chain Approach care and support for overweight and obese children'.

GLI consists of a combination of interventions aimed at healthy eating, increased physical activity and, if necessary, the addition of tailor-made psychological interventions in support of a behavioural change. GLI is offered in the form of a care programme. The care programme consists of individual sessions and sessions offered in groups and distinguishes between a treatment phase and a maintenance phase. The care programme lasts 24 consecutive months (two years).

You are entitled to the care programmes on the list of Designated care programmes of GLI for adults. This list may change in the interim. An up-to-date version can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- A care provider listed as a lifestyle coach in the register of the Netherlands Professional Association of Lifestyle Coaches (BLCN)
- A physiotherapist, registered with the endorsement of 'lifestyle coach' in the Individual Physiotherapy Register of Kwaliteitshuis Fysiotherapie
- A remedial therapist registered with the endorsement of 'lifestyle coach' in the Paramedics Quality Register
- A dietician registered with the endorsement of 'lifestyle coach' in the Paramedics Quality Register
- A care group contracted by us.

Is a referral needed?
Yes, from a general practitioner or medical specialist.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Chain Approach care and support for overweight and obese children

If the insured party is younger than 18, the insured party is entitled to:

- a broad anamnesis by the central care provider (the permanent point of contact for the child and family).
- support and coordination of the right care and support at the right time by the right professional for the child and family by the central care provider. In that case, combined lifestyle intervention (GLI) for children must form part of the action plan. The action plan must demonstrate that the insured party is dependent on GLI for children.
- combined lifestyle intervention (GLI) for children. The insured party must have at least a moderately increased weight-related health risk (GGR) according to the indication criteria from the NHG Guidelines for Obesity and the Addendum for children to the Obesity Care Standard.

GLI is a tailor-made care programme, focused on a healthy diet, more exercise and, if necessary, psychological help. The tailor-made care programme consists of individual sessions and has a treatment phase and a maintenance phase. The care programme lasts 24 consecutive months (two years).

The insured party is entitled to the care programmes on the list of Designated care programmes of GLI for children. This list may change in the interim. An up-to-date version can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:

Broad anamnesis and support and coordination by the central care provider:

- A paediatric nurse with additional specific training as a central care provider with attention to knowledge of the social and care domains, specifically aimed at youths and family.
- A care group contracted by us.

GLI for children:

- The care providers designated by us for each of the care programmes on the list of Designated care programmes of GLI for children. The designated care providers can be found on the list of Designated care programmes of GLI for children. You can view and download the up-to-date list at www.hollandzorg.com/conditions.

- A care group contracted by us.

Is a referral needed?
Yes, from a general practitioner, paediatrician or medical specialist

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No

Fall prevention for adults

You are entitled to fall prevention if you are 18 or older. Fall prevention consists of the following components:

- Fall risk assessment, if, based on a fall risk assessment, you are at a high risk of falling.
- Intake for a training programme to prevent falls (fall-preventive exercise intervention), if you are at a high risk of falling based on a fall risk assessment and if you are dependent on support from a physiotherapist or remedial therapist during the training programme due to underlying or additional somatic problems.
- A maximum of one training programme to prevent falls (fall-preventive exercise intervention) per 12 months. You must be at a high risk of falling according to a fall risk assessment. And due to underlying or additional somatic problems, you must be dependent on support from a physiotherapist or remedial therapist during the training programme. You are entitled to the training programmes to prevent falls on the list of Designated fall prevention training programmes for adults. This list may change in the interim. The up-to-date content can be found at www.hollandzorg/com/conditions.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:

For fall risk assessment: a general practitioner or a care group contracted by us.

For the intake for a training programme and for the training programme itself: a physiotherapist or remedial therapist who is certified to carry out the relevant training programme.

Is a referral needed?
Yes, the intake for a training programme to prevent falls and the training programme itself require a referral from a general practitioner.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, with the exception of the fall risk assessment.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Giving up smoking

You are entitled to follow a programme to give up smoking. This comprises a medical care programme, possibly in combination with nicotine-replacement therapy (including medicines), aimed at a change in behaviour with the objective of giving up smoking. You are only entitled to nicotine-replacement therapy (including medicines) relating to giving up smoking if they form part of the programme. The care is limited to one programme per calendar year. You are not entitled to a giving up smoking programme, if you receive counselling to stop smoking as part of integrated care, unless you need counselling that is more intensive than agreed within the integrated care.

What do I need to keep in mind?
The following care providers are permitted to provide this type of care:
- a general practitioner who offers the Stop Smoking Programme
- a care provider who:
    - is registered in the Stop Smoking Quality Register. You can consult this register at www.kwaliteitsregisterstopmetroken.nl; and
    - delivers the intervention offered in accordance with the Stop Smoking care module and which complies with the guideline 'Treatment of Tobacco Addiction and Stop Smoking Support'
- a care provider for giving up smoking, contracted by us. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
The costs of the Stop Smoking programme are listed in the overview 'Designated care not subject to excess'. The costs therefore do not count towards the compulsory excess. The costs do count towards the voluntary excess, if applicable.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Rehabilitation care

Geriatric rehabilitation care

You are entitled to geriatric rehabilitation care plus the required admission. Geriatric rehabilitation includes integrated and multidisciplinary rehabilitation care provided by specialists in geriatric medicine. Vulnerable elderly people who have been admitted to hospital for treatment sometimes need geriatric rehabilitation care to be able to return to their home situation. This concerns care aimed at restoring functional impairments.

You are only entitled to the care if:
- you were hospitalised (you must have been admitted) at the start of the care, *and*
- the care is provided within one week of your hospitalisation in connection with specialist medical care and the admission to the hospital was not preceded by a stay at a nursing home. This does not apply if you suffer from an acute condition causing mobility disorders or impaired self-reliance and you received specialist medical care for that acute disorder prior to the geriatric rehabilitation care.

The care lasts a maximum of six months. In special cases, we may permit a longer period.

What do I need to keep in mind?
- Hospitals, rehabilitation centres and institutions for geriatric rehabilitation care can provide this type of care and offer admission. The care must be provided under the final responsibility of a specialist geriatrics doctor (practitioner in charge).

Is prior written authorisation required?
For the right to rehabilitation care for a period longer than six months, you will need to have our written authorisation before the period of six months has elapsed. When applying for this type of care, you must enclose the following details: the reason why it is not possible to return home and the treatment plan for further treatment, including the prognosis for recuperation and a return to the home situation and the expected duration of the further treatment.

Is a referral needed?
Yes, from a medical specialist or specialist geriatrics doctor.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Medical specialist rehabilitation care

You are entitled to rehabilitation care plus the required admission. Rehabilitation means having to learn to live with a disability after an accident or illness. This involves examinations, advice and treatment. A multidisciplinary team of experts, under the management of a medical specialist, provides this type of care. You must need the care in order to prevent, reduce or overcome a handicap. It must concern a disability as a result of disorders or restrictions in the locomotor apparatus or a disorder of the central nerve system that leads to restrictions in communication, intellect or behaviour.

What do I need to keep in mind?
Hospitals and rehabilitation centres can provide this type of care and offer admission. The care must be provided under the final responsibility of a rehabilitation specialist (practitioner in charge).

Is prior written authorisation required?
For rehabilitation care provided by a non-contracted care provider plus the required admission you need our written authorisation before you can receive the care. When applying for care you will need to send us (a copy of) a report from the attending physician with the medical diagnosis/diagnoses, a description of the current problems and the proposed treatment plan (care activity).

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, paediatrician, doctor for the mentally disabled, sports doctor, geriatrics specialist or company doctor.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Second Opinion

Second opinion

You are entitled to a second opinion. If you are in doubt about a diagnosis or treatment, you can ask for a second opinion from another independent medical specialist working in the same field. You must present the second opinion to the original care provider, who remains in control of your treatment.

Is a referral needed?
Yes, from your general practitioner or attending physician. The referral will remain valid for a period of twelve months from the day it was issued.

Nursing and care

First-line in-patient stay

You are entitled to first-line in-patient stays. A first-line in-patient stay involves a short-term stay for which there is a medical need in connection with medical care such as general practitioners provide. First-line in-patient stays are aimed at recovery and a return to the home situation in the short term. This can also concern palliative terminal care (care in the last phase of life).

The care does not include:
- admission as referred to in these policy conditions.
- stays in connection with the temporary takeover of care to relieve an informal carer (respite care).
- stays you require in connection with a psychiatric disorder or impairment if you are under 18.
- stays for insured parties by virtue of a Wlz indication.

What do I need to keep in mind?
An institution for first-line in-patient stay can provide this type of care.

Is a referral needed?
Yes, from a general practitioner or medical specialist.

Is prior written authorisation required?
You must obtain written authorisation from us before the (extended) stay if it concerns a stay in an institution that does not have a contract with us.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

District nursing (nursing without in-patient care)

You are entitled to nursing without in-patient care if the care is related to your need for medical care as referred to in Article 2.4 of the Health Insurance Decree (Besluit zorgverzekering) or if you have a high risk of needing such care. If you need nursing and care at home, you can contact the district nurse.

Nursing without in-patient care involves care such as nurses generally provide.
The care consists of nursing (provision of care), as well as indicating, coordinating, identifying, coaching and prevention.

The care does not include:
- nursing and care as part of admission in a hospital or another institution.
- maternity care.

What do I need to keep in mind?
- You or your legal representative must have signed a care plan. This care plan must be drawn up by your care provider. The care plan must contain the type, extent, frequency and intended duration of the nursing and care required without in-patient care, as well as a specification of performances and a substantiation.
- The care plan must also involve the contribution of your social network.
- A district nurse, paediatric nurse and nursing specialist are permitted to specify the indication for your care and draw up a care plan. The indication must have been made in accordance with the Standards for indicating and organising nursing and care in the personal environment, drawn up by the Netherlands Association for Nurses & Carers (V&VN).

The following care providers are permitted to provide the indicated care:
- a nursing specialist
- a district nurse
- a qualified nurse
- a qualified IG carer or qualified level-3 carer

If you receive care from a care provider contracted by us, the indicated care may also be provided by:
- a qualified carer level C or D
- a qualified assistant carer.

Is prior written authorisation required?
In the following cases you must obtain our written authorisation, prior to you receiving the care:
- For reimbursement of nursing without in-patient care provided by a non-contracted care provider. For this application, you must use the application form for non-contracted district nursing. The application form can be found at www.hollandzorg.com/forms. If the care plan changes, you need to obtain our written authorisation again prior to you receiving the care.
- For reimbursement of nursing without in-patient care provided abroad. With your application, you

must enclose a copy of the care plan and a quotation for the care (stating the care concerned, the costs and the period in which the care is to be provided abroad).

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
No

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website.

Personal budget
Instead of the right to care, you may qualify for a personal budget. In that case, you will receive an amount to purchase the care and nursing yourself. The right to a personal budget is subject to special conditions. They are defined in the Healthcare Insurance Personal Budget Regulations. You can view and download the Healthcare Insurance Personal Budget Regulations at www.hollandzorg.com/conditions. If the costs you incur for nursing and care are higher than the reimbursement in the form of a personal budget, the difference between the costs and the personal budget will be payable by you.

Patient transport

Ambulance transport

You are entitled to ambulance transport. Ambulance transport is patient transport by ambulance over a distance of no more than 200 kilometres.

This concerns:
a. transport to a healthcare provider for treatment which is (partially) charged to your public healthcare insurance
b. transport to an institution where you are staying and (partly) paid for under the Long-term Care Act (Wlz institution)
c. transport to receive mental health care that falls under the Youth Act
d. transport from a Wlz institution, to:
1. a care provider for an examination or treatment, the costs of which are fully or partially covered under the Long-Term Care Act (Wlz)
2. a care provider for measuring and fitting a prosthesis the cost of which is fully or partially covered under the Long-Term Care Act (Wlz)
e. transport from one of the care providers as referred to under a. to d. back to your home or to another home, if you cannot reasonably receive the necessary care in your own home.

PLEASE NOTE! Transport over a distance of more than 200 kilometres only falls under ambulance transport if we have given our written authorisation prior to the transport.

PLEASE NOTE! Transport by a means of transport other than an ambulance can also fall under ambulance transport, if transport by ambulance is not possible and we have given our prior written authorisation for transport by a different mode of transport, to be designated by us.

What do I need to keep in mind?
The care may be provided by an ambulance transport company with a recognised licence.

Is a referral needed?
Yes, you need a prescription from a general practitioner, medical specialist, doctor for the mentally disabled, specialist geriatrics doctor, physician assistant, nursing specialist or obstetrician. This condition does not apply in the case of unforeseen care that cannot reasonably be postponed (emergency care).

Is prior written authorisation required?
In two cases, the ambulance transport is subject to our written authorisation before you are transported. They are:
- Transport over a distance of more than 200 kilometres.
- Transport by a mode of transport other than an ambulance.

Authorisation is not required in the case of unforeseen care that cannot reasonably be postponed (emergency).

When submitting the request for transport, you must include a report from the attending physician stating the medical diagnosis/diagnoses, a description of the current problem and a substantiation of the request.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Patient transport

You are entitled to patient transport. Patient transport is transport by (private) car, taxi (not an ambulance) or public transport, over a single travel distance of no more than 200 kilometres.

The transport consists of:
a. transport to a healthcare provider for treatment which is (partially) charged to your public healthcare insurance
b. transport to an institution where you are staying and (partly) paid for under the Long-term Care Act (Wlz institution)
c. transport from a Wlz institution, to:
1. a care provider for an examination or treatment, the costs of which are fully or partially covered under the Long-Term Care Act (Wlz)
2. a person or institution for measuring and fitting a prosthesis the cost of which is fully or partially covered under the Long-Term Care Act (Wlz)
d. transport from one of the care providers as referred to under a. to c. back to your home or to another home, if you cannot reasonably receive the necessary care in your own home

This is subject to one of the following reasons:
- you have to undergo dialysis. This includes transport to consultations, examinations and check-ups needed as part of the treatment.
- you have to undergo oncological treatment with chemotherapy, immunotherapy or radiotherapy. This includes transport to consultations, examinations and check-ups needed as part of the treatment.

- you are confined to a wheelchair
- your eyesight does not allow you to move unaided
- the insured party is under 18 and relies on intensive paediatric care
- you rely on geriatric rehabilitation care
- you rely on daycare treatment that is provided in a group and that is part of a care programme for chronically progressive degenerative disorders, non-congenital brain damage or in connection with a mental impairment.

The reimbursement for patient transport by car (private transport) is € 0.38 per kilometre. We calculate the number of kilometres based on the fastest route (assuming the absence of delays) according to the ANWB route planner on internet (www.anwb.nl/verkeer/routeplanner) by entering the departure postcode and the destination postcode. The reimbursement for the use of public transport only applies to the lowest class of public transport.

What applies in exceptional circumstances?
You are also entitled to patient transport if you rely on transport for a prolonged period of time in connection with the treatment of a long-term illness or disorder and for consultations, examinations and check-ups needed as part of the treatment and denying the reimbursement of that transport would be extremely unreasonable towards you.

We use various data in order to determine if you are nevertheless entitled to reimbursement of transport. To that end, we use the following formula: (the number of weeks the treatment takes) x (the number of times per week you need transport for the treatment) x (the single travel distance in kilometres for transport to the care provider) x 0.25. If the sum of this calculation is 250 or higher, you are entitled to patient transport.

Example: for a period of 12 weeks you need to visit the hospital 3 times a week for treatment, which is 40 km from your place of residence. In that case, the formula for entitlement to reimbursement is 12 x 3 x 40 x 0.25 = 360. In this case, you are entitled to patient transport.

Patient transport also includes the transport of a companion. It must be must be medically necessary for the insured party to have a companion, or the insured party must be under the age of sixteen. In special cases, we can give our written authorisation for the transport of two companions.

Transport by a mode of transport other than a car or public transport may also fall under patient transport. This is the case if transport by car or public transport is not possible and we have given our written authorisation for transport by a different mode of transport, designated by us.

Transport over a distance of more than 200 kilometres falls under patient transport as well, provided we have given our written authorisation prior to the transport.

Cost of accommodation
You are entitled to reimbursement of accommodation costs instead of (a reimbursement of the costs of) patient transport:

- when you are entitled to patient transport; and
- you need such transport at least three consecutive days; and
- using accommodation is more effective and less of a strain on you than travelling between your home and the treatment centre every day.

In that case, you qualify for transport to and from the treatment centre (to and from your home) and reimbursement of the costs of two overnight stays near the treatment centre. The reimbursement of accommodation costs is a maximum of € 89.00 per night. You must book the accommodation

yourself. Any transport from your accommodation address to the treatment location and back to your accommodation address will not be reimbursed.

What do I need to keep in mind?
- For patient transport with your (private) car, you can use your own car or that of someone else. For patient transport by taxi, you can use a taxi operator. For patient transport by public transport, you can use a public transport company.

Is a referral needed?
Yes, from a general practitioner or medical specialist.

Is prior written authorisation required?
Ambulance transport is subject to our written authorisation prior to the transport. In doing so, we determine whether you are entitled to patient transport by (private) car, by public transport or by taxi. You also need our prior written authorisation for the reimbursement of accommodation costs. When requesting transport or accommodation, you must give the reason for your request and enclose the prescription. You can view and download the application form for patient transport at www.hollandzorg.com/forms.

Is there a statutory personal contribution?
Yes, a maximum of € 118 per calendar year. The statutory personal contribution does not apply:
- to transport from an institution where you have been admitted under the public healthcare insurance or the Long-Term Care Act (Wlz) to another institution where you are admitted under the public healthcare insurance or the Long-Term Care Act (Wlz), where you will undergo a specialist examination or specialist treatment that cannot be provided in the institution where you have been admitted.
- to transport from an institution as referred to in subparagraph a. to a person or institution where you will undergo a specialist examination or specialist treatment under the public healthcare insurance that cannot be provided at the former institution and transport back to that institution.
- to transport from an institution where you have been admitted under the Long-Term Care Act (Wlz) to a person or institution where you will undergo dental treatment under the Long-Term Care Act (Wlz) that cannot be provided at the institution where you have been admitted and transport back to that institution.
- to accommodation costs.

The statutory personal contribution also applies to the return trip to the treatment centre if you use accommodation.

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Hospital care

Specialist medical care (general)

You are entitled to specialist medical care (general) plus the required admission. Specialist medical care is care such as medical specialists generally provide. Most medical specialists are affiliated to a hospital.

Specialist medical care includes:
- medical aids within the framework of an admission or medical specialist treatment provided they are (deemed to form) part of that admission or treatment
- medicinal care you receive within the framework of an admission or medical specialist treatment, provided they are (deemed to form) part of that admission or treatment
- conditionally permitted physiotherapy and specialist medical care as referred to in Article 2.2 of the Health Insurance Regulations under the associated conditions, insofar as it concerns responsible care. An up-to-date version can be found at www.hollandzorg.com/conditions.

specialist medical care does not include:
- treatment for snoring with uvuloplasty
- sterilisation of the insured party or the reversal thereof (either man or woman)
- circumcision of male insured parties, unless in the event of a medical need
- treatment of asymmetrical distortion of the back of the head (plagiocephaly) and central flattening of the back of the head (brachycephaly) in young children using a cranial remodelling helmet without the premature fusing of the cranial sutures (craniosynostosis)
- medicines as referred to in Appendix 0 of the Healthcare Insurance Regulations (Regeling zorgverzekering), subject to the conditions stipulated therein. The number of medicines and the conditions are subject to change in the interim. An up-to-date version can be found at www.hollandzorg.com/conditions.
- external devices as part of treatment of diabetes to monitor and control blood sugar disorders, including ketone test strips and insulin pumps.
- laboratory testing at the request of an alternative care provider.

PLEASE NOTE! Cover provided by specialist medical care (general) does not include care the cover for which is provided elsewhere in these policy conditions, such as transplant care or rehabilitation care.

Stays outside the institution
You are entitled to reimbursement of the costs of stays near the institution for your treatment if this is medically necessary in connection with specialist medical care, not involving nursing or (paramedical) care. However, some conditions apply, i.e.:
• you have an informal carer during your stay; and
• the travel time between the hospital where you receive treatment and your place of residence is more than 60 minutes; and
• the travel time between the hospital where you receive treatment and your place of accommodation is a maximum of 60 minutes.
The reimbursement of the accommodation costs is a maximum of € 89.00 per night. You arrange the stay yourself.

Plastic surgery
Plastic surgery only falls under specialist medical care if it concerns:
- defects in your appearance related to demonstrable physical functional disorders.
- mutilation resulting from a disease, accident or medical operation.

- paralysis or weakening of the upper eyelids, if this seriously restricts the range of vision or is caused by a congenital defect or a congenital chronic disorder.
- the following congenital malformations: cleft lip, jaw and palate, malformation of the facial bone structure, benign morbid growth of blood vessels, lymphatic vessels or connecting tissue, birth marks or malformation of the urinary organs or genitals.
- primary sexual characteristics in the event of diagnosed transsexuality.

specialist medical care does not include:
- treatment of paralysis or weakening of the upper eyelids, if this does not seriously restrict the range of vision or if caused by a congenital defect or a congenital chronic disorder
- liposuction of the stomach
- plastic surgical treatment to reconstruct the breast or replace a breast prosthesis, other than following full or partial mastectomy or in the case of agenesis or aplasia of the breast in women and a comparable situation in the event of diagnosed transsexuality
- the operative removal of a breast prosthesis without a medical need
- an abdominal wall correction (abdominal plastic surgery), except in the case of mutilation or serious functional disability

What do I need to keep in mind?
Hospitals, medical specialists or dental surgeons who work outside a hospital and independent treatment centres can provide this type of care. Hospitals and independent treatment centres are authorised to offer admission. If you are staying outside the institution, you may determine your place of accommodation.

Is prior written authorisation required?
Yes, to be reimbursed for treatments on the 'Pre-Authorisation List' and the 'Exhaustive List of Authorisations for Dental Surgery', you must have received written authorisation from us before receiving the care. These overviews can be viewed and downloaded at www.hollandzorg.com/conditions.

Your medical specialist knows for which treatments authorisation must be requested and which conditions you must meet for authorisation. Most hospitals are registered with the national authorisation portal. Your medical specialist can request digital authorisation via this portal. Your medical specialist will receive an answer from us to your request via the authorisation portal. If you visit a medical specialist who is not registered with the national authorisation portal or if you travel abroad for treatment, you must request and obtain authorisation from us to be entitled to reimbursement before the start of treatment. When applying for care, you must include a report from the attending physician, including the medical diagnosis/diagnoses, a description of the problem, the proposed treatment plan (care activity), the medical need for admission and, if applicable, appropriate photographs.

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, house officer, obstetrician, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, infectious disease and tuberculosis prevention doctor, A&E doctor, physician assistant, nursing specialist, sports doctor, clinical physiologic-audiologist, company doctor, dentist, dental surgeon, optometrist, orthoptist or triage hearing specialist.

This condition does not apply in the case of unforeseen care that cannot reasonably be postponed (emergency care). The referral will remain valid for a period of twelve months from the day it was issued.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Audiological care

You are entitled to audiological care. Audiological care consists of:
- a hearing test
- advise on the hearing aid to be purchased
- information on the use of the aid
- psychosocial care, if necessary, for issues related to impaired hearing
- assistance in establishing a diagnosis in the event of speech and language disorders in children.

What do I need to keep in mind?
Audiological centres can provide this type of care.

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, paediatrician, doctor for the mentally disabled, geriatrics specialist or triage hearing specialist. The referral will remain valid for a period of twelve months from the day it was issued.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Dialysis without admission

You are entitled to reimbursement of the costs of dialysis care. Dialysis is an artificial way of removing excess waste and fluid from the body when the kidneys are not working properly. Dialysis care comprises non-clinical blood dialysis (haemodialysis) and abdominal irrigation (peritoneal dialysis). The dialysis care can take place in a dialysis centre or at home.

You are entitled to reimbursement of the costs of:
- home dialysis equipment with accessories.
- regular inspection and maintenance of the dialysis equipment and the chemicals and liquids required for the dialysis.
- other consumables reasonably necessary for home dialysis.
- training organised by the dialysis centre of those carrying out or assisting in home dialysis.

- required expert assistance from the dialysis centre.

You are further entitled to reimbursement of:
- the costs for reasonable adjustments in and around the home and the costs of restoring the house to its original condition. The condition is that no reimbursement is provided under other statutory regulations.
- other reasonable costs directly related to home dialysis. The condition is that no reimbursement is provided under other statutory regulations.

What do I need to keep in mind?
The care must be provided under the final responsibility of a medical specialist.

Is a referral needed?
Yes, from a medical specialist or clinical technologist.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Genetic advice

You are entitled to genetic advice plus the required admission. Sometimes your family can have a predisposition to a hereditary disease. This can be investigated. Genetic advice consists of:
- investigation into and of hereditary defects through genealogical research, chromosome tests, biochemical diagnosis, ultrasound examinations and DNA tests.
- giving advice about the heredity of disorders/defects or an apparent increased risk thereof.
- psychosocial support in connection with the advice.
- examination of persons other than yourself, if necessary for the advice to be given to you. In that case, the other persons may also be given advice.

What do I need to keep in mind?
A centre for genetic advice can provide this type of care and offer admission.

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, doctor for the mentally disabled or geriatrics specialist. The referral will remain valid for a period of twelve months from the day it was issued.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

IVF and ICSI

You are entitled to the first, second and third IVF attempt or ICSI treatment and associated medication if you are under 43 at the start of the attempt and there are medical grounds to do so. If you are under 38, you are entitled to a maximum of one embryo transfer on the first and second attempt.

IVF is short for in vitro fertilisation. IVF treatment consists of:

1. hormone treatment to stimulate the maturation of egg cells in the woman's body.
2. A follicle puncture.
3. Fertilising egg cells and growing embryos in the laboratory.
4. The transfer of one or two embryos into the woman's uterine cavity for the purpose of creating a pregnancy.

ICSI treatment is a special form of IVF treatment. ICSI stands for 'intracytoplasmic sperm injection'. ICSI treatment involves an extra step in the laboratory.

An IVF attempt only counts as an attempt if a follicle puncture is successful, regardless of the quality (for example, ripe or unripe) or the number of eggs obtained during the puncture. Only attempts that are subsequently abandoned count towards the total number of three attempts. An IVF attempt after a viable pregnancy counts as a new, first attempt. This also applies if the pregnancy was terminated prematurely. In that respect, an ICSI attempt is equivalent to an IVF attempt.

Within the meaning of this document, a viable pregnancy is:

- a pregnancy lasting at least ten weeks, calculated from the moment of a successful follicle puncture

- in the event that (a) frozen embryo(s) are re-implanted, a pregnancy of at least nine weeks and three days, calculated from the moment that the frozen embryo(s) are re-implanted

- a spontaneous pregnancy of at least twelve weeks after the date of last menstruation.

What do I need to keep in mind?
An IVF centre can provide this type of care.

Is a referral needed?
Yes, from a general practitioner or medical specialist.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do you have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website.

The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Outside the Netherlands
It is possible that your IVF or ICSI treatment and associated medication will not be fully reimbursed if you choose to have this done abroad. That is why we advise you to contact us before you start the treatment process and enquire about the amount of the reimbursement for the planned process. This way, you will not be faced with financial surprises. If admission is part of the care, you will require our written authorisation before you receive the care.

Artificial respiration

You are entitled to artificial respiration plus the required admission. This can be at a respiratory centre or at home, on the advice and under the responsibility of a respiratory centre.

What is covered by this care in a respiratory centre?
- the necessary artificial respiration
- specialist medical care, medicinal care and the nursing and care
- the required admission

What is covered by this care if artificial ventilation takes place at home?
- medical specialist and medicinal care for artificial respiration
- the equipment needed for artificial respiration. The respiratory centre ensures that the equipment is ready for use before each treatment.
- an allowance for electricity costs (power consumption) in the case of chronic artificial ventilation.

What do I need to keep in mind?
A respiratory centre can provide this type of care and offer admission.
- The claim form for a contribution towards the electricity costs for artificial respiration at your home can be viewed and downloaded at www.hollandzorg.com/forms.

Is a referral needed?
Yes, from a general practitioner, medical specialist or clinical technologist.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Transplant care

You are entitled to transplant care plus the required admission. This applies to transplants of tissues and organs in the Netherlands.
If you are going abroad, you are only entitled to reimbursement of the costs of transplant care if the transplant care takes place in another EU or EEA country. Or in the country where the donor lives if the donor is your spouse, registered partner or blood relative in the first, second or third degree.
People with a malfunctioning or non-functioning organ may be eligible for a transplant.

The person who receives the organ or tissue is the recipient. The person who donates the organ or tissue is the donor.

Recipient
As the recipient, you are entitled to reimbursement of the following costs of transplant care:

a. the costs of specialist medical care in relation to selection of the donor.
b. the costs of specialist medical care in relation to the operative removal of transplant material from the selected donor.
c the costs of examination, preservation, removal and transport of the transplant material from a deceased donor in relation to the aforesaid transplant.
d. the care received by the donor during a period of no more than thirteen weeks after being discharged from the institution where the donor was admitted for selection or removal of the transplant material. This only applies if the care is related to that admission. For a liver transplant, this is six months. The costs will be reimbursed under the recipient's insurance. Once this period has expired, the costs are covered by the donor's health insurance.
e. costs of transporting the donor. This concerns the costs of the lowest class of public transport in the Netherlands. Or, if medically necessary, the costs of transport by car within the Netherlands. This in connection with the selection, admission and discharge from hospital and with the care referred to under d. This does not apply if the donor has health insurance. In that instance, the transport is at the expense of the donor's health insurance.
f. costs of transporting the donor to and from the Netherlands if the donor for a kidney, bone marrow or liver transplant lives abroad and the transplant care takes place in the Netherlands. This does not apply if the donor has health insurance. In that instance, the transport is at the expense of the donor's health insurance.
g. other transplant costs if they relate to the donor residing abroad. This does not include the accommodation expenses in the Netherlands and loss of income.

Donor
If someone else by virtue of health insurance is entitled to (reimbursement of the costs of) transplant care and you are the donor, you are entitled to reimbursement of:
h. specialist medical care in relation to the operative removal of transplant material from the selected donor, via the health insurance of the recipient.
i. care you receive in connection with the selection or surgical removal of the transplant material. The costs incurred after the date of discharge from the institution are covered by the health insurance of the recipient for a maximum of thirteen weeks. This term is six months in the event of liver transplants. When this term has expired, the costs are payable by your own health insurance.
j. your transport in the lowest class of a public transport option within the Netherlands and, if medically necessary, transport by car within the Netherlands. This in connection with the selection, admission and discharge from hospital and with the care referred to under j.
k. your transport to and from the Netherlands if you reside abroad, in connection with the transplant of a kidney, bone marrow or liver to an insured in the Netherlands.
l. other transplant costs if they relate to residing abroad, via the health insurance of the recipient. This does not include the accommodation expenses in the Netherlands and loss of income.

What do I need to keep in mind?
A transplant centre can provide this type of care and offer admission.

Is a referral needed?
Yes, from a medical specialist or clinical technologist. This condition does not apply in the case of unforeseen care that cannot reasonably be postponed.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess of the recipient?
Yes, from 18 years and older.

Are the costs deducted from the compulsory and voluntary excess of the donor?
No

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Thrombosis care

You are entitled to thrombosis care. People taking anticoagulant drugs will receive counselling and have their blood levels checked on a regular basis.

Thrombosis care consists of:
- regular blood tests.
- the laboratory tests required to determine the coagulation time of your blood under the responsibility of a thrombosis service.
- availability of equipment and accessories with which you can measure the coagulation time of your blood.
- your training for measuring the coagulation time of your blood and using the appropriate equipment plus assistance when taking these measurements.
- advice regarding the use of medicines to influence the coagulation.

What do I need to keep in mind?
Thrombosis services can provide this type of care.

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, doctor for the mentally disabled, geriatrics specialist or obstetrician.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates, under specialist medical care.

Sensory disability care

Sensory disability care

You are entitled to sensory disability care plus the required admission. You are eligible if you are visually impaired, blind, hard of hearing and/or deaf or have a serious speech-language development disorder. This concerns multidisciplinary care aimed at learning to live with, the elimination of or the compensation of the impairment, with the objective of allowing you to live as independently as possible. Multidisciplinary care means that different disciplines are involved in the treatment.

The care consists of:
- examination into the nature, cause and seriousness of your impairment.
- treatments aimed at learning to live with the impairment from a psychological viewpoint.
- treatments that remove or compensate the impairment, thereby increasing your self-reliance.
- secondary treatment of parents/carers, children and adults close to you. They learn skills in your interest. Secondary treatment is covered by your public healthcare insurance.

Impaired vision
Conditions for entitlement to care in the event of visual impairment are:
- visual acuity of < 0.3 in the least affected eye.
- range of vision < 30 degrees, or
- visual acuity between 0.3 and 0.5 in the least affected eye thus causing serious impairments in the daily functioning.

Impaired hearing
Conditions for entitlement to care in the event of impaired hearing are:
- Threshold loss in the audiogram of at least 35 dB, obtained by averaging the hearing loss at frequencies of 1000, 2000 and 4000 Hz, or
- you suffer from a threshold loss in excess of 25 dB when measuring in accordance with the Fletcher index, the average loss at frequencies of 500, 1000 and 2000 Hz.

Speech and linguistic difficulties
Conditions for entitlement to care in the event of serious speech and linguistic difficulties are:
- The insured party is not over the age of 22.
- You suffer from serious difficulty in acquiring your native language due to neurobiological and/or neuropsychological factors. Other (psychiatric, physiological, neurological) issues need to be subordinate to the language development disorder.

What do I need to keep in mind?
A centre for sensory disability care can provide this type of care and offer admission.

Is prior written authorisation required?
Admission for sensory disability care by a non-contracted care provider is subject to our written authorisation, prior to you being admitted. You must enclose a (copy of the) treatment plan with your application.

Is a referral needed?
Yes, from a medical specialist or clinical physiologic-audiologist. You must have a second or subsequent referral from a medical specialist, clinical physiologic-audiologist, paediatrician or general practitioner.

A second or subsequent referral is not required if you have a visual impairment and meet the following conditions:
- You previously received sensory disability care for your visual impairment; and
- There has been a change in your medical or personal situation, as a result of which you have a renewed requirement for treatment.
- The healthcare provider establishes that your treatment requirement is non-complex, which can be dealt with in a short programme, the so-called care programme 11.

A second or subsequent referral is also not needed if the insured party is under the age of 18 and the insured party has a renewed requirement for treatment that is the result of a predictable treatment need due to the insured party's growing up.

Is there a statutory personal contribution?
No

Are the costs deducted from the compulsory and voluntary excess?
Yes, from 18 years and older.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. Contracted care providers are listed at www.hollandzorg.com/careprovider.

Supplementary Insurance Flexpolis No Risk I

Flexpolis No Risk I provides cover for compulsory excess.

Specific provisions for the Flexpolis No Risk I

The Flexpolis No Risk I is a supplementary insurance. The following applies to the Flexpolis No Risk I:

• the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the public healthcare insurance;

• the arrangements in this chapter Supplementary insurance Flexpolis No Risk I;

• the list of terms;

• all appendices referred to in the applicable terms and conditions.

The supplementary insurance is further based on the information provided by you (policyholder) during the application for the supplementary insurance and on agreements in connection with any group scheme you participate in.

Taking out and cancelling the Flexpolis No Risk I

1. When can I take out a Flexpolis No Risk I policy?

The following acceptance conditions apply to taking out a Flexpolis No Risk I policy:

• you (policyholder) can only take out Flexpolis No Risk I insurance if the person you wish to insure has public healthcare insurance as well.

• you (policyholder) and the person to be insured do not have any payment arrears with or have been expelled in the past by Salland Zorgverzekeraar N.V. or Salland Aanvullende Verzekeringen N.V.

• you (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk I policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk policy can be taken out.

We reserve the right to refuse the provision of the Flexpolis No Risk I for other reasons.

2. How do I take out a Flexpolis No Risk I policy?

Your employer or other (legal) person with whom we have concluded a group healthcare scheme applies for the Flexpolis No Risk I on your behalf. You must have authorised this person to do so.

3. When does the Flexpolis No Risk I commence?

If the application for the Flexpolis No Risk I is made simultaneously with an application for public health insurance for the same person, the supplementary insurance incepts on the day that the public health insurance incepts for that person. In all other cases, the supplementary insurance commences on 1 January of the following year.

If you (policyholder) apply for a Flexpolis No Risk I, we assume that, by doing so, you have authorised us to terminate your supplementary healthcare insurance with the previous health insurer. If you do not want this, you must notify us thereof in writing when making the application.

4. When does the Flexpolis No Risk I terminate?

In addition to the reasons for termination contained in the General Provisions chapter, the Flexpolis No Risk I terminates on the day following that on which:

a) the group (healthcare) scheme within the meaning of article 1 of the Specific provisions for the Flexpolis No Risk I is terminated;

b) if you (insured/policyholder) cease to be employed by the employer with whom we concluded the group scheme;

c) if you (insured party/policyholder), for reasons other than those under b, no longer meet the conditions for participation as described in the group scheme within the meaning of article 1, Specific provisions for the Flexpolis No Risk I.

Premium

5. When are premium payments waived?

You (policyholder) must pay us premium, except for the period that cover for the Flexpolis No Risk I is suspended (temporarily discontinued), because you are serving a custodial sentence.

Specific restrictions for the Flexpolis No Risk I

6. What restrictions apply in the case of exceptional circumstances?

You are not entitled to reimbursement of the costs of care if the harm is caused by, occurred during or ensues from a nuclear reaction. This exclusion does not apply to harm caused by radioactive nuclides which are located outside a nuclear facility and are used or intended for use for industrial, commercial, agricultural, medical, scientific or security purposes. The above is subject to a valid permit having been issued by the central government for the manufacture, use, storage and disposal of radioactive substances. The provisions of the previous three sentences do not apply if somebody else is liable for the injury caused, pursuant to Dutch law or the law of another country.

7. Which restrictions apply in case of concurrence with other provisions?

You are not entitled to reimbursement of the costs of care:

• if you are entitled to reimbursement of the costs of that care by virtue of another agreement, law or other provision;

• if you would be entitled to reimbursement of the costs of that care by virtue of that other agreement, law or other provision if your Flexpolis No Risk I had not been in existence.

No excess or personal contribution applicable to that other agreement, law or other provision is ever covered by the Flexpolis No Risk I.

Flexpolis No Risk I Cover

Compulsory excess

Flexpolis No Risk I	
Compulsory excess	100%

You are entitled to reimbursement of the costs that are subject to your compulsory excess.

Flexpolis No Risk I and III

The Flexpolis No Risk II and III provide cover for specific care and services.

Specific provisions for the Flexpolis No Risk II and III

The Flexpolis No Risk II and III are supplementary insurances. The following applies to the Flexpolis No Risk II and No Risk III:

• the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the public healthcare insurance;

• the arrangements in this chapter Supplementary insurance Flexpolis No Risk II and No Risk III;

• the list of terms;

• all appendices referred to in the applicable terms and conditions.

The supplementary insurance is further based on the information provided by you (policyholder) during the application for the supplementary insurance and on agreements in connection with any group scheme you participate in.

Taking out and cancelling the Flexpolis No Risk II and III.

1. When can I take out supplementary insurance?

The following acceptance conditions apply to taking out a Flexpolis No Risk II and No Risk III policy.

• you (policyholder) can only take out a Flexpolis No Risk II policy if the person you (policyholder) want to insure also has public health insurance at the time of the Flexpolis No Risk II policy coming into force;

You (policyholder) can only take out a Flexpolis No Risk III policy if the person you (policyholder) want to insure also has a Flexpolis No Risk II at the time of the Flexpolis No Risk III policy coming into force;

• you (policyholder) and the person to be insured do not have any payment arrears with or have been expelled in the past by Salland Zorgverzekeraar N.V. or Salland Aanvullende Verzekeringen N.V.;

• You (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk II policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk I and II policy can be taken out.

• You (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk III policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk I, II and III policy can be taken out.

PLEASE NOTE! We reserve the right to refuse the provision of a Flexpolis No Risk II and No Risk III policy for other reasons.

2. How do you take out a Flexpolis No Risk II and No Risk III policy?

Your employer submits an application for a Flexpolis No Risk II and III policy on your behalf. You must have authorised your employer to do so.

You will receive your Flexpolis No Risk II policy automatically if HollandZorg has agreed such arrangements within a group scheme.

3. When does the Flexpolis No Risk II and No Risk III incept?

If the application for the Flexpolis No Risk II or No Risk III is made simultaneously with an application for public health insurance for the same person, the supplementary insurance incepts on the day that the public health insurance incepts for that person. In all other cases, the supplementary insurance commences on 1 January of the following year.

If you (policyholder) apply for a Flexpolis No Risk II or No Risk III, we assume that, by doing so, you (policyholder) have authorised us to terminate your supplementary healthcare insurance with the previous health insurer. If you (policyholder) do not want this, you (policyholder) must notify us in writing when making the application.

4. When does the Flexpolis No Risk II and No Risk III end?

In addition to the reasons for termination contained in the General Provisions chapter, Flexpolis No Risk II and No Risk III terminate on the day following that on which:

a) the group scheme within the meaning of article 1 of the Specific provisions for Flexpolis No Risk II and No Risk III is terminated;

b) if you (insured/policyholder) cease to be employed by the employer with whom we concluded the group scheme;

c) if you (insured party/policyholder), for reasons other than those under b, no longer meet the conditions for participation as described in the group scheme within the meaning of article 1, Specific provisions for Flexpolis No Risk II and No Risk III.

Premium

5. When are premium payments waived?

You (policyholder) must pay us premium, except for the period that cover for Flexpolis No Risk II and No Risk III is suspended (temporarily stopped), because you are serving a custodial sentence.

Insurance cover general

6. When am I entitled to reimbursement?

The content and scope of the care are partially determined by the state of the art and practice. If there is no such benchmark, it is determined by that which is regarded as responsible and adequate care in the discipline in question.

You are only entitled to reimbursement of the costs of care if:

• you have complied with all the conditions set by us;

• the care in question can reasonably be regarded as necessary for you in terms of content and scope. The care to be provided must be effective and not unnecessarily expensive or unnecessarily complicated;

• you receive the care at a location which can be regarded as customary, given the nature of the care and the circumstances.

If a guideline/care standard/quality standard has been established for healthcare, you are entitled to (reimbursement of the costs of) the care, if the care has been provided according to that standard. The current care standards can be viewed and downloaded at www.zorginzicht.nl/kwaliteitsinstrumenten. If your care provider deviates from the guideline/care standard/quality standard, you are still entitled to (reimbursement of the costs of) the care if your care provider demonstrates that deviation from this is medically necessary in your case and your care provider justifies this in your medical file.

You are not entitled to a higher level of reimbursement of the cost of care exceeding the actual cost paid for that care.

You may only receive the care from a care provider designated by us. Which care providers may deliver the care is specified for each type of care. You are entitled to reimbursement of the costs of care provided by a care provider not appointed by us, provided we have given our written authorisation before you receive the care.

For some forms of care, we set a maximum rate per session or treatment from a non-contracted care provider. The maximum rates do not apply to care from contracted care providers. The care providers contracted by us can be found at www.hollandzorg.com/careprovider.

In some cases, the agreement between us and the care provider ends the moment you receive care from that care provider. In that case, you are entitled to reimbursement of the costs of the remaining care to be provided by this care provider as if the contract was still in place.

If you have to pay VAT on that care, the reimbursement also covers those costs.

Specific restrictions for the Flexpolis No Risk II and No Risk III

7. Which general restrictions apply to the insurance cover?

You are not entitled to reimbursement of the costs of care:

• provided abroad, unless explicitly stated otherwise in these policy conditions;

• that are subject to the compulsory excess, unless explicitly stated otherwise in these policy conditions;

• that are subject to the statutory personal contribution, unless explicitly stated otherwise in these policy conditions;

• incurred as a result of your negligence or intention;

• for injury sustained during your participation in a crime;

• for injury sustained during and partly the result of playing competitive sport abroad;

• for injury sustained and partly the result of practising dangerous sports or professional or semi-professional sport;

• for injury sustained during and partly the result of mountaineering of a nature which would be challenging for an untrained person;

• incurred during winter sports, except sledging, skating, cross-country skiing, snowboarding and on-piste skiing;

You are not entitled to reimbursement of search, rescue and recovery.

8. What restrictions apply in the case of exceptional circumstances?

You are not entitled to reimbursement of the costs of care if the harm is caused by, occurred during or ensues from a nuclear reaction. This exclusion does not apply to harm caused by radioactive nuclides which are located outside a nuclear facility and are used or intended for use for industrial, commercial, agricultural, medical, scientific or security purposes. The above is subject to a valid permit having been issued by the central government for the manufacture, use, storage and disposal of radioactive substances. The provisions of the previous three sentences do not apply if somebody else is liable for the injury caused, pursuant to Dutch law or the law of another country.

9. Which restrictions apply in case of concurrence with other provisions?

You are not entitled to reimbursement of the costs of care:

• if you are entitled to reimbursement of the costs of that care by virtue of another agreement, law or other provision;

• if you would be entitled to reimbursement of the costs of that care by virtue of that other agreement, law or other provision if the Flexpolis No Risk II or No Risk III had not been in existence.

The Concurrence Agreement contains agreements about the distribution of costs by health insurers and travel insurers. If you are insured under a (travel) insurance policy with cover for medical costs abroad with a (travel) insurer that has not signed the Concurrence Agreement, our supplementary insurance applies as excess insurance. In that case, you are only entitled to reimbursement if the medical costs abroad exceed the cover of that (travel) insurance.

This also applies to costs paid or advanced by the other (travel) insurer on other grounds.

No excess or personal contribution applicable to that other agreement, law or other provision is ever covered by the Flexpolis No Risk II and No Risk III.

Cover and reimbursement per care form

Medically necessary repatriation

Flexpolis No Risk II	
Medically necessary repatriation worldwide	100 %

You are entitled to transport of yourself and the organisation of such transport:

- from the country of temporary residence to the Netherlands or your country of origin;
- from the Netherlands to your country of origin.

Transport of family members and other travel companions does not fall under this. Furthermore, there has to be a medical need for the transport.

A medical need is deemed to exist if, in our opinion, treatment in your country of origin is medically needed, because proper local care is not available or is not of a sufficient medical standard, or because medical treatment locally entails higher costs than in the Netherlands or your country of origin. Social reasons such as family reunion and language problems are not included.

You retain entitlement to this cover for a 14-day period after termination of your Flexpolis No Risk II.

What do I need to keep in mind?

We will arrange the repatriation. To that end, you or your representative has to contact the HollandZorg emergency line: +31 (0)570 687 110.

Transport of mortal remains

Flexpolis No Risk II	
Transport of mortal remains worldwide	maximum of € 15,000

You are entitled to transport of your mortal remains from the place of death in the Netherlands or a country of temporary stay to your country of origin and the arrangements for that transport. Transport is given to mean: the costs of the transport itself (the ticket) and the additional costs necessary for transport (compulsory embalming, transport coffin, etc.). Entitlement to this cover continues for a 14-day period after termination of your Flexpolis No Risk II.

What do I need to keep in mind?

We will arrange the transport. To that end, your representative has to contact the HollandZorg emergency line: +31 (0)570 687 110. Reimbursement can only be paid by contacting the emergency line.

Pharmaceutical care

Flexpolis No Risk II	
Pharmaceutical care	100 %

You are entitled to reimbursement of the statutory personal contribution for medicinal care under the public health insurance.

Emergency oral care in the Netherlands

Flexpolis No Risk II	
Emergency oral care in the Netherlands	a maximum of € 200 per calendar year

You are entitled to reimbursement of the costs for urgent dental treatment in the Netherlands.

Here, emergency care is given mean: unforeseen care that cannot reasonably be postponed. It concerns care that is intended to alleviate acute pain and ensure sufficient chewing capacity. A dental overhaul is not urgent care.

For every usual treatment a description of the care is available. The Dutch Healthcare Authority provides is. Only treatments with a description of care as referred to in HollandZorg's Operations list for urgent dental care qualify for reimbursement. The HollandZorg's Operations list for urgent oral care can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?
- A dentist can provide all types of care.
- A prosthodontist may only provide prosthodontic treatments and measure, make and fit removable (full) dental prosthetics for the upper or lower jaw, whether or not secured on dental implants.

Is a referral needed?
You must have a referral from a dentist for the measuring, making, fitting and placing of a removable (full) prosthetic provision for the upper or lower jaw by a dental prosthodontist, secured on dental implants.

Contracted care providers are listed at www.hollandzorg.com/careprovider. Alternatively, you can call our Customer Service on +31 (0)570 687 123.

Oral care

Flexpolis No Risk III	
Oral care in the Netherlands	100% up to a maximum of € 250 per calendar year, for consultations and other oral care jointly

For oral care, we provide cover for the elements set out below. The reimbursement applies to the various elements jointly.

By a consultation we mean a consultation for a periodic check-up (C002) and a consultation other than a periodic check-up (C003) in the performance list for oral care of the Dutch Healthcare Authority.

Codes are shown next to each type of treatment, the so-called performance codes. These have been formulated by the Dutch Healthcare Authority. You can view them and download the list at www.nza.nl. You are only entitled to reimbursement of the costs of care with those service codes. We will not reimburse the costs of an appointment which you fail to keep.

General oral care in the Netherlands

You are entitled to reimbursement of all treatments listed below which are included in the list of oral care services of the Dutch Healthcare Authority.

Type of treatment	Performance code
• consultation and diagnosis	all C codes
• taking and assessing X-rays	all X codes
• preventive oral care	all M codes
• anaesthetic	all A codes
• light anaesthetic	all B codes
• fillings	all V codes
• root canal treatments	all E-codes with the exception of E97 (external bleaching of teeth and molars)
• crowns and bridges	all R codes
• gnathological treatments	all G codes
• surgery	all H codes
• dentures	all P codes
• gum treatments	all T codes
• implants	all J-codes and, for care provided by dental surgeons, the relevant medical specialist performance services (other care products).

You are not entitled to reimbursement of the costs of cosmetic oral care. By cosmetic oral care we mean the non-medically necessary dental treatments ‘placement of facings’ and ‘external whitening of teeth and molars’, which fall within the experiment ‘deregulated rates for Cosmetic Oral Care’ and for which deregulated rates according to the regulations of the Dutch Healthcare Authority apply.

Material and Technical costs
You are entitled to reimbursement of material and technical costs for the codes listed above, if they apply. Material and technical costs are the costs of creating e.g. crowns, dentures or braces. Your reimbursement is calculated on the basis of no more than the amount included for the treatment in question on the Maximum reimbursement for technical costs list. This list can be viewed and downloaded at www.hollandzorg.com/conditions.

Urgent dental treatment outside the Netherlands
You are entitled to reimbursement of emergency oral care abroad. The cover for oral care abroad is limited to treatments on the 'List of emergency oral care'. You can view this list at www.hollandzorg.com/conditions.

Concurrent cover oral care in No Risk II and No Risk IIII
The costs of oral care in the Netherlands are first charged to the cover for dental care in the Netherlands based on the No Risk III. Once the maximum reimbursement amount has been reached, costs will be reimbursed from the cover that No Risk II provides for emergency dental care in the Netherlands. Costs that are no longer covered under either No Risk III or under No Risk II are payable by you.

What do I need to keep in mind?
A dentist, whether or not affiliated to a centre for centre special dentistry or a youth dental care institution, is permitted to provide all care.

A dental hygienist, whether or not affiliated to a centre for special dentistry or an institution for youth dentistry, may provide the care insofar as it concerns care that dental hygienists tend to provide.

A dental surgeon can only provide implantology.

A prosthodontist may only provide prosthodontic treatments and measure, make, fit and place removable (full) dental prosthetics for the upper or lower jaw, whether or not secured on dental implants. You must have a referral from a dentist for the measuring, making, fitting and placing of a removable (full) prosthetic provision for the upper or lower jaw by a dental prosthodontist, secured on dental implants.

Physiotherapy and remedial therapy

Flexpolis No Risk III	
Physiotherapy and remedial therapy	6 sessions per calendar year

You are entitled to reimbursement of the costs of:

• general physiotherapy;

• manual therapy;

• Cesar and Mensendieck exercise therapy;

• scar treatment;

• psychosomatic physiotherapy and psychosomatic remedial therapy;

• geriatric physiotherapy and geriatric remedial therapy;

• pelvic physiotherapy and pelvic remedial therapy;

• oedema therapy and lymph drainage;

• paediatric physiotherapy and paediatric remedial therapy.

The reimbursement applies to the various therapies jointly.

The insured party is only entitled to paediatric physiotherapy and paediatric remedial therapy if the insured party is younger than 18.

A treatment or consultation is referred to as a session. We also reimburse sessions abroad. Sessions abroad are subject to the rates for non-contracted care.

NOTE: manual therapy treatments E.S. (Egg Shell) / Van der Bijl method and orthomanual medicine are not covered under physiotherapy and remedial therapy.

Not every treatment counts as one session. A session is calculated as follows:

• telephone session ½ session

• screening ½ session

• intake and examination after screening ½ session

• group session 3-10 people ½ session

• other 1 session.

What do I need to keep in mind?

The following care providers are permitted to provide this type of care:

• general physiotherapy: a physiotherapist;

• pelvic physiotherapy: a pelvic physiotherapist;

• geriatric physiotherapy; a geriatric physiotherapist;

• paediatric physiotherapy: a paediatric physiotherapist;

• scar treatment: a physiotherapist and skin therapist;

• manual physiotherapy: a manual therapist;

• psychosomatic physiotherapy: a psychosomatic physiotherapist;

• oedema therapy and lymph drainage: an oedema therapist and skin therapist;

• general remedial therapy: a remedial therapist (Cesar or Mensendieck);

• pelvic remedial therapy: a pelvic remedial therapist;

• geriatric remedial therapy: a geriatric remedial therapist;

• psychosomatic remedial therapy: a psychosomatic remedial therapist;

• paediatric remedial therapy: a paediatric remedial therapist.

• supervised remedial therapy in the event of peripheral arterial vascular disease (intermittent claudication): a physiotherapist or remedial therapist who is affiliated to the Chronisch ZorgNet national network. These care providers can be found in the Chronisch ZorgNet care finder at www.chronischzorgnet.nl/nl/zorgzoeker. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation to Chronisch ZorgNet is not compulsory if the provision of care started before 1 January 2018;

• physiotherapy and remedial therapy in the event of Parkinson's disease: a physiotherapist or remedial therapist affiliated to the national ParkinsonNet network. These care providers can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl/#/. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.

Is a referral needed?

Yes, from a general practitioner, medical specialist, paediatrician, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, dentist, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP):

• for treatment of a complaint on the List of chronic disorders that qualify for physiotherapy and remedial therapy. The List of chronic disorders that qualify for physiotherapy and remedial therapy can be viewed at www.hollandzorg.com/conditions.

No referral is needed for all remaining treatments.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care at www.hollandzorg.com/rates. If the rates of the non-contracted care provider are higher than our maximum rates, the difference will be payable by you. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

Glossary
What do all the terms mean?

In these policy conditions, the following terms are defined as follows:

A&E doctor
A doctor who is entered as A&E doctor in the KNMG's Board of Registration's Medical Specialists register.

Addiction specialist
A doctor who is listed as an addiction specialist in the KNMG's Board of Registration's Medical Specialists register.

Admission
Medically necessary stay of 24 hours or more during an uninterrupted period of up to 1095 days (three years).

An interruption of the admission for a maximum period of thirty days is not regarded as an interruption to the uninterrupted period. The duration of the interruption does not count in the calculation of the 1095 days, except in the event of weekend and holiday leave. Interruptions for weekend and holiday leave are included in the calculation of the 1095 days.

Admission does not include:

- stays you require in connection with a psychiatric disorder or impairment if you are under 18.
- stays in connection with the temporary takeover of care to relieve an informal carer (respite care).

Admission does not include first-line in-patient stays.

A doctor affiliated to Nederlandse Straatdokters Groep
Nederlandse Straatdokters Groep (NSG) is the executive organisation of the Doctors for Homeless Foundation (DHF).

Ambulance
A motor vehicle, vessel or helicopter as referred to in Article 1, paragraph 1 of the Ambulance Care Services Act (Wet Ambulancezorgvoorzieningen).

Audiological centre
A centre that provides audiological care and, insofar as required by law, is licensed accordingly.

Authorisation (consent)
Written authorisation from us for the purchase of specific care, prior to the purchase of that specific care.

Birth centre
A centre that provides obstetric care and, insofar as required by law, has a permit for this. Here you can give birth and possibly stay during the maternity period after delivery.

BRP
Key Register of Persons.

BSN
BSN stands for citizen service number. Your BSN is shown on your passport or identity document.

Bureau Jeugdzorg
An agency as defined in Article 4 of the Youth Care Act (Wet op de Jeugdzorg).

CAK
The Central Administrative Office for Exceptional Medical Insurance (CAK) referred to Article 6.1.1, paragraph 1 of the Long-Term Care Act.

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

Care
The care and other services as referred to in the Healthcare Insurance Act with regard to public healthcare insurance. The care and services in the articles on cover and reimbursement in the chapter on specific provisions for the supplementary insurances as regards the supplementary insurances. The care and other services in the article on cover and reimbursement in the chapter on dental insurance as regards dental insurances.

Care group
A care provider who, as the principal contractor, provides integrated care and/or combined lifestyle interventions. The care provider can provide the care with or without the help of other care providers who, at the instructions of the principal contractor, provide coherent and collaborative integrated care and/or combined lifestyle interventions. In principle, the care is invoiced by the principal contractor.

Care institute
National Health Care Institute.

Care plan
A dynamic set of agreements between you and your care provider(s) regarding nursing and care and your personal contribution to the care (self-management). These agreements are based on individual targets, needs and situations. They are formulated as part of a joint decision-making process. The care plan must at least state the type, scope and intended duration of the required nursing and care and the performances. You or your legal representative must have signed the care plan. The obligation to sign also applies when adjustments are made to the care plan.

Care Programme 11 11
Care Programme 11 as referred to in Bureau HHM's Visual Care Programmes report, auditive and communicative, of November 2016. Care Programme 11 is available if you have a few non-complex questions about learning skills to enable you to carry on living as independently as possible. Questions relating to communication, housekeeping, the use of special aids, personal care and mobility, which can easily be answered.

Care provider
A natural or legal person that provides care professionally or commercially.

Chemist
A chemist listed in the register of established dispensing chemists as defined in Article 61, paragraph 5 of the Medicines Act.

Doctor
A doctor listed as a doctor in the register as defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Chemist's preparations
A medicine that is prepared on a small scale at a dispensing chemist's pharmacy by or on behalf of the dispensing chemist or (a general practitioner who runs a joint practice with a) dispensing general practitioner, as referred to in Article 40, paragraph 3, subparagraph d of the Medicine Act (Geneesmiddelenwet).

Centre for genetic advice
A centre with a permit under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) for the application of clinical genetic research and genetic advice and, insofar as required by law, has a permit pursuant to the Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorginstellingen). A centre for genetic advice examines whether your symptoms, or those of your child or other family members have a hereditary cause.

Centre for sensory disability care
An institution for the provision of sensory disability care, which is a member of FENAC (Netherlands Federation of Audiological Centres or NOG (Netherlands Ophthalmological Society).

Centre for special dentistry
A university or other centre considered by us to be equivalent to a university for providing oral care in special cases where treatment by a team or special skills are required.

Chiropodist
A chiropodist who:

• is listed in the Chiropodist's Quality Register specialising as a diabetic foot chiropodist or medical chiropodist; or

• is listed in the Medical Foot Care Providers Quality Register (KMV) which is managed by the Quality Registration and Accreditation of Healthcare Professionals (KABIZ) in collaboration with the Dutch Medical Foot Care Providers Association (NMMV); or

• is listed as a paramedical chiropodist in the Paramedic Foot Care Register (RPV).

A chiropodist who provides pedicure treatment within the meaning of the supplementary insurance may also be listed in the Chiropodists Quality Register (KRP) specialising in foot care for rheumatics.

Clinical geriatrics doctor
A doctor who is entered as clinical geriatrics doctor in the KNMG's Board of Registration's Specialists register.

Clinical neuropsychologist
A healthcare psychologist registered as a clinical neuropsychologist in accordance with the conditions defined in Article 14 of the Individual Health Care Professions Act (Wet BIG).

Clinical physiologic-audiologist.
A clinical physicist having completed nationally recognised training as a clinical physiologic-audiologist. The clinical physicist/audiologist investigates hearing problems in children and adults with complex hearing problems, such as irritating tinnitus.

Clinical psychologist
A healthcare psychologist registered as a clinical psychologist in accordance with the conditions defined in Article 14 of the Individual Health Care Professions Act (Wet BIG).

Clinical Technologist
A clinical technologist (technical physician) who is entered as a clinical technologist in the register as defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Company doctor
A doctor who is listed as a company doctor in the KNMG's Board of Registration of Doctors of Social Medicine register and acts on behalf of the employer or the Working Conditions Service (Arbodienst) with which the employer is affiliated.

Competitive Dutch rate
The costs of care minus the costs in excess of what can reasonably be regarded as appropriate under Dutch market conditions.

Contracted care provider
A care provider with whom we have concluded an agreement. This agreement outlines arrangements such as the ability to claim directly for the care provided and the quality of the care. Contracted care providers are listed at www.hollandzorg.com. You can also contact our Care Advice Line on +31 (0)570 687 123.

Coordinating practitioner/practitioner in charge
The supplier who, in response to your request for care, diagnoses you and is responsible for the treatment. The coordinating practitioner may provide the care him/herself. If the care is also provided by others, the coordinating practitioner retains ultimate responsibility for the treatment. In medical care for specific patient groups, the coordinating practitioner is the officer responsible for drawing up the care and treatment plan and for implementing the care and treatment plan in a multidisciplinary context.

COPD
Chronic obstructive pulmonary disease.

DBC (care product)
DBC is the abbreviation for diagnostic treatment combination. A DBC or DBC care product describes the finished process of (medical) specialised care, as set out in decisions by the Dutch Healthcare Authority, by means of a DBC performance code or care product code. The DBC procedure commences when the insured party reports his care requirement and is completed at the end of the treatment or after the maximum number of days the DBC (care product) can be 'open' if the treatment has not yet been completed by that time.

Dental surgeon
A Dental, Oral and Maxillofacial Surgery specialist registered by the Dentistry Specialisms Board of Registration (RTS) of the Royal Dutch Dental Organisation (KNMT) in the Dental, Oral and Maxillofacial Surgery specialists register.

Dentist
A dentist registered as such in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Diagnosis
Examination into the nature, cause and seriousness of a disorder.

Dialysis centre
A centre that provides dialysis care and, insofar as required by law, has a permit for this. A dialysis centre may be affiliated to a hospital, but not necessarily so.

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

Dietician
A dietician who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Dispensing general practitioners
A general practitioner licensed to dispense medicines.

District nurse
A qualified nurse.

Doctor for the mentally disabled
A doctor registered as a doctor for the mentally disabled in the KNMG's Board of Registration of general practitioners, geriatrics specialists and doctors for the mentally disabled.

EEA country
A country which, like the EU countries, is party to the Agreement on the European Economic Area: Liechtenstein, Norway and Iceland.

Entire period of insurance
The uninterrupted period during which you were insured by virtue of supplementary insurance.

EU country
A country that is a member of the European Union: Austria, Belgium, Bulgaria, Croatia, the Czech Republic, Cyprus (Greek part), Denmark, Estonia, Finland, France (including Guadeloupe, French Guyana, Martinique, Reunion, St. Martin), Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal (including Madeira and the Azores), Romania, Slovenia, Slovakia, Spain (including Ceuta, Melilla and the Canaries) and Sweden.

Excess
1. Compulsory excess
The amount of healthcare costs covered by the public healthcare insurance that you must pay yourself and that is determined by the government.

2. Voluntary excess
The amount of healthcare costs covered by the public healthcare insurance that you must pay yourself if you (policyholder) have opted for this in addition to the compulsory excess. If you opt for this, you (policyholder) will receive a discount on the healthcare premium. The higher the voluntary excess, the higher the discount. However, this also means you have to pay a higher lump sum amount if you use care that is subject to excess.

Eye clinic
An independent treatment centre specialising in eye treatment.

Fraud
To commit, to attempt to commit or to instruct others to commit forgery of documents, fraud, deceit, embezzlement or deliberate prejudice to us, aimed at obtaining (a reimbursement of the costs of) care to which no right exists, or to conclude, extend or terminate an insurance contract or to obtain insurance cover under false pretences.

General practitioner
A doctor registered as a general practitioner in the register of general practitioners, geriatrics specialists and doctors for the mentally disabled of KNMG's Board of Registration. The general practitioner may be independently established or work in a general practitioner services structure (GP out-of-hours surgery), a GP surgery or care group.

General practitioner services structure (GP out-of-hours surgery)
An organisational association of general practitioners with a corporate personality. The association is set up to provide general practitioner's care in the evening, at night and at the weekends and charges a legally valid rate.

Geriatric physiotherapist
A physiotherapist who is listed as a geriatric physiotherapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Geriatric physiotherapy
Care generally provided by geriatric physiotherapists.

Geriatric remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a geriatric remedial therapist.

Geriatric remedial therapy
Care generally provided by geriatric remedial therapists.

Geriatrics specialist
A doctor entered as a geriatrics specialist (nursing home doctor) in the KNMG's Board of Registration of general practitioners, geriatrics specialists and doctors for the mentally disabled.

GGZ
Mental healthcare.

Group scheme
An agreement between us and a third party, such as an employer or association, that sets out agreements about benefits which the persons described in that agreement, such as employees or members, can enjoy if they comply with the conditions stipulated in the agreement. We refer to such employees or persons as participants.

G-standard of Z-index
An electronic database that lists all medicines, aids and health products that can be obtained through the pharmacy and institutions. The database is kept up-to-date by Z-index B.V.

Health insurance
Health insurance as defined in the Healthcare Insurance Act (Zorgverzekeringswet).

Healthcare psychologist
A healthcare psychologist who is listed as a healthcare psychologist in the registered as defined in Article 3 of the Wet BIG.

HollandZorg
Salland Zorgverzekeraar N.V. In the event of references to supplementary insurance, 'HollandZorg' is taken to mean: Salland Aanvullende Verzekeringen N.V.

Hospital
A specialist medical care facility for the examination, treatment and nursing of the sick.

House Officer
An AIOS, House Officer or an ANIOS, Senior House Officer, who is listed as a doctor in the register as defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Independent treatment centre
An institution for specialist medical care.

Infectious disease and tuberculosis prevention doctor
Een doctor registered as Public Health Doctor in the Infectious Disease Prevention register or Tuberculosis Prevention register the of the Commission for the Registration of Social Medicine of the KNMG (Royal Netherlands Medical Society).

Informal care
Unpaid care for an elderly, chronically ill or handicapped loved one in need of assistance. The care is provided for more than 8 hours per week and at least three months in a row.

Informal carer
An informal carer is a person who provides care other than in a professional capacity.

Institution
• an institution in the sense of the Healthcare Institutions Eligibility Act (Wet toelating zorgaanbieders);

• a legal entity established outside the Netherlands that provides care in the country in question within the framework of the social security system of that country, or specialises in providing care to specific groups of public officials.

Integral birth care organisation
A care provider in which the various disciplines of the birth care chain are equally represented and which provides that integrated birth care.

Insurance
Public healthcare insurance, supplementary insurance, dental insurance.

Insured party
The person whose risk of requiring care is covered by the insurance and who is listed on the policy as the insured person.

Integrated care
Coordinated, multidisciplinary care for a specific disorder on the basis of the relevant care standard as referred to in the policy document for general practitioner care and multidisciplinary care defined on the basis of the Healthcare (Market Regulation) Act (Wet Marktordening gezondheidszorg). The objective is for care providers to work closely together and to properly coordinate the care for you.

Intensive paediatric care
The care for an insured party under 18, because he has a complex physical medical disorder (complex somatic disorder) or a physical handicap:

• requiring permanent monitoring; or

• requiring the availability of round-the-clock care combined with nursing.

Invoice
Written proof of the costs incurred by a care provider, which shall at least contain the following information: the name, address and profession of the care provider, invoice date, date on which the care was provided and description of that care and the name and date of birth of the insured party. An invoice (also referred to as account or bill) also has to comply with the statutory requirements for claiming the care. A quotation, an advance bill, reminder or demand does not constitute an invoice.

IVF centre
An institution licensed under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) to provide IVF.

KNMG
The Royal Dutch Medical Association.

Manual therapist
A physiotherapist who is registered as a manual therapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Manual therapy
Manual therapy is care generally provided by manual therapists.

Maternity carer
A trained care provider who provides support and care during childbirth (in addition to the obstetric care provided by the obstetrician) and to the mother and her family during the maternity period. A maternity carer ensures the wellbeing of mother and child, and reports to the obstetrician or doctor if necessary.

Medical advisor
One of our employees who is listed in the registers in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Medical specialist
A doctor who is listed as a specialist with a legally recognised specialist title in a specialists register as referred to in Article 14, paragraph 1 of the The Individual Healthcare Professions Act (Wet op de beroepen in de individuele gezondheidszorg).

NIP-certified paediatric and adolescent psychologist A care provider registered as a paediatric and adolescent psychologist in the register of the Netherlands Institute of Psychologists (NIP).

NIPT
Non-invasive prenatal test.

Non-contracted care provider
A care provider with whom we have not concluded an agreement. We apply a maximum reimbursement for many types of care provided by a non-contracted care provider. In that case, the reimbursement is limited to the rates in accordance with the rates list for non-contracted care. The rates list can be viewed and downloaded at www.hollandzorg.com/rates. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your

expense. Contracted care providers are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123.

Nuclear facility
A nuclear facility in the sense of the Nuclear Accident Liability Act.

Nurse
A nurse registered as such in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Nursing home
A treatment and accommodation facility as defined by the Long-Term Care Act (Wlz) for the treatment of somatic or psychogeriatric disorders.

NVLF
Dutch Association of Speech Therapy and Phoniatry.

NZa
Dutch healthcare Authority

Obstetrician
An obstetrician registered as such in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Occupational therapist
An occupational therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Oedema therapist
A physiotherapist who is listed as an oedema therapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Oedema therapy and lymph drainage
Care generally provided by oedema therapists.

Optometrist
An optometrist who complies with the requirements of the Optometrist training requirements and area of expertise decree (Besluit opleidingseisen en deskundigheidsgebied optometrist) and is listed in the Paramedics Quality Register.

Oral hygienist
An oral hygienist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podotherapists Decree and is listed in the Paramedics Quality Register.

Orthodontics
Care of an orthodontic nature as generally provided by dentists.

Orthodontist
A specialist dentist who is listed in the register for dentomaxillary orthopaedics of the Dutch Dental Association's (NMT) Board of Registration for Medical Specialists.

Orthoptist
A orthoptist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and is listed in the Paramedics Quality Register.

Other healthcare product (OZP)
A performance within specialist medical care, other than a DBC care product.

Over-the-counter medicines
• Over-the-counter medication (referred to as AV-category medicine in the Medicine Act); and

• Over-the-counter medication sold at a chemist's or elsewhere under the supervision of a chemist, and which cannot only be sold at a chemist's without a prescription (referred to as UAD-category medicine in the Medicine Act).

Paediatrician
A doctor who:

• is registered as a Public Health doctor in the Public Health register of the Commission for the Registration of Social Medicine of the KNMG (Royal Netherlands Medical Society); or

• is registered as a paediatrician in the youth healthcare profile register of the Commission for the Registration of Social Medicine of the KNMG (Royal Netherlands Medical Society).

In both cases, it must be a doctor who provides youth healthcare as referred to in the Public Health (Preventive Measures) Act.

Paediatric nurse
A qualified nurse with an MBO Nursing diploma and completed nationally recognised advanced training for nursing children.

Paediatric nurse (youth healthcare nurse)
A nurse with completed post-HBO training in paediatric nursing.

Paediatric physiotherapist
A physiotherapist who is registered as a paediatric physiotherapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Paediatric physiotherapy
Care for minors generally provided by paediatric physiotherapists.

Paediatric remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a paediatric remedial therapist.

Paediatric remedial therapy
Care for minors generally provided by paediatric remedial therapist.

Patient day
A patient day as described in the policy document for specialist medical care performance and rates defined by the Dutch Healthcare Authority.

Pelvic physiotherapy
Care generally provided by pelvic physiotherapists.

Pelvic physiotherapist
A physiotherapist who is registered as a pelvic physiotherapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Pelvic remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a pelvic remedial therapist.

Pelvic remedial therapy
Care generally provided by pelvic remedial therapists.

Physician assistant
A physician assistant who complies with the requirements of the Temporary Decision on independent authority of physician assistants and is registered as physician assistant in the Dutch Association of Physician Assistants (NAPA) Quality Register of physician assistants.

Physiotherapist
A physiotherapist who is registered as a physiotherapist in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG) and who is listed in the Dutch Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Prescription
Prescription for medicines.

Podiatric therapy
Care generally provided by podiatrists.

Podiatrist
A podiatrist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Policy conditions
The rights and obligations as they apply to you (insured party/policyholder) and us, and which form the insurance.

Policyholder
The person who has taken out insurance with us. If this person takes out the insurance for him/herself, he/she is also the insured party.

Prescription
The written direction and explanations you receive from a care provider for care to be provided to you, which you need on medical grounds. This may be for a certain medicine or aid. The care provider issuing the prescription is the prescribing party.

A prescription for medicines includes the quantity or number of each form of administration of one UR medicine, compound or otherwise. The prescription determines the duration of the prescription, the period for which the medicine is prescribed based on the combination of the stated quantity and

method of use (including frequency and intake volume). The prescription thus determines the maximum term for the medicine. The Latin term ‘iter’ (itera) or similar designation on the prescription indicates repetition. In that case, the prescription also indicates how often the prescription must be repeated.

Prosthodontist
A prosthodontist who complies with the requirements of the Prosthodontist Training Requirements and Area of Expertise Decree (Besluit opleidingseisen en deskundigheidsgebied tandprotheticus).

Psychiatric hospital
An institution that specialises in providing mental healthcare.

Psychiatrist
A doctor who is listed in the KNMG's Board of Registration's Medical Specialists register for psychiatrists.

Psychosomatic physiotherapy
Care generally provided by psychosomatic physiotherapists.

Psychosomatic physiotherapist
A physiotherapist who is registered as a psychosomatic physiotherapist in the Physiotherapy Quality Register (KRF NL) of the Royal Dutch Association for Physiotherapy (Koninklijk Nederlands Genootschap voor Fysiotherapie) and/or the individual quality register of Stichting Keurmerk Fysiotherapie.

Psychosomatic remedial therapy
Care generally provided by Psychosomatic remedial therapists.

Psychosomatic remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a Psychosomatic remedial therapist.

Psychotherapist
A psychotherapist registered in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Public healthcare insurance
HollandZorg Public healthcare insurance, which is health insurance.

Public transport
Passenger transport open to all operated in accordance with a timetable by car, bus, train, underground train, tram or a vehicle propelled by a guidance system as defined in the Passenger Transport Act 2000 (Wet personenvervoer), and passenger transport open to all operated in accordance with a timetable in the form of a regular ferry service.

Rational pharmacotherapy
Treatment with a medicine in a form that suits you. The effectiveness of the medicine must be evidenced by scientific literature. Furthermore, treatment with that medicine must be the most economical treatment.

Referral
The written advice and explanations you receive from a care provider who provides you with care, addressed to the care provider who can provide you with further care and which you need on

medical grounds. The care provider giving the referral is the referrer. A referrer cannot refer you to himself.

Rehabilitation centre
A centre that provides rehabilitation care and, insofar as required by law, has a permit for this. A multidisciplinary team of experts, under the management of a medical specialist, is employed at the centre.

Rehabilitation specialist
A doctor who is listed as rehabilitation specialist in the KNMG's Board of Registration's Medical Specialists register.

Remedial educationalist
A remedial educationalist who is registered in the NVO Register (Remedial Educationalist-Generalist of the Dutch Association of educationalists and teachers (NVO)).

Remedial therapist
A Cesar or Mensendiek remedial therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Remedial therapy
Care generally provided by remedial therapists.

Registered medicine
A medicine for which a trade licence or a parallel trade licence has been granted pursuant to the Medicines Act (Geneesmiddelenwet) or pursuant to regulation 726/2004/EC, Pb EC L136. Mutually replaceable medicines are registered medicines that are regarded as mutually replaceable under the Health Insurance Regulations. Non-mutually replaceable medicines are registered medicines that are not regarded as mutually replaceable (interchangeable) under the Health Insurance Regulations.

Respiratory centre
A centre that provides artificial respiration and, insofar as required by law, has a permit for this. A respiratory centre may be affiliated to a hospital, but not necessarily so.

Salland Zorgverzekeraar
The entire organisation of legal entities that directly or indirectly fall under Coöperatie Salland U.A.

Scar treatment
Physiotherapy aimed at preventing or reducing pain and movement restrictions due to scars.

Setting
The distinction between forms of care based on the required infrastructure and the use of different professions.

Shortage of medicines
A registered medicine specified by us temporarily cannot be delivered (or not in sufficient quantities) by the holder or holders of the (parallel) trade licence granted pursuant to the Medicine Act or pursuant to European Regulation 726/2004.

SKGZ
Stichting Klachten en Geschillen Zorgverzekeringen.

Skin therapist
A skin therapist who complies with the requirements of the Skin therapist training requirements and area of expertise decree (Besluit opleidingseisen en deskundigheidsgebied huidtherapeut) and is listed in the Paramedics Quality Register.

Specialist mental healthcare nurse
A nurse registered as a specialist mental healthcare nurse in accordance with the conditions defined in Article 14 of the Dutch Individual Health Care Professions Act (Wet BIG).

Specialist nurse
A nurse registered as a specialist nurse in accordance with the conditions defined in Article 14 of the Dutch Individual Health Care Professions Act (Wet BIG).

Speech therapist
A speech therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Sports doctor
A doctor registered as a doctor of Society and Health in the KNMG's Board of Registration of Doctors of Social Medicine register of Society and Health Doctors, designated as a sports doctor.

Statutory personal contribution
The share of the costs of care covered by the public healthcare insurance that remains payable by you. The minister has determined which costs this relates to. The statutory personal contribution exists in addition to the compulsory and, if applicable, voluntary excess.

Supplementary insurance
The agreement for non-life insurance concluded or to be concluded with Salland Aanvullende Verzekeringen N.V. This insurance covers a number of other services in addition to cover provided under the public healthcare insurance. Dental insurance also falls under this, unless explicitly stated otherwise.

Supplier of medical aids
An organisation which provides (medical) aids and which is registered in the General Care Providers Database (AGB database). This database records data on care providers in the Netherlands. This data is given a unique code, the AGB code. This ensures a uniform registration of care provider data for the healthcare insurers.

SVB
Sociale Verzekeringsbank (Social Insurance Bank).

Temporary stay abroad
A stay outside the Netherlands of no more than six consecutive months.

Thrombosis Service
A centre that provides thrombosis care and which qualifies as such, insofar as required, pursuant to the law.

Transplant centre
An institution licensed under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) to provide transplant care.

Treaty country
A country that is not an EU or EEA country with which the Netherlands has made agreements concerning the provision of medical care and the reimbursement of the costs of such care: Australia (only for temporary stays of less than one year), Bosnia-Herzegovina, North Macedonia, Montenegro, Serbia, Tunisia, Turkey, the United Kingdom (England, Northern Ireland, Scotland and Wales) and Switzerland.

Triage hearing specialist
A triage hearing specialist who is listed in the Triage Specialist Quality Register of the Centre for Certification.

Ultrasound centre
A centre for prenatal screening which holds a licence pursuant to the Population Screening Act (Wet op het bevolkingsonderzoek).

UR medicine
A medicine that may only be provided on prescription as referred to in Article 1, preamble and under s, of the Medicines Act (Geneesmiddelenwet).

We
Whenever these policy conditions refer to 'we' or 'us', this refers to 'Salland Zorgverzekeraar N.V.'. In the event of references to supplementary insurance, these terms refer to 'Salland Aanvullende Verzekeringen N.V.'.

Wet BIG
The Individual Healthcare Professions Act.

Wlz
Long-Term Care Act.

Written or in writing
Transfer of information via hardcopy, e-mail or Internet web form.

You/your
Whenever these policy conditions refer to 'you/your', they refer to the insured party. Whenever these policy conditions refer to 'you (policyholder)', they refer to the policyholder. Whenever these policy conditions refer to 'you (insured party/policyholder)', they refer to both the insured party and the policyholder.

Youth Dental Care Institution
An institution for the provision of oral care characterised by oral care providers with specific expertise and skills and facilities for consultation, diagnosis and treatment for insured parties aged up to 18. Insofar as legally required, the institution must be licensed.