Public healthcare insurance | Flexpolis

2021

HollandZorg

What is important to know and which conditions apply?

Public healthcare insurance Flexpolis

2021

Eno Zorgverzekeraar N.V.
Eno Aanvullende Verzekeringen N.V.

These insurance conditions take effect on 01 January 2021. All previous insurance conditions will be superseded as of the same date.

Contents

Supplementary insurance

Flexpolis No Risk I

Specific provisions for the Flexpolis No Risk I

Taking out and cancelling the Flexpolis No Risk I.

Premium

Specific restrictions for the Flexpolis No Risk I

Flexpolis No Risk I Cover

Flexpolis No Risk II

Specific provisions for the Flexpolis No Risk II

Taking out and cancelling the Flexpolis No Risk II.

Premium

Insurance cover general

Specific restrictions for the Flexpolis No Risk II

Cover and reimbursement per care form

What do all the terms mean?

Contact

You can find many answers to your questions online, at www.hollandzorg.com. If this still does not answer your questions, please get in touch. You can contact us on working days from 08:00 to 18:00, through the following channels:

Online

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

Customer Service

You can also call us on +31 (0)570 687 123.

Other telephone numbers you may need are:

- Healthcare Services: +31 (0)570 687 470

These employees can help you find a care provider, waiting list mediation, arrange medical aids and provide information about health, illness and the prevention of health problems.

- Emergency centre: +31 570 687 112

Are you staying abroad and do you need medical care? Always call the Emergency Centre. Our employees can tell you where to go and contact care providers for you. 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

The information contained in this document

General provisions

Some of the provisions apply to both the public healthcare insurance and the supplementary insurances and dental insurances. For this reason, we have combined them. For example, these general provisions tell you how you need to submit an invoice and within how many days it will be paid by us, but also in which cases you need to ask our permission for a treatment.

Public healthcare insurance

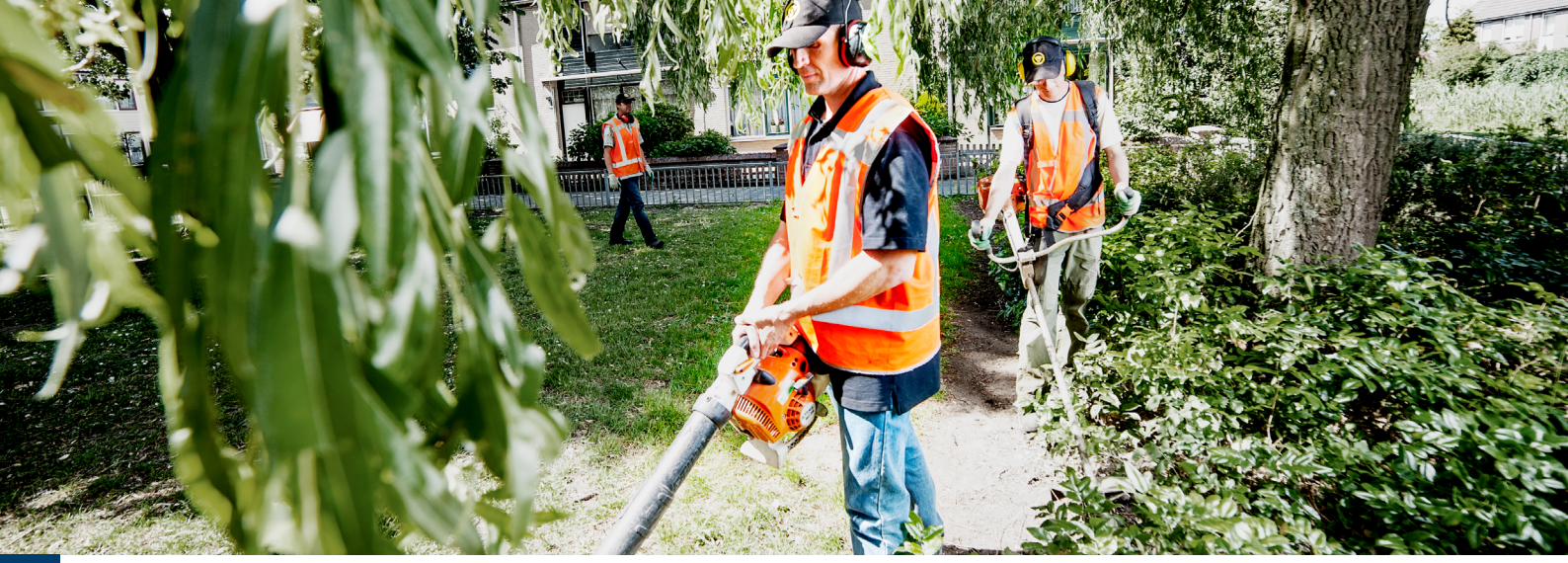
In this chapter, you will find the arrangements which apply only to the public healthcare insurance. In addition, we will explain what is reimbursed for each type of care (e.g. GP care), whether a policy excess applies and whether you pay a personal contribution for this care.

Supplementary insurances

In this chapter, you will find the arrangements which only apply to the supplementary insurances Flexpolis No Risk I and Flexpolis No Risk II. We will also explain what is reimbursed per supplementary insurance.

Definitions

In order to avoid confusion about the explanation of terms, you will find an explanation of all the important terms at the end of this terms and conditions document.



General provisions

Provisions which apply to the public healthcare insurance and the supplementary insurances

The provisions in the General Provisions chapter apply to the public healthcare insurance and the supplementary insurances.

Invoices and payment

1. How do we allocate the costs of care?

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 costs of a DBC (Diagnosis Treatment Combination) care product are allocated to the calendar year in which the DBC or the DBC care product commenced.

2. How do you submit an invoice?

You are not supposed to receive an invoice for care provided by a contracted care provider. A contracted care provider will send the invoice directly to us. If you go to a non-contracted care provider, you can claim the invoice yourself.

We will process an invoice if the following conditions have been met:

- the invoice includes, at least, the name, address and profession of the care provider, invoice date, date on which the care was provided and description of that care, name and date of birth of the insured party;
- the invoice complies with the statutory requirements for claiming the care, including the requirements of the Dutch Healthcare Authority (NZa);
- the invoice is submitted in one of the following ways:
  - the original invoice has been handed in to us or submitted by post; or
  - the electronic/scanned invoice is submitted via www.hollandzorg.com (Mijn HollandZorg). In that case, you must - for verification purposes - keep the original invoice for a period of two years after having submitted the copy. We may ask you to send us 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 will claim back any money reimbursed incorrectly;
- the invoice is drawn up in Dutch, English, French, German, Polish, Spanish or Turkish. If the invoice is drawn up in a different language, In that case you must include a sworn translation. If you do not, we may refuse to process the invoice;
- an invoice for healthcare expenses incurred abroad must be accompanied by a fully completed and signed foreign claim form. The foreign claim form can be viewed and downloaded at www.hollandzorg.com. Alternatively, we can send it to you on request;
- an invoice for Personal District Nursing Regulations must be accompanied by a fully completed and signed Personal District Nursing Regulations claim form. The Personal District Nursing Regulations claim Form can be viewed and downloaded at www.hollandzorg.com. Alternatively, we can send it to you on request;
- the original invoice is clearly legible.

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 (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 the 12-month period, we may decide to reimburse the invoice partially or not at all. 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.

If you submit a hardcopy invoice, appendices or other documents to us, we will not return them. If you so wish, we will provide you with a certified copy of the documents we received from you.

We may ask you for more information in order to find out if the care you claim meets the insurance conditions. You are not permitted to transfer any current or future claims against us to any third party (another natural person or legal entity). This ban must be interpreted

as a stipulation with property-law consequences as referred to in Section 3:83, subsection 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 shall not be obliged to pay the claim to the said third party. Payment of the claim to you will in that case also constitute a valid discharge.

3. When do we pay?

In principle, we will reimburse an invoice submitted by you within 5 working days of receiving the invoice. All conditions for full or partial reimbursement must have been met. It takes longer to process the invoice if the invoice is incomplete or if more time is needed to check whether the care meets the insurance conditions. You can check the processing of the invoice via Mijn HollandZorg.

We are entitled to pay the costs of care directly to the care provider who has 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 reimburse 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.

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.

Taking out and terminating insurances

4. How do you take out an insurance policy?

You (insured party/policyholder) can make a request to take out public health insurance by sending us a fully completed and signed request form. You can also do so via our website and the request form at www.hollandzorg.com/register. We can send a request form to you if you wish. You can also submit a request via an agent with whom we have made arrangements about brokering our insurances.

When submitting the request you (policyholder) are to specify your address and the address of the person or persons to be insured.

The public healthcare insurance commences on the day we have received a request from you (policyholder) to take out public healthcare insurance. We will send you (policyholder) and the person to be insured a confirmation of receipt of the request, stating the date on which we received it.

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 for that person to be insured 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 Section 7:940, subsection 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.

We will provide you (insured party/policyholder) with a policy document 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) have given us your consent to send the policy document electronically, you (insured party/policyholder) are entitled to withdraw that consent. You can do so as follows:

- in writing. Written requests must be addressed to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- via the contact form at www.hollandzorg.com;
- via Mijn HollandZorg, which can be found at www.hollandzorg.com.

5. How long do you 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 insurance conditions.

6. What happens if you change your mind?

You (policyholder) can change your mind after having taken out the insurance. In that case, you (policyholder) can cancel the insurance within 14 days of receiving the initial policy document. The insurance is then deemed not to have commenced. This means we refund any premiums already paid and you (insured party/policyholder) are obliged to repay us any healthcare costs paid by us.
You (policyholder) must cancel in one of the following ways:

- in writing. Written requests must be addressed to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- via the contact form at www.hollandzorg.com;
- via Mijn HollandZorg, which can be found at www.hollandzorg.com.

Verbal cancellations are not accepted.

7. When does the insurance end?

The insurance terminates 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 die. The insured party or your heirs are obliged to notify us of your death as soon as possible.

In addition, the public healthcare insurance terminates on the day following that on which:

- 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 from the moment that your public healthcare insurance incepted. 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;
- you, as a result of changes to our territory, reside outside our territory.

8. How can you cancel the insurance?

You (policyholder) can cancel the insurance no later than 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 is 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 Care 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 insurance conditions to your 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.

These cancellation options do not apply for the public healthcare insurance if the outstanding premium and collection costs have not been paid and we have demanded payment from you (policyholder) of one or more outstanding instalments for the premium payable, unless we have suspended cover of the public healthcare insurance, or unless we have confirmed the cancellation to you (policyholder) within two weeks.

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

- in writing. Written requests must be addressed to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- via the contact form at www.hollandzorg.com;
- via Mijn HollandZorg, which can be found at www.hollandzorg.com.

Verbal cancellations are not accepted.

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

If you (insured/policyholder) request another health insurer to provide insurance, we at the same time consider that request 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.

9. How does it work if you are 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 cancel the public healthcare insurance. This is possible only in the two-week period from the date that the CAK has notified you that you are insured. 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 a healthcare insurance policy.

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 8 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 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.

10. When may we cancel or suspend the insurance?

We can cancel or dissolve the insurance, or suspend 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) have failed to make the full payment after having received a demand to pay within the specified term, stating the consequences of failure to pay. 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 documents, or if you give us incomplete or incorrect information or documents that are relevant for the execution of the public healthcare insurance and are or may be of detriment to us;
- if you (insured party/policyholder) have intentionally misled us or if we would not have taken out any public healthcare insurance if we had been aware of the true state of affairs;
- if you seriously misbehave towards us or our members of staff.

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.

11. What happens to your insurance if you are in detention?

The cover and obligation to pay premiums under the public healthcare insurance are suspended 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 in detention abroad, you must send us a statement from the Minister of Foreign Affairs or a statement from the Dutch probation service (Reclassering Nederland) as evidence of this fact.

Premium

12. How is the premium made up?

The premium is equal to the premium calculation basis, minus any discounts on account of a voluntary excess for example, or on account of participation in a group scheme.

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

The premium calculation basis, any discounts and the premium due are set out in the policy.

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.

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 to you in the form of a surcharge in addition to your premium. You must then pay the surcharge to us. If a surcharge applies, this will be specified in the policy.

13. How must you pay the premium?

You (policyholder) must pay your premiums 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. We can make other arrangements if it concerns a group scheme.

If you fail to pay the premium or other amounts payable to us in time, we can charge you (insured party/policyholder) the statutory interest rate, collection costs and administration costs.

You (insured party/policyholder) are not entitled to set off the premium payable or other amounts payable to us against any amounts we owe you. Neither are you (insured party/policyholder) permitted to suspend payment 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 already paid relating to the period commencing on the day after the date of death will be refunded.

Important rules

14. Who are the insurances designed for?

These insurance conditions are intended to be provided to 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.

15. Which information requirements must you 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 promptly inform us of all facts and circumstances that may be of importance to the correct execution of the public healthcare insurance, including moving house, births, deaths, changes to IBAN, divorce, termination of participation in a collectivity or any facts or circumstances that have caused or may cause your public healthcare insurance to end.

If you (the insured party/policyholder) do not comply with the duty of disclosure referred to in this article and in the other insurance conditions, you are not entitled to the care if our interests are harmed by this.

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

Our notifications to you (insured party/policyholder) apply only if we have confirmed them in writing or, with your permission, by e-mail. If we use the most recent residential address or e-mail address of you (insured party/policyholder) held on our records, we will assume that you (insured party/policyholder) have received the notification.

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 consent to send notifications electronically, you (insured party/policyholder) are entitled to withdraw that consent. You can do so as follows:

- in writing. Written requests must be addressed to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- via the contact form at www.hollandzorg.com;
- by calling +31(0)570 687 123;
- in writing. Address your letter 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. On our website, you will immediately be given a rough indication of whether it is possible for you or us to recover the damages.

16. What should you do if someone else is liable for the care 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:

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 consent.

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.

17. 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.

18. How do we handle your personal data?

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

We use this data for the following purposes:

- to conclude and execute the insurance policy;
- scientific and statistical analyses;
- to increase our customer portfolio and provide information about our products;
- to comply with statutory obligations;
- monitoring the safety and integrity of the financial sector, including preventing and combating fraud;
- conducting research into the quality of care as perceived by you.

The processing of personal data is governed by our privacy statement. You (insured party/policyholder) can view and download this at www.hollandzorg.com/privacy. Alternatively, we will send this to you on request.

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 feel you need that additional protection, please let us know. If we feel your notification is justified, we will take additional measures to protect your personal data.

19. How do we act in case of fraud?

If we identify behaviour which threatened, threatens or may threaten the (financial) interests of our company, our staff, our customers or the continuity or integrity of the financial sector, we may record your personal data in the External Reference Register (EVR). This will be done in accordance with the rules of the Protocol Incident Warning system for Financial Institutions. This protocol can be viewed and downloaded at www.hollandzorg.com. Alternatively, we will send this to you on request. The EVR is used by financial institutions to assess the integrity of customers and business relations and can be accessed by us from the central database of Stichting CIS.

In the event of fraud:

- we may have your details recorded in the Fraud Information System Holland (Fraude Informatie Systeem Holland) (FISH) or other fraud identification systems recognised by the insurers. This will be done in accordance with the rules of the FISH Protocol. The protocol can be viewed and downloaded at www.hollandzorg.com/fraude. Alternatively, we can send it to you on request;
- we may report the case to 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;
- 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;
- we can recover the costs of recovery from you.

20. How can you 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 Eno U.A. This does not apply if you (insured party/policyholder) have told us of your wish to opt out of this provision. The member's council of Coöperatie Eno U.A. takes decisions on a number of important issues. The member's council is elected from among the members. Membership ceases upon death, cancellation or member disqualification.

Membership will be deemed to have been cancelled at the moment that the last insurance with us has been terminated.

21. What restrictions apply in the 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. We can also send this to you on request. 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.

22. When are we allowed to amend the policy conditions?

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

23. 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 insurance conditions state, per type of care, whether or not you need written consent from us. When assessing the application for authorisation we will gauge whether the requested care complies with the insurance 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 consent must always contain your name and address and the name, address and profession of the care provider. Any additional information the request must contain is set out

per care form in the specific conditions for the public healthcare insurance and supplementary insurance.

Please send requests for consent to:
HollandZorg, Medisch adviseur, Antwoordnummer 30,
7400 VB Deventer (no stamp required).

If your care provider submits the request on your behalf, please let us know that you agree with this. You can do so by signing the request.

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, if applicable, reimbursement of the costs of the care in accordance with the rules in our policy conditions. Forwarding that authorisation to us 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 in the meantime.

24. Referral or prescription

The right to care or the reimbursement thereof will often be subject to a referral or prescription. The insurance 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, commencing on the day the referral or prescription was issued. The validity may be longer or shorter, provided this is expressly stated in the insurance 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 during the period you were still insured with another care provider, you do not have to ask for the referral or prescription again unless the term of validity has expired.

25. How can you 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 (insured party/policyholder) should preferably submit your request in one of the following ways:

- Written requests must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- you can submit requests electronically by using the complaints form at www.hollandzorg.com.

What if we do not respond to your request within six weeks or if you (insured party/policyholder) are not happy with our response? In that case, you (insured party/policyholder) 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 only applies if you (insured party/policyholder) have not 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 (insured party/policyholder) feel that a form we use is too complicated or unnecessary, you may ask us to review that form. You (insured party/policyholder) should preferably submit your request in one of the following ways:

- Written requests must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required);
- You can submit requests electronically by using the complaints form at www.hollandzorg.com/klachten.

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 arrangements set out in the General Provisions chapter apply to the public healthcare insurance and the supplementary insurances. Further specific provisions apply to public healthcare insurance. In this chapter, you can read what they are.

Taking out and terminating public healthcare insurance

1. When can we refuse you?

We are not obliged to provide public healthcare insurance if:

- you already have health insurance;
- 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 income tax as a result of work performed under an employment contract in the Netherlands.

2. 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 also based on the application form completed by you (policyholder) and agreements in connection with a group scheme you (policyholder) 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 insurance 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 insurance 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 appendixes referred to in these insurance conditions form part of the public healthcare insurance.

Premium

3. When do you not have to pay a premium?

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

- no premium is due by you (policyholder) for an insured party until the first day of the calendar month following the calendar month in which the insured party reaches the age of 18;

- you (policyholder) do not have to pay us premiums during the period that you 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 No more than ten working days after our records indicate arrears of two month's premium in the payment of the public healthcare insurance, we will make you (policyholder) a proposal to agree a repayment arrangement. The repayment arrangement will at least entail the following:
- agreements about the payment of new premium instalments falling due;
- arrangements with regard to repaying your debts, including interest and collection costs, in connection with the public healthcare insurance and the repayment instalments;
- our promise that we will not terminate or suspend the public healthcare insurance during the term of the repayment arrangement on account of the existence of debts, including interest and collection costs, in connection with 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.

4.2 If you (policyholder) took out the public healthcare insurance for another party, then our offer includes our willingness to accept the cancellation of the public healthcare insurance of that other party, with effect from the date on which the repayment arrangement commences, subject to the following conditions:
- the insured party has taken out other health insurance on the day on which the repayment arrangement commences; and,
- if the insured party has taken out the health insurance with us (public healthcare insurance) and has authorised us to automatically collect future premiums each month or has instructed 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.

4.3 At the same time as the proposal referred to in 4.1, we will send you (policyholder) a letter stating that you (policyholder) have four weeks to accept the proposal. It will also state what the consequences will be if the proposal is not accepted and the premium arrears, excluding interest and collection costs, have risen to six or more months' premium. We will also remind you (policyholder) of the option of debt counselling.

4.4 Once the premium debt, exclusive of interest and collection costs, has risen to four monthly premiums or more, we will notify you (insured party/policyholder) of our intention to make a notification as referred to in 4.7, if the premium debt, exclusive of interest and collection costs, rises to six monthly premiums or more. We will refrain from making the notification if you (insured party/policyholder) have disputed the premium arrears with us within four weeks of having been notified by us.

4.5 If you (insured party/policyholder) have disputed the premium arrears with us within the period specified above, but your complaint is not upheld, we will notify you (insured/policyholder) that we will make the notification referred to in 4.7 if the premium debt, exclusive of interest and collection costs, rises to 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.

4.6 If the repayment arrangement takes effect due to the premium arrears, exclusive of interest and collection costs, having risen to four monthly premiums, we will refrain from making the notification referred to in 4.7 for as long as the future premiums are paid.

4.7 Once the premium debt, exclusive of interest and collection costs, has risen to 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 4.4 to 4.7. We will refrain from making the notification referred to in the first sentence of 4.7:
- if the premium arrears have been disputed within the period referred to in 4.4 but we have not yet given a response;
- for a period of four weeks as referred to in 4.5;
- 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 4.5 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 1, bullet point three of the Specific Provisions for Public Healthcare Insurance (Specifieke bepalingen voor de Basisverzekering).

4.8 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 ensuing from the public health insurance are paid or voided;
- the debt management scheme for natural persons referred to in the Bankruptcy Act is declared applicable;
- the written agreement referred to under 4.7, point four, has been concluded or a debt settlement has been agreed in which at least you (policyholder) and we are participants.

4.9 If you are in arrears for less than two months or no payment arrangement is made after arrears of two or four months,

we may dissolve the public health insurance by virtue of Article 10 of the General Provisions.

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 stated in the premium appendix to these insurance conditions.

The following are excluded from the compulsory excess:

- the costs of obstetric and maternity care;
- the costs of general practitioner care. The costs of examinations which the care providers appointed by us for general practitioner care ask others to perform, and which are invoiced separately, such as laboratory tests, do fall under the compulsory excess;
- the costs of registering with a general practitioner or with a GP centre
- the costs of other medical care (e.g. GP care).
- the costs of preventive foot care;
- the costs of integrated care (multidisciplinary primary care, which general practitioner care forms part of);
- the costs of nursing and care without in-patient care;
- the costs of a combined lifestyle intervention
- if you are a transplant donor, the costs of care incurred by you in connection with the admission as referred to below, after the period has lapsed during which the costs of care provided to you in connection with the admission for the selection and removal of the transplant material referred to in section e of the article on transplant care are payable under the health insurance of the recipient of the transplant material;
- if you are the donor and the recipient of the transplant material is entitled to (reimbursement of the costs of) transplantation care by virtue of a health insurance contract, the costs of transport as referred to in the article on transplantation care, under i and j.
- 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. The designated medicinal care, aids and care providers are listed in the overview 'Designated Care Not Applicable to the Excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/excess. Alternatively, we will send this to you on request;
- 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/excess. Alternatively, we will send this to you on request.

The compulsory excess is indexed on an annual basis, in the manner prescribed by the Healthcare Insurance Act (Zorgverzekeringswet). The basic principle is the indexation of the minimum wage referred to in article 8.1.a of the Minimum Wage and Minimum Holiday Allowance Act (Wet minimumloon en minimumvakantiebijslag). The amount calculated is rounded down to a multiple of € 5.

6. When does the voluntary excess apply?

For insured parties aged 18 or older, you (policyholder) can opt for a voluntary excess. The higher the voluntary excess, the lower the premium. The voluntary excess amounts which can be selected and the associated premiums are shown in the Premium Appendix to these insurance conditions. The selected voluntary excess is stated on the policy document.

If an insured turns 18 and you (policyholder) did not opt for voluntary excess previously, we will calculate the premium for the public healthcare insurance of that insured without voluntary excess.
The following are excluded from the voluntary excess:

- the costs of obstetric and maternity care;
- the costs of general practitioner care. The costs of examinations which the care providers appointed by us to perform general practitioner care ask others to carry out, and which are invoiced separately, such as laboratory tests, do fall under the voluntary excess.
- the costs of registering with a general practitioner or with a GP centre;
- the costs of other medical care (e.g. GP care).
- the costs of preventive foot care;
- the costs of integrated care (multidisciplinary primary care, which general practitioner care forms part of);
- the costs of nursing and care without in-patient care;
- the costs of a combined lifestyle intervention;
- if you are a transplant donor, the costs of care incurred by you in connection with the admission as referred to below, after the period has lapsed during which the costs of care provided to you in connection with the admission for the selection and removal of the transplant material referred to in section e of the article on transplant care are payable under the health insurance of the recipient of the transplant material;
- if you are the donor and the recipient of the transplant material is entitled to (reimbursement of the costs of) transplantation care by virtue of a health insurance contract, the costs of transport as referred to in the article on transplantation care, under i and j.
- 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. The designated medicinal care, aids and care providers are listed in the overview 'Designated Care Not Applicable to the Excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/excess. Alternatively, we will send this to you on request.

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

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

If your public healthcare insurance does not commence or end on 1 January of a calendar year, the compulsory excess and any voluntary excess in that calendar year are set lower, in proportion to the number of days insured. 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.

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 Insurance claims per type of care) in these insurance 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 by us in order to obtain care, if you ask us to do so. You can do so via www.hollandzorg.com/zorgadvies. You can also contact our Care Advice Line on +31(0)570 687 123.

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.

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 extent of the reimbursement is described further down in the policy conditions.

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 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.
The insurance conditions state whether or not a statutory personal contribution applies, per type of care. The statutory personal contribution exists in addition to the compulsory and, if applicable, voluntary excess.

9. What 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 certain type of care are stated per type of care; and
- the care provider from whom you receive the care has been appointed by us. The insurance 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 granted our written authorisation, prior to you receiving 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. How is the amount of reimbursement in the Netherlands calculated?

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, subject to a maximum of the rate we have stipulated. The insurance 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. We can also send it to you on request;
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 certain type of care are stated per type of care; and
- we have granted you our written consent before you receive the care if it concerns care with hospitalisation of at least one night. This does not apply if the care in question is medically necessary care. In this case, medically necessary care is given to mean unforeseen care that cannot reasonably be postponed until after returning to the Netherlands; and
- the care provider giving the care holds qualifications, under the laws of the country where the care provider has his business address, that are equal to qualifications that apply to the 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 are deemed to comply with this.

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 the following ways:

- by calling telephone number +31 (0)570 68 71 12;
- by sending an e-mail to 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 a temporary stay 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, i.e.:
   i) if we apply a maximum rate for that care, subject to a maximum of the rate we have stipulated. The insurance 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. We can also send it to you on request;
   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 a temporary stay 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:

- to care provided by a contracted care provider, 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 Dutch rate;
- 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.

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, subject to a maximum of the rate we have stipulated. The insurance 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. We can also send it to you on request;
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. Alternatively, we will send this to you on request.

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

General practitioner care

What is covered?

You are entitled to general practitioner care. General practitioner care is care such as general practitioners generally provide. This type of care does not include the preventive flue jab. Laboratory testing in a hospital or independent laboratory at the request of a general practitioner is not included in the care either.

What should you keep in mind?

General practitioners are entitled to provide this type of care. The general practitioner may be independently established or work in a general practitioner services structure (GP out-of-hours surgery), a GP centre or care group.

Is there a statutory personal contribution?

There is no statutory personal contribution for GP care.

Are the costs deducted from the compulsory and voluntary excess?

The costs of general practitioner care do not count towards the compulsory and, if applicable, voluntary excess. The compulsory and, if applicable, voluntary excess do include the costs of (laboratory) testing in a hospital or independent laboratory at the request of a general practitioner.

Preventive foot care

What is covered?

You are entitled to preventive foot care such as general practitioners and medical specialists generally provide if you have Diabetes Mellitus type I or II. The preventive foot care includes 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 procedures you actually receive.

When screening the feet of diabetes sufferers, the Sims classification is used in order to express the risk of the feet being affected. Diabetic 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, 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 footwear.

Preventive foot care includes procedures which are not purely care procedures, such as the removal of callus and cutting of toenails for cosmetic or health reasons.

Preventive foot care can be part of integrated care. The conditions for the right to integrated care are stated in the article about integrated care. Preventive foot care can also be part of medical specialist care. The conditions for the right to medical specialist care are stated in the article on medical specialist care (general). 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 should you 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 who is independently established or works in a general practitioner services structure (GP out-of-hours surgery) or a GP centre;
- a podiatrist;
- a pedicure provider.
- for Sims classifications 2 and 3 (care profiles 2 to 4):
- a general practitioner who is independently established or works in a general practitioner services structure (GP out-of-hours surgery) or a GP centre;
- 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 sends the invoice to the podiatrist.

You need a referral from a general practitioner, medical specialist, nursing specialist or physician assistant in order to receive foot care from a chiropodist or a podiatrist. The referral must state the type of diabetes and your care profile.

If a non-contracted care provider provides the care, you must include a copy of the referral when you submit the first invoice. The invoice must show which type of care has been provided.

Is there a statutory personal contribution?
There is no statutory personal contribution for preventive foot care.

Are the costs deducted from the compulsory and voluntary excess?
The costs of preventive foot care do not count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for preventive foot care provided by a non-contracted podiatrist. 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. We can also send it to you on request. If the rates of the non-contracted podiatrist 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.

Other medical care (e.g. GP care)

What is covered?
You are entitled to other medical care (e.g. GP care) comparable to GP care and for which the Dutch Care Authority has defined treatment descriptions. Other medical care (e.g. GP care) includes medical care within the framework of individual care for tuberculosis and infectious diseases.

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

What should you keep in mind?
The following care provider is 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, whose criteria have been determined by the KNMG's Board of Registration's Medical Specialists register;

You need a referral from a general practitioner, medical specialist, nursing specialist or physician assistant.

Is there a statutory personal contribution?
There is no statutory personal contribution for other medical care (e.g. GP care).

Are the costs deducted from the compulsory and voluntary excess?
The costs of other medical care (e.g. GP care) do not count towards the compulsory and, if applicable, voluntary excess.

Medical care for specific patient groups

What is covered?
You are entitled to medical care for specific groups of patients. This care comprises general medical care for specific patient groups under or pursuant to the Healthcare Insurance Act (Zorgverzekeringswet). The care may include diagnostics, consultations, specific consultation with your attending physician and implementation or management of the treatment plan. 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 eighteen and older. 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.

Transitional arrangement for care
If the care was started before 2021, you will continue to receive

the care for the duration you need. The coordinating practitioner determines the length of this duration together with you.

What should you 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 psychologist
- clinical psychologist
- NIP-certified child and adolescent psychologist
- remedial educationalist.

You need a referral from a general practitioner or paediatrician.

Transitional arrangement for referrals
an indication issued by the Care Needs Assessment Centre (CIZ) before 1 January 2021 is valid as a referral until 31 March 2021 at the latest. If the care has not started by then, you will need a new referral for the care.

Is there a statutory personal contribution?
There is no statutory personal contribution for medical care for specific groups of patients.

Are the costs deducted from the compulsory and voluntary excess?
The costs of medical care for specific groups of patients do not count towards the compulsory and, if applicable, voluntary excess.

Medical specialist care (general)

What is covered?
You are entitled to specialist medical care (general). Specialist medical care is care such as medical specialists generally provide. This type of care also comprises:
- medical aids which you receive as part of an admission or medical specialist treatment, provided they form (or are supposed to form) part of that admission or treatment.
- medicines you receive within the framework of an admission or medical specialist treatment, provided they form (or are supposed to form) part of that admission or treatment.
- conditional specialist medical care as referred to in the article on Conditional care.

Plastic surgery (treatment of a plastic surgical nature) is only included under medical specialist care if it is carried out in order to correct:
- 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 the paralysis or weakening seriously restricts the range of vision or is caused by a congenital defect or a chronic disorder present at birth;
- 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 and genitals;
- primary sexual characteristics in the event of established transsexuality.

Medical specialist care does not include:
- The fourth or subsequent IVF attempt per ongoing pregnancy to be realised. An IVF attempt is regarded an attempt only when a follicle puncture is successful. Only attempts that are subsequently abandoned count towards the number of attempts. Within the meaning of this document, a viable pregnancy is:
  - a pregnancy lasting at least ten weeks, calculated from the moment that a follicle puncture succeeded;
  - in the event that frozen embryos are re-implanted, a pregnancy of at least nine weeks and three days, calculated from the moment that the frozen embryos are re-implanted;
  - a spontaneous pregnancy of twelve weeks after the date of the last menstruation.

  An IVF attempt after a viable pregnancy is regarded as a new, first attempt, even if that pregnancy was terminated prematurely;
- the first and second IVF attempt, provided you are younger than 38 and one or more embryos are re-placed;
- fertility-related care if you are a woman aged 43 or older. If the IVF treatment began before you turned 43, you are entitled to completion of that attempt;
- treatment of paralysis or weakening of the upper eyelids, other than when the paralysis or weakening seriously restricts the range of vision or is caused by a congenital defect or a chronic disorder present at birth;
- liposuction of the stomach;
- the operative placement and the operative removal of 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 established transsexuality;
- the operative removal of a breast prosthesis without medical grounds;
- treatment for snoring with uvuloplasty;
- treatment aimed at reversing the sterilisation of the insured party (either man or woman);
- treatments aimed at the circumcision of a male insured party, other than medically necessary;
- an abdominal wall correction (abdominal plastic surgery), except in the case of mutilation or serious functional disability;
- 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 where there is no premature fusing of the cranial sutures (craniosynostosis);
- the medicines as defined 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. We can also send it to you on request.
- the use of external devices during the treatment of diabetes to monitor and control blood sugar disorders, including the ketone test strips and insulin pumps;
- laboratory testing at the request of an alternative care provider.

What should you keep in mind?
Hospitals, medical specialists or dental surgeons who work outside a hospital and independent treatment centres can provide this type of care.

You need a referral from a general practitioner, medical specialist, clinical technologist, obstetrician, youth healthcare doctor, 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. The referral will remain valid for a period of twelve months, commencing on the day the referral was issued.

In order to be reimbursed for treatments on the 'Pre-Authorisation List' and the 'Exhaustive List of Authorisations for Dental Surgery', you must have received written consent from us before receiving the care. The 'Pre-Authorisation List' and the 'Exhaustive List of Authorisations for Dental Surgery' can be viewed and downloaded at www.hollandzorg.com. We can also send it to you on request.

When applying for care, you must include a report from the attending physician, including the medical diagnosis/diagnoses, a description of the current problem, the proposed treatment plan (care activity) and, if applicable, appropriate photographs.

Is there a statutory personal contribution?
There is no statutory personal contribution for specialist medical care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for medical specialist 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. We can also send it to you on request. 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 and their addresses are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31(0)570 687 123.

Second opinion

What is covered?
You are entitled to a second opinion. A second opinion is a diagnosis by or advice about medical care to be provided by a care provider other than the care provider who made the initial diagnosis or gave the initial advice. The other care provider has to operate in the same discipline as the original care provider. You must present the second opinion to the original care provider, who remains in control of your treatment.

What should you keep in mind?
You need a referral from your general practitioner or attending physician. The referral will remain valid for a period of twelve months, commencing on the day the referral was issued.

Transplant care

What is covered?
You are entitled to transplant care as set out under a. below and to reimbursement of the costs of transplant care as set out under b. to h. below. Transplantation care comprises:

a. transplants of tissue and organs, if the transplant is carried out in an EU or EEA country. If the transplant is carried out in a country other than an EU or EEA country, the donor must reside in that country and be your spouse, registered partner or a blood relation of the first, second or third degree;
b. the costs of specialist medical care in relation to selection of the donor;
c. the costs of specialist medical care in relation to the operative removal of the transplant material from the chosen donor;
d. the costs of examination, preservation, removal and transport of the transplant material from a deceased donor in relation to the aforementioned transplant;
e. the costs of 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. In the case of a liver transplant, a six-month instead of a thirteen-week period applies;
f. costs of transport of the donor by the lowest class of public transport within the Netherlands or, if and insofar as medically necessary, transport by car within the Netherlands, related to the selection, admission and discharge from the hospital and to the care referred to in subparagraph e. 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. the costs of transport to and from the Netherlands of a donor who resides abroad, in connection with the transplant of a kidney, bone marrow or liver to an insured party 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;
h. other costs of the transplant if they relate to the donor residing abroad. This does not include the accommodation expenses in the Netherlands and loss of income.

If someone else by virtue of health insurance is entitled to (reimbursement of the costs of) transplantation care and you are the donor, you are entitled to reimbursement of the costs of:
i. transport of you in the lowest class of public transport within the Netherlands or, if and insofar as medically necessary, transport by car within the Netherlands, in connection with the selection, admission and discharge from hospital and the care referred to in subparagraph e;
j. transporting you to and from the Netherlands if you reside abroad, in connection with the transplant of a kidney, bone marrow or liver to an insured party in the Netherlands;

What should you keep in mind?
A transplantation centre can provide this type of care.

You need a referral 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?
There is no personal contribution for transplant care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory

and, if applicable, voluntary excess. This does not apply in the following situations.

If you are the donor, the costs of care for you are payable by the health insurance of the recipient of the transplant material referred to in this provision under 'What is covered', under section e. If the period stated therein has expired, the costs of care in connection with transplant care are payable by your public healthcare insurance. In that case, they are excluded from compulsory and, if applicable, voluntary excess.

If you are the donor and the recipient of the transplant material is entitled to (reimbursement of the costs of) transplant care by virtue of a health insurance contract, the costs of transport as referred to under i. and j. above are excluded from compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for 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, under specialist medical care. We can also send it to you on request. 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.

Rehabilitation care

What is covered?
You are entitled to rehabilitation care. Rehabilitation care comprises examinations, advice and treatment of a medical specialist, paramedical, behavioural science and rehabilitational nature. You must need the care in order to prevent, reduce or overcome a handicap. It must concern a handicap that is the 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. A multidisciplinary team of experts, under the management of a medical specialist, provides this type of care.

What should you keep in mind?
Hospitals and rehabilitation centres can provide this type of care. The care must be provided under the final responsibility of a rehabilitation specialist (practitioner in charge).

You need a referral from a general practitioner, medical specialist, clinical technologist, youth healthcare doctor, doctor for the mentally disabled, sports doctor, geriatrics specialist or company doctor.

For rehabilitation care provided by a non-contracted care provider, you need our written consent 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 there a statutory personal contribution?
There is no statutory personal contribution for rehabilitation care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for rehabilitation 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, under specialist medical care. We can also send it to you on request. 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.

Geriatric rehabilitation care

What is covered?
You are entitled to geriatric rehabilitation care. Geriatric rehabilitation includes integrated and multidisciplinary rehabilitation care provided by specialists in geriatric medicine. This involves treatment related to vulnerability, complex multi-morbidity and a decrease in learning and trainability. Care is aimed at reducing functional limitations in such a way that you can return to the home situation.
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 acute mobility disorders or impaired self-reliance and you received specialist medical care for that acute disorder prior to the geriatric rehabilitation care.

The duration of care does not exceed six months. In special cases, we may permit a longer period.

What should you keep in mind?
Hospitals, rehabilitation centres and institutions for geriatric rehabilitation care can provide this type of care. The care must be provided under the final responsibility of a geriatrics specialist (practitioner in charge).

You need a referral from a medical specialist or a geriatrics specialist.

For entitlement to geriatric care for a period longer than six months, you will need to have our written consent 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 after a six-month rehabilitation period and the treatment plan for the further treatment, including the prognosis for recuperation and return to the home situation and the expected duration of the further treatment.
Is there a statutory personal contribution?
There is no statutory personal contribution for geriatric rehabilitation care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for geriatric rehabilitation 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, under specialist medical care. We can also send it to you on request. 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.

Dialysis without admission

What is covered?
You are entitled to reimbursement of the costs of dialysis care. Dialysis care comprises non-clinical blood dialysis (haemodialysis) and abdominal irrigation (peritoneal dialysis). The dialysis care may take place in a dialysis centre or at your home.

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

In addition, you are entitled to reimbursement of:
- the costs of reasonable adjustments to be made in and around the home, and the costs of restoring the house to its original condition. This is subject to the condition that no reimbursement is provided under other statutory regulations;
- other reasonable costs directly related to home dialysis. This is subject to the condition that no reimbursement is provided under other statutory regulations.

What should you keep in mind?
The care must be provided under the final responsibility of a medical specialist.

You need a referral from a medical specialist or clinical technologist.

Is there a statutory personal contribution?
There is no personal contribution for dialysis care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for dialysis 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, under specialist medical care. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

The contracted dialysis centres are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31(0)570 687 123.

Artificial respiration

What is covered?
You are entitled to artificial respiration. The artificial respiration can be carried out at a respiratory centre or at home, on the advice and under the responsibility of a respiratory centre.

If the artificial respiration is carried out at a respiratory centre, this type of care comprises:
- the necessary artificial respiration;
- the medical specialist care, the medicinal care and the nursing and care related to the artificial respiration;
- A contribution towards the cost of electricity.

If the artificial respiration is carried out at home, this type of care comprises:
- the medical specialist and medicinal care related to the artificial respiration;
- the equipment needed for artificial respiration. This will be provided to you by the respiratory centre ready for use before each treatment.

What should you keep in mind?
Respiratory centres can provide this type of care.

You need a referral from a general practitioner, medical specialist or clinical technologist.

For a contribution towards the electricity costs for artificial respiration at your home, you must submit a completed and signed declaration form for electricity costs of artificial respiration at your home. You can view and download the claim form for a contribution towards the electricity costs for artificial respiration at your home at www.hollandzorg.com/arrange-now. Alternatively, we will send this to you on request.

Is there a statutory personal contribution?
There is no statutory personal contribution for artificial respiration.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for 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, under specialist medical care. We can also send it to you on request. 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.

Oncological examination in children

What is covered?
Insured parties up to the age of 18 are entitled to central (reference) diagnostics, coordination and registration of bodily material sent in.

What should you keep in mind?
Stichting Kinderoncologie Nederland (Skion) can provide this type of care.

The insured party needs a referral from a general practitioner, medical specialist, clinical technologist or doctor for the mentally disabled.

Is there a statutory personal contribution?
There is no statutory personal contribution for research into cancer in children.

Are the costs deducted from the compulsory and voluntary excess?
There is no compulsory or voluntary excess for insured parties under the age of 18.

Thrombosis care

What is covered?
You are entitled to thrombosis care. Thrombosis care comprises:

- regular blood tests for you;
- the laboratory tests required to determine the coagulation time of your blood under the responsibility of a thrombosis service;
- supplying you with 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, and the assistance you receive when taking these measurements;
- giving you advice regarding the use of medicines to influence the coagulation.

What should you keep in mind?
Thrombosis services can provide this type of care.

You need a referral from a general practitioner, medical specialist, clinical technologist, doctor for the mentally disabled, geriatrics specialist or obstetrician.

Is there a statutory personal contribution?
There is no statutory personal contribution for thrombosis care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for 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, under specialist medical care. We can also send it to you on request. 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.

Genetic advice

What is covered?
You are entitled to genetic advice. Genetic advice comprises:

- the investigation into and of hereditary defects by means of genealogical research, chromosome tests, biochemical diagnosis, ultrasound examinations and DNA tests;
- giving you advice about the heredity of disorders/defects or an apparent increased risk thereof;
- psychosocial guidance in connection with the advice on the heredity of disorders/defects;
- the examination of persons other than yourself, should this be required for the advice to be given to you. In that case, the other persons may also be given advice.

What should you keep in mind?
Centres for genetic advice can provide this type of care.

You need a referral from a general practitioner, medical specialist, clinical technologist, doctor for the mentally disabled or specialist geriatrics doctor. The referral will remain valid for a period of twelve months, commencing on the day the referral was issued.

Is there a statutory personal contribution?
There is no statutory personal contribution for genetic advice.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for 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, under specialist medical care. We can also send it to you on request. 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.

Audiological care

What is covered?
You are entitled to audiological care. Audiological care comprises:

- testing the hearing function;
- advising on the hearing aid to be purchased;
- information on the use of the aid;
- psychosocial care, if necessary, related to problems of impaired hearing;
- assistance in establishing a diagnosis in the event of speech and language disorders in children.

What should you keep in mind?
Audiological centres can provide this type of care.

You need a referral from a general practitioner, medical specialist, clinical technologist, youth healthcare doctor, doctor for the mentally disabled or specialist geriatrics doctor. The referral will remain valid for a period of twelve months, commencing on the day the referral was issued.

Is there a statutory personal contribution?
There is no statutory personal contribution for audiological care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for audiological 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, under specialist medical care. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

The contracted audiological centres are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31(0)570 687 123.

Sensory disability care

What is covered?
You are entitled to sensory disability care. You qualify for this if you suffer from a serious impairment in your vision or hearing or suffer from serious speech/linguistic difficulties. Sensory disability care comprises of multidisciplinary care aimed at learning to live with, the removal of or the compensation of the impairment, with the objective of allowing you to live as independently as possible. Multidisciplinary care means that various disciplines are involved in the treatment with simultaneous and/or successive interventions in the treatment process.

The care consists of:
- diagnostic examination;
- interventions aimed at learning to live with the impairment from a psychological viewpoint;
- interventions that remove or compensate the impairment, thereby increasing your self-reliance.

The care also includes 'secondary' treatment of parents/carers, children and adults close to you. They learn skills in your interest. 'Secondary' treatment is covered by your health insurance.

Impaired vision

The right to care in connection with impaired vision is subject to:
- visual acuity of <0.3 in the best eye;
- range of vision <30 degrees; or
- visual acuity between 0.3 and 0.5 in the best eye in combination with related, serious impairments in the daily functioning.

Impaired hearing

The right to care in connection with impaired hearing is subject to:
- you suffer from a 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

You qualify for the right to care in connection with serious speech and linguistic difficulties if you are aged 22 or under. You need to 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 should you keep in mind?
Centres for sensory disability care can provide this type of care.

You must have a first referral from a medical specialist or a clinical physiologic-audiologist. You must have a second or subsequent referral from a medical specialist, clinical physiologic-audiologist, youth healthcare doctor or general practitioner. A second or subsequent referral is not required if you have a visual impairment and the following conditions are met:
- you previously received sensory disability care for your visual impairment;
- there has been a change in your medical or personal situation, as a result of which you have a new requirement for treatment;
- the healthcare provider who provides the sensory disability care establishes that your treatment requirement is non-complex, which can be dealt with in a short programme, the so-called care programme 11.

An admission for sensory disability care is subject to our written consent prior to the admission commencing. You must enclose a (copy of the) treatment plan with your application.

Is there a statutory personal contribution?
There is no statutory personal contribution for sensory disability care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for sensory disability 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. We can also send it to you on request. 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.

Obstetric care

What is covered?

You are entitled to obstetric care. Obstetric care includes care such as obstetricians generally provide.

This type of care also comprises prenatal screening.
Prenatal screening includes:

- counselling (explanations about the prenatal screening for congenital defects when you are pregnant);
- the '20-week ultrasound scan' (a structural ultrasound examination in the second term of pregnancy);
- the combination test, if there are medical grounds to do so. The combination test consists of the NT scan (nuchal scan) and serum test (blood test);
- the NIPT, if there are medical grounds to do so. Medical grounds shall also be deemed to exist if a combination test reveals a reasonable risk of the child developing Down syndrome or Edwards or Patau syndrome;
- invasive diagnostics, (chorionic villus sampling or amniocentesis) if there are medical grounds to do so. Medical grounds shall also be deemed to exist if a combination test or 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:

- obstetricians;
- general practitioners;
- a hospital;
- a birth centre;
- a birth care organisation which has been contracted for this purpose by us;
- echoscopic centres, for echoscopic examinations only.

Prenatal screening may only be provided if the care provider referred to above:

- is a licensee by virtue of the Population Screening Act; or
- has a cooperation agreement with a regional centre that is a licensee under the Population Screening Act.

For obstetric care in a hospital, you need a referral from a general practitioner, medical specialist or obstetrician.

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?

The use of a hospital delivery room, if there are no medical grounds, is subject to a statutory personal contribution. For the calculation of the statutory personal contribution, the use of the delivery room is deemed to fall under maternity care.

Are the costs deducted from the compulsory and voluntary excess?

The costs of obstetric care do not count towards the compulsory and, if applicable, voluntary excess. The compulsory and, if applicable, voluntary excess do include:

- the cost of laboratory testing in a hospital or independent laboratory at the request of an obstetric care provider;
- costs of a NIPT;
- indirect costs, such as medicine and transport costs.

Do you have to pay extra for non-contracted care?

We apply a maximum reimbursement for obstetric 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 care provided by a non-contracted care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/rates. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

Maternity care

What is covered?

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 care only comprises the care during the first ten days after the day the child is born.

The actual number of hours of maternity care are established by the care provider in consultation with the obstetrician and ourselves. The National Maternity Care Indication Protocol ('Landelijk Indicatieprotocol Kraamzorg') serves as the guiding principle for determining the number of hours and days. The number of hours and days partly depend on the family composition and the presence of volunteer aid. The protocol can be viewed and downloaded at www.hollandzorg.com/maternitycare. Alternatively, we will send this to you on request.

What should you keep in mind?

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

- a maternity carer;
- a hospital;
- a birth centre;
- a birth care organisation which has been contracted for this purpose by us.

In order to receive maternity care, you must register with us. If you register before the twentieth week of pregnancy, we will have ample time to arrange adequate care. You can register by using the registration form at www.hollandzorg.com/pregnant.

Is there a statutory personal contribution?

Maternity care at home is subject to a statutory personal contribution of €4.60 per hour. Maternity care at an institution, for both mother and child, is subject to a statutory personal contribution of €18.50 per day, plus the sum of the rate of the institution in excess of €131 per day. This does not apply if there are medical grounds.

Are the costs deducted from the compulsory and voluntary excess?

The costs of maternity care do not count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?

We apply a maximum reimbursement for maternity 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. We can also send it to you on request. 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.

Physiotherapy and remedial therapy

What is covered?

You are entitled to reimbursement of physiotherapy and remedial therapy. Physiotherapy is care such as physiotherapists generally provide. Remedial therapy is care such as remedial therapists generally provide.

18 or older

If you are 18 or older, you are entitled to:

- physiotherapy or remedial therapy for a disorder on a list stipulated by the Minister (Appendix 1 to the Health Insurance Decree (Besluit zorgverzekering)), the List of disorders for long-term physiotherapy and remedial therapy. The right starts after the 21st treatment. Some disorders on the List of disorders for physiotherapy and remedial therapy are subject to a maximum treatment term. If you receive physiotherapy or remedial therapy for a disorder and that therapy is subject to a maximum term, you are entitled to the care until the end of the maximum term;
- pelvic physiotherapy in connection with incontinence, subject to a maximum of the first nine treatments (once-only);
- supervised remedial therapy for peripheral arterial disease (PAD) in Fontaine stage 2 (intermittent claudication). In that case you will be entitled to a maximum of 37 treatments during a maximum of 12 months;
- supervised remedial therapy for arthrosis in your hip or knee joint. In that case you will be entitled to a maximum of the first 23 treatments during a maximum of 12 months.
- supervised remedial therapy for COPD, if it concerns stage II or higher of the GOLD Classification for spirometry. In that case, you are entitled to:
  - in the case of class A of the GOLD Classification for symptoms and risk of exacerbations and a moderate burden of disease or sufficient physical capacity: no more than the first five treatments during a maximum of twelve months;
  - in the case of class B of the GOLD Classification for symptoms and risk of exacerbations and a high burden of disease and limited physical capacity: no more than the first twentyseven treatments during a maximum of twelve months after the start of treatment and a maximum of three treatments per 12 months in the following years;
  - in the case of class B of the GOLD Classification for symptoms and risk of exacerbations and a high burden of disease and limited physical capacity or in the case of class B of the GOLD Classification for symptoms and risk of exacerbations: no more than the first seventy treatments during a maximum of twelve months after the start of treatment and a maximum of three treatments per 12 months in the following years;
  - if it concerns Class C or D of the GOLD Classification for symptoms and a risk of exacerbation: no more than the first seventy treatments during a maximum of twelve months after the start of the treatment and a maximum of fifty-two treatments per twelve months in subsequent years;
- conditional physiotherapy and remedial therapy as referred to in the article on Conditional care.

Younger than 18

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

- physiotherapy or remedial therapy for a disorder on a list stipulated by the Minister (Appendix 1 to the Health Insurance Decree (Besluit zorgverzekering)), the List of disorders for long-term physiotherapy and remedial therapy. The right becomes effective from the first treatment. Some disorders on the List of disorders for physiotherapy and remedial therapy are subject to a maximum treatment term. If the insured party receives physiotherapy or remedial therapy for a disorder and that therapy is subject to a maximum term, the insured party is entitled to the care until the end of the maximum term.
- physiotherapy and remedial therapy which are not on the List of disorders for physiotherapy and remedial therapy. In those cases, the insured party is entitled to a maximum of the first nine treatments per calendar year. If those treatment do not give the desired result, the insured party is subsequently entitled to a maximum of nine treatments for the same disorder.

The insured party is only entitled to reimbursement of children's physiotherapy if the insured party is younger than 18.

The List of disorders for physiotherapy and remedial therapy can be viewed at www.hollandzorg.com/physiotherapy. We can also send it to you if you wish.

What should you 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;
- children's physiotherapy: a children's physiotherapist
- scar treatment: a physiotherapist and skin therapist;
- manual physiotherapy: a manual therapist;
- oedema therapy and lymph drainage: an oedema therapist and skin therapist;
- general remedial therapy: a remedial therapist (Cesar or Mensendieck);
- geriatric remedial therapy: a geriatric remedial therapist;
- children's remedial therapy: a children's 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 are listed at www.hollandzorg.com/careprovider. 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 who is affiliated with the national ParkinsonNet network. These care providers are listed at www.hollandzorg.com/careprovider. 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.

You need a referral from a general practitioner, medical specialist, youth healthcare doctor, 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):

- for treatment of a complaint on the List of disorders for long-term physiotherapy and remedial therapy.
- for treatment by a pelvic physiotherapist in connection with urine incontinence;
- for supervised remedial therapy in the event of peripheral arterial disease (PAD) in stage 2 Fontaine (intermittent claudication).
- for supervised remedial therapy in the event of arthrosis in your hip or knee joint;
- for supervised remedial therapy for COPD, if it concerns stage II or higher of the GOLD Classification for spirometry;
- for care at home or in an institution by a non-contracted care provider.

If you go to a non-contracted care provider, you must include a copy of the referral when you submit the first invoice.

To be entitled to reimbursement of the costs of care by a non-contracted provider, you must also enclose a statement from your care provider when submitting the first invoice. This statement must list any historic physiotherapy or remedial therapy received for that same disorder. This does not apply if the insured person:

- is younger than 18
- when it concerns costs for pelvic physiotherapy in connection with urinary incontinence.
- if it concerns supervised remedial therapy in connection with:
  - peripheral arterial disease (PAD) in Fontaine stage 2 (intermittent claudication);
  - arthrosis in your hip or knee joint;
  - COPD, if it concerns stage II or higher of the GOLD Classification for spirometry.

Is there a statutory personal contribution?
There is no statutory personal contribution for physiotherapy and remedial therapy.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for physiotherapy and remedial therapy 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. We can also send it to you on request. 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.

Speech therapy

What is covered?
You are entitled to reimbursement for speech therapy. Speech therapy is care such as speech therapists generally provide, as long as the care has a medical objective and recovery or improvement of the speech function or power of speech can be expected from the treatment. This type of care also comprises stuttering therapy. The care includes conditional speech therapy as referred to in the article on Conditional care.

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 should you keep in mind?
The following care providers are permitted to provide this type of care:

- preverbal speech therapy: a speech therapist who is listed on the preverbal speech therapy sub-register of the NVLF.
- Aphasia therapy: a speech therapist who is listed on the NVLF's Aphasia register;
- the Hanen parent programme It Takes Two to Talk (*Praten Doe je Met z'n Tweeën* = PDMT): a speech therapist who is listed on the NVLF's PDMT Hanen parent programme sub-register;
- the Hanen parent programme More than Words (*Meer Dan Woorden* = MDW): a speech therapist who is listed on the NVLF's MDW Hanen parent programme sub-register;
- individual stutter therapy: a speech therapist who is listed on the NVLF's stutter therapy sub-register;
- integrated stutter care: a speech therapist or stutter therapist who is listed on the NVLF's integrated stutter care sub-register.
- speech therapy in the event of Parkinson's disease: a speech therapist who is affiliated with the national ParkinsonNet network. These speech therapists are listed at www.hollandzorg.com/carefinder. You may also call our Care Advice Line: +31 (0)570 68 74 70. Affiliation with the ParkinsonNet is not compulsory if the provision of care started before 1 January 2018;
- other speech therapy: a speech therapist.

You need a referral from a general practitioner, medical specialist, youth healthcare doctor, 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 Accessibility course can be found at www.kwaliteitsregisterparamedici.nl with the annotation 'DA'. 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?
There is no statutory personal contribution for speech therapy.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for speech therapy 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. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

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

Occupational therapy

What is covered?
You are entitled to reimbursement of occupational therapy, subject to a maximum of 10 hours of treatment per calendar year. Occupational therapy is care provided by occupational therapists. The aim of occupational care is to improve and restore self-care and independence. The care includes conditional occupational therapy as referred to in the article on Conditional care.

What should you 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 who is affiliated with the national ParkinsonNet network. These occupational therapists are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet is not compulsory if the provision of care started before 1 January 2018;
- other occupational therapy: an occupational therapist.

You need a referral from a general practitioner, medical specialist, youth healthcare doctor, 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 Accessibility course can be found at www.kwaliteitsregisterparamedici.nl with the annotation 'DA'. 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?
There is no statutory personal contribution for occupational therapy.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for occupational therapy 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. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

The contracted occupational therapists are listed at www.hollandzorg.com/careprovider. You can also contact our Care Advice Line on +31(0)570 687 123.

Dietetics

What is covered?
You are entitled to dietetic care, subject to a maximum of three hours of treatment per year. Dietetic care consists of education, with a medical objective, about diet and eating habits and treatment in the form of dietotherapy aimed at removing, reducing or compensating diseases related to or influenced by diet, such as dieticians generally provide. The care includes conditional dietetic care as referred to in the article on Conditional care.

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 should you 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 who is affiliated with the national ParkinsonNet network. These dieticians are listed at www.hollandzorg.com/zorgzoeker. You can also contact our Care Advice Line on +31 (0)570 687 123. Affiliation with the ParkinsonNet is not compulsory if the provision of care started before 1 January 2018;
- other dietetic care: a dietician.

You need a referral from a general practitioner, medical specialist, youth healthcare doctor, 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 Accessibility course can be found at www.kwaliteitsregisterparamedici.nl with the annotation 'DA'. 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?
There is no personal contribution for dietetic treatment.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for dietetic 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. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

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

Integrated care

What is covered?
You are entitled to integrated care. Integrated care can be available to people aged 18 and older with Diabetes Mellitus type II, for vascular risk management, for COPD and asthma.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- a contracted care group. Contracted care groups are listed at www.hollandzorg.com/careprovider. 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.

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

You need a referral from a general practitioner or medical specialist.

Is there a statutory personal contribution?
There is no statutory personal contribution for integrated care.

Are the costs deducted from the compulsory and voluntary excess?
The costs do not count towards the compulsory and, if applicable, voluntary excess. 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.

Dental care

What is covered?
You are entitled to dental care. Dental care (oral care) includes care such as dentists generally provide.

All ages

You are entitled to dental care if:
- you have a serious development disorder, growth disorder or acquired deformation of 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 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 occurred.

Younger than 18

If the insured party is younger than 18, the insured party, in addition to all-ages dental care, is also entitled to:
- periodic preventive dental check-up once a year. The insured party is entitled to a reimbursement of the costs several times a year only if this is necessary 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 entitled to reimbursement of costs several times a year only if this is 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 anaesthesia;
- 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 dental care, entitled to:
- dental surgery of a specialist nature and the associated X-rays, with the exception of periodontal surgery, fitting a dental implant 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 shall also include 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 'dental care for all ages', you are entitled to tooth replacement with non-plastic materials and fitting dental implants if this concerns the replacement of one or more missing permanent incisors or canines which have not grown or a tooth or teeth missing as the 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 should you keep in mind?
A dentist, whether or not affiliated to a centre for centre special dentistry, is permitted to provide this type of care.

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

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.

A dental surgeon may provide surgical dental assistance of a specialist nature. For the care provided by a dental surgeon, you need a referral from a general practitioner, dentist, orthodontist or other dental surgeon.

Removable (full) prostheses for the upper or lower jaw, whether or not secured on dental implants, may also be measured and fitted by a prosthodontist. You need a referral from a dentist, dental surgeon or orthodontist for the measuring, making, fitting and placement of removable (full) prostheses on dental implants by a prosthodontist.

A number of forms of dental care are subject to our written consent before you receive the care. They are:
- gnathologic care if the insured is younger than 18;
- making an overall jaw image if the insured is younger than 18;
- the third or fourth fluoride treatment per year from the moment the adult teeth emerge if the insured person is younger than 18;
- tooth replacement care with non-plastic materials if you are younger than 23;
- the care described under the heading 'All ages';
- treatment under general anaesthetic;
- osteotomy and treatment combining orthodontics and osteotomy;
- fitting a dental implant;
- 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/service-contact/conditions;
- making, fitting, repairing or rebasing full prostheses for the upper or lower jaw, whether or not secured on dental implants;
- care provided by a centre for special dentistry.

Requests for care must be accompanied by a written, substantiated treatment plan by the care provider, 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?
There is a statutory personal contribution:
- for care that falls under the heading 'All ages', if the care in question is not directly related to the referral for 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 aged 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?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Orthodontics in special cases

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

What should you keep in mind?
Orthodontists, whether or not affiliated to a centre for centre special dentistry, are permitted to provide this type of care.

You need a referral from a general practitioner, dentist or specialist dentist:

You must obtain our written authorisation, prior to you receiving the care. Requests for care must be accompanied by a written, substantiated treatment plan by the care provider, 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?
There is no statutory personal contribution for orthodontics in exceptional cases.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Medicinal care

What is covered?
You are entitled to medicinal care. Medicinal care (pharmaceutical care) includes the provision of:
- the following registered medicines, subject to authorisation by us:
  - the registered medicines contained in appendix 1 (not those in appendix 2) of the Healthcare Insurance Regulations (Regeling zorgverzekering);
  - the registered medicines contained in appendix 2 of the

Healthcare Insurance Regulations (Regeling zorgverzekering). Appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) contains additional conditions per medicine for the provision of that medicine. You are only entitled to reimbursement of the costs of these medicines if the conditions contained in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) for the medicine in question have been met;

The registered medicines authorised by us are specified in the Pharmacy Regulations. You can view and download the Pharmacy Regulations at www.hollandzorg.com/pharmaceuticals. Alternatively, we will send this to you on request.

Preference policy

For a number of groups of mutually replaceable medicines, we have allocated a preferred medicine. If you are you entitled to a preferred medicine, you are not entitled to another medicine, unless you have a medical necessity or a logistical need.

You have a medical need when it would be medically irresponsible for you to use the preferred medicine. Your prescriber may only note 'medical need' on the prescription if he can substantiate that need. The chemist will check the existence of a medical need. In the event of doubt, the chemist and the prescriber will decide together on the medical need. If the prescriber and the chemist are unable to reach an agreement, the position of the chemist takes precedence, unless we decide otherwise.

In the event of a medical necessity, you will not receive the preferred medicine. In that case, your chemist will choose another medicine with the lowest price on the basis of the prescribed active ingredient and the explanation of the prescriber. Before you receive the medicine of your choice, you must have tried at least two cheaper medicines with the same active ingredient. However, these medicines do need to be available and medically acceptable to you.

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.

The list of preferred medicines forms a part of the Pharmacy Regulations. We may change the list of preferred medicines at any time. We will announce changes at www.hollandzorg.com. We refer to the allocation of preferred medicine as preference policy.

With regard to the other allocated medicines, you are entitled to the medicine in accordance with the policy of the so-called Lowest Price Guarantee. The Pharmacy Regulations explain which conditions apply to that policy. Does your prescriber, by noting 'medical need' on the prescription, indicate that the medicine allocated under that policy is not medically advisable? the chemist will check the existence of a medical need. In the event of doubt, the chemist and the prescriber will decide on the medical need. If the prescriber and the chemist are unable to reach an agreement, the position of the chemist takes precedence, unless we decide otherwise. If you are entitled to another registered medicine, your chemist will decide which other medicine he will dispense, on the basis of the active ingredient and associated explanation prescribed by the prescriber.

- the following non-registered medicines in case of rational pharmacotherapy:
  - chemist's preparations, unless in the event of:
    - 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 with regard to which no decision has been made about the qualification within the meaning of Article 2.8.1.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;
  - medicines which, following prior consent 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;
  - medicines for which the Board has granted a trade licence for the assessment of medicines for public health reasons, if those medicines are not sold in the Netherlands but are sold in another EU country as a replacement medicine on account of a shortage of medicines.

- the following dietary preparations:
  - 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.
- the following over-the-counter medicines and gastric acid inhibitors:
  - 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.

- 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 also includes the advice and support which dispensing chemists generally provide for the assessment and responsible use of prescribed medicines.

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 as part of an admission or medical specialist treatment, provided they form (or are supposed 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. We can also send it to you on request.

How long do we reimburse medicines?

We do not issue medicines in unlimited quantities. Each time provided, 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 provision of benzodiazepines, hypnotic drugs and anxiolytic drugs is subject to a maximum period of one month. The care provider issuing the prescription determines whether it concerns a chronic disorder;
- 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 should you 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 GP, a medical specialist, an orthodontist, a dentist, an obstetrician, a doctor for the mentally disabled, a sports doctor, a specialist geriatrics doctor, a nursing specialist, an A&E doctor, or 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.

For dietary preparations, in addition to the prescription, doctor's note, and dispensing chemist's instruction, you will also need to submit a Dietary Preparations Statement completed by a dietician or a medical specialist. You can view and download the Dietary Preparations Statement at www.hollandzorg.com/pharmaceuticals. We can also send it to you on request.

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), per medicine. You can view and download the Pharmacy Regulations at www.hollandzorg.com/pharmaceuticals. Alternatively, we will send this to you on request.

Consent 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 consent 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.

These conditions are outlined in the Pharmacy Regulations (Reglement Farmacie) per medicine. You can view and download the Pharmacy Regulations at www.hollandzorg.com/pharmaceuticals. Alternatively, we will send this to you on request.

Consent for resold preparations

Resold preparations are non-registered preparations prepared in one dispensing chemist (chemist's preparations) and sold on to another dispensing chemist. The reimbursement of certain resold preparations designated by us is subject to our written consent before you receive the care. The resold preparations which require consent are listed in the overview 'Resold preparations'. This can be viewed and downloaded at www.hollandzorg.com. Alternatively, we will send this to you on request. 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?

You must pay a statutory personal contribution for a medicine classified into a group of interchangeable medicines if 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 years 2020 and 2021, 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.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

The provision of contraceptives as referred to in appendix 2 of the Healthcare Insurance Regulations (Regeling zorgverzekering) and medication assessment as stipulated under the conditions in the overview 'Designated Care Not Applicable to Excess' are exempted from the compulsory excess. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/excess. Alternatively, we will send this to you on request.

The preferred medicines allocated by us as stipulated under the conditions in the overview 'Designated Care Not Applicable to Excess' are exempted from the compulsory and the voluntary excess. The delivery costs, the counselling consultation for a preferred medicine and inhaler instructions do fall under the compulsory and, if applicable, the voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for medicinal 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. We can also send it to you on request. 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.

In-patient care

What is covered?
You are entitled to a stay and the corresponding nursing, caring or paramedic care. A stay is an admission for an uninterrupted period of no more than 1095 days (three years). The stay must be required on medical grounds in connection with general medical specialist care, plastic surgery, rehabilitation care, geriatric rehabilitation, transplant care, artificial respiration, sensory disability care, obstetric care, specialist medical mental care, genetic advice or surgical dental care of a specialist nature.

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

The care does not include:
- stays you require in connection with a psychiatric disorder or impairment if you are younger than 18;
- stays in connection with the temporary takeover of care to release a family caregiver (respite care);
- first-line in-patient stay. The cover of this care is listed in a separate article.

What should you keep in mind?
The following care providers can provide accommodation for your stay:
- hospitals, if you are receiving medical specialist care, rehabilitation care, geriatric rehabilitation care, transplantation care, artificial respiration, obstetric care, specialist medical mental care or surgical dental care of a specialist nature;
- rehabilitation centres, if you are receiving rehabilitation care or geriatric rehabilitation care;
- a psychiatric hospital, if you are receiving specialist medical mental care;
- respiratory centres, if you are receiving artificial respiration;
- centres for genetic advice, if you are receiving genetic advice;
- an institution for geriatric rehabilitation care;
- an institution for sensory disability care.

You need a referral from a general practitioner, medical specialist, dentist or obstetrician. This condition does not apply in the case of unforeseen care that cannot reasonably be postponed.

Your stay for the following types of admission is subject to our written consent before you are admitted:
- treatments that appear on the 'Pre-Authorisation List'. This list can be viewed and downloaded at www.hollandzorg.com/service-contact/conditions;
- treatments that appear on the 'Exhaustive List of Authorisations for Dental Surgery'. This list can be viewed and downloaded at www.hollandzorg.com/service-contact/conditions;
- rehabilitation care by a non-contracted care provider;
- sensory disability care;
- specialist medical mental care by a non-contracted care provider;
- specialised medical mental care for the second year of continuous stay and for the third year of continuous stay. You must enclose a (copy of the) national checklist for prolonged medical mental care (LGZZ) with each application. The national checklist for prolonged medical mental care (LGZZ) can be viewed and downloaded at www.hollandzorg.com/medicalmentalcare. We can also send it to you on request.

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 problem and the medical need for in-patient stay.

Is there a statutory personal contribution?
There is no statutory personal contribution for admissions.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for 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. We can also send it to you on request. 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.

First-line in-patient stay

What is covered?

You are entitled to first-line in-patient stays. A first-line in-patient stay in this context is a short-term stay required on medical grounds in connection with medical care such as general practitioners provide. This is to include round-the-clock availability and provision of nursing and/or care, whether or not in conjunction with paramedical care connected to the grounds for the stay. First-line in-patient stays are aimed at recovery and return to the home situation in the short term or relate to palliative terminal care.

The care does not include:

- stays as referred to in the separate article on stays in these policy conditions;
- stays in connection with the temporary takeover of care to release a family caregiver (respite care);
- stays you require in connection with a psychiatric disorder or impairment if you are younger than 18;
- stays for insured parties by virtue of a Wlz indication.

What should you keep in mind?

An institution for first-line in-patient stay can provide this type of care.

You need a referral from a general practitioner or medical specialist.

Your (extended) stay for the following types of admission is subject to our prior written consent:

- stays in an institution that is not contracted by us;
- stays that last longer than three months and which not involve stays for palliative care.

Is there a statutory personal contribution?

There is no statutory personal contribution for admissions.

Are the costs deducted from the compulsory and voluntary excess?

If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?

We apply a maximum reimbursement for first-line in-patient stays 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. We can also send it to you on request. 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.

Nursing without in-patient care

What is covered?

Nursing without in-patient care includes care such as nurses generally provide. 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.

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 during your stay in a hospital or another institution;
- maternity care.

What should you keep in mind?

You or your legal representative must have signed a care plan. The care plan must at least contain the type, extent, frequency and intended duration of the nursing and care required without in-patient care, the performances and be motivated. The care plan must also involve the contribution of your social network.

A district nurse, paediatric nurse and nursing specialist are permitted to define 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 remaining care:

- a nursing specialist;
- a district nurse;
- a nurse with a nursing diploma at intermediate vocational education level;
- an IG carer or level-3 carer with a diploma at intermediate vocational education level 3;

You must obtain our written authorisation, prior to you receiving the care:

- for reimbursement for 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.nl. Alternatively, we will send this to you on request. If the care plan changes, you need to obtain our written consent again prior to you receiving the care.
- for reimbursement for 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?

There is no statutory personal contribution for nursing without in-patient care.

Are the costs deducted from the compulsory and voluntary excess?

The costs of home nursing without in-patient care do not count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for nursing without in-patient 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. We can also send it to you on request. 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.

Personal budget

Instead of the right to care, you may qualify for a personal budget. In that case, you will receive a budget to purchase the care and nursing yourself. The right to a personal budget is subject to special conditions. They are defined in the Personal District Nursing Regulations. The Personal District Nursing Regulations can be viewed and downloaded at www.hollandzorg.com/wijkverpleging. Alternatively, we will send this to you on request. 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.

Ambulance transport

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

a. to a care provider that will provide you with care which is covered, in full or in part, by your public healthcare insurance;
b. to an institution where you will be staying, which stay is covered, in full or in part, by the Long-Term Care Act (Wlz);
c. to a person from whom or an institution in which an insured person under the age of eighteen will receive mental health care the costs of which are payable in full or in part by the Municipal Executive responsible under the Youth Law;
d. from an institution defined in subparagraph b, to:
    1. a person or institution where you are given an examination or receive care, the costs of which are fully or partially covered by 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 by the Long-Term Care Act (Wlz);
e. to your home or another home if you cannot reasonably receive the required care at your home, if you are coming from one of the care providers defined in sections a to d.

A distance of more than 200 kilometres also falls under ambulance transport, provided we have given our written consent before you are transported.
Transport by a mode of transport other than an ambulance may also fall under ambulance transport. This is the case if transport by ambulance is not possible and we have given our prior written consent for transport by a different mode of transport designated by us.

What should you keep in mind?
The care may be provided by an ambulance transport company with a recognised permit.

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.

Ambulance transport is subject to our written consent, 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.

Consent is not required in the case of unforeseen care that cannot reasonably be postponed.

When submitting the request, you should include a report from the attending physician, including the medical diagnosis/diagnoses, a description of the current problem and a substantiation of the request.

Is there a statutory personal contribution?
There is no statutory personal contribution for ambulance transport.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Seated patient transport

What is covered?
You are entitled to seated patient transport. Seated patient transport is transport by private car or taxi, other than by ambulance, or public transport, over a maximum single travel distance of 200 kilometres:

a. to a care provider that will provide you with care which is covered, in full or in part, by your public healthcare insurance;
b. to an institution where you will be staying, which stay is covered, in full or in part, by the Long-Term Care Act (Wlz);
c. from an institution defined in subparagraph b, to:
    1. a person or institution where you are given an examination or receive care, the costs of which are fully or partially covered by 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 by the Long-Term Care Act (Wlz);
d. to your home or another home if you cannot reasonably receive the required care at your home, if you are coming from the care providers defined in subparagraphs a, b or c or to a person from whom or an institution in which an insured person under the age of eighteen will receive mental health care the costs of which are payable in full or in part by the Municipal Executive responsible under the Youth Law.

On the condition that one of the following reasons applies:
- you need dialysis: transport regarding consultations, examinations and check-ups needed as part of the treatment will also fall under this reimbursement;
- you need oncological treatment (chemotherapy, immune therapy or radiotherapy: transport regarding consultations, examinations

and check-ups needed as part of the treatment will also fall under this reimbursement;
- you are only able to move about in a wheelchair;
- your eyesight is so poor that you cannot move unaided;
- the insured party is under eighteen 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 seated patient transport by car (private transport) is € 0.32 per kilometre. We calculate the number of kilometres on the basis of the fastest route according to the most recent version of the online ANWB route planner (www.anwb.nl/verkeer/routeplanner), by entering the postcode of the point of departure and the postcode of the destination. The reimbursement for the use of public transport only applies to the lowest class of public transport.

What applies in exceptional circumstances?
Seated patient transport also includes transport in cases other than described above if you rely on transport for a long 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 it would be extremely unreasonable towards you if that transport were not reimbursed. 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 a reimbursement.

Seated 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 consent for the transport of two companions.

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

A distance of more than 200 kilometres also falls under seated patient transport, provided we have given our written consent.

Cost of accommodation
You are entitled to reimbursement of accommodation costs instead of (a reimbursement of the costs of) seated patient transport:
- when you are entitled to seated 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 and reimbursement of the costs of two overnight stays near the treatment centre. The reimbursement of the accommodation costs is a maximum of €76.50 per night. You must book the accommodation yourself.

What should you keep in mind?
For this type of transport, you can use your own car or that of someone else. You can also use a taxi firm or public transport provider.

You need a prescription from a general practitioner or medical specialist.

The reimbursement of transport is subject to our written consent before you are transported. You also need our prior written consent 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 seated patient transport at www.hollandzorg.com. We can send a form to you if you wish.

Is there a statutory personal contribution?
Seated patient transport is subject to a maximum statutory personal contribution of €108 per calendar year. The statutory personal contribution does not apply:
- to transport from an institution where you are admitted at the cost of the public healthcare insurance or the Long-Term Care Act (Wlz) to another institution where you are admitted at the cost of 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 at the former institution;
- 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, at the cost of 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 at the cost of the Long-Term Care Act (Wlz), to a person or institution where you will undergo dental treatment, at the cost of the Long-Term Care Act (Wlz), that cannot be provided at the former institution, and transport back to that institution;
- to the costs of using accommodation.

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?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for patient transport provided by a non-contracted taxi firm. 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. We can also send it to you on request. If the rates of the non-contracted care provider are higher than our listed maximum rates, the difference will be at your expense.

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

Basic mental healthcare

What is covered?

You are entitled to basic mental healthcare. Basic mental healthcare includes diagnosis and treatment of mild to moderate non-complex psychological disorders or stable chronic disorders such as clinical psychologists generally provide. In basic mental healthcare a psychiatrist cannot be a coordinating practitioner.
The care is divided into the following treatment programmes:

- General Basic Mental Healthcare Short:
- General Basic Mental Healthcare Medium:
- General Basic Mental Healthcare Intensive:
- General Basic Mental Healthcare Chronic:
- Incomplete treatment process.

The treatment programmes may consist of various elements, such as: intake, diagnosis, treatment by individual sessions, group sessions or online treatment, effect measurement, reports and consultation.

Basic mental healthcare does not include:

- the care you require in connection with a psychiatric disorder or impairment if you are younger than 18;
- treatment of post-traumatic disorders. A post-traumatic disorder is understood to mean ongoing psychological symptoms that impede everyday functioning at home or at work following a traumatic event or change (a stressful situation);
- help with work and relationship problems;
- indicated prevention in the case of depression, panic and anxiety disorders and problematic alcohol abuse.

More information on which treatments meet the state of the art and practice can be viewed at www.hollandzorg.com. We can also send you an overview on request.

Treatment programme

In principle, you are entitled to one treatment programme per year (365 days). If you have different care needs, your healthcare provider will deal with them in one and the same programme. You are not entitled to two (or more) treatment programmes simultaneously or consecutively within the same year. Your healthcare provider can adjust the treatment programme in the interim, in line with your care needs.

After closing a treatment programme, you will only be entitled to a new treatment programme within the same year (365 days) if your treatment programme has ended and you unexpectedly (unexpectedly for both you and your healthcare provider):

- return with the same symptoms (relapse); or
- are developing other symptoms.

What should you keep in mind?

The following care providers can provide basic mental healthcare as the coordinating practitioner:

- healthcare psychologists;
- clinical psychologists;
- a clinical neuropsychologist;
- psychotherapists;
- a specialist geriatrics doctor who works at an institution for the provision of basic mental healthcare;
- an addiction specialist who works at an institution for the provision of basic mental healthcare;
- a clinical geriatrics doctor who works at an institution for the provision of basic mental healthcare;
- a specialist mental healthcare nurse who works at an institution for the provision of basic mental healthcare.

The condition is that the care provider has a quality standard, which is listed in the Register for Quality Standards of the Dutch National Health Care Institute.

Transitional arrangement

If you turn 18 in the year 2021 and you receive care at that time from a remedial educationalist or care provider who is registered as a child and adolescent psychologist registered in the Netherlands Institute of Psychologists (NIP), these care providers may continue to provide care as a coordinating practitioner for a maximum period of 365 days, starting from the day on which you turn 18.

You need a referral 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 diagnosis and treatment;
- after 365 days have expired after the start of care, except in the case of the care product 'Generalist Basic GGZ Chronic';
- in the event of a new need for care. This is determined by your referrer.

The requirement for a referral does not apply:

- in the event of unforeseen care that cannot reasonably be postponed.
- in the case of mandatory treatment under the Dutch Mandatory Mental Healthcare Act;
- if the care is a direct continuation of;
  - care provided to you by order of a judicial procedure;
  - care provided to you by the same healthcare provider after the indication under the Long-Term Care Act has ended;
  - care provided to you under the Dutch Youth Act;
  - specialist mental healthcare for the same care need;
- in the case of a referral for the same care need between healthcare providers who are authorised to offer basic mental healthcare or specialist mental healthcare under these policy conditions.

The term of validity of the referral is nine months (275 days), counting from the date on which you registered with a designated care provider referred to in these insurance conditions to provide the care.

Is there a statutory personal contribution?

There is no statutory personal contribution for basic mental healthcare.

Are the costs deducted from the compulsory and voluntary excess?

If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?

We apply a maximum reimbursement for basic mental healthcare

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. We can also send it to you on request. 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.

Specialist mental healthcare

What is covered?

You are entitled to specialist mental healthcare. Specialised mental healthcare includes diagnosis and specialist treatment of (highly) complex psychological disorders such as clinical psychologists generally provide.

Specialist mental healthcare does not include:

- the care you require in connection with a psychiatric disorder or impairment if you are younger than 18;
- treatment of post-traumatic disorders. A post-traumatic disorder is understood to mean ongoing psychological symptoms that impede everyday functioning at home or at work following a traumatic event or change (a stressful situation);
- help with work and relationship problems;
- indicated prevention in the case of depression, panic and anxiety disorders and problematic alcohol abuse.

More information on which treatments meet the state of the art and practice can be viewed at www.hollandzorg.com/mentalhealthcare. We can also send you an overview on request.

What should you keep in mind?

The following care providers can provide specialist mental healthcare as the coordinating practitioner:

- clinical psychologists;
- a clinical neuropsychologist;
- psychiatrists;
- psychotherapists;
- a specialist geriatrics doctor who works at an institution for the provision of specialist mental healthcare;
- an addiction specialist who works at an institution for the provision of specialist mental healthcare;
- a clinical geriatrics doctor who works at an institution for the provision of specialist mental healthcare;
- a specialist mental healthcare nurse who works at an institution for the provision of specialist mental healthcare;
- a healthcare psychologist who works at an institution for the provision of specialist mental healthcare;

The condition is that the care provider has a quality standard, which is listed in the Register for Quality Standards of the Dutch National Health Care Institute.

Transitional arrangement

If you turn 18 in the year 2021 and you receive care at that time from a remedial educationalist or NIP-certified child and adolescent psychologist, these care providers may continue to provide care as a coordinating practitioner for a maximum period of 365 days, starting from the day on which you turn 18.

You need a referral 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 diagnosis and treatment;
- in the event of a relapse pertaining to the same care need after 365 days after the care started;
- in the event of a new need for care. This is determined by your referrer.

The requirement for a referral does not apply:

- in the event of unforeseen care that cannot reasonably be postponed (acute GGZ/crisis DTC (diagnosis treatment combination)/urgent care);
- in the case of mandatory treatment under the Dutch Mandatory Mental Healthcare Act;
- if the care is a direct continuation of;
  - care provided to you by order of a judicial procedure;
  - care provided to you by the same healthcare provider after the indication under the Long-Term Care Act has ended;
  - care provided to you under the Dutch Youth Act;
  - basic mental healthcare for the same care need;
- in the event of a referral for the same care need between healthcare providers who are authorised to offer basic mental healthcare or specialist mental healthcare under these policy conditions.
- for opening one or more DTCs if a first DTC has already been opened (so-called parallel DTCs).

The term of validity of the referral is nine months (275 days), counting from the date on which you registered with a designated care provider referred to in these insurance conditions to provide the care.

Reimbursement for specialist mental healthcare by a non-contracted care provider is subject to our written authorisation, prior to you receiving 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 problem and the medical need for in-patient stay.

For specialised medical mental care in combination with an in-patient say, you must obtain written authorisation from us for the second and third consecutive years before the you 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 problem and the medical need for in-patient stay.

For specialised medical mental care in combination with an in-patient say, you must obtain written authorisation from us for the second and third consecutive years before the you receive the care. You must enclose a (copy of the) national checklist for prolonged medical mental care (LGZZ) with your application. The national checklist for prolonged medical mental care (LGZZ) can be viewed and downloaded at www.hollandzorg.com/medicalmentalcare. We can also send it to you on request.

Is there a statutory personal contribution?

There is no statutory personal contribution for specialist medical mental healthcare.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for specialist mental healthcare 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. We can also send it to you on request. 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.

Medical aids

What is covered?
You are entitled to medical aids (care in kind). Medical aids means functioning aids and dressings designated in the Medical Devices Regulations (Reglement Hulpmiddelen). These regulations define the scope of this type of care. The regulations also stipulate 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. Alternatively, we will send this to you on request.

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 supposed 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 required accessories (which belong to the main unit) are also included in the medical aids; In this situation, the 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 insurance conditions.

What should you 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.

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

Is there a statutory personal contribution?
Some medical aids are subject to a statutory personal contribution. This is defined in the Medical Devices Regulations (Reglement hulpmiddelen). 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?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess. 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 you 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, we will apply a maximum reimbursement.

In that case, a medical aid or dressing that we would normally sell to you is reimbursed 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. We will reimburse a maximum of 75% of the costs we would incur for providing that care on loan in that calendar year. 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. You can also contact our Care Advice Line on +31 (0)570 687 123.

Giving up smoking

What is covered?
You are entitled to a programme to give up smoking. This type of care comprises a medical care programme, possibly in combination with medicines, aimed at a change in behaviour with the objective of giving up smoking. You are only entitled to medicines relating to giving up smoking if they form part of the programme. The care is limited to one programme per calendar year.

Counselling for giving up smoking other than by participation in the giving-up-smoking programme may also be part of the general practitioner care, specialist medical care, obstetric care or basic mental healthcare. In that case, the right to counselling for giving up smoking is also subject to the conditions for those types of care. The conditions are set out in the articles relating to that care, namely: general practitioner care, specialist medical care (general), obstetric care and basic mental healthcare.

You are not entitled to a giving up smoking programme, if you receive counselling to stop smoking as part of integrated care.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- a general practitioner who provides the Stop Smoking Programme;
- a care provider who:
  - is registered in the Stop Smoking Quality Register; *and*
  - offers the programme (the intervention) through which he is registered in the Stop Smoking Quality Register. The intervention offered must meet the 2019 Tobacco Addiction Care Standard. You can consult this register at www.kwaliteitsregisterstopmetroken.nl;
- 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.

Care providers designated in the articles for those types of care are authorised to provide counselling for giving up smoking as part of general practitioner care, medical specialist care, obstetric care or basic mental healthcare.

Is there a statutory personal contribution?
There is no statutory personal contribution for giving up smoking.

Are the costs deducted from the compulsory and voluntary excess?
The Stop Smoking programmes designated by us are listed in the overview 'Designated Care Not Subject to Compulsory Excess'. The costs therefore do not count towards the compulsory excess. The costs do count towards the voluntary excess, if applicable.

Counselling for giving up smoking as part of general practitioner care, medical specialist care, obstetric care, integrated care or basic mental healthcare is subject to the provisions relating to the excess for those types of care.

Do you have to pay extra for non-contracted care?
We apply a maximum reimbursement for a giving-up-smoking programme 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. We can also send it to you on request. 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.

Combined lifestyle intervention

What is covered?
You are entitled to a combined lifestyle intervention if 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. A combined lifestyle interventions consists of a combination of interventions aimed at reducing the intake of energy, increasing physical exercise and any customised addition of psychological interventions to support a change in behaviour.

A combined lifestyle intervention 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 takes a total of 24 consecutive months to complete.

You are entitled to the care programmes on the Designated care programmes of combined lifestyle intervention list. This list may change in the interim. An up-to-date version can be found at www.hollandzorg.com/service-contact/conditions. We can also send it to you on request.

What should you keep in mind?
The following care providers are permitted to provide this type of care:
- a care provider who as a minimum complies with the competencies of the HBO lifestyle coach and who is listed in the register of the Netherlands Professional Association of Lifestyle Coaches (BLCN) as a lifestyle coach;
- a physiotherapist who as a minimum complies with the competencies of the HBO lifestyle coach and who is listed in the quality register of a relevant professional association with the designation of 'lifestyle coaching';
- a remedial therapist who as a minimum complies with the competencies of the HBO lifestyle coach and who is listed in the Paramedics Quality Register with the designation of 'lifestyle coaching';
- a dietician who as a minimum complies with the competencies of the HBO lifestyle coach and who is listed in the Paramedics Quality Register with the designation of 'lifestyle coaching'.
- a care group contracted by us.

You need a referral from a general practitioner.

Is there a statutory personal contribution?
There is no statutory personal contribution for the combined lifestyle intervention.

Are the costs deducted from the compulsory and voluntary excess?
The costs of the combined lifestyle intervention do not count towards the compulsory and, if applicable, voluntary excess.

Conditional care

What is covered?
You are entitled to conditional care and services designated by ministerial regulation (article 2.2. of the Healthcare Insurance Regulations (Regeling zorgverzekering)) subject to the applicable conditions, insofar as the care and services in question are responsible in nature. Conditional care included in the list of Conditional care. This list can be viewed and downloaded at www.hollandzorg.com/voorwaardelijkezorg. We can also send it to you on request.

If expensive and orphan drugs or other types of care are allowed conditionally during the term of the public health insurance, the right to that care is subject to the conditions laid down in the relevant ministerial regulation.

Is there a statutory personal contribution?
There is no statutory personal contribution for conditional care.

Are the costs deducted from the compulsory and voluntary excess?
If you are aged 18 or older, the costs count towards the compulsory and, if applicable, voluntary excess. This does not apply if the care forms part of the care referred to in articles 5 and 6 of the specific provisions of the public healthcare insurance.

Supplementary insurance Flexpolis No Risk I

The Flexpolis No Risk I provides 'flex migrants' cover for the 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.

Taking out and cancelling the Flexpolis No Risk I.

1. When can you take out the Flexpolis No Risk I?

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

- You (policyholder) can only take out a Flexpolis No Risk I policy if the person you (policyholder) want to insure also has public health insurance at the time of the Flexpolis No Risk I 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 Eno Zorgverzekeraar N.V. or Eno Aanvullende Verzekeringen N.V.;
- You (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk I, 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 you take out a Flexpolis No Risk I policy?

Your employer or other (legal) person with whom we have concluded the group 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 incept?

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 (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 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 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 agreed 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. How is the premium made up?

You (policyholder) must pay us premium, except for the period that cover for the Flexpolis No Risk I is suspended, 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. What 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
100%

What is covered?

You are entitled to reimbursement of the costs that have been charged to your compulsory excess.

Flexpolis No Risk II

The Flexpolis No Risk I provides cover for specific care and services to flex-migrants.

Specific provisions for the Flexpolis No Risk II

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

- 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;
- the list of terms;
- all appendices referred to in the applicable terms and conditions.

Taking out and cancelling the Flexpolis No Risk II.

1. When can you take out the supplementary insurance?

The following acceptance conditions apply to taking out a Flexpolis No Risk II 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) and the person to be insured do not have any payment arrears with or have been expelled in the past by Eno Zorgverzekeraar N.V. or Eno 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 II policy can be taken out.

We reserve the right to refuse the provision of a Flexpolis No Risk II policy for other reasons.

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

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

You will automatically receive the Flexpolis No Risk II, provided HollandZorg has made agreements about this within the framework of a group scheme.

3. When does the Flexpolis No Risk II incept?

If the application for the Flexpolis No Risk II 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 (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 terminate?

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

a) the group scheme within the meaning of article 1 of the Specific provisions for the Flexpolis No Risk II is terminated;
b) if you (insured/policyholder) cease to be employed by the employer with whom we agreed 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 II.

Premium

5. When do you not have to pay a premium?

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

Insurance cover general

6. When are you 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 may reasonably be regarded as necessary for you in terms of content of scope. The care to be provided must be effective and not unnecessarily expensive or unnecessarily complicated;
- you receive the care at a location which may be regarded as customary, given the nature of the care and the circumstances.

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 consent 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. If our contract with a care provider ends during the period you are receiving care from that care provider, you retain the right to reimbursement for the rest of the treatment programme as if the care provider were still contracted by us.

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

Specific restrictions for the Flexpolis No Risk II

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 insurance conditions;
- that falls within the scope of the compulsory policy excess or voluntary policy excess, unless explicitly stated otherwise in these insurance conditions;
- they are subject to the statutory personal contribution , unless explicitly stated otherwise in these insurance conditions;
- which is required due to your own 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;
- for injury sustained during winter sports except sledging, skating, cross-country skiing and on-piste downhill skiing.
- for 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 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 II.

Cover and reimbursement per care form

Medically necessary repatriation

Flexpolis No Risk II
100%

What is covered?

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

i. from the country you are temporarily staying in to the Netherlands or your country of origin;
ii. from the Netherlands to your country of origin.

The country where you are temporarily staying and your country of origin have to be in geographical Europe. 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 arises if, in our opinion, treatment in your country of origin is medically required because it is difficult to obtain locally or is medically irresponsible or because local treatment is more expensive 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 should you 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
100%

What is covered?

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 taken to mean: the costs of the transport itself (the ticket) and the

additional costs necessary for transport (compulsory embalming, transport coffin, etc.). The country where you are temporarily staying and your country of origin have to be in geographical Europe.

Entitlement to this cover continues for a 14-day period after termination of your Flexpolis No Risk II.

What should you 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.

Emergency dental care in the Netherlands

Flexpolis No Risk II

a maximum of € 200 per calendar year

What is covered?
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 Care 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. We can also send it to you on request.

What should you keep in mind?
A dentist can provide all types of care.

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.

Contracted care providers are listed at www.hollandzorg.com.
You can also contact our Customer Service on +31 (0)570 687 123.

Medicinal care

Flexpolis No Risk II

100%

What is covered?
You are entitled to reimbursement of the statutory personal contribution for medicinal care under the public health insurance

What do all the terms mean?

In these insurance 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 entered as addiction specialist in the KNMG's Board of Registration's Medical Specialists register.

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

Basic mental healthcare
General basic mental healthcare.

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.

Birth centre
An institution for obstetric care. Here you can give birth and possibly stay during the maternity period after delivery.

BRP
Key Register of Persons (BRP).

CAK
The Central Administrative Office for Exceptional Medical Insurance (CAK) referred to in the first subparagraph of article 6.1.1 of the Long-Term Care Act.

Calendar year
The period from 1 January to 31 December inclusive.

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 provides integrated care as a principal contractor. 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. 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 district nursing 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 district nursing 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
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 to you 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 person or legal person that provides care professionally or commercially.

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 which qualifies as such, insofar as required by or pursuant to the Healthcare Institutions Eligibility Act (Wet toelating zorginstellingen).

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

Cesar/Mensendieck remedial therapy
Care generally provided by remedial therapists.

Chemist's preparation
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(d) of the Medicine Act (Geneesmiddelenwet);

Children's physiotherapist
A physiotherapist who is registered as a children's physiotherapist in the NL Physiotherapy Quality Register (KRF NL) and/or the quality register of Stichting Keurmerk Fysiotherapie.

Children's physiotherapy
Care for minors generally provided by children's physiotherapists.

Children's remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a children's remedial therapist.

Children's remedial therapy
Care for minors generally provided by children's remedial therapists.

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 Medical 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.

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) registered as a clinical technologist in accordance with the conditions defined in article 3 of the Individual Health Care Professions Act (Wet BIG).

Company doctor
A doctor who is entered 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.

Compulsory excess
The sum of costs for care that remains payable by you.

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 Customer Service 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 Care 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
The examination into the nature, cause and seriousness of a disorder.

Dialysis centre
A centre that provides dialysis care and which qualifies as such, insofar required, pursuant to the law. 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 entered in the Paramedics Quality Register.

Dispensing chemist
A chemist who is entered in the register of established dispensing chemists as defined in article 61, paragraph 5 of the Medicines Act.

Dispensing general practitioner
A general practitioner who, pursuant to article 61, paragraph 10 or 11 of the Medicines Act, has been granted a licence to dispense medicines.

District nurse
A nurse with an HBO Nursing diploma (higher professional education);

Doctor
A doctor registered as such in accordance with the conditions defined in article 3 of the Individual Health Care Professions Act (Wet BIG).

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

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, specialist geriatric doctors and doctors for the mentally disabled.

Echoscopic centre
An institution for prenatal screening which holds a licence pursuant to the Population Screening Act (Wet op het bevolkingsonderzoek).

EER country
A country party to the Agreement on the European Economic Area: Liechtenstein, Norway and Iceland.

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.

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 (GP)
A doctor registered as a general practitioner in the register of general practitioners, specialist geriatric doctors and doctors for the mentally disabled of KNMG's Board of Registration.

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.

Geographical Europe
Mainland Europe (the European peninsula), with the exception of Belarus, the Ukraine, the Russian Federation, Moldavia, the European part of Turkey and the European part of Kazakhstan.

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 physiotherapist
A physiotherapist who is registered as a geriatric physiotherapist in the NL Physiotherapy Quality Register (KRF NL) and/or the quality register of Stichting Keurmerk Fysiotherapie.

Geriatrics specialist
A doctor entered as a geriatrics specialist (nursing home doctor) in the KNMG's Board of Registration of general practitioners, specialist geriatric doctors and doctors for the mentally disabled.

GGZ
Mental healthcare.

GP centre
An institution for the provision of general practitioner care.

Group scheme
An agreement between us and an employer or legal entity which is not an employer and which looks after the interests of a group of people. The employees or the persons of that group enjoy the benefits under the agreement if they meet the conditions set out in the agreement. We refer to such employees or persons as participants.

Health insurance
Health insurance as defined in the Healthcare Insurance Act (Zorgverzekeringswet).

Healthcare psychologist
A healthcare psychologist registered as such in accordance with the conditions defined in article 3 of the Wet BIG.

HollandZorg
Eno Zorgverzekeraar N.V. In the event of references to supplementary insurance, 'HollandZorg' is taken to mean: Eno Aanvullende Verzekeringen N.V.

Hospital
A specialist medical care facility for the examination, treatment, and nursing of the sick.

In writing
Transfer of information via hardcopy, e-mail or Internet web form.

Independent treatment centre
An institution for medical specialist care.

Infectious disease and tuberculosis prevention doctor
A 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).

In-patient care
Admission with a duration of 24 hours or longer.

Institution
- an institution in the sense of the Healthcare Institutions Eligibility Act (Wet toelating zorginstellingen);
- 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.

Institution 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).

Insurance
Public healthcare insurance, supplementary insurance, dental insurance.

Insurance conditions
The rights and obligations as they apply to you (insured party/ policyholder) and us, and which form the insurance.

Insured party
The party whose risk of requiring care is covered by the insurance and who is listed on the policy as the insured party.

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
Care because an insured person who is younger than 18 years of age has a complex physical medical disorder (complex somatic disorder) or a physical handicap, and:
- there is a need for permanent monitoring; or
- round-the-clock care must be available close to the insured and that care at the same time includes 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.

IVF treatment (in vitro fertilisation treatment)
Care in accordance with the in-vitro fertilisation method, entailing:
- stimulating the maturation of egg cells in the woman's body by means of hormone treatment;
- the follicle puncture (obtaining mature egg cells);
- fertilising egg cells and growing embryos in the laboratory;
- implanting one or two embryos, kept frozen or not, once or several times in the uterus to achieve a pregnancy.

KNGF
The Royal Dutch Society of Physiotherapy.

KNMG
The Royal Dutch Medical Association.

Manual therapist
A physiotherapist who is registered as a manual therapist in the NL Physiotherapy Quality Register (KRF NL) and/or the quality register of Stichting Keurmerk Fysiotherapie.

Manual therapy
Manual therapy encompasses care that is generally provided by manual therapists.

Maternity carer
A trained assistant who provides maternity care to the new mother and her family after childbirth. A maternity carer ensures the wellbeing of mother and child, and reports to the obstetrician or doctor if necessary.

Maternity centre
A centre that provides maternity care and which qualifies as such, insofar as required, pursuant to the law.

Medical adviser
One of our employees who is entered in the registers in accordance with the conditions defined in article 3 of the Individual Health Care Professions Act (Wet BIG).

Medical aids supplier
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.

Medical specialist
A doctor who is entered 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).

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

NIP-certified child and adolescent psychologist
A care provider registered as a child 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.

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.

Nursing specialist
A nurse registered as a specialist nurse in accordance with the conditions defined in section 14 of the Dutch Individual Health Care Professions Act (Wet BIG).

NVLF
Dutch Association of Speech Therapy and Phoniatry.

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 entered in the Paramedics Quality Register.

Oedema therapist
A physiotherapist who is registered as an oedema therapist in the NL Physiotherapy Quality Register (KRF NL) and/or the 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.

Orthodontic care
Care of an orthodontic nature as generally provided by dentists.

Orthodontist
A specialist dentist who is entered 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 care product (ozp)
A performance service within specialist medical care, other than a DBC care product.

Paediatric nurse
A nurse with an MBO or HBO Nursing diploma (medium or higher professional education) and having completed nationally recognised advanced training for nursing children.

Patient day
A patient day as described in the policy document for specialist medical care performance and rates defined by the Netherlands Care Authority.

Pelvic physiotherapist
A physiotherapist who is registered as a pelvic physiotherapist in the NL Physiotherapy Quality Register (KRF NL) and/or the quality register of Stichting Keurmerk Fysiotherapie.

Pelvic physiotherapy
Care generally provided by pelvic physiotherapists.

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 registered as such in accordance with the conditions defined in article 3 of the Individual Health Care Professions Act (Wet BIG). Physiotherapist is also given to mean a remedial gymnastics masseur as defined in article 108 of the Individual Health Care Professions Act (Wet BIG).

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
Prescription for medicines.

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 which has been authorised as psychiatric hospital.

Psychiatrist
A doctor who is entered in the KNMG's Board of Registration's Medical Specialists register for psychiatrists.

Psychosomatic physiotherapist
A physiotherapist who is registered as a psychosomatic physiotherapist in the NL Physiotherapy Quality Register (KRF NL) and/or the quality register of Stichting Keurmerk Fysiotherapie.

Psychosomatic physiotherapy and remedial therapy
Care generally provided by psychosomatic physiotherapists and psychosomatic remedial therapists, respectively.

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
The HollandZorg public health insurance, which is a 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 (Wet personenvervoer) 2000, 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, about 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.

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.

Rehabilitation centre
An institution which provides rehabilitation care and that qualifies as an institution for rehabilitation, insofar as required, pursuant to the law. A multidisciplinary team of experts, under the management of a medical specialist, is employed at the centre.

Rehabilitation specialist
A doctor who is entered as rehabilitation specialist in the KNMG's Board of Registration's Medical Specialists register.

Remedial educationalist
An educationalist-generalist who is registered in the NVO Register (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 entered in the Paramedics Quality Register.

Respiratory centre
A centre that provides artificial respiration and which qualifies as such pursuant to the law, insofar as required. A respiratory centre may be affiliated to a hospital, but not necessarily so.

Scar treatment
Physiotherapy aimed at preventing or reducing pain and movement restrictions due to scars.

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
Health Insurance Complaints and Disputes Committee

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
Specialist medical mental healthcare.

Specialist mental healthcare
Specialist medical mental healthcare.

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).

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 entered 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 Eno Aanvullende Verzekeringen N.V. This non-life insurance covers a risk of a need of care or other services, in addition to the cover provided by the public healthcare insurance. Dental insurance also falls under this, unless explicitly stated otherwise.

SVB
Social Insurance Bank (Sociale Verzekeringsbank).

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.

Transplantation centre
An institution with a permit under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) to provide transplantation 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, Switzerland, Tunisia and Turkey.

Triage hearing specialist
A triage hearing specialist who is listed in the Triage Specialist Quality Register of the Centre for Certification.

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).

Voluntary excess
An amount of costs for care, agreed by you (policyholder) and HollandZorg as part of the public healthcare insurance, which is payable by the insured party.

We
Whenever these insurance conditions refer to 'we' or 'us', this refers to 'Eno Zorgverzekeraar N.V.'. In the event of references to supplementary insurance, these terms refer to 'Eno Aanvullende Verzekeringen N.V.'

Wet BIG
The Individual Healthcare Professions Act.

Wlz
Long-term Care Act.

You
Whenever these insurance conditions refer to 'you', they refer to the insured party. Whenever these insurance conditions refer to 'you (policyholder)', they refer to the policyholder. Whenever these insurance conditions refer to 'you (insured party/policyholder)', they refer to both the insured party and the policyholder.

Youth healthcare doctor
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 youth healthcare doctor in the youth healthcare profile register of the Commission for the Registration of Social Medicine of the KNMG (Royal Netherlands Medical Society);

and who provides youth healthcare as referred to in the Public Health (Preventive Measures) Act.

HollandZorg

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