HollandZorg

Policy conditions 2027

HollandZorg basic health insurance
Flexpolis No Risk Student
Flexpolis No Risk Top



Valid from January 2027

HollandZorg is een handelsnaam van Salland Zorgverzekeraar N.V.
en Salland Aanvullende Verzekeringen N.V.

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Important to know

Contact and service

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

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

Customer Service: +31 (0)570 687 123 (lines are open Monday to Friday, from 8 am to 6 pm, also for waiting list mediation and care advice)

Emergency centre: +31 570 687 112 (standard rate/for emergency care abroad only). The emergency centre is reachable 7 days a week and 24 hours a day.

Postal address: HollandZorg, Postbus 166, 7400 AD Deventer

Care Finder

Our Care Finder is an easy tool to help you find a care provider near you. In addition, you can instantly see whether and for which treatments we have made agreements with this care provider. Visit: hollandzorg.z-zoeker.nl.

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

Submit a claim online

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

The My HollandZorg app now makes claiming your healthcare expenses even easier. You enter your details, take a picture of the invoice and submit it with a single mouse-click. In most cases, we will pay the claim within 3 working days.

Sending documents

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

Compulsory excess

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

Compulsory excess

Each year, the government determines the amount of the compulsory excess. In 2027, the amount is € 400. This means that, in the year 2027, you will never pay more than this amount as compulsory excess.

Compulsory excess exceptions

Not all care provided through public health insurance is subject to compulsory excess.

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

Paying excess

1. We receive an invoice from your care provider. We check whether excess applies. If so, we will invoice you the amount due.
2. You receive an invoice from your care provider directed at you. You can claim this amount from us. We will deduct the excess from the payment. We will deposit the reimbursement into the bank account (IBAN) of the policyholder.
3. A statutory personal contribution applies to the healthcare or medical expenses (see glossary). The personal contribution is first deducted from the total amount. The amount remaining does not count towards the compulsory excess. How this works in practice is shown in the calculation examples.

Example 1: compulsory excess

In 2027, you spend € 415 on hospital care. The compulsory excess is € 400.

This is the amount you pay yourself. We will reimburse the payable amount that remains. So the reimbursement is € 15 (€ 415 - € 400).

You have now paid the full amount of the compulsory excess for 2027. We will no longer deduct compulsory excess on new healthcare expenses for the year 2027.

Example 2: compulsory excess

In 2027, you spend € 85 on medicines via the chemist. The full amount of € 85 is subject to compulsory excess. These costs are payable by you. You will not be reimbursed under the public healthcare insurance. For the year 2027, your remaining compulsory excess is € 315 (€ 400 - € 85).

Example 3: statutory personal contribution and compulsory excess

In 2027, you spend € 200 on patient transport. The statutory personal contribution for transport is € 113 per calendar year. These costs are payable by you. The amount that remains after that is € 87 (€ 200 - € 113). This amount is subject to the compulsory excess of € 400.

These costs are payable by you too. For the year 2027, your remaining compulsory excess is € 313 (€ 400 - € 87).

General provisions

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

1. General

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

2. Invoices and payments

2.1. What year do the healthcare expenses relate to?

The costs of care are allocated to the calendar year in which you received the care. If you received the care in 2 successive calendar years but the care has been charged as a single sum, the care is allocated to the calendar year in which the care started. The date on which you were treated, a medicine was issued or a medical aid supplied determines the reimbursement and excess. The invoice date or the date on which payment was made is not relevant in this respect.

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

The costs of a dbc care product (diagnosis treatment combination) apply to the calendar year in which the dbc product was opened. Therefore, in the event of a dbc care product that was opened in year A and closed in year B, you will be reimbursed in accordance with year A. The excess also applies to year A.

2.2. How do I submit an invoice?

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

Submitting the invoice online:
- You can do so in My HollandZorg (mijn.hollandzorg.com) or the app.
- We may ask you to submit the original invoice after all. If we do not receive the original invoice, the right to reimbursement of that invoice lapses. In that case, we may claim back any money reimbursed incorrectly.
- You must keep the original invoice for up to 2 years after submission.

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

An invoice must meet the following conditions:

- It must in any case state the name, address and profession of the care provider, invoice date, date on which the care was provided and a description of that care and name and date of birth of the insured party.
- The invoice must be drawn up in Latin script, the alphabet used for almost all Western languages. If the invoice is drawn up in a different language, you must include a sworn translation of the invoice. We do not reimburse the costs of the translation. If you do not provide a sworn translation, we may refuse to process the invoice.
- An invoice for healthcare expenses incurred abroad must be accompanied by a fully completed and signed foreign claim form (can be downloaded at www.hollandzorg.com/forms).
- In the event of a healthcare insurance personal budget (Zvw-pgb) invoice, you must enclose a completed and signed healthcare insurance personal budget claim form (available for download at www.hollandzorg.com/forms) with the invoice.
- The invoice must be clearly legible.
- The invoice must comply with the statutory requirements applicable to the care provider for claiming that care.

2.3. Until when can I submit an invoice?

Care-related invoices must be submitted within 12 months of the end of the calendar year in which you received the care. This means the treatment or delivery date and not the date on which the invoice was issued. If the care is described as a dbc or dbc care product, you must submit the invoice within 12 months of the dbc or dbc care product ending. If you submit an invoice after 12 months, we may decide to reimburse the invoice partially or not at all. In that case, the additional costs for administrative processing will be payable by you. Invoices submitted 3 years after the treatment or delivery or the date on which the dbc or dbc care product is terminated are never eligible for reimbursement.

2.4. Can I transfer a claim?

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

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

2.5. When do we pay?

We will pay an invoice submitted to us within 3 working days of receipt. This is based on the assumption that all conditions for (partial) reimbursement have been met. The processing time will be longer if the invoice is incomplete or if more time is needed to check whether the care meets the policy conditions.

We may request additional information from you to verify whether the care claimed complies with the policy conditions. You can view your claims via My HollandZorg. Alternatively, we are entitled to pay the costs of care directly to the care provider who provided the care. Your entitlement to reimbursement is nullified by that payment.

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

We pay the costs of care and other amounts payable to you (insured party/policyholder) by transferring the money into the policyholder's bank account number (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 health insurance, unless the statutory personal contribution has already been settled with the care provider. If an excess applies, we will also deduct the excess from the reimbursement. Finally, we will deduct any other amounts that remain payable by you from the reimbursement.

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

2.6. How do we process your payments?

You (insured party/policyholder) can pay our invoices via:
- direct debit
- iDEAL from My HollandZorg (mijn.hollandzorg.com)
- Internet banking
- transfer form from your bank.

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

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

2.7. Interest and collection costs

If you (insured party/policyholder) fail to pay the premium or other amounts owed to us in time, we may charge statutory interest and collection costs. You will first receive written notice from us in which we inform you that you have not paid in time. The letter also states that you (insured party/policyholder) will be given the opportunity to pay the amount due, without additional costs (interest and collection costs), within 14 days from the day after the notice was delivered to you. Only if you have not paid everything after these 14 days will we charge statutory interest and collection costs on the unpaid amount. We will state the amount of the collection costs in the message to you and this is in accordance with the Extrajudicial Collection Costs (Fees) Decree (Besluit vergoeding voor buitengerechtelijke incassokosten.).

3. Taking out and cancelling insurances

3.1. How do I take out an insurance policy?

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

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

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

If the public health insurance commences within 4 months of the obligation to take out health insurance coming into force, the public health insurance will be backdated to the date on which the obligation to take out health insurance arose.

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

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

You (insured party/policyholder) will be issued policy documents as soon as possible after the insurance is taken out and subsequently at the start of each new calendar year. If you (insured party/policyholder) believe the policy is incorrect, you must report this to us within 1 month of receiving the policy. If we do not receive any notification from you within a month, we assume the details are correct.

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

The insurance is taken out for 1 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 health insurance is tacitly renewed for 1 calendar year on 1 January of each calendar year, unless it is terminated prematurely in accordance with these policy conditions.

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

3.3. What happens if I change my mind?

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

You (policyholder) can cancel in one of the following ways:
- via the contact form at www.hollandzorg.com/contact
- via My HollandZorg (mijn.hollandzorg.com)
- in writing to: HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

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

3.4. When does the insurance end?

The insurance terminates automatically on the day following that on which:
- our licence entitling us to provide healthcare insurance terminates. In that case, we will inform you (policyholder) of the termination date and reason no later than 2 months before termination of the insurance.
- you die. The insured party or your heirs are obliged to notify us of your death promptly.
- your obligation to take out insurance ends. You (insured/policyholder) must inform us of that fact as soon as possible. If you were not subject to compulsory health insurance, we will terminate the public health insurance and, if applicable, the supplementary insurance, from the moment that your public health insurance came into force. We will set off the premium that has been paid against the care that has been reimbursed. The difference is either paid out or charged.

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

3.5. How can I cancel the insurance?

- You (policyholder) can cancel the insurance on or before 31 December of any year with effect from 1 January of the following calendar year.

- You (policyholder) can cancel the public health insurance of another person you have insured and who will be insured under a different health insurance. If we receive the notice of cancellation before the commencement date of the other health insurance, the public health 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) can cancel the public health insurance within 6 weeks of receiving notification from the Dutch Healthcare Authority that we have received an order or an administrative penalty has been imposed upon us because we breached the law by accessing your data by means of an electronic exchange system. The public health insurance will then end on the first day of the second calendar month following the day on which you (policyholder) have cancelled.
- You (policyholder) can cancel the insurance if we change the policy conditions to the disadvantage of you (insured party/policyholder). 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 1 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 health insurance ends on the starting date of the new health insurance. This is usually the day of commencement at your new employer if this is the first day of the calendar month, otherwise it will be the first day of the month after commencement of employment. In other cases, the insurance ends on the first day of the second calendar month following the day on which you (policyholder) have cancelled.

The stated cancellation options do not apply to the public health insurance if the premium and collection costs owed have not been paid and we have demanded payment from you (the policyholder) for the premium owed. This does not apply if we have suspended (temporarily discontinued) the cover of the public health insurance or if we have confirmed the cancellation to you (the policyholder) within 2 weeks.

You (policyholder) can cancel in one of the following ways:
- via the contact form at www.hollandzorg.com/contact
- via My HollandZorg (mijn.hollandzorg.com)
- in writing to: HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)

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

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

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

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

If you are insured through the Central Administrative Office for Exceptional Medical Insurance (CAK) within the framework of measures against the uninsured, you can still cancel (terminate) the public healthcare insurance. This must be done within 2 weeks of the date on which the CAK has notified you that you are insured with us. In addition, you must demonstrate that you have been given another health insurance in the 3-month period from the date of dispatch by the CAK of the second administrative penalty on account of being uninsured and the instruction to take out insurance (or arrange for insurance to be taken out on your behalf) under the public health insurance scheme.

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

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

3.7. When may we cancel or suspend the insurance?

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

- if you (policyholder) have failed to pay the premium or other amounts you (policyholder) owe us in a timely fashion. This only applies if you (policyholder), after a written reminder stating the consequences of non-payment, continue to be in default of payment within the applicable term. Cancellations or dissolutions on account of non-payment will not be backdated. A suspension on account of non-payment ends on the day after that on which we have received the outstanding amount, including interest and costs.
- if you (insured party/policyholder) fail to provide us with information or provide incomplete or incorrect information or documents which are important for executing the insurance and which could or does disadvantage 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 (insured party/policyholder) seriously misbehave towards us or our employees.

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

3.8. What happens to my insurance if I am detained?

The cover and obligation to pay premiums under the public health insurance are suspended (temporarily discontinued) during the time you are detained. We cannot cancel or dissolve your public health 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 1 month of the detention commencing. The end date must be reported within 1 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/contact; or
- by post to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

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

4. Premium

4.1. How is the premium made up?

The premium that you (the policyholder) must pay is the premium base minus any discount.

The premium base, any discount and the premium due that you (the policyholder) must pay can be found on the policy.

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

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

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 that case, we may charge you that amount in the form of a surcharge in addition

to your premium. You (policyholder) must then pay the surcharge to us. If a surcharge applies, this will be specified in the policy.

4.2. When do I pay the premium?

You (the policyholder) must pay the premium in advance. Your payment must be made before the first day of the period to which the premium relates. We decide whether you can pay per month, per six months or per year, and which form of payment is possible.

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

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

5. Important rules

5.1. Who are the insurances for?

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

The insurance is governed by the laws of the Netherlands.

5.2. What information requirements do I have to meet?

You (insured party/policyholder) are obliged:

- to prove your identity when receiving care in a hospital or outpatient' department by means of a driver's licence, passport, Dutch identity card or an alien's 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 health insurance.
- to swiftly notify us of all the facts and circumstances which may be important for the correct execution of the insurance, such as moving house, birth, death, changes to bank account number, divorce or end of participation in a group scheme. Or circumstances that have led or could lead to the termination of your insurance.

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

5.3. How do we send notifications?

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

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

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

- a written request addressed to HollandZorg, Polisadministratie, Antwoordnummer 30, 7400 VB Deventer (no stamp required)
- via the contact form at www.hollandzorg.com/contact

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

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

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

- by calling +31 (0)570 687 123
- in writing to: HollandZorg, Verhaal, Antwoordnummer 30, 7400 VB Deventer (no stamp required)
- by e-mail at verhaal@hollandzorg.nl
- by completing the Accident claim form at www.hollandzorg.com/forms. On our website, you will immediately be given a rough indication of whether it is possible for you or us to recover the damages.

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

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

5.5. What limits to liability apply?

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

Any liability on our part for damage or losses suffered as the result of our own shortcomings in the execution of the public health 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 health insurance.

5.6. How do we handle your personal data?

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

We use this data for the following purposes:

- to conclude and execute the insurance policy.
- to increase our customer portfolio and provide information about our products.
- conducting research into the quality of care as perceived by you.
- to comply with statutory obligations.
- monitoring the safety and integrity of the financial sector, including preventing and combating fraud.
- exercising the right of recourse, including exchanging data with the non-life insurer of the liable person and with your travel insurer in the event of concurrence of cover abroad.
- scientific and statistical analyses.

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

In connection with a responsible acceptance, risk and fraud policy, we may check your data with Stichting CIS. 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 statement is available at www.stichtingcis.nl.

If relevant arrangements have been made with your care provider, the latter can consult your address details and policy details we have registered through the national Internet portal VECOZO (Veilige Communicatie in de Zorg). This is necessary for the care provider in order to claim the costs of the care provided to you directly from us.

In some cases, your personal data may need additional protection, for instance because you are staying at a shelter. If you believe that you need this additional protection, you can ask your municipality for additional protection of your personal data in the Key Register of Persons (BRP). After processing by the municipality, your personal data will receive additional protection. We will automatically take over this modified registration. This way, we can take that into account.

5.7. How do we act in case of fraud?

If we suspect fraud, we will conduct an investigation to determine whether fraud has occurred. In the event of confirmed fraud:

- we can have your (insured party/policyholder) data included in the Internal Reference Register (IVR) or the External Reference Register (EVR). The IVR and EVR are used by financial institutions to assess the integrity of insured parties and other customers. The IVR can only be consulted by us. The EVR can also be consulted by other financial institutions. Consultation runs via the central database of Stichting CIS. This will be done in accordance with the rules of the Protocol incident warning system for financial institutions. You (insured party/policyholder) can view and download this protocol at www.hollandzorg.com/conditions.
- we can file a report with the police.
- we may recover the investigation costs we incurred in identifying and proving the fraud committed by you (insured party/policyholder).
- we may terminate the insurance contract.
- you will not be entitled to a reimbursement of the care costs and we can demand that any compensations paid, including the costs incurred to do so, are paid back.

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

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

5.9. What restrictions apply in case of exceptional circumstances?

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

You are not entitled to reimbursement of the costs of care which is provided by yourself or by your partner or first- or second-degree blood relative. In exceptional cases, we may deviate from this:

- Can you prove that it is really essential that your partner or first- or second-degree blood relative provides the care and that no other care provider can provide that care? Before the care starts, we can then provide written consent for the right to (reimbursement of costs of) that care by your partner or that relative.
- In principle, care that you receive via a Personal Care Budget may be provided by your partner or relative unless this is excluded based on the Personal Care Budget under the Dutch Health Insurance Act (Zvw-pgb).

You are not entitled to (reimbursement of the costs of) care if the injury is caused by, occurred during or ensues from armed conflict, civil war, uprising, domestic riots, revolt and mutiny as referred to in Article 3:38 of the Financial Supervision Act (Wet op het financieel toezicht). For the definitions of these terms, please refer to the text filed by the Netherlands Association of Insurers (Verbond van Verzekeraars in Nederland) on 2 November 1981 at the Registry of the District Court in The Hague.

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

5.10. Can we change the policy conditions?

We can change the policy conditions with effect from a date to be set by us. A change to the premium calculation basis for the public health insurance will come into force no earlier than 7 weeks after the date on which we have informed you (policyholder) of that change.

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

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

When assessing the request for authorisation we will gauge whether the care complies with the policy conditions, whether the care is the most appropriate in your situation and whether the care provider meets our quality requirements. In that case, you will know in advance if and how much reimbursement you will receive for the care. If we grant our authorisation, it is valid for 1 year, counting from the date on which the written authorisation is granted. This authorisation may be valid for a shorter or longer period of time, if we explicitly mentioned that fact when we granted the authorisation.

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

You can e-mail a request for authorisation to our medical advisor at: toestemming@salland.nl. Alternatively, send your request for authorisation to: HollandZorg, Medisch adviseur, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

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

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

It is possible that you need care under the public healthcare insurance that requires authorisation and that you have already received the authorisation for that care or the reimbursement thereof from your previous health insurer. In that case, the authorisation applicable to the period issued by your previous health insurer is continued. This authorisation will entitle you to the care or to the reimbursement of the costs of the care in accordance with the rules in our policy conditions. Sending us that authorisation at toestemming@salland.nl or to the address above suffices. If your previous health insurer did not specify a period, the authorisation remains valid for a maximum of 1 year of the date the authorisation was granted by your previous health insurer.

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

5.12. Referral or prescription

The right to care or the reimbursement thereof will often be subject to a referral or prescription. The policy conditions state, per type of care, whether or not you need a referral or prescription. These conditions also state which care provider may be the referrer or prescriber. The referral or prescription will remain valid for a period of 9 months from

the day the referral or prescription was issued. The validity may be longer or shorter, provided this is expressly stated in the policy conditions in relation to the type of care concerned. If the care did not commence within the validity period, then the right to care or the reimbursement thereof will be subject to a new referral or prescription.

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

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

5.13. How can I submit a complaint?

If you (insured party/policyholder) disagree with a decision made by us within the framework of the public healthcare insurance, you (insured party/policyholder) can ask us to reconsider such a decision. You (insured party/policyholder) must submit your request within 6 weeks of receiving our decision. You can do so as follows:

- you can submit requests electronically by using the complaints form at www.hollandzorg.com/insured/customer-services/complaints.
- a written request must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

If we do not respond to your request within 4 weeks or if you are not happy with our response, you can lodge the dispute with the Health Insurance Complaints and Disputes Foundation (Stichting Klachten en Geschillen Zorgverzekeringen) (SKGZ). This does not apply if you already presented the dispute to a civil court. The SKGZ acts in accordance with its own regulations. The SKGZ ombudsman acts as the mediator in the dispute. If mediation is impossible or yields no satisfactory result, the SKGZ Disputes Committee can issue a binding recommendation. For more information, visit www.skgz.nl.

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

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

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

- you can submit requests electronically by using the complaints form at www.hollandzorg.com/insured/customer-services/complaints.
- a written request must be addressed to HollandZorg, Klachtencommissie, Antwoordnummer 30, 7400 VB Deventer (no stamp required).

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

Public health insurance

Specific provisions for public health insurance

The public health insurance is subject to the following conditions:

- the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the supplementary insurance.
- the arrangements set out in this chapter, Specific provisions for the public health insurance.
- the list of terms.
- all appendices referred to in the applicable terms and conditions.

Grounds and reasons for refusal

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

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

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

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

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

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

2. When can we refuse you?

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

- You are not obliged to insure under the public health insurance scheme.
- You are already insured under the public health insurance scheme.
- We cancelled your previous public health insurance in the 5 years preceding the request to conclude the new public health 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 health 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 health insurance:
  - a statement from the Social Security Bank (SVB) which shows that the insured person is insured under the Long-Term Care Act (Wlz); or
  - An employer's statement or a wage slip, both no older than one month, showing that the person to be insured is liable to pay Dutch income tax.

Premium

3. When are premium payments waived?

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

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

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

- you (policyholder) do not have to pay us premiums during the period that you (policyholder) have to pay the Central Administrative Office for Exceptional Medical Insurance (CAK) an administrative premium. In that case, you will have premium arrears of more than 6 months.

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

4.1. No later than 10 working days after our records indicate payment arrears of 2 monthly premiums for public health insurance, we will contact you (the policyholder) to agree on a payment arrangement. The payment arrangement consists of:
- agreements about the payment of new premium instalments falling due;
- agreements about paying off your debts (including interest and collection costs) relating to the public health insurance and the instalments for settlement;
- our commitment that we will not terminate or suspend (temporarily discontinue) the public healthcare insurance during the term of the payment arrangement due to these debts relating to the public health 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. Our payment arrangement proposal further includes the following option. If you (policyholder) took out the public health insurance for another party, you can cancel the public health insurance of that other party with effect from the date on which the repayment arrangement commences. The conditions for this are:
- The insured party has taken out alternative health insurance on or before the day on which the payment arrangement takes effect; and,
- If the insured party has taken out the health insurance with us (public health insurance), this party must authorise us to automatically collect future premiums each month or instruct a party from whom the insured party receives periodic payments (e.g. the employer) to pay us the amount of the future premiums on behalf of the insured party and to deduct this from the payments made to the insured party. In that case, we will send a copy of our proposal to the insured party.

4.3. With the payment arrangement proposal, we will send you (policyholder) a letter stating that you (policyholder) have 4 weeks to accept the proposal. It will further state the consequences if you (policyholder) were to reject the proposed payment arrangement and the premium arrears (excluding interest and collection costs) have risen

to 6 or more monthly premium payments. We will also remind you (policyholder) of the option of debt counselling.

4.4. Do you (the policyholder) have premium arrears, excluding interest and collection costs, of at least 4 monthly premiums? In that case, we will notify you (the policyholder) as soon as possible about our intention to report to the CAK if the debt (excluding interest and collection costs) has risen to an amount of at least 6 monthly premiums. We will refrain from making the report if you (insured party/policyholder) have objected to the payments arrears within 4 weeks of having received the notification.

4.5. If you (insured party/policyholder) have objected to the premium arrears in time, but we maintain our position, we will report you to the CAK as soon as your arrears, excluding interest and collection costs, have increased to an amount of 6 monthly premiums or more. We will refrain from making the notification if you (insured party/policyholder), within 4 weeks of having been notified by us, have submitted a dispute in respect of the premium arrears to SKGZ, Postbus 291, 3700 AG Zeist, or to the civil court.

4.6. If the payment arrangement takes effect when the premium arrears, excluding interest and collection costs, have increased to an amount of 4 monthly premiums, we will not report to the CAK as long as future premiums are paid.

4.7. Once the premium debt, exclusive of interest and collection costs, has risen to an amount of 6 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 do not report to the CAK:

- if the premium arrears have been disputed within the period referred to in 4.4, but we have not yet responded.
- 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 4.7 and no final and irreversible decision has yet been made.
- if you (policyholder) have applied to a debt counsellor as referred to in Article 48 of the Consumer Credit Act, such as a municipal authority or municipal credit institution and demonstrate that, within that framework, a written agreement has been concluded in order to service your debt.
- if your address is not shown in the Key Register of Persons (BRP) or if the address we have for you in our records does not correspond with your address in the BRP. This does not apply if the discrepancy is the result of the exceptional situations described in Article 2, bullet point four of the Specific Provisions for Public Health Insurance.

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 by virtue of the public health insurance have been repaid or cancelled.
- the debt management scheme for natural persons referred to in the Bankruptcy Act is declared applicable.
- the written agreement referred to under 4.7, point four, has been concluded or a debt settlement has been agreed in which at least you (policyholder) and we are participants.

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

Compulsory excess

5. When does the compulsory excess apply?

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

The following are excluded from the compulsory excess:

- the costs of obstetric and maternity care.

- the NIPT.
- the costs of general practitioner care. The compulsory excess does, however, include the costs of examinations that the general practitioner has performed by others and that are charged separately, such as laboratory tests and blood tests.
- the costs of registering with a general practitioner.
- the costs of other medical (GP) care.
- the costs of preventive foot care.
- the costs of integrated care (multidisciplinary primary care including general practitioner care).
- the costs of care for nursing without in-patient care (district nursing).
- the costs of a combined lifestyle intervention.
- the costs of the exploratory consultation as part of medical mental health care.
- the costs of the collegial consultation and collegial advice.
- if you are the donor, the costs of care, accommodation and transport relating to the admission for the selection and removal of the transplant material, as described in the article on transplant care in these policy conditions.
- the costs of collaboration between care providers that is not specifically aimed at individual insured parties or between care providers and other parties (cross-domain and cross-sector cooperation within the Healthcare Insurance Act). In that case, the collaboration must directly serve the provision of care or other services that are covered by your health insurance.
- the costs of medicinal care or aids designated by us and the costs of care provided to you by a care provider appointed by us in that regard. These are listed in the overview 'Designated care not subject to excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.
- the costs of care provided to you if you have followed a programme, designated by us, for diabetes, depression, cardiovascular diseases, COPD, obesity, dementia, thrombosis care, incontinence care or giving up smoking. In that case, the costs must relate to the disease for which you followed that programme. The programmes designated by us are listed in the overview 'Designated Care Not Subject to Excess'. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.

6. Which rules are applicable to the compulsory excess?

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

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

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

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

7. No voluntary excess

You (policyholder) cannot opt for a voluntary excess.

Insurance cover general

8. Which services are insured?

You are entitled to:
- the care (non-monetary) described further down in the policy conditions of the public health insurance, with the exception of physiotherapy, occupational therapy and speech therapy.

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

In principle, you need to use the care provided by contracted care providers. Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

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

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

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

Your care provider must provide care in accordance with the professional standard and the quality standards as referred to in the Healthcare Quality, Complaints and Disputes Act (Wet kwaliteit, klachten en geschillen zorg (WKKGZ). Has a guideline, care standard or quality standard been established for the care? Then you are entitled to (reimbursement of costs of) the care, if the care was provided in accordance with that standard. The current quality standards can be viewed and downloaded at www.zorginzicht.nl/kwaliteitsinstrumenten. Does your care provider deviate from the guideline, care standard or quality standard? You are still entitled to (reimbursement of costs of) the care if your care provider demonstrates that a deviation from this is medically necessary in your case and your care provider motivates this in your medical file.

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

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

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

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

Cover and reimbursement in the Netherlands

10. What is the cover in the Netherlands?

You are entitled to care in the Netherlands if:

- all conditions in connection with that care have been met before you receive that care. In addition to the general terms and conditions, many types of care are also subject to specific conditions, such as the need for a referral, a prescription or our prior written authorisation before you receive the care. The policy conditions refer to the general terms and conditions in the chapters General Provisions and Specific Provisions for the public healthcare insurance. The specific conditions that apply to a particular type of care are stated per type of care; and

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

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

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

Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service 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:
11.a. if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non- contracted care. The rates lists can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027.
11.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 11a 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 11b.

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 a hospital admission of at least 1 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 be postponed until after returning to the Netherlands; and
- the care provider responsible for the care, according to the law of the country in which the care provider is based, has qualifications which are equivalent to qualifications that apply to care providers designated by us in the Netherlands. In many cases, care providers abroad have received different training to care providers in the Netherlands. Qualifications that comply with the recognised professional qualifications within the meaning of the General EU Professional Qualifications (Recognition) Act suffice in most cases.

Are you staying abroad and do you need medical care? Please contact our emergency centre if you require emergency care. Our emergency centre will help you find care. They can also give you information about the reimbursement of the care. You can reach the emergency centre by telephone: +31 570 687 112. The emergency centre can be contacted 24 hours a day, 7 days a week.

13. How is the amount of reimbursement abroad determined?

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

13.a. to reimbursement of the costs of the care you would have received from us if this care was provided by a non-contracted care provider in the Netherlands. In practice, this means:

i. if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non-contracted care. The rates lists can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027.

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).

13.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 13b.

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

a. to care provided by a contracted care provider, 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 the maximum 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, by virtue of the provisions of the applicable European social security regulations or the relevant treaty.

Please note: Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

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

a. if we apply a maximum rate for that care, up to the maximum of the rate set by us. The policy conditions state, per type of care, whether or not we apply a maximum reimbursement for non- contracted care. The rates lists can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027.

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. The invoice must be drawn up in Latin script, the alphabet used for almost all Western languages. The invoice must also contain a description of the care provided. If the invoice is drawn up in a different language, you must include a sworn translation of the invoice. We do not reimburse the costs of the translation. If you do not provide a sworn translation, we may refuse to process the invoice.

An invoice for care provided abroad must be accompanied by a fully completed and signed Foreign Claim Form. The claim form can be downloaded at www.hollandzorg.com/forms.

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

Turnover limits and volume agreements

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

We make 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 in our care finder which care providers it concerns, as well as the possible consequences. You can find this information at HollandZorg Care finder (hollandzorg.z-zoeker.nl).

Obstacle (hinderpaal)

15. Obstacle and non-contracted care

Do you feel that the amount of the maximum reimbursement of the non-contracted care makes impossible for you to benefit from that care? We call that an obstacle. In that case, you may request us to grant you higher reimbursement for that non-contracted care. You can submit your request using the contact form at www.hollandzorg.com/contact. In addition, you must state what non-contracted care is involved, when the care starts and why you feel that an obstacle criterion prevents you from using the care. We will contact you within 10 working days of submitting the contact form.

Cover per care type

Birth care

Maternity care

You are entitled to maternity care. Maternity care is care such as maternity carers generally provide to mother and child in connection with childbirth. The right to maternity care applies for a maximum of 6 weeks, counting from the day of delivery. the maternity carer assists during the delivery (partum assistance), takes care of you and the baby during the maternity period and gives advice.

The number of hours of maternity care are established by your care provider in consultation with and under ultimate responsibility of the obstetrician. The 'National Maternity Care Indication Protocol' is leading in this. The number of hours and days partly depend on the family composition and the presence of informal care (family and friends). The protocol can be viewed and downloaded at www.hollandzorg.com/conditions.

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

What do I need to keep in mind?

The following care providers are permitted to provide maternity care:

- a maternity carer
- a hospital
- a birth centre
- a maternity hotel
- an integral birth care oragnisation contacted by us for this purpose.

Is there a statutory personal contribution?

Yes, maternity care at home is subject to a statutory personal contribution of € 6 per hour. As regards maternity care without medical grounds in an institution (hospital, birth centre or maternity hotel), the statutory personal contribution is € 23.50 per day for the mother and € 23.50 per day for the baby, plus that part of the institution's rate per day higher than € 169.

Example 1: You have given birth and recieved 49 hours of maternity care at home. In that case, your personal contribution is 49 x 6 = € 294.

Example 2: You have given birth without medical ground and are staying with your baby in hospital or a birth centre. The maximum reimbursement is 2 x € 169 = € 338. A personal contribution of 2 x € 23.50 = € 47 per day will be deducted from this. The total reimbursement is therefore € 338 - € 47 = € 291 per day. You must pay the difference between the daily costs charged by the hospital or birth centre and the maximum reimbursement of € 291 per day as a personal contribution.

Are the costs deducted from the compulsory excess?

No.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be

found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027, under maternity care. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Prenatal screening

You are entitled to prenatal screening. Prenatal screening comprises tests that can determine whether your unborn child has an increased risk of a congenital chromosomal or structural abnormality. You decide if you want to have these tests done.

They are:
- the NIPT, if there are medical grounds to do so;
- invasive diagnostics, (chorionic villus sampling or amniocentesis), if there are medical grounds to do so. Medical grounds are also deemed to exist if an NIPT reveals a reasonable risk of the child developing Down syndrome or Edwards or Patau syndrome or major structural chromosome abnormalities.

What do I need to keep in mind?
A hospital is authorised to conduct prenatal screening. The hospital must then have a licence pursuant to the Population Screening Act (Wet op het bevolkingsonderzoek) or have a collaboration agreement with a regional centre for prenatal screening with a licence pursuant to the Population Screening Act.

Is a referral needed?
Yes, from a general practitioner (GP), obstetrician or medical specialist.

Is there a statutory personal contribution?
No.

Are the costs deducted from the compulsory excess?
No, not for the NIPT.

The excess does include the costs of invasive diagnostics and any other diagnostic follow-up examinations.

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Obstetric care without medical grounds

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

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

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

Is a referral needed?

No

Is there a statutory personal contribution?

Yes, if you give birth in a birth centre or use a delivery room in a hospital. In that case, the personal contribution is € 23.50 per day for the mother and € 23.50 per day for the baby plus that part of the rate of the birth centre or hospital for the use of the delivery room per day higher than € 169.

> **Example:** You have given birth without medical ground and are staying with your baby in hospital or a birth centre. The maximum reimbursement is 2 x € 169 = € 338 per day. A personal contribution of 2 x € 23.50 = € 47 per day will be deducted from this. The total reimbursement is therefore € 338 - € 47 = € 291 per day. You must pay the difference between the daily costs charged by the hospital or birth centre and the maximum reimbursement of € 291 per day as a personal contribution.

Are the costs deducted from the compulsory excess?

No.

The following are included in the excess:

- the cost of laboratory testing at the request of an obstetric care provider
- indirect costs, such as medicines and transport costs.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027 under Obstetric care or medical specialist care. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Obstetric care with medical grounds

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

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

What do I need to keep in mind?

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

- a hospital
- an integral birth care organisation contracted by us for this purpose

Is a referral needed?

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No.

The following are included in the excess:

- the cost of laboratory testing at the request of an obstetric care provider.
- indirect costs, such as medicines and transport costs.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Medical mental healthcare (ggz)

Medical mental healthcare (ggz)

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

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

Medical mental healthcare up to the age of 18 falls under the Youth Act. For this you can contact the municipality. Medical mental healthcare does not include:

- treatment of post-traumatic disorders. This is taken to mean ongoing psychological symptoms impeding your everyday functioning at home or work following a traumatic event or change (a stressful situation).
- help in the event of work and relationship issues, such as being overstressed or burnout
- help in the event of learning disabilities
- indicated prevention in the case of depression, panic and anxiety disorders and problematic alcohol abuse, which falls under general practitioner care.

Your treatment must comply with the state of the art and practice. In the List of permitted mental health treatments, you will find more information about which treatments meet the current state of the art and practice and in which situation they may be applied by your care provider. You will find the list at www.hollandzorg.com/conditions.

Admission to a mental health institution

Admission includes stays 24 hours or longer during an uninterrupted period of no more than 1.095 days, for which there is a medical need in connection with medical care.

An interruption of admission for a maximum period of 30 days is not regarded as an interruption to the uninterrupted period. The duration of the interruption does not count in the calculation of the 1.095 days, except in the event of weekend and holiday leave. Interruptions for weekend and holiday leave are included in the calculation of the 1.095 days.

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

Field agreements

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

What do I need to keep in mind?

As directive practioners for mental health, these care providers may provide a healthcare or clinical psychologist, clinical neuropsychologist, psychotherapist, psychiatrist, specialist mental health nurse, a specialist or clinical geriatrics doctor, addiction specialist, remedial educationalist-generalist, physician assistant, social psychiatric nurse clinical geriatrics.

A psychiatric hospital is authorised to offer admission.

Transitional arrangement

Medical mental healthcare up to the age of 18 falls under the Youth Act. This involves other coordinating practitioners as those prescribed by your health insurance. If treatment needs to continue with this youth mental healthcare coordinating practitioner after your 18th birthday, this care provider may continue the treatment for a maximum of 365 days (1 year) after your 18th birthday. This must be a coordinating practitioner with a post-master's registration in the register of Stichting kwaliteitsregister Jeugd (SKJ) or the BIG register (usually a remedial educationalist or care provider registered as an NIP-certified paediatric and adolescent psychologist in the association register of the Netherlands Institute of Psychologists). In that case, this care provider does not need to prescribe to a certain Quality Charter. Continuation of treatment should aim at closure or transfer.

Quality Charter

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

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

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

Is a referral needed?

Yes, from a general practitioner, medical specialist, coordinating practitioner (in case of a referral), a company doctor or a doctor affiliated to Nederlandse Straatdokters Groep:

- at the start of the care programme
- upon re-registration if the care programme was completed more than 365 days ago.

This does not apply to the exploratory consultation. For an exploratory consultation you need a referral from your general practitioner.

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

No referral is needed:

- in the event of unforeseen care that cannot reasonably be postponed (urgent mental healthcare).
- in the case of forced care under the Mandatory Mental Healthcare Act.
- if the care is a direct continuation of care to you from a judicial programme, care provided to you by the same care provider after the end of the Wlz indication or care provided to you under the Youth Act.
- in the event of a re-registration within 1 year of completing a previous care programme.
- follow-up after treatment has started within acute mental health care (mental health care provided to you in a crisis situation where there is a suspicion that you have an acute psychiatric disorder).
- in the event of a referral between mental health care providers.

The referral is valid for a maximum of 9 months (275 days). This means that your treatment must start within 9 months of the referral being issued.

Is prior written authorisation required?

Receiving the care is subject to our written authorisation for medical mental healthcare by a non-contracted care provider in combination with admission.

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

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

This does not apply to the costs of the exploratory consultation. The costs of the exploratory consultation have been exempted from the compulsory excess.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Pharmaceutical care

Medicinal care

You are entitled to medicinal care. Medicinal care (pharmaceutical care) consists of the dispensing (by the chemist) of the medicines and dietary preparations listed below at bullet point 1 through 4. Medicinal care also includes the advice and support which dispensing chemists generally provide for the medication assessment and responsible use of prescribed medicines.

1. You are entitled to the registered medicines listed under a through d contained in Appendix 1 or Appendix 2 of the Health Insurance Regulations (Regeling zorgverzekering).

   Appendix 2 of the Health Insurance Regulations (Regeling zorgverzekering) contains specific conditions for the provision of the medicines listed in Appendix 2. You are only entitled to these medicines if you meet the relevant conditions contained in Appendix 2 of the Health Insurance Regulations (Regeling zorgverzekering).

   The contents of Appendices 1 and 2 of the Health Insurance Regulations may change from time to time. You can view and download the current content at www.hollandzorg.com/conditions.

   a. You are entitled to the registered medicines from a group of medicines which are interchangeable and insofar as they are allocated by us. You are then not entitled to another medicine, unless in the event of a medical need or a logistical need' (more about this in points b and c below). We have allocated the following medicines:
      i. the medicines on the List of preferred medicines. We call these medicines preferred medicines. You can view the up-to-date list of preferred medicines at https://www.hollandzorg.com/about-hollandzorg/preferred-medicines-policy. Are you entitled to a preferred medicine? You are then not entitled to another medicine, unless in the event of a medical need or a logistical need' (more about this in points b and c below). We may change the List of preferred medicines on a monthly basis. We can also send you the list on request.
      ii. if we have not allocated a preferred medicine as referred to under i in a group of interchangeable medicines, we have prescribed as medicine:
         - the cheapest medicine in the group of interchangeable medicines. The cheapest medicine is the medicine with the lowest pharmacy purchase price (AIP) according to the G-Standard. You can ask about the cheapest medicine and its price at www.hollandzorg.com/contact. Alternatively, ask your chemist;
         - the medicine that is a maximum of 3% more expensive than the cheapest medicine in the same group.

   b. If there is medical need (MN), you are entitled to another medicine than the allocated medicine. A medical need is deemed to exist when it would be medically irresponsible for you to use the allocated medicine. Based on healthcare criteria, you need another medicine. Your prescriber may only note 'medical need' on the prescription if they can substantiate that need. The chemist assesses the existence of a medical need. If in doubt, the chemist will contact the prescriber for consultation and coordination about the medical need. Your prescriber may only note 'medical need' on the prescription if he can substantiate that need. The chemist assesses the existence of a medical need. If in doubt, the chemist will contact the prescriber for consultation and coordination about the medical need.

   c. If there is a logistical need (LN), in deviation from a and b above, you are entitled to the medicine chosen by the chemist. There is a logistical need if the medicine is not available in the Netherlands for a prolonged period of time and no other available medicine has been allocated. With respect to preferred medicines, no other preferred medicine must have been allocated in the meantime. Your chemist will then choose which other medicine they will dispense, on the basis of the active ingredient and associated explanation prescribed by the prescriber. If in doubt, the chemist will contact the prescriber for consultation and coordination about the other medicine.

   d. You are entitled to all registered medicines which are not interchangeable.

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

3. You are entitled to the following non-registered medicines in case of rational pharmacotherapy:
   a. chemist's preparations, unless they are chemist's preparations that are (virtually) equivalent to a registered medicine not included in appendix 1 of the Health Insurance Regulations (Regeling zorgverzekering), with the exception of chemist's preparations that:
      i. are (virtually) equal to registered UR medicines (prescription medicines only) with regard to which no decision has been made about the qualification within the meaning of Article 2.8, paragraph 1, subparagraph a of the Health Insurance Decree (Besluit zorgverzekering), according to Appendices 1 and 3 to this regulation
      ii. are (virtually) equal to a registered UR medicine that is listed in Appendix 3, section A of the Health Insurance Regulations (Regeling zorgverzekering), provided the criteria given are met.
   b. medicines which, following prior consent of the Health and Youth Care Inspectorate (Inspectie Gezondheidszorg en Jeugd (IGJ)) 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:
      i. 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
      ii. 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;
      iii. these medicines are sold in another EU country or in a third country and are imported into Dutch territory as a replacement medicine on account of a shortage of medicines.
   c. medicines for which a marketing authorisation has been granted by the Medicines Evaluation Board (MEB) for public health reasons, as a replacement medicine due to a shortage of medicines. The condition is that those medicines are not available in the Netherlands, but are in another EU country.

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

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

How long do we reimburse medicines?

We do not issue medicines in unlimited quantities. Per dispensing (by the chemist), you are entitled to medicines for a period of:

- a maximum of 12 months, if it concerns the contraceptive pill (oral contraceptives).
- a minimum of 3 and a maximum of 12 months, if you have a chronic condition and you have been using the medicine for at least 6 months and you have properly adjusted to that medicine. In derogation from this, the dispensing of benzodiazepines, hypnotic drugs and anxiolytic drugs is subject to a maximum period of 1 month. The prescriber determines whether it concerns a chronic condition.
- a maximum of 1 course or 1 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 1 month in all other cases.

What do I need to keep in mind?

- Dispensing chemists and dispensing general practitioners can provide this type of care.
- Dietary preparations may also be supplied by suppliers of dietary preparations.
- You need a prescription. A physician (which also includes a GP, a medical specialist, a doctor for the mentally disabled, a sports doctor, a specialist geriatrics doctor, a nursing specialist or an A&E doctor), an orthodontist, a dentist, an obstetrician and a physician assistant may issue a prescription for most medicines. This is subject to the condition that the prescribed medicine is related to the care that the prescribing party generally provides.
- The following applies to the medicines contained in Appendix 2 of the Health Insurance Regulations (Regeling zorgverzekering):
  - for polymer, oligomer, monomer and modular dietary preparations, the first prescription for each indication may only be issued by a dietician, youth healthcare doctor, general practitioner or medical specialist.
  - for a hepatitis vaccine, diphtheria vaccine, poliomyelitis vaccine, whooping cough vaccine or combinations of two or more of these vaccines or with the tetanus vaccine, the first prescription for each indication may only be issued by a general practitioner or medical specialist.
  - for a pneumococcal vaccine, the first prescription for each indication may only be issued by a medical specialist.
  - for the other medicines listed in Appendix 2 of the Health Insurance Regulations, the first prescription for each indication may only be issued by a medical specialist with demonstrable specific expertise in the treatment of the indication for the medicine in question listed in Appendix 2 of the Health Insurance Regulations. Is a doctor's note from Zorgverzekeraars Nederland available for the medicine? And does that doctor's note not only mention medical specialists as prescribers, but also other care providers? For example, a general practitioner? The first prescription per indication may then also be issued by the other care provider(s) mentioned in the doctor's note.
  - a medicine may be prescribed by a prescriber other than the prescriber named for the medicine if you suffer from a very rare condition with a non-registered indication for the supply of that medicine and that prescriber is specialised in the treatment of that condition. In that case, the supply of the medicine is subject to our written authorisation.

Consent

In order for you to be entitled to these medicines contained in Appendix 2 of the Health Insurance Regulations (Regeling zorgverzekering), you must have received our written authorisation before receiving the care.

- infant formula in the event of cow's milk allergy without a challenge test being performed;
- infant formula in the event of cow's milk allergy for children aged 2 years and older;
- infant formula in the event of cow's milk allergy in quantities of more than 1000 ml per day;
- epoprostenol intravenous;
- iloprost for inhalation;
- treprostinil subcutaneously and intravenously;
- contraceptives in case of treatment of endometriosis and menorrhagia;
- medicines if you suffer from a very rare condition with a non-registered indication for the supply of those medicines;

- a medicine that has been added to Appendix 2 of the Health Insurance Regulations during the calendaryear. This does not apply if the procedure of a doctor's note and dispensing chemist's instruction exists for that medicine. In that case, that procedure can be followed.

You must enclose a copy of the prescription with your request.

Doctor's note and dispensing chemist's instruction

The procedure of the doctor's note and dispensing chemist's instruction may apply to the right to other medicines included in Appendix 2 of the Healthcare Insurance Regulations. In that case, the dispensing chemist or dispensing general practitioner must determine the right to the medicine based on a doctor's note or dispensing chemist's instruction. The prescription must then be accompanied by a fully completed, dated and signed doctor's note. The dispensing chemist or dispensing general practitioner must act in accordance with the associated dispensing chemist's instruction and, on that basis, assess whether you are entitled to reimbursement of the costs of the medicine. Visit www.znformulieren.nl to check whether the procedure of the doctor's note and dispensing chemist's instruction applies. The procedure of the doctor's note and dispensing chemist's instruction and their content may change from time to time. Visit www.znformulieren.nl for up-to- date information.

If you object to the procedure of doctor's note and dispensing chemist's instruction, you can also submit a request for authorisation directly to us.

Authorisation for (resold) chemist's preparations

Chemist's preparations are non-registered medicines that are made on a small scale in one pharmacy by or on behalf of a chemist or dispensing general practitioner. Transferred chemist's preparations are chemist's preparations that are transferred to another pharmacy. The reimbursement of certain chemist's preparations, designated by us, is subject to our written authorisation before you receive the care. The chemist's preparations for which authorisation is required are listed in the overview Reimbursement for chemist's preparations. This overview can be viewed and downloaded at www.hollandzorg.com/conditions.

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

Is there a statutory personal contribution?

Yes, if the medicine is classified into a group of interchangeable medicines and the purchase price is higher than the reimbursement limit. A statutory personal contribution is also due when a medicine is prepared from a medicine for which a statutory personal contribution is due. The Healthcare Insurance Regulations (Regeling zorgverzekering) stipulate how the personal contribution is calculated. In the year 2027, 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 contribution for your public healthcare insurance for that calendar year is set lower, in proportion to the number of days insured. The calculated amount is rounded off to whole Euros.

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

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older with the exception of the following cases.

No compulsory excess applies to contraceptives and the dispensing thereof as referred to in appendix 2 of the Health Insurance Regulations. Also for a medication assessment, there is no compulsory excess, as included and under the conditions in the overview ‘Allocated care outside the compulsory excess’. The up-to-date overview can be viewed and downloaded at www.hollandzorg.com/conditions.

Preferred medicines are subject to a partial exemption from the compulsory excess. The overview ‘Designated care outside the excess’ sets out the amount of the partial exemption.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027, under Pharmaceutical healthcare. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

General practitioner care

General practitioner care

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

What do I need to keep in mind?

General practitioners are entitled to provide this type of care.

Is there a statutory personal contribution?

No

Are the costs deducted from compulsory excess?

No. The costs of medicines or (laboratory) testing in a hospital or an independent laboratory at the request of the general practitioner do count towards the compulsory excess.

Integrated care

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

What do I need to keep in mind?

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

- a contracted care group. Contracted care groups are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.
- a care provider appointed by us for providing general practitioner care, preventive foot care and dietetic care, each for the relevant part of the integrated care.

Is a referral needed?

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No. The compulsory excess does include the costs of any (laboratory) testing in a hospital or independent laboratory at the request of a general practitioner.

Medical aids

Medical aids

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

The cover for medical aids does not include:

- medical aids and dressings you receive as part of an admission or medical specialist treatment if they form or are deemed to form part of that admission or treatment. In that case, those medical aids form part of that care. In case of transmural care at home, the aids and the required accessories (which form part of those aids) are included in the medical specialist care. In this situation, dressings do fall under the medical aids.
- medical aids and dressings you are entitled to pursuant to the Long-Term Care Act (Wlz), the Social Support Act (Wet maatschappelijke ondersteuning (Wmo)), the Work and Income (Capacity for Work) Act (Wet inkomen naar arbeidsvermogen (WIA)).
- the costs of normal use of medical aids such as energy consumption and batteries, unless stipulated otherwise in these policy conditions.

What do I need to keep in mind?

- In principle, you must use the care provided by contracted care providers. Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service 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) outline which care providers can provide the care in that case.
- You need a prescription in order to qualify for medical aids. The Medical Devices Regulations (Reglement hulpmiddelen) outline, per category of medical aids, which care provider can issue the prescription.

Is prior written authorisation required?

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

Is there a statutory personal contribution?

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

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older. This does not apply to aids that you receive on loan. The consumables or usage costs associated with the loaned aids are covered by the excess.

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

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

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

Oral care and orthodontics in exceptional cases

Oral care

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

All ages

You are entitled to oral care if:

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

Younger than 18

If the insured party is younger than 18, the insured party, in addition to all-ages oral care, is also entitled to:

- periodic preventive dental check-up once a year. The insured party is only entitled to more times per year if required from a dental point of view.
- occasional dental examination
- plaque removal
- a maximum of 2 fluoride treatments per year from the moment that the adult teeth emerge. The insured party is only entitled to more times a year if desirable from a dental point of view.
- application of a protective coating to the biting surfaces of molars (sealing)
- treatment of the tissues supporting the teeth, such as gums (periodontal treatment)
- local anaesthetic
- treatment of the dental nerve (endodontic treatment)
- fillings (restoration of the dental elements with plastic materials)
- bite correction (gnathological treatment)
- removable prostheses
- dental surgery with the exception of fitting dental implants
- X-rays, with the exception of X-rays for orthodontic care.

18 years or older

If you are aged 18 or older, you are, in addition to all-age oral care, entitled to:

- dental surgery of a specialist nature and the associated X-rays, with the exception of periodontal surgery, dental implants and uncomplicated extractions.
- removable full prostheses for the upper or lower jaw, whether or not fitted to dental implants. A removable full prosthesis secured on dental implants includes fitting the fixed part of the superstructure (the click system).

Younger than 23

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

What do I need to keep in mind?

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

Is prior written authorisation required?

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

- gnathologic care if the insured is under 18.
- making an overall jaw image if the insured is under 18.
- a third or fourth fluoride treatment in a year from the moment the adult teeth emerge when the insured party is under 18.
- placing an autotransplant.
- dental replacement care involving non-plastic materials if you are under 23.
- the care as described under the heading 'All ages'.
- treatment under general anaesthetic.
- fitting dental implants.
- surgical dental care of a specialist nature if the treatment is on the 'Exhaustive List of Authorisations for Dental Surgery'. This list can be viewed and downloaded at www.hollandzorg.com/conditions.
- replacing a complete dental prosthesis for the upper or lower jaw, with or without dental implants, within 5 years of the placement of the previous complete dental prosthesis.
- making, fitting, repairing or rebasing full prostheses for the upper or lower jaw, secured on dental implants.
- care provided by a centre for special dentistry.

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

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

Is a referral needed?

Yes, in the following cases:

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

Is there a statutory personal contribution?

Yes, in the following cases:

- for care that falls under the heading 'All ages', if the relevant care is not directly related to specialist dental care. In that case, the extent of the statutory personal contribution is the maximum amount that the care provider would have charged if there was no right to reimbursement of the costs under the heading 'All ages'. This means that you are in fact entitled to a reimbursement of only the additional costs associated with that type of care.
- For 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.

- For a removable full dental prosthesis for the upper or lower jaw, if you are 18 or older and the care does not fall under the heading 'All ages'. In that case, the statutory personal contribution amounts to 25% of the costs of that dental prosthesis. Contrary to the above, the statutory personal contribution for a removable full dental prosthesis secured on dental implants amounts to:
  - 10% of the costs of that dental prosthesis, if it is a denture for the lower jaw.
  - 8% of the costs of that dental prosthesis, if it is a denture for the upper jaw.

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

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

Orthodontics in special cases

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

What do I need to keep in mind?

An orthodontist, whether or not affiliated to a centre for special dentistry, is permitted to provide this type of care.

Is a referral needed?

Yes, from a general practitioner, dentist, dental surgeon or orthodontist.

Is prior written authorisation required?

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

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

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

No, unless the invoice exceeds the competitive Dutch rate.

Other care

Medical care for specific patient groups

You are entitled to medical care for specific groups of patients (GZSP). This is general medical care for specific patient groups under or pursuant to the Healthcare Insurance Act (Zorgverzekeringswet).

This concerns care for vulnerable groups living at home, for example vulnerable elderly people, people with chronically progressive degenerative diseases, people with non-congenital brain damage and people with a mental impairment aged 18 and older.

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

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

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

GZSP Principles

The care provider must provide the care in accordance with the GZSP Principles. You can view and download these principles at www.hollandzorg.com/conditions.

What do I need to keep in mind?

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

- a specialist geriatrics doctor
- a doctor for the mentally disabled
- a healthcare psychologist
- a psychiatrist
- a remedial educationalist-generalist
- a clinical psychologist
- a clinical neuropsychologist

Is a referral needed?

Yes, from a general practitioner, medical specialist, geriatrics specialist or doctor for the mentally disabled.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Other medical care (e.g. GP care)

You are entitled to other medical care (e.g. GP care). Other medical (GP) care includes:

- medical care within the framework of individual care for tuberculosis and infectious diseases
- cow's milk allergy test (double-blind placebo-controlled food challenge test).

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

What do I need to keep in mind?

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

- for medical care within the framework of individual care for tuberculosis and infectious diseases: a qualified and nationally registered doctor, the criteria of which are determined by the KNMG's Registration Committee for Medical Specialists.
- for cow's milk allergy test: a care provider contracted by us for this purpose. Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

Is a referral needed?

Yes, from a general practitioner, medical specialist, nursing specialist or physician assistant.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

Preventive foot care

You are entitled to preventive foot care as generally provided by general practitioners or medical specialists if you have an increased risk of developing wounds that penetrate all layers of the skin (foot ulcers) due to loss of protective sensitivity of the feet, reduced blood circulation in the feet, fragile skin or increased pressure on the skin due to illness or medical treatment, if you have a history of foot ulcers or amputation, an inactive Charcot foot or if you are in end-stage renal failure (eGFR < 15 ml/min) or if you are receiving kidney dialysis.

The preventive foot care includes the total package of examinations and treatments as laid down in the Position on foot care for diabetes mellitus and the Memorandum clarifying the position on foot care for people with diabetes mellitus of Zorginstituut Nederland, and as laid down in care profiles 1 to 4 in the 2019 Prevention of Diabetic Foot Ulcers Care Module. An individual treatment plan determines the number of treatments you will receive.

When your feet are examined, the Sims classification is used in order to express the risk of the feet being affected. Foot care is subdivided into the care profiles according to the Sims classification and several other factors. Your general practitioner or podiatrist determines your care profile. The preventive foot care comprises:

- annual foot check (screening), consisting of case history, examination and risk inventory.
- frequent specific foot examinations, the ensuing diagnosis and treatment of skin and nail problems and deviations in the foot shape and position and the treatment of risk factors. To qualify, you must have a moderately increased (Sims classification 1) or increased risk (Sims classification 2 and 3) of inflammation, artery problems and loss of sensation in your feet.
- information and encouragement to modify your lifestyle as part of the treatment.
- advice on suitable shoes.

> **Please note:** Treatments for cosmetic or nurturing reasons only, such as removing calluses and clipping toenails, are not covered under preventive foot care.

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

What do I need to keep in mind?

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

For Sims classification 1 (care profile 1):
- a general practitioner (GP)
- a podiatrist
- a registered podologist
- a pedicure provider

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

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 or registered podologist. In that case, the podiatrist or registered podologist acts as the medical specialist who is ultimately responsible and the podiatrist or registered podologist will invoice the care.

Is a referral needed?

Yes, for preventive foot care by a chiropodist, podiatrist or registered podologist, you must have a referral from a general practitioner, medical specialist, nursing specialist or physician assistant. If a non-contracted care provider provides the care, you must include a copy of the referral when you submit the first invoice.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. We apply a maximum reimbursement for preventive foot care provided by a non-contracted podiatrist and a non-contracted registered podologist. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Paramedical care

Physiotherapy and remedial therapy

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

18 or older

If you are 18 or older, you are entitled to reimbursement of the costs of:
- physiotherapy and remedial therapy for a disorder on a list stipulated by the Minister (Appendix 1 to the Health Insurance Decree (Besluit zorgverzekering)), the List of chronic disorders for physiotherapy and remedial therapy. The right starts after the 21st treatment. This means that you have to pay for the first 20 treatments for conditions on the 'List of chronic disorders for remedial therapy' or take out supplementary insurance for this. Some conditions on the list are subject to a maximum treatment term. In that case, you are entitled to a reimbursement of the costs of the care until the end of the maximum term.
- pelvic physiotherapy in connection with incontinence, subject to a maximum of 9 treatments (once-only).
- walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication). In that case, you will be entitled to reimbursement of the costs of only 37 treatments for a maximum of 12 months.

- remedial therapy under the supervision of a physiotherapist or remedial therapist for osteoarthritis in your hip or knee joint. In that case, you will be entitled to reimbursement of the costs of only the first 12 treatments for a maximum of 12 months.
- remedial therapy under the supervision of a physiotherapist or remedial therapist for COPD, if it concerns stage II or higher of the GOLD classification for spirometry. Your care provider must follow the KNGF COPD guideline of the Royal Dutch Society of Physiotherapy (KNGF) to determine the number of treatments.
- long-term, active remedial therapy tailored to your situation under the supervision of a physiotherapist or remedial therapist if you have rheumatoid arthritis with severe functional restrictions or axial spondyloarthritis with severe functional restrictions.

Younger than 18

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

- physiotherapy and remedial therapy for a condition that is on the List of chronic disorders for physiotherapy and remedial therapy stipulated by the Minister (Appendix 1 of the Health Insurance Decree (Besluit zorgverzekering)). The right starts after the first treatment. Some conditions on the list are subject to a maximum treatment term. In that case, the insured is entitled to a reimbursement of the costs of the care until the end of the maximum term.
- physiotherapy and remedial therapy which are not on the List of chronic disorders for physiotherapy and remedial therapy. In those cases, the insured party is entitled to a reimbursement of the costs of a maximum of the first 9 treatments per calendar year. If those treatments do not yield sufficient result, the insured party is entitled to reimbursement of the costs of a maximum of 9 additional treatments for the same condition.

The insured party is only entitled to reimbursment of the costs of paediatric physiotherapy and children's remedial therapy if the insured party is younger than 18. The List of chronic disorders for physiotherapy and remedial therapy can be viewed at www.hollandzorg.com/conditions.

What do I need to keep in mind?

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

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

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

Is a referral needed?

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

- for treatment of a complaint on the List of chronic disorders for long-term physiotherapy and remedial therapy.
- for treatment by a pelvic physiotherapist in connection with urine incontinence.
- for walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication).
- for remedial therapy under the supervision of a physiotherapist or remedial therapist for osteoarthritis in your hip or knee joint.
- for remedial therapy under the supervision of a physiotherapist or remedial therapist for COPD, if it concerns stage II or higher of the GOLD classification for spirometry.
- for long-term active remedial therapy tailored to your situation under the supervision of a physiotherapist or remedial therapist if you have rheumatoid arthritis or axial spondyloarthritis with severe functional restrictions.

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older. With the exception of the compulsory excess for remedial therapy under the supervision of a physiotherapist or remedial therapist in the event of osteoarthritis in your hip or knee joint and walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication), as included in and under the conditions of the overview Designated care not subject to a compulsory excess. The up-to-date overview form can be viewed and downloaded at www.hollandzorg.com/conditions.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Occupational therapy

You are entitled to reimbursment of the costs of the occupational therapy usually provided by occupational therapists, subject to a maximum of 10 hours of treatment per year. Occupational therapy helps you improve your self-reliance and self-care.

You will receive advice, instructions, training or treatment to be able to perform general daily or work-related activities again and to function as independently as possible in your private or working situation.

What do I need to keep in mind?

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

- occupational therapy in the event of Parkinson's disease: an occupational therapist affiliated to the national ParkinsonNet network. These occupational therapists can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other occupational therapy: an occupational therapist

Is a referral needed?

No

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Dietetics

You are entitled to dietetic care such as dieticians generally provide, subject to a maximum of 3 hours of treatment per year. You can go to a dietician for information about nutrition and eating habits, provided this serves a medical purpose. The care also consists of treatment aimed at eliminating, reducing or compensating for food-affected or related illnesses or symptoms.

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

What do I need to keep in mind?

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

- dietetic care in the event of Parkinson's disease: a dietician who is affiliated with the national ParkinsonNet network. These dieticians can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other dietetic care: a dietician

Is a referral needed?

No

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Speech therapy

You are entitled to reimbursement of the costs of speech therapy. Speech therapy is care such as speech therapists generally provide. The care must serve a medical purpose and the treatment must be expected to restore or improve speech function or the ability to speak. The care further includes stutter therapy.

This type of care does not include:

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

What do I need to keep in mind?

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

- preverbal speech therapy: a speech therapist who is listed in the Preverbal speech therapy sub-register of the Dutch Association of Speech Therapy and Phoniatry (Nederlandse Vereniging voor Logopedie en Foniatrie (NVLF)).
- aphasia therapy: a speech therapist who is listed in the NVLF Aphasia register.
- the Hanen parent programme It Takes Two to Talk (Praten Doe je Met z'n Tweeën = PDMT): a speech therapist listed in the NVLF PDMT Hanen parent programme sub-register.
- the Hanen parent programme More than Words (Meer Dan Woorden = MDW): a speech therapist listed in the NVLF MDW Hanen parent programme sub-register.
- individual stutter therapy: a speech therapist who is listed in the NVLF Stutter therapy sub-register.
- integrated stutter care: a speech therapist or stutter therapist listed in the NVLF integrated stutter care sub-register.
- speech therapy in the event of Parkinson's disease: a speech therapist affiliated to the national ParkinsonNet network. These speech therapists can be found in the ParkinsonNet care finder at www.parkinsonzorgzoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.
- other speech therapy: a speech therapist.

Is a referral needed?

No

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Prevention

Combined lifestyle intervention (GLI) for adults

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

The GLI is a tailored care programme that consists of a combination of interventions aimed at healthy eating, increased physical activity and, if necessary, psychological help in support of a behavioural change. The care programme consists of individual sessions and sessions offered in groups and distinguishes between a treatment phase and a maintenance phase. The care programme lasts 24 consecutive months (2 years).

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

What do I need to keep in mind?

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

- a care provider listed as a lifestyle coach in the register of the Netherlands Professional Association of Lifestyle Coaches (BLCN)

- A physiotherapist, registered with the endorsement of 'lifestyle coach' in the Individual Physiotherapy Register (IRF) of Kwaliteitshuis Fysiotherapie or the Individual Physiotherapy Register Quality Mark (KFIR) from the Physiotherapy Quality Mark Foundation (SKF).
- a remedial therapist registered with the endorsement of 'lifestyle coach' in the Paramedics Quality Register
- a dietician registered with the endorsement of 'lifestyle coach' in the Paramedics Quality Register
- a care group contracted by us.

Is a referral needed?

Yes, from a general practitioner, medical specialist of company doctor.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Chain Approach care and support for overweight and obese children

The insured party is entitled to care and support in the case of obesity if the insured party is younger than 18 and there is at least a moderately increased weight-related health risk (GGR) in accordance with the indication criteria in the Obesity guideline and obesity in adults and children. The care and support in the case of obesity consist of:

- a comprehensive case history by the central care provider (the permanent point of contact for the child and family).
- guidance and coordination of the right care and support at the right time by the right professional for the child and family by the central care provider. In that case, a combined lifestyle intervention (GLI) for children should be part of the action plan of the central healthcare provider. The action plan must provide substantiated evidence that the insured party is dependent on a GLI for children.
- a combined lifestyle intervention (GLI) for children.

The GLI for children is a tailor-made care programme, focused on a healthy diet, more exercise and, if necessary, psychological help to support behavioural change. The care programme consists of individual sessions and has a treatment phase and a maintenance phase. The care programme lasts 24 consecutive months (2 years).

The insured party entitled to the care programmes on the list of Designated care programmes of GLI for children. This list may change in the interim. The current content can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?

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

Comprehensive case history and guidance and coordination by the central care provider:

- a paediatric nurse registered with the endorsement of ‘Central Healthcare Provider’ in the Quality Register V&V Nurses
- a paediatric lifestyle coach registered as Central Healthcare Provider in the register of the Netherlands Professional Association of Lifestyle Coaches (BLCN)
- a youth and family professional registered as Central Healthcare Provider in the register of the Dutch Association of Social Workers (BPSW)
- a paediatric advisor registered as Central Healthcare Provider in the register of the Dutch Association of Social Workers (BPSW)
- a care group contracted by us

GLI for children:

- a dietitian who is registered in the Paramedics' Quality Register with the designation 'children's lifestyle coach'
- a youth and family professional who is registered as a children's lifestyle coach in the register of the Professional Association for Social Work (BPSW)
- a paediatric nurse registered with the qualification 'children's lifestyle coach' in the Quality Register for Nursing and Care Nurses
- a paediatric physiotherapist who is registered with the designation 'children's lifestyle coach' in the Individual Physiotherapy Register (IRF) of the Physiotherapy Quality Centre and/or the Physiotherapy Quality Mark Individual Register (KFIR) of the Physiotherapy Quality Mark Foundation (SKF)
- a paediatric lifestyle coach who is registered in the register of the Professional Association of Lifestyle Coaches in the Netherlands (BLCN)
- a paediatric exercise therapist who is registered with the designation 'paediatric lifestyle coach' in the Paramedics' Quality Register
- a care group contracted by us.

Is a referral needed?

Yes, from a general practitioner, youth healthcare doctor or paediatric nurse.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

Fall prevention for people with a high risk of falling

You are entitled to fall prevention if you have a high risk of falling based on a fall risk assessment. Fall prevention consists of the following components:

- fall risk assessment.
- intake for a training programme to prevent falls (fall preventive exercise intervention) if, as a result of underlying or additional somatic problems, you are dependent on guidance during the training programme by a physiotherapist or remedial therapist.
- a maximum of 1 training programme to prevent falls (fall preventive exercise intervention) per 12 months. Due to underlying or additional somatic problems, you may require guidance during the training programme by a physiotherapist or remedial therapist. You are entitled to the training programmes to prevent falls on the list of Designated training programmes for adults. This list may change in the interim. An up-to-date version can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?

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

- for fall risk assessment: a general practitioner or a care group contracted by us.
- for the intake for a training programme to prevent falls and for the training programme itself: a physiotherapist or remedial therapist who is certified to carry out the training programme in question.

Is a referral needed?

Yes, a referral from a general practitioner, geriatrics specialist, clinical geriatrics doctor, physician assistant or nursing specialist is required for the intake for a training programme to prevent falls and the training programme itself.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. We have a maximum reimbursement for the intake for a training programme to prevent falls and for the training programme itself by a non-contracted physiotherapist or remedial therapist The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Giving up smoking

You are entitled to follow a programme to give up smoking. This comprises a medical care programme, possibly in combination with nicotine-replacement therapy (including medicines), aimed at a change in behaviour with the objective of giving up smoking. You are only entitled to nicotine-replacement therapy (including medicines) relating to giving up smoking if they form part of the programme. The care is limited to 3 programmes per calendar year. You are not entitled to a giving up smoking programme, if you receive counselling to stop smoking as part of integrated care, unless you need counselling that is more intensive than agreed within the integrated care.

What do I need to keep in mind?

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

- a general practitioner who offers the Stop Smoking Programme
- a care provider who is registered in the Stop Smoking Quality Register. You can consult this register at www.kwaliteitsregisterstoppenmetroken.nl and delivers the intervention offered in accordance with the Standard of Care related to Tobacco and Nicotine addiction 2025 and the most recent guideline Tobacco and Nicotine addiction.
- a care provider for giving up smoking, contracted by us. Contracted care providers are listed at hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

The costs of the Stop Smoking programme are listed in the overview Designated care not subject to excess. The costs therefore do not count towards the compulsory excess.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Rehabilitation care

Geriatric rehabilitation care

You are entitled to geriatric rehabilitation care plus the required admission. Geriatric rehabilitation includes integrated and multidisciplinary rehabilitation care provided by specialists in geriatric medicine. The care is intended for vulnerable elderly people who are dealing with complex problems due to various conditions (multi-morbidity). The aim of care is to restore or improve your functional restrictions and your participation in society.

You are only entitled to care if geriatric rehabilitation care does not correspond to a stay with treatment in a nursing home under the Long-Term Care Act.

What do I need to keep in mind?

Rehabilitation centres and institutions for geriatric rehabilitation care can provide this type of care and offer admission. The care must be provided under the final responsibility of a specialist geriatrics doctor (practitioner in charge).

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

Is there a statutory personal contribution?
No

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Medical specialist rehabilitation care

You are entitled to rehabilitation care plus the required admission. Rehabilitation means having to learn to live with a disability after an accident or illness. This involves examinations, advice and treatment. A multidisciplinary team of experts, under the management of a rehabilitation specialist, provides this type of care. You must need the care in order to prevent, reduce or overcome a handicap. The disability must be due to a musculoskeletal disorder, neurological disorder or another illness associated with problems moving your spine, body or limbs; or non-congenital brain damage with problems moving, thinking, speech or swallowing problems or a combination thereof.

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

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

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

Is there a statutory personal contribution?
No

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Second opinion

Second opinion

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

Is a referral needed?
Yes, from your general practitioner or attending physician. The referral will remain valid for a period of 12 months from the day it was issued.

Nursing and care

First-line in-patient stay

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

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

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

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

Is prior written authorisation required?
If you wish to be admitted to an institution we do not have a contract with, your (extended) stay is subject to our prior written authorisation.

Is there a statutory personal contribution?
No

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

District nursing (nursing without in-patient care)

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

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

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

What do I need to keep in mind?
- You need a care plan. Your district nurse will draw up the care plan in consultation with you or your legal representative. Agreement regarding the care plan is reached between you or your legal representative and the district nurse. This agreement is recorded by the district nurse in the client dossier or client report. If your care is provided by a non-contracted care provider, the care plan must be signed by you or your legal representative and by the district nurse. If you receive non-contracted care, this also applies to an amendment of the care plan.
- A care plan consists of the minimum following information about:
  - nature, extent, duration and goals of the care (desired care outcome). Intended results/goals are clearly specified, measurable, feasible, relevant and time bound;
  - current and potential nursing diagnoses (including substantiation via subjective, objective or context-related information);
  - nursing and care interventions;
  - whether and how your social network can contribute and what that contribution consists of;
  - evaluation of the achieved care outcomes.
- A district nurse, paediatric nurse and nursing specialist are permitted to specify the indication for your care and draw up the care plan. The condition is that the person who makes the indication must demonstrably be professionally competent in indicating in line with the V&VN statement 'Professional indication for the Health Insurance Act' of 14 May 2024 of the Netherlands Association for Nurses & Carers (V&VN). The indication must be established in accordance with the Indication Process Standards Framework of December 2024 and the Conceptual Framework Indication Process, drawn up by the Vereniging Verpleegkundigen & Verzorgenden Nederland (V&VN). The referring professional must demonstrably have assessed all the standards.

These care providers may provide the indicated care, except for case management for dementia 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.

If you receive care from a care provider contracted by us, the indicated care, except for case management for dementia care, may also be provided by:
- a qualified carer level C or D with a diploma at intermediate vocational education level 3.
- an assistant with a diploma in Assistant Care and Well-Being at intermediate vocational education level 2.

These care providers may carry out case management for dementia care:
- a district nurse.
- a social worker who complies with the Case Manager for dementia care expertise profile, drawn up by the V&VN and the Beroepsvereniging van Professionals in Sociaal werk (BPSW).

Is prior written authorisation required?

Receiving the care is subject to our written authorisation in the following cases:

- for reimbursement of nursing without in-patient care provided by a non-contracted care provider. For this application, you must use the application form for non-contracted district nursing. The application form can be found at www.hollandzorg.com/forms. If the care plan changes, you need to obtain our written authorisation again prior to you receiving the care.
- for reimbursement of nursing without in-patient care provided abroad. With your application, you must enclose a copy of the care plan and a quotation for the care (stating the care concerned, the costs and the period in which the care is to be provided abroad).

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

No

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027.

Personal budget

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

Patient transport

Ambulance transport

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

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

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

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

What do I need to keep in mind?

The care may be provided by an ambulance transport company with a recognised licence.

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

Is prior written authorisation required?

In 2 cases, the ambulance transport is subject to our written authorisation before you are transported. This concerns:

- transport over a distance of more than 200 kilometres.
- transport by a mode of transport other than an ambulance.

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

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

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

Patient transport

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

The transport consists of:

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

This is subject to one of the following reasons:

- you have to undergo dialysis. This includes transport to consultations, examinations and check-ups needed as part of the treatment.
- you have to undergo oncological treatment with chemotherapy, immunotherapy or radiotherapy. This includes transport to consultations, examinations and check-ups needed as part of the treatment.
- you are confined to a wheelchair
- your eyesight does not allow you to move unaided
- the insured party is under 18 and relies on medical paediatric care
- you rely on geriatric rehabilitation care

- you rely on daycare treatment that is provided in a group and that is part of a care programme for chronically progressive degenerative disorders, non-congenital brain damage or in connection with a mental impairment.

The reimbursement for patient transport by car (private transport) is € 0.43 per kilometre. We calculate the number of kilometres based on the fastest route (assuming the absence of delays) according to the ANWB route planner on internet (www.anwb.nl/verkeer/routeplanner) by entering the departure postal code and the destination postal code. The reimbursement for the use of public transport only applies to the lowest class of public transport.

What applies in exceptional circumstances?

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

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

> **Example:** for a period of 12 weeks you need to visit the hospital 3 times a week for treatment, which is 40 kilometers from your place of residence. In that case, the calculation is 12 x 3 x 40 x 0.25 = 360. This is higher than 250. In this case, you are entitled to patient transport.

Patient transport also includes the transport of a companion. It must be medically necessary for the insured party to have a companion, or the insured party must be under the age of sixteen. In special cases, we can give our written authorisation for the transport of 2 companions.

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

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

Cost of accommodation

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

- when you are entitled to patient transport; and
- you need such transport at least 3 consecutive days; and
- using accommodation is more effective and less of a strain on you than travelling between your home and the treatment centre every day.

In that case, you qualify for transport to and from the treatment centre (to and from your home) and reimbursement of the costs of 2 overnight stays near the treatment centre. The reimbursement of accommodation costs is a maximum of € 97 per night. You must book the accommodation yourself. Any transport from your accommodation address to the treatment location and back to your accommodation address will not be reimbursed.

What do I need to keep in mind?

For patient transport with your (own) car, you can use your own car or that of someone else. For patient transport by taxi, you can use a taxi operator. For patient transport by public transport, you can use a public transport company.

Is a referral needed?

Yes, from a general practitioner or medical specialist.

Is prior written authorisation required?

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

Is there a statutory personal contribution?

Yes, a maximum of € 140 per calendar year. The statutory personal contribution does not apply:

- to transport from an institution where you have been admitted under the public healthcare insurance or the Long-Term Care Act (Wlz) to another institution where you are admitted under the public healthcare insurance or the Long-Term Care Act (Wlz), where you will undergo a specialist examination or specialist treatment that cannot be provided in the institution where you have been admitted.
- to transport from an institution as referred to in subparagraph a to a person or institution where you will undergo a specialist examination or specialist treatment, 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 under the Long-Term Care Act (Wlz) to a person or institution where you will undergo dental treatment under the Long- Term Care Act (Wlz) that cannot be provided at the institution where you have been admitted and transport back to that institution.
- to the costs of using accommodation.

The statutory personal contribution does apply to the return trip to the treatment centre if you use accommodation.

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Hospital care

Medical specialist care (general)

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

Medical specialist care includes:

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

Medical specialist care does not include:

- treatment for snoring with uvuloplasty
- sterilisation of the insured party or the reversal thereof (either man or woman)
- circumcision of male insured parties, unless in the event of a medical need
- treatment of asymmetrical flattening of the back of the head (plagiocephaly) and central flattening of the back of the head (brachycephaly) in young children using a cranial remodelling helmet without the premature fusing of the cranial sutures (craniosynostosis)

- medicines as referred to in Appendix 0 of the Healthcare Insurance Regulations (Regeling zorgverzekering), subject to the conditions stipulated therein. The number of medicines and the conditions are subject to change in the interim. An up-to-date version of the Healthcare Insurance Regulations can be found at www.hollandzorg.com/conditions.
- external devices as part of treatment of diabetes to monitor and control blood sugar disorders, including ketone test strips and insulin pumps.
- laboratory testing at the request of an alternative care provider.

Please note: Cover provided by medical specialist care (general) does not include care for which is provided elsewhere in these policy conditions, such as transplant care or rehabilitation care.

Stays outside the institution

You are entitled to reimbursement of the costs of stays near the institution for your treatment if this is medically necessary in connection with medical specialist care, not involving nursing or (paramedical) care. However, some conditions apply, i.e.:

- you have an informal carer during your stay; and
- the travel time between the hospital where you receive treatment and your place of residence is more than 60 minutes; and
- the travel time between the hospital where you receive treatment and your place of accommodation is a maximum of 60 minutes.

The reimbursement of the accommodation costs is a maximum of € 97 per night. You arrange the stay yourself.

Plastic surgery

Plastic surgery only falls under medical specialist care if it concerns:

- defects in your appearance related to demonstrable physical functional disorders.
- mutilation resulting from a disease, accident or medical operation.
- paralysis or weakening of the upper eyelids, if this seriously restricts the range of vision or is caused by a congenital defect or a congenital chronic disorder.
- the following congenital malformations: cleft lip, jaw and palate, malformation of the facial bone structure, benign morbid growth of blood vessels, lymphatic vessels or connecting tissue, birth marks or malformation of the urinary organs or genitals.
- primary sexual characteristics in the event of diagnosed transsexuality.

Medical specialist care does not include:

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

What do I need to keep in mind?

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

Is prior written authorisation required?

To be reimbursed for treatments on the Pre-Authorisation List and the Exhaustive List of Authorisations for Dental Surgery, you must have received written authorisation from us before receiving the care. These lists can be viewed and downloaded at www.hollandzorg.com/conditions.

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

Is a referral needed?

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

No referral is needed in the case of unforeseen care that cannot reasonably be postponed (emergency care). The referral will remain valid for a period of 12 months from the day it was issued.

Is there a statutory personal contribution?

No.

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older. The costs of a collegial consultation and collegial advice do not count towards the compulsory excess.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Audiological care

You are entitled to audiological care. Audiological care consists of:

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

What do I need to keep in mind?

Audiological centres can provide this type of care.

Is a referral needed?

Yes, from a general practitioner, medical specialist, clinical technologist, paediatrician, doctor for the mentally disabled, geriatrics specialist or triage hearing specialist. The referral will remain valid for a period of 12 months from the day it was issued.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Dialysis without admission

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

You are entitled to reimbursement of the costs of:

- home dialysis equipment with accessories.
- regular inspection and maintenance of the dialysis equipment and the chemicals and liquids required for the dialysis.
- other consumables reasonably necessary for home dialysis.
- training organised by the dialysis centre of those carrying out or assisting in home dialysis.
- required expert assistance from the dialysis centre.

You are further entitled to reimbursement of:

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

What do I need to keep in mind?

The care must be provided under the final responsibility of a medical specialist.

Is a referral needed?

Yes, from a medical specialist or clinical technologist.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Genetic advice

You are entitled to genetic advice plus the required admission.

Sometimes your family can have a predisposition to a hereditary disease. This can be investigated. Genetic advice consists of:

- research into hereditary defects through genealogical research, chromosomal research, biochemical diagnosis, ultrasound examination and DNA research.
- giving advice about the heredity of disorders/defects or an apparent increased risk thereof.
- psychosocial support in connection with the advice.
- examination of persons other than yourself, if necessary for the advice to be given to you. In that case, the other persons may also be given advice.

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

Is a referral needed?
Yes, from a general practitioner, medical specialist, clinical technologist, doctor for the mentally disabled or geriatrics specialist. The referral will remain valid for a period of 12 months from the day it was issued.

Is there a statutory personal contribution?
No

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

IVF and ICSI

You are entitled to the 1st, 2nd and 3rd IVF attempt or ICSI treatment and associated medication if you are under 43 at the start of the attempt and there are medical grounds to do so. If you are under 38, you are entitled to a maximum of 1 embryo transfer on the 1st and 2nd attempt.

IVF is short for in vitro fertilisation. IVF treatment consists of:
1. hormone treatment to stimulate the maturation of egg cells in the woman's body
2. a follicle puncture
3. fertilising egg cells and growing embryos in the laboratory
4. the transfer of 1 or 2 embryos into the woman's uterine cavity for the purpose of creating a pregnancy

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

An IVF attempt only counts as an attempt if a follicle puncture has been successful, regardless of the quality (e.g. ripe or immature) or the number of eggs obtained during the puncture. Only attempts that are subsequently abandoned count towards the total number of 3 attempts. An IVF attempt after a viable pregnancy counts as a new, first attempt. This also applies if the pregnancy was terminated prematurely. In that respect, an ICSI attempt is equivalent to an IVF attempt.

Within the meaning of this document, a viable pregnancy is:
- a pregnancy lasting at least 10 weeks, calculated from the moment of a successful follicle puncture
- if a frozen embryo or embryos has/have been transferred, a pregnancy of at least 9 weeks and 3 days, calculated from the moment of implanting the frozen embryo(s).
- a spontaneous pregnancy of at least twelve weeks after the date of last menstruation.

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

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

Is there a statutory personal contribution?
No

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

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on our website. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Outside the Netherlands

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

Artificial respiration

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

What is covered by this care in a respiratory centre?

- the necessary artificial respiration.
- medical specialist care, medicinal care and the nursing and care.
- the required admission.

What is covered by this care if artificial ventilation takes place at home?

- medical specialist and medicinal care for artificial respiration
- the equipment needed for artificial respiration. The respiratory centre ensures that the equipment is ready for use before each treatment.
- an allowance for electricity costs (power consumption) in the case of chronic artificial ventilation.

What do I need to keep in mind?

- A respiratory centre can provide this type of care and offer admission.
- The Electricity costs for artificial respiration at your home claim form can be viewed and downloaded at www.hollandzorg.com/forms.

Is a referral needed?

Yes, from a general practitioner, medical specialist or clinical technologist.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Transplant care

You are entitled to transplant care plus the required admission. This applies to transplants of tissues and organs in the Netherlands.

Going abroad? In that case, you are only entitled to reimbursement of the costs of transplant care if the transplant care takes place in another EU or EEA country. Or in the country where the donor lives if the donor is your spouse, registered partner or 1st, 2nd or 3rd degree blood relative.

People with a malfunctioning or non-functioning organ may be eligible for a transplant.

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

Recipient

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

a. the costs of specialist medical care in relation to selection of the donor.
b. the costs of specialist medical care in relation to the operative removal of transplant material from the selected donor.
c. the costs of examination, preservation, removal and transport of the transplant material from a deceased donor in relation to the aforesaid transplant.
d. the care received by the donor during a period of no more than 13 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, this is 6 months. The costs will be reimbursed from the recipient's insurance. Once this period has expired, the costs will be covered by the donor's health insurance.
e. costs of transporting the donor. This concerns the costs of the lowest class of public transport within the Netherlands. Or, if medically necessary, the costs of transport by car within the Netherlands. This in connection with the selection, admission and discharge from hospital and with the care referred to under d. This does not apply if the donor has health insurance. In that instance, the transport is at the expense of the donor's health insurance.
f. costs of transporting the donor to and from the Netherlands if the donor for a kidney, bone marrow or liver transplant lives abroad and the transplant care takes place in the Netherlands. This does not apply if the donor has health insurance. In that instance, the transport is at the expense of the donor's health insurance.
g. other transplant costs if they relate to the donor residing abroad. This does not include the accommodation expenses in the Netherlands and loss of income.

Donor

If someone else by virtue of health insurance is entitled to (reimbursement of the costs of) transplant care and you are the donor, you are entitled to reimbursement of:

a. specialist medical care in relation to the operative removal of transplant material from the selected donor, via the health insurance of the recipient.
b. care you receive in connection with the selection or surgical removal of the transplant material. The costs incurred after the date of discharge from the institution are covered by the health insurance of the recipient for a maximum of 13 weeks. This term is six months in the event of liver transplants. When this term has expired, the costs are payable by your own health insurance.
c. your transport in the lowest class of a public transport option within the Netherlands of, if medically necessary, transport by car within the Netherlands. This in connection with the selection, admission and discharge from hospital and with the care referred to under j.
d. your transport to and from the Netherlands if you reside abroad, in connection with the transplant of a kidney, bone marrow or liver to an insured in the Netherlands.
e. other transplant costs if they relate to residing abroad, via the health insurance of the recipient. This does not include the accommodation expenses in the Netherlands and loss of income.

What do I need to keep in mind?

A transplant centre can provide this type of care and offer admission.

Is a referral needed?

Yes, from a medical specialist or clinical technologist. This condition does not apply in the case of unforeseen care that cannot reasonably be postponed (emergency).

Is there a statutory personal contribution?

No

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

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Thrombosis care

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

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

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

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

Is there a statutory personal contribution?
No

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

Do I have to pay extra for non-contracted care?
Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027, under medical specialist care.

Sensory disability care

Sensory disability care

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

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

Impaired vision

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

Impaired hearing

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

Speech and linguistic difficulties

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

What do I need to keep in mind?

A centre for sensory disability care can provide this type of care and offer admission.

Is prior written authorisation required?

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

Is a referral needed?

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

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

A second or subsequent referral is also not necessary if the insured party is younger than 18 years of age and has a new need for care that is the result of a predictable treatment need due to the insured party growing up.

Is there a statutory personal contribution?

No

Are the costs deducted from the compulsory excess?

Yes, from 18 years and older.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care on www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Supplementary Insurance Flexpolis No Risk Student

Flexpolis No Risk Student provides cover for compulsory excess.

Flexpolis No Risk Student provide cover for specific care and services.

Specific provisions for the Flexpolis No Risk Student

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

- the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the public health insurance;
- the arrangements set out in this chapter, Supplementary insurance Flexpolis No Risk Student;
- the list of terms
- all appendices referred to in the applicable terms and conditions

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

Taking out and cancelling the Flexpolis No Risk Student

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

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

- you (policyholder) can only take out Flexpolis No Risk Student insurance if the person you wish to insure has public health insurance as well.
- you (policyholder) and the person to be insured do not have any payment arrears with or have been expelled in the past by Salland Zorgverzekeraar N.V. or Salland Aanvullende Verzekeringen N.V.
- you (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk Student policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk Student policy can be taken out.

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

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

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

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

3. When does the Flexpolis No Risk Student commence?

If the application for the Flexpolis No Risk Student 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 Student, 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 Student end?

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

a. the group scheme within the meaning of article 1 of the Specific provisions for Flexpolis No Risk Student is terminated.
b. if you (insured/policyholder) cease to be employed by the employer with whom we concluded the group scheme.
c. if you (insured party/policyholder), for reasons other than those under b, no longer meet the conditions for participation as described in the group scheme within the meaning of article 1, Specific provisions for Flexpolis No Risk Student.

Premium

5. When are premium payments waived?

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

Insurance cover general

6. When am I entitled to reimbursement?

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

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

- you have complied with all the conditions set by us
- the care in question can reasonably be regarded as necessary for you in terms of content and scope. The care to be provided must be effective and not unnecessarily expensive or unnecessarily complicated
- you receive the care at a location which may be regarded as customary, given the nature of the care and the circumstances

Has a guideline, care standard or quality standard been established for the care? Then you are entitled to (reimbursement of costs of) the care, if the care was provided in accordance with that standard. The current care standards can be viewed and downloaded at . Does your care provider deviate from the guideline, care standard or quality standard? You are still entitled to (reimbursement of costs of) the care if your care provider demonstrates that a deviation from this is medically necessary in your case and your care provider motivates this in your medical file.

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

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

For some forms of care, we set a maximum rate per session or treatment from a non-contracted care provider. The maximum rates do not apply to care from contracted care providers. The care providers contracted by us can be found at hollandzorg.z-zoeker.nl. In some cases, the agreement between us and the care provider ends the moment you receive care from that care provider. In that case, you are entitled to reimbursement of the costs of the remaining care to be provided by this care provider as if the contract still existed.

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

Specific restrictions for Flexpolis No Risk Student

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

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

- provided abroad, unless explicitly stated otherwise in these policy conditions;
- that are subject to the compulsory excess, unless explicitly stated otherwise in these policy conditions;
- that are subject to the statutory personal contribution, unless explicitly stated otherwise in these policy conditions;
- incurred as a result of your own negligence or intention;
- incurred as a result of you participating in a crime;
- incurred during and partly the result of playing competitive sport abroad;
- incurred during and partly needed as a result of practising dangerous sports or practising professional or semi-professional sports;
- incurred during and partly the result of mountaineering of a nature which would be challenging for an untrained person;
- incurred during winter sports, except sledging, skating, cross-country skiing, snowboarding and on- piste skiing;

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

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

You are not entitled to reimbursement of the costs of care if the harm is caused by, occurred during or ensues from a nuclear reaction. This exclusion does not apply to harm caused by radioactive nuclides which are located outside a nuclear facility and are used or intended for use for industrial, commercial, agricultural, medical, scientific or security purposes. The above is subject to a valid permit having been issued by the central government for the manufacture, use, storage and disposal of radioactive substances. The provisions of the previous 3 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 Student had not been in existence.

The Concurrence Agreement (Convenant Samenloop) contains agreements on the distribution of costs by health insurers and travel insurers. Are you insured under a (travel) insurance policy that provides cover for medical expenses abroad with a (travel) insurer that has not signed the Concurrence Agreement? In that case, our supplementary insurance will apply as excess insurance. In that case, you are only entitled to reimbursement if the medical costs abroad exceed the cover of that (travel) insurance.

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

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

Flexpolis No Risk Student Cover

Outside the Netherlands

Medically necessary repatriation

Flexpolis No Risk Student
100%

You are entitled to transport of yourself and the organisation of such transport:
- from the country of temporary residence to the Netherlands or your country of origin;
- from the Netherlands to your country of origin.

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

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

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

What do I need to keep in mind?
We will arrange the repatriation. To that end, you or your representative has to contact the emergency center. You can reach the emergency centre day and night on +31 570 687 112 (standard rate).

Transport of mortal remains

Flexpolis No Risk Student
100%

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

Important!
Your next of kin must contact our emergency centre within 24 hours, or as soon as possible. You can reach the emergency centre day and night on +31 570 687 112 (standard rate).

Please note: you are only entitled to reimbursement if the Emergency Centre coordinates the transport.

Pharmaceutical care

Flexpolis No Risk Student
100%

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

Emergency oral care in the Netherlands

Flexpolis No Risk Student
a maximum of € 200,- per calendar year

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

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

For every usual treatment a description of the care is available. The Dutch Healthcare Authority provides is. Only treatments with a description of care as referred to on the 'List of emergency oral care' qualify for reimbursement. The 'List of emergency oral care' can be found at www.hollandzorg.com/conditions.

What do I need to keep in mind?

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

Is a referral needed?

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

Contracted care providers are listed at hollandzorg.z-zoeker.nl. Alternatively, you can call our Customer Service on +31 (0)570 687 123.

Compulsory excess

Flexpolis No Risk Student
100%

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

Supplementary Insurance Flexpolis No Risk Top

Flexpolis No Risk Top provide cover for specific care and services.

Specific provisions for the Flexpolis No Risk Top

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

- the arrangements set out in the General Provisions chapter, unless expressly stated that they only apply to the public health insurance;
- the arrangements set out in this chapter, Supplementary insurance Flexpolis No Risk Top;
- the list of terms
- all appendices referred to in the applicable terms and conditions

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

Taking out and cancelling the Flexpolis No Risk Top

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

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

- you (policyholder) can only take out a Flexpolis No Risk Top policy if the person you (policyholder) want to insure also has public health insurance at the time of the Flexpolis No Risk Top policy coming into force;
- you (policyholder) can only take out a Flexpolis No Risk Top policy if the person you (policyholder) want to insure also has a Flexpolis No Risk Top policy at the time of the Flexpolis No Risk Top policy coming into force;
- you (policyholder) and the person to be insured do not have any payment arrears with or have been expelled in the past by Salland Zorgverzekeraar N.V. or Salland Aanvullende Verzekeringen N.V.;
- you (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk Top policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk Top policy can be taken out.
- you (policyholder) and the remaining person(s) to be insured, at the inception date of the Flexpolis No Risk Top policy, must form part of a group scheme of persons approved by us for whom a Flexpolis No Risk Top policy can be taken out.

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

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

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

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

3. When does the Flexpolis No Risk Top commence?

If the application for the Flexpolis No Risk Top 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 Top, 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 Top end?

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

a. the group scheme within the meaning of article 1 of the Specific provisions for Flexpolis No Risk Top is terminated.
b. if you (insured/policyholder) cease to be employed by the employer with whom we concluded the group scheme.
c. if you (insured party/policyholder), for reasons other than those under b, no longer meet the conditions for participation as described in the group scheme within the meaning of article 1, Specific provisions for Flexpolis No Risk Top.

Premium

5. When are premium payments waived?

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

Insurance cover general

6. When am I entitled to reimbursement?

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

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

- you have complied with all the conditions set by us
- the care in question can reasonably be regarded as necessary for you in terms of content and scope. The care to be provided must be effective and not unnecessarily expensive or unnecessarily complicated
- you receive the care at a location which may be regarded as customary, given the nature of the care and the circumstances

Has a guideline, care standard or quality standard been established for the care? Then you are entitled to (reimbursement of costs of) the care, if the care was provided in accordance with that standard. The current care standards can be viewed and downloaded at . Does your care provider deviate from the guideline, care standard or quality standard? You are still entitled to (reimbursement of costs of) the care if your care provider demonstrates that a deviation from this is medically necessary in your case and your care provider motivates this in your medical file.

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

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

For some forms of care, we set a maximum rate per session or treatment from a non-contracted care provider. The maximum rates do not apply to care from contracted care providers. The care providers contracted by us can be found at hollandzorg.z-zoeker.nl. In some cases, the agreement between us and the care provider ends the moment you receive care from that care provider. In that case, you are entitled to reimbursement of the costs of the remaining care to be provided by this care provider as if the contract still existed.

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

Specific restrictions for Flexpolis No Risk Top

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

You are not entitled to reimbursement of the costs of care:
- provided abroad, unless explicitly stated otherwise in these policy conditions;
- that are subject to the compulsory excess, unless explicitly stated otherwise in these policy conditions;
- that are subject to the statutory personal contribution, unless explicitly stated otherwise in these policy conditions;
- incurred as a result of your own negligence or intention;
- incurred as a result of you participating in a crime;
- incurred during and partly the result of playing competitive sport abroad;
- incurred during and partly needed as a result of practising dangerous sports or practising professional or semi-professional sports;
- incurred during and partly the result of mountaineering of a nature which would be challenging for an untrained person;
- incurred during winter sports, except sledging, skating, cross-country skiing, snowboarding and on- piste skiing;

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

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

You are not entitled to reimbursement of the costs of care if the harm is caused by, occurred during or ensues from a nuclear reaction. This exclusion does not apply to harm caused by radioactive nuclides which are located outside a nuclear facility and are used or intended for use for industrial, commercial, agricultural, medical, scientific or security purposes. The above is subject to a valid permit having been issued by the central government for the manufacture, use, storage and disposal of radioactive substances. The provisions of the previous 3 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 Top had not been in existence.

The Concurrence Agreement (Convenant Samenloop) contains agreements on the distribution of costs by health insurers and travel insurers. Are you insured under a (travel) insurance policy that provides cover for medical expenses abroad with a (travel) insurer that has not signed the Concurrence Agreement? In that case, our supplementary insurance will apply as excess insurance. In that case, you are only entitled to reimbursement if the medical costs abroad exceed the cover of that (travel) insurance.

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

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

Flexpolis No Risk Top Cover

Oral care

No Risk Top
100% up to a maximum of € 250,- per calendar year, for consultations and other oral care jointly

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

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

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

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

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

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

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

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

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

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

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

A dental surgeon can only provide implantology.

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

Physiotherapy and remedial therapy

Physiotherapy and remedial therapy

No Risk Top
6 sessions per calendar year

You are entitled to reimbursement of the costs of:
- general physiotherapy
- manual therapy
- Cesar and Mensendieck remedial therapy
- scar treatment
- psychosomatic physiotherapy and psychosomatic remedial therapy
- geriatric physiotherapy and geriatric remedial therapy
- pelvic physiotherapy and pelvic remedial therapy
- oedema therapy and lymph drainage
- children's physiotherapy and children's remedial therapy

The reimbursement applies to the various therapies jointly.

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

> **Note:** Manual therapy treatments E.S. (Egg Shell), van der Bijl method and orthomanual medicine are not covered under physiotherapy and remedial therapy. These treatments may be covered under alternative treatments.

A treatment or consultation is referred to as a session. We also reimburse sessions abroad. Are you receiving the care abroad? In that case, we will not reimburse more than the maximum reimbursement per session that applies to non-contracted care.

Not every treatment counts as one session. A session is calculated as follows:
- telephone session ½ session
- screening ½ session
- intake and examination after screening ½ session
- group session 3-10 people ½ session
- other 1 session

What do I need to keep in mind?

The following care providers are permitted to provide this type of care:
- general physiotherapy: a physiotherapist
- pelvic physiotherapy: a pelvic physiotherapist
- geriatric physiotherapy: a geriatric physiotherapist
- children's physiotherapy: a children's physiotherapist
- scar treatment: a physiotherapist and skin therapist
- manual therapy: a manual therapist
- psychosomatic physiotherapy: a psychosomatic physiotherapist
- oedema therapy and lymph drainage: an oedema therapist and skin therapist
- general remedial therapy: a remedial therapist
- pelvic remedial therapy: a pelvic remedial therapist
- geriatric remedial therapy: a geriatric remedial therapist
- psychosomatic remedial therapy: a psychosomatic remedial therapist
- children's remedial therapy: a children's remedial therapist
- walking therapy under the supervision of a physiotherapist or remedial therapist for peripheral arterial disease in Fontaine stage 2 (intermittent claudication): a physiotherapist or remedial therapist who is affiliated with the national Chronisch ZorgNet network. These care providers can be found in the Chronisch ZorgNet care finder at . You can also contact our Customer Service 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 can be found in the ParkinsonNet care finder at . You can also contact our Customer Service on +31 (0)570 687 123. Affiliation with the ParkinsonNet network is not compulsory if the provision of care started before 1 January 2018.

Is a referral needed?

For treatment of a disorder on the List of chronic disorders for physiotherapy and remedial therapy, you need a referral from a general practitioner, medical specialist, youth healthcare doctor, doctor for the mentally disabled, specialist geriatrics doctor, company doctor, dentist, nursing specialist, physician assistant or a coordinating practitioner within the framework of medical care for specific groups of patients (GZSP). The List of chronic disorders for physiotherapy and remedial therapy can be viewed at www.hollandzorg.com/conditions.

No referral is needed for all remaining treatments.

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

Do you wish to use the care from a care provider with whom we have not concluded a contract? In that case, the reimbursement may be less than the amount charged by your care provider. The maximum reimbursements can be found on the rates lists for non-contracted care at www.hollandzorg.com/insured/customer-services/rate-lists2027. Contracted care providers are listed at hollandzorg.z-zoeker.nl.

Definitions

What do all the terms mean?

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

Supplementary insurance

The agreement for non-life insurance concluded or to be concluded with Salland Aanvullende Verzekeringen N.V. This insurance covers a number of other services in addition to cover provided under the public health insurance. Dental insurance also falls under this, unless explicitly stated otherwise.

Ambulance

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

Chemists preparations

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

Dispensing general practitioners

A general practitioner licensed to dispense medicines.

Dispensing chemists instruction

The instruction for the dispensing chemist or dispensing general practitioner for the assessment of a doctor's note, drawn up by Zorgverzekeraars Nederland. You can view it at www.znformulieren.nl.

Chemist

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

Doctor

A doctor registered in the register defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

House Officer

An AIOS, House Officer or an ANIOS, Senior House Officer, who is entered as a doctor in the register defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

Infectious disease and tuberculosis prevention doctor

Een doctor registered as Public Health Doctor in the Infectious Disease Prevention register or Tuberculosis Prevention register the of the Commission for the Registration of Social Medicine of the KNMG (Royal Netherlands Medical Society).

Doctor for the mentally disabled

A doctor registered as a doctor for the mentally disabled in the register of general practitioners, geriatrics specialists and doctors for the mentally disabled of the KNMG's Registration Committee for Medical Specialists.

Doctors note

The note to be completed, dated and signed by the prescriber for the medicine in question. The doctor's note is drawn up by Zorgverzekeraars Nederland. You can view it at www.znformulieren.nl.

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

Public health insurance
HollandZorg Public health insurance, which is health insurance.

Respiratory centre
A centre that provides artificial respiration and, insofar as required by law, has a permit for this. A respiratory centre may be affiliated to a hospital, but not necessarily so.

Company doctor
A doctor who is listed as a company doctor in the register of Society and Health Doctors of KNMG's Registration Committee for Medical Specialists and acts on behalf of the employer or the Working Conditions Service (Arbodienst) with which the employer is affiliated.

Pelvic physiotherapy
Care generally provided by pelvic physiotherapists.

Pelvic physiotherapist
A physiotherapist who is registered as a pelvic physiotherapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

Pelvic remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a pelvic remedial therapist.

Pelvic remedial therapy
Care generally provided by pelvic remedial therapists.

BMI
Body Mass Index. The BMI shows whether a person's weight is healthy in relation to his or her height.

BRP
Key Register of Persons.

BSN
Citizen service number. Your BSN is shown on your passport or identity document.

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

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

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

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

Group scheme
An agreement between us and a third party, such as an employer or association, that sets out agreements about benefits which the persons described in that agreement, such as employees or members, can enjoy if they comply with the conditions stipulated in the agreement. We refer to such employees or persons as participants.

COPD
Chronic obstructive pulmonary disease.

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

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

Dermatologist
A doctor who is listed as a dermatologist in the Dermatology and venerology register of the KNMG's Registration Committee for Medical Specialists.

Dialysis centre
A centre that provides dialysis care and, insofar as required by law, has a permit for this. A dialysis centre may be affiliated to a hospital, but not necessarily so.

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

Dietician
A dietician who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

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

EEA country
A country which, like the EU countries, is party to the Agreement on the European Economic Area: Liechtenstein, Norway and Iceland.

Occupational therapist
An occupational therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

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, Réunion, 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.

Phlebology
Care that phlebologists tend to provide, including the treatment of varicose veins and oedema.

Forensic doctor
A doctor who is registered as a forensic doctor in the specialists' register of the KNMG's Registration Committee for Medical Specialists.

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.

Physiotherapist
A physiotherapist who is registered as a physiotherapist according to the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG) and is registered in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

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

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 hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

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.

Entire period of insurance
The uninterrupted period during which you were insured by virtue of supplementary insurance.

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. Interchangeable medicines are registered medicines that are considered to be interchangeable under the Healthcare Insurance Regulations. Non-interchangeable medicines are registered medicines that are not considered to be interchangeable under the Healthcare Insurance Regulations.

Geriatric physiotherapist
A physiotherapist who is registered as a geriatric physiotherapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

Geriatric remedial therapist
A remedial therapist listed in the Paramedics Quality Register as a geriatric remedial therapist.

Geriatric physiotherapy
Care generally provided by geriatric physiotherapists.

Geriatric remedial therapy
Care generally provided by geriatric remedial therapists.

A healthcare psychologist
A healthcare psychologist registered as such in the register defined in Article 3 of the Wet BIG.

Ggz
Mental healthcare.

G-standard
An electronic database that lists all medicines, aids and health products that can be obtained through the pharmacy and institutions. The database is kept up-to-date by the company Z-index B.V.

HollandZorg
Label of the same name from Salland Zorgverzekeraar N.V. In the event of references to supplementary insurance, 'HollandZorg' is taken to mean: the label of the same name of Salland Aanvullende Verzekeringen N.V.

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.

General practitioner
A doctor entered as a general practitioner in the register of general practitioners, geriatrics specialists and doctors for the mentally disabled of the KNMG's Registration Committee for Medical Specialists. The general practitioner may be independently established or work in a general practitioner services structure (GP out-of-hours surgery), a GP surgery or care group.

General practitioner services structure (GP out-of-hours surgery)
An organisational association of general practitioners with a corporate personality. The association is set up to provide general practitioner's care in the evening, at night and at the weekends and charges a legally valid rate.

Institution
- an institution in the sense of the Healthcare and Care Providers (Accreditation) Act (Wet toetreding zorgaanbieders);
- a legal entity established outside the Netherlands that provides care in the country in question within the framework of the social security system of that country, or specialises in providing care to specific groups of public officials.

Youth Dental Care Institution
An institution for the provision of oral care characterised by oral care providers with specific expertise and skills and facilities for consultation, diagnosis and treatment for insured parties aged up to 18. Insofar as legally required, the institution must be licensed.

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

Integral birth care organisation
A care provider in which the various disciplines of the birth care chain are equally represented and which provides that integrated birth care.

IVF centre
An institution licensed under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) to provide transplant care.

Paediatrician

A doctor who:

- is registered as a Public Health doctor in the Public Health register of the KNMG's Registration Committee for Medical Specialists; or
- is registered as a youth healthcare doctor in the youth healthcare profile register of the KNMG's Registration Committee for Medical Specialists.

In both cases, it must be a doctor who provides youth healthcare as referred to in the Public Health (Preventive Measures) Act.

Youth nurse (youth healthcare nurse)

A nurse with completed higher professional education in youth nursing.

Dental surgeon

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

Calendar year

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

Nuclear facility

A nuclear facility in the sense of the Nuclear Accident Liability Act.

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.

NIP-certified paediatric and adolescent psychologist

A care provider registered as a paediatric and adolescent psychologist in the register of the Netherlands Institute of Psychologists (NIP).

Paediatric physiotherapist

A physiotherapist who is registered as a paediatric physiotherapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

Paediatric physiotherapy

Care for minors generally provided by paediatric physiotherapists.

Paediatric remedial therapist

A remedial therapist listed in the Paramedics Quality Register as a paediatric remedial therapist.

Paediatric remedial therapy

Care for minors generally provided by paediatric remedial therapist.

Paediatric nurse

A nurse who has completed a nationally recognised course of further education in paediatric nursing at higher professional (hbo) level.

Clinical physicist -audiologist

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

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

Clinical geriatrics doctor
A doctor who is entered as clinical geriatrics doctor in the specialists' register of the KNMG's Registration Committee for Medical Specialists.

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 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).

KNMG
The Royal Dutch Medical Association.

KNMT
Royal Dutch Dental Organisation.

Maternity carer
A trained care provider who provides support and care during childbirth (in addition to the obstetric care provided by the obstetrician) and to the mother and her family during the maternity period. A maternity carer ensures the wellbeing of mother and child, and reports to the obstetrician or doctor if necessary.

Supplier of medical aids
An organisation which provides (medical) aids and which is registered in the General Care Providers Database (AGB database). This database records data on care providers in the Netherlands. This data is given a unique code, the AGB code. This ensures a uniform registration of care provider data for the health insurers.

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

Speech therapist
A speech therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Manual therapist
A physiotherapist who is registered as a manual therapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

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

Informal care
Unpaid care for an elderly, chronically ill or handicapped loved one in need of assistance. The care is provided for more than 8 hours per week and at least 3 months in a row.

Informal carer
An informal carer is a person who provides care other than in a professional capacity.

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

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

Medical specialist
A doctor who is listed as a specialist with a legally recognised specialist title in a specialists register as referred to in Article 14, paragraph 1 of the Individual Health Care Professions Act (Wet BIG).

Medical child care
Care provided to children up to the age of 18 whereby there is a need for care as usually offered by nurses in relation to medical care or a high risk thereof, whereby:
- there is a need for permanent monitoring; or
- round-the-clock care must be available and that care at the same time includes nursing.

Collegial consultation and collegial advice
In a collegial consultation, the general practitioner (GP) calls on the expertise of another more specialised care provider to decide on a suitable diagnosis, treatment policy or referral. This involves direct patient contact, face-to-face or digital, between you and that other care provider.

In collegial advice, the general practitioner (GP) calls on the expertise of another more specialised care provider to decide on a suitable diagnosis, treatment policy or referral, but there is no direct patient contact between you and that care provider.

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.

Non-contracted care provider
A care provider with whom we have not concluded an agreement. We apply a maximum reimbursement for many types of care provided by a non-contracted care provider. In that case, the reimbursement is limited to the rates in accordance with the rates list for non-contracted care. The rates list can be viewed and downloaded at www.hollandzorg.com/insured/customer-services/rate-lists2027. 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 hollandzorg.z-zoeker.nl. You can also contact our Customer Service on +31 (0)570 687 123.

NIPT
Non-invasive prenatal test.

NZa
Dutch healthcare Authority.

Oedema therapist
A physiotherapist who is registered as an oedema therapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

Oedema therapy and lymph drainage
Care generally provided by oedema therapists.

Remedial therapist
A Cesar or Mensendiek remedial therapist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Remedial therapy
Care generally provided by remedial therapists.

Eye clinic
An independent treatment centre specialising in eye treatment.

Public transport
Passenger transport open to all operated in accordance with a timetable by car, bus, train, underground train, tram or a vehicle propelled by a guidance system as defined in the Passenger Transport Act 2000 (Wet personenvervoer), and passenger transport open to all operated in accordance with a timetable in the form of a regular ferry service.

Admission
Medically necessary stay of 24 hours or more during an uninterrupted period of up to 1095 days (3 years). An interruption of the admission for a maximum period of 30 days is not regarded as an interruption to the uninterrupted period. The duration of the interruption does not count in the calculation of the 1095 days, except in the event of weekend and holiday leave. Interruptions for weekend and holiday leave are included in the calculation of the 1095 days.

Admission does not include:
- stays you require in connection with a psychiatric disorder or impairment if you are under 18.
- stays in connection with the temporary takeover of care to relieve an informal carer (respite care).

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

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.

Orthodontics
Care of an orthodontic nature as generally provided by dentists.

Orthodontist
A dental specialist who is registered in the Orthodontic Specialist Register of the Dentistry Specialisms Board of Registration of the Royal Dutch Dental Organisation (KNMT).

Remedial educationalist (generalist)
A remedial educationalist who is registered in the NVO Register (Remedial Educationalist-Generalist of the Dutch Association of educationalists and teachers (NVO)).

Orthoptist
A orthoptist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree (Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut) and is listed in the Paramedics Quality Register.

Other healthcare product (OZP)
A performance within specialist medical care, other than a DBC care product.

Chiropodist

A chiropodist who:

- is listed in the Chiropodist's Quality Register specialising as a diabetic foot chiropodist or has a medical chiropodist diploma; 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 Stichting LOOP-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.

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.

Podology

Care that registered podiatrists and podopostural therapists generally provide.

Podopostural therapist

The care provider is affiliated with the professional association Stichting LOOP - NMMV and listed as a podopostural therapist in the Quality Registration and Accreditation of Health Care Professionals (Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ)).

Podiatric therapy

Care generally provided by podiatrists.

Podiatrist

A podiatrist who complies with the requirements of the Dieticians, Occupational Therapists, Speech Therapists, Oral Hygienists, Remedial Therapists, Orthoptists and Podiatrists Decree and is listed in the Paramedics Quality Register.

Policy conditions

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

Psychiatrist

A doctor who is registered in the specialists' register of the KNMG's Registration Committee for Medical Specialists.

Psychiatric hospital

An institution that specialises in providing mental healthcare.

Psychosomatic physiotherapy

Care generally provided by psychosomatic physiotherapists.

Psychosomatic physiotherapist

A physiotherapist who is registered as a psychosomatic physiotherapist in the Register of the Kwaliteitshuis Fysiotherapie (IRF) or the Keurmerk Fysiotherapie Individueel Register (KFIR) of Stichting Keurmerk Fysiotherapie (SKF).

Psychosomatic remedial therapy

Care generally provided by Psychosomatic remedial therapists.

Psychosomatic remedial therapist

A remedial therapist listed in the Paramedics Quality Register as a Psychosomatic remedial therapist.

Psychotherapist
A psychotherapist registered in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

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.

Prescription
Prescription for medicines.

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.

Registered podiatrist
The care provider is affiliated with the professional association Stichting LOOP and listed as a registered podiatrist in the Quality Registration and Accreditation of Health Care Professionals (Kwaliteitsregistratie en Accreditatie Beroepsbeoefenaren in de Zorg (KABIZ)).

Bill
Also referred to as note or invoice. Written proof of the costs incurred by a care provider, which shall at least contain the following information: the name, address and profession of the care provider, invoice date, date on which the care was provided and description of that care and the name and date of birth of the insured party. An invoice also has to comply with the statutory requirements for claiming the care. A quotation, an advance bill, reminder or demand does not constitute an invoice.

Rehabilitation specialist
A doctor who is listed as rehabilitation specialist in the specialists' register of the KNMG's Registration Committee for Medical Specialists.

Rehabilitation centre
A centre that provides rehabilitation care and, insofar as required by law, has a permit for this. A multidisciplinary team of experts, under the management of a medical specialist, is employed at the centre.

Salland Zorgverzekeraar
The entire organisation of legal entities that directly or indirectly fall under Coöperatie Salland U.A.

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

A&E doctor
A doctor who is entered as A&E doctor (emergency doctor) in the profile register of the KNMG's Registration Committee for Medical Specialists.

Setting
The distinction between forms of care based on the required infrastructure and the use of different professions.

SKGZ
Stichting Klachten en Geschillen Zorgverzekeringen.

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

Sports doctor
A doctor registered as a doctor of society and health in the register of society and health doctors of the KNMG's Registration Committee for Medical Specialists, designated as a sports doctor.

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

SVB
Sociale Verzekeringsbank (Social Insurance Bank).

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

Prosthodontist
A prosthodontist who complies with the requirements of the Prosthodontist Training Requirements and Area of Expertise Decree (Besluit opleidingseisen en deskundigheidsgebied tandprotheticus).

Temporary stay abroad
A stay outside the Netherlands of no more than 6 consecutive months.

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

Transplant centre
An institution licensed under the Special Medical Procedures Act (Wet op bijzondere medische verrichtingen) to provide transplant care.

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

Thrombosis Service
A centre that provides thrombosis care and which qualifies as such, insofar as required, pursuant to the law.

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

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).

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 1 year), Bosnia-Herzegovina, North Macedonia, Montenegro, Serbia, Tunisia, Turkey, the United Kingdom (England, Northern Ireland, Scotland and Wales) and Switzerland.

Exploratory consultation
The exploratory consultation as referred to in the NZa's policy rule on the experiment of mental healthcare professionals participating in the exploratory consultation. An exploratory consultation can be part of medical mental healthcare. The exploratory consultation is a consultation between you and at least a mental healthcare professional and a professional from the social domain (someone employed by the municipality or a welfare organisation). In addition, your loved one(s) or an expert by experience can also join. During the exploratory consultation, your request for help is central and mental healthcare and social domain professionals will help come up with the most appropriate solution.

Obstetrician
An obstetrician registered as such in accordance with the conditions defined in Article 3 of the Individual Health Care Professions Act (Wet BIG).

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

Nursing home
A treatment and accommodation facility as defined by the Long-Term Care Act (Wlz) for the treatment of somatic or psychogeriatric disorders.

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

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

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).

Compulsory excess
The amount of healthcare expenses covered by the public health insurance that you must pay yourself and that is determined by the government.

Addiction specialist
A doctor who is registered in the specialists' register of the KNMG's Registration Committee for Medical Specialists.

Referral
The written advice and explanations you receive from a care provider who provides you with care, addressed to the care provider who can provide you with further care and which you need on medical grounds. The care provider giving the referral is the referrer. A referrer cannot refer you to himself.

Insurance
Public health insurance, supplementary insurance, dental insurance.

Policyholder
The person who has taken out insurance with us. If this person takes out the insurance for him/herself, he/she is also the insured party.

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

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.

Wet BIG
The Individual Healthcare Professions Act.

Statutory personal contribution
The share of the costs of care covered by the public health 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 excess.

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

District nurse
A nurse with an hbo Nursing diploma (higher professional education).

Wlz
Long-Term Care Act.

Independent treatment centre (ZBC)
An institution for medical specialist care.

Over-the-counter medicines
- Over-the-counter medication (referred to as AV-category medicine in the Medicine Act); and
- over-the-counter medication, but only available from a chemist or elsewhere under the supervision of a chemist (referred to as UAD-category medicine in the Medicine Act); and
- over-the-counter medication, but only available from a chemist (referred to as UA-category medicine in the Medicine Act).

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

Ziekenhuisarts
Een arts die als ziekenhuisarts is ingeschreven in het profielartsenregister van de Registratiecommissie Geneeskundig Specialisten van de KNMG.

Care
The care and other services as referred to in the Healthcare Insurance Act with regard to public health insurance. The care and services in the articles on cover and reimbursement in the chapter 'Cover and reimbursement per care form' for the supplementary insurances as regards the supplementary insurances. The care and other services in the article

General oral care and the article Orthodontics when under 18 in the chapter on dental insurance as regards dental insurances.

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

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

Care plan
A dynamic set of agreements between you and your care provider(s) regarding nursing and care and your personal contribution to the care (self-management). These agreements are based on individual targets, needs and situations. They are formulated as part of a joint decision-making process.

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 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.

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

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