AMERSFOORTSE RESTITUTIE 2017
TERMS AND CONDITIONS

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Amersfoortse Restitutie 2017 Terms and Conditions

Contents

1. Definitions

Pharmacy

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

Dispensing practitioner

The dispensing general practitioner or an established pharmacist registered in the register of established pharmacists, or a pharmacist who engages the assistance of pharmacists listed in that register. The term dispensing practitioner also covers the party that commissions the care from pharmacists listed in the aforementioned register.

Company doctor

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

Pelvic therapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a pelvic

therapist in the Central Register for Quality Physical Therapy [*Centraal Kwaliteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy (KNGF) or the Physiotherapy Accreditation Foundation [*Stichting Keurmerk Fysiotherapie*].

Special dentistry

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

Centre for special dental treatment

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

Centre for genetic counselling

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

Infant welfare centre physician

A physician who is listed as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (RGS) or who is listed as a Health and Society physician [*arts Maatschappij en Gezondheid*] in the Specialists Register maintained by the Royal Dutch Medical Association (KNMG) established by the RGS, and who works as such in Youth Healthcare.

Contract rate

The rate charged for a particular treatment or provision by us or on our behalf as agreed with the care provider.

Emergency mental healthcare

Treatment for a patient who requires emergency assistance. This care is provided by a practitioner employed by a 24-hour emergency service. It is also referred to as emergency treatment. An emergency situation exists if emergency assistance is required within 24 hours, as in the case of an impending suicide.

Day treatment

Admission for less than 24 hours.

Daytime activities (mental healthcare)

Promoting, maintaining and compensating the patient's self-sufficiency. Daytime activities always take place as part of psychiatric treatment and are indicated in the patient's treatment plan. Daytime activities are not taken to mean:

- A customary manner of spending the day offered in a home/residential situation;
- A welfare activity, such as excursions, singing and bingo.

DBC Table of Mental Healthcare Professions

The mental healthcare professions framework issued by the Dutch Healthcare Authority (NZa) that includes all professions whose practitioners are qualified to perform a role in the individual diagnosis-oriented (and other) treatment of clients in the mental healthcare sector. This professions framework identifies six clusters of professions: medical, psychotherapeutic, adult educational, psychological, specialised therapeutic and nursing professions. Practitioners in the professions cluster of ‘somatic professions in mental healthcare’ that has been added to the DBC Table of Professions cannot serve as secondary medical specialists.

DBC Care Product

A DBC Care Product describes the full path of medical specialist care or specialised mental healthcare using a performance code laid down by the Dutch Healthcare Authority (NZa). This covers the request for care, the type of care provided, the diagnosis and the treatment.
The DBC pathway commences as soon as you submit a request for care (the DBC is opened), and is completed at the end of the treatment, or after 120 days (in the case of medical specialist care) or 365 days (in the case of specialised mental healthcare).

Organisational structure of services

An organisational association of general practitioners having legal personality as referred to in Section 29c of the Decree governing the Scope of Operation of the Healthcare (Market Regulation) Act [*Besluit uitbreiding en beperking werkingssfeer Wet marktordening gezondheidszorg*], which has been established to ensure the provision of treatment by general practitioners in the evening, at night and at weekends, and which charges legally valid rates.

Dietician

A dietician who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

DSM disorder

A psychiatric disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (abbreviated to DSM). The DSM is a classification system for psychiatric disorders. It contains cluster descriptions of all disorders based on symptoms.

Primary care admission

Admission to an institution that is medically necessary for the medical care customarily provided by general practitioners.

Occupational therapist

An occupational therapist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

EU and EEA Member State

In addition to the Netherlands, this is taken to mean the following countries within the European Union: Austria, Belgium, Bulgaria, Croatia, (Greek) Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom.
Switzerland enjoys equal status pursuant to the relevant treaty provisions.
The EEA countries (the states that are party to the Agreement on the European Economic Area) are Liechtenstein, Norway and Iceland.

Pharmaceutical care

The supply of medicine and dietary preparations and/or advice and guidance as provided by dispensaries in the interests of medication assessment and responsible use, designated as such under or pursuant to the Health Insurance Decree [*Besluit Zorgverzekeringen*], with due observance of the Pharmaceutical Care Regulations stipulated by us.

Fraud

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

Physiotherapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act [*Wet BIG*]. A remedial masseur as referred to in Section 108 of the Individual Healthcare Professions Act is also deemed to be a physiotherapist.

Contracted care

The care which, in accordance with the Healthcare Insurance Act [*Zorgverzekeringswet*], we are obliged to provide, or to reimburse the costs of, by virtue of an agreement entered into between us and the care provider.

General Basic Mental Healthcare [*Generalistische Basis GGZ*].

The supplementary or other diagnostics and general treatment for minor to moderately severe, non-complex mental or stable chronic problems.

Geriatric physiotherapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also listed as a geriatric physiotherapist in the Central Register for Quality Physical Therapy (CKR) maintained by the Royal Dutch Society for Physical Therapy (KNGF) or the Physiotherapy Accreditation Foundation [*Stichting Keurmerk Fysiotherapie*].

Specialised Mental Healthcare [*Gespecialiseerde* GGZ]

Diagnostic and specialist treatment of moderately/severely complex psychological ailments.

Healthcare psychologist

A healthcare psychologist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act [*Wet BIG*].

Mental healthcare institution

An institution [*GGZ-instelling*] entitled to provide mental healthcare in connection with a psychiatric disorder, which may or may not include a stay at the institution. The healthcare institution must be accredited under the Care Institutions (Accreditation) Act (WTZi).

Skin therapist

A skin therapist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

General practitioner

A doctor who is listed as a general practitioner in the register of recognised general practitioners established by the Commission for the Registration of Medical Specialists (RGS) and maintained by the Royal Dutch Medical Association (KNMG).

Provision of medical aids

A provision to meet the need for medical aids and dressing materials designated by a ministerial regulation with due observance of the Medical Aids Regulations under the 2017 'Restitutie' policy [*Reglement Hulpmiddelen Restitutie 2017*] laid down by us regarding the requirements for consent, period of use and quantity.

In vitro fertilisation attempt

Care according to the in vitro fertilisation method, which involves:

- stimulating the maturation of ova in the body of the female by means of hormone treatment;
- follicular aspiration;
- fertilising the ova and growing embryos in the laboratory;

- implanting one or two embryos in the womb, one or more times, in order to instigate pregnancy.

Intensive paediatric care

Intensive paediatric care is for children up to eighteen years of age who require the care typically provided by nurses in connection with medical care or a high probability thereof. These children also require constant supervision or 24-hour care, in combination with specialist nursing activities.

Youth healthcare physician

A physician who is listed as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (RGS) or who is listed as a Health and Society physician [*arts Maatschappij en Gezondheid*] in the Specialists Register maintained by the Royal Dutch Medical Association (KNMG) established by the RGS, and who works as such in Youth Healthcare.

Dental surgeon

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

Multidisciplinary care

Care funded under the policy rule for the performance-related funding of multidisciplinary care provision for chronic disorders laid down in the Healthcare (Market Regulation) Act.

Paediatric physiotherapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a paediatric physiotherapist in the Central Register for Quality Physical Therapy [*Centraal Kwaliteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy (KNGF) or the Physiotherapy Accreditation Foundation [*Stichting Keurmerk Fysiotherapie*].

Clinical psychologist

A healthcare psychologist who is registered as such in accordance with the terms and conditions referred to in Section 14 of the Individual Healthcare Professions Act.

Maternity care agency

An institution that provides maternity care and is accredited as such in accordance with regulations laid down by or pursuant to the law, as well as any institution recognised as such by us. This is understood to include a maternity centre.

Maternity hotel

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

Maternity care

The care provided by a maternity care provider affiliated with a hospital, maternity centre or maternity hotel who provides the care in accordance with the way in which such care should be provided.

Laboratory tests

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

Speech therapist

A speech therapist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

Manual therapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a manual therapist in the Central Register for Quality Physical Therapy [*Centraal Kwaliteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy (KNGF) or the Physiotherapy Accreditation Foundation [*Stichting Keurmerk Fysiotherapie*].

Market rate

Costs deemed reasonably appropriate given the current market conditions in the Netherlands.

Medical adviser

A physician who is listed as a Policy and Advice physician [*arts Beleid en Advies*] in the Profile Register established by the Commission for the Registration of Medical Specialists (RGS) or is listed as a Health and Society physician [*arts Maatschappij en Gezondheid*] in the Specialists Register established by the RGS and maintained by the Royal Dutch Medical Association (KNMG), and who works as such for a health insurer.

Medical sexologist

A medical sexologist is a qualified doctor who meets the conditions laid down by the Fellows of the European Committee of Sexual Medicine (FECSM).

Medical specialist

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

Oral hygienist

An oral hygienist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

Dutch Healthcare Authority (NZa)

The Dutch Healthcare Authority [*Nederlandse Zorgautoriteit,* NZa] which concerns itself with the regulation, supervision and implementation of healthcare.

Oedema therapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as an oedema therapist in the Central Register for Quality Physical Therapy [*Centraal Kwaliteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy (KNGF) or the Physiotherapy Accreditation Foundation [*Stichting Keurmerk Fysiotherapie*].

Cesar/Mensendieck remedial therapist

A Cesar/Mensendieck remedial therapist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

Turnover ceiling

In order to reduce healthcare costs and keep premiums low, we apply a turnover ceiling to some contracted care providers. This means that we have agreed on a maximum amount that may be claimed from these providers per calendar year.

Admission

Admission to a hospital or rehabilitation centre for 24 hours or longer in the event that and insofar as, on medical grounds, nursing, examinations and treatment can only be offered in a hospital or

rehabilitation centre, while continuous treatment by a medical specialist is necessary.

Orthodontist

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

Orthoptist

An orthoptist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

Chiropodist

A chiropodist who is registered in the Quality Register for Chiropodists [*KwaliteitsRegister voor Pedicures*, KRP] for treating patients with diabetes or risk foot.

Physician's assistant

A medical professional trained at higher vocational level (HBO), registered in accordance with the Individual Healthcare Professions Act and specialising as a physician's assistant. A physician's assistant is authorised to perform certain tasks independently, such as endoscopies, catheterisations, giving injections and prescribing prescription drugs, and can also operate at the request or under supervision of a medical specialist or general practitioner.

Podotherapist

A podotherapist who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podotherapists.

Mental healthcare sector privacy declaration

This document allows clients in the mental healthcare sector (GGZ) to prevent health insurers from viewing the details of their diagnosis or any information that could be used to establish their diagnosis.

Foreign private clinic

An institution that is not part of the social medical expenses system in the country in which it is established and where the medical specialist care for nursing, examination and treatment is demonstrably provided in accordance with the relevant Dutch suitability and quality standards.

Psychiatrist

A physician listed as a psychiatrist in the Specialists Register established by the Commission for the Registration of Medical Specialists (RGS) and maintained by the Royal Dutch Medical Association (KNMG). 'Psychiatrist' may also be interpreted as 'neurologist'.

Psychotherapist

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

Rehabilitation

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

Rehabilitation institution

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

Second opinion

Requesting an assessment regarding a diagnosis and/or proposed treatment provided by a physician from a second, independent physician operating in the same specialist area/professional field as the physician initially consulted.

SOS International

BV Nederlandse Hulpverleningsorganisatie SOS International, Hoogoorddreef 58, 1101 BE Amsterdam. Telephone: + 31 (0)20 651 51 51, email info@sosinternational.nl. SOS International provides travellers with illness or accident assistance 24 hours a day, 7 days a week. Medical travel assistance can also be requested via www.smartmelden.nl. You will receive a response within 15 minutes.

Geriatric specialist

A physician who is listed as a geriatric specialist in the register of recognised geriatric specialists established by the Commission for the Registration of Medical Specialists (RGS) and maintained by the Royal Dutch Medical Association (KNMG).

Emergency care

Care that cannot be foreseen in advance, arising from an acute illness or accident for which immediate medical care is required that cannot reasonably be postponed until after returning to the Netherlands.

Sports physician

A sports physician who is registered as such in accordance with the terms and conditions referred to in Section 14 of the Individual Healthcare Professions Act.

Dentist

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

Prosthodontist

A prosthodontist who has been trained in accordance with the Decree governing Educational Requirements and the Discipline of Prosthodontics.

TSN Maternity care mediation

TSN provides maternity care throughout the Netherlands. For maternity care mediation. Telephone number: +31 (0)70 343 04 68.

You/your

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

V&VN

V&VN Dutch Nurses' Association, the association of care professionals in the Netherlands.

A stay

Admission for a period of 24 hours or longer.

'Admission day' for intensive paediatric care

An 'admission day' is a calendar day that is part of the period of admission for intensive paediatric care. Admission must include at least one overnight stay. An admission day may only be claimed if the patient is admitted before 20:00, and spends the night at the institution. An admission day is counted as the day on which the patient was admitted, plus the subsequent night. The day of discharge (i.e. the day on which the patient does not spend the night) can therefore not be claimed as an admission day.

Treaty country

A country that is not part of the European Union or the EEA or Switzerland with which the Netherlands has concluded a social insurance treaty that includes a scheme for the provision of medical care. This group includes the following countries: Australia (only during temporary residence), Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Serbia and Montenegro, Tunisia and Turkey.

Obstetrician

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

Nurse specialist in mental healthcare

A nurse specialist in mental healthcare who is registered as such in a specialists register referred to in Section 14 of the Individual Healthcare Professions Act.

Nurse

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

Nurse (Level 5)

A nurse holding a level 5 qualification (a Bachelor's degree from a higher professional education institution under Section 3a of the Individual Healthcare Professions Act) or a nurse specialist (holding a Master's degree from a higher professional education institution under Section 14 of the above Act).

Referral letter / referral

A recommendation issued by a care provider or care institution to an insured party stating that the insured party should undergo treatment or continue a treatment at another care provider or healthcare institution. Referral letters must be issued prior to treatment, and must state: the insured person's contact information and date of birth, the referrer's name, position, AGB code and practice stamp/signature, date of issue, reason for the referral and any other relevant details. A referral letter remains valid for a period of one year following the date of issue.

Insured party

Any person who is designated as such in the health insurance policy, the policy endorsement or in the certificate of application.

Policyholder

The person who has entered into the insurance contract with us.

Individual Healthcare Professions Act [*Wet BIG*]

Individual Healthcare Professions Act [*Wet op de Beroepen in de Individuele Gezondheidszorg,* abbreviated to *Wet BIG*].

We/us/our

ASR Basis Ziektekostenverzekeringen N.V.

Wlz

The Long-Term Care Act [*Wet langdurige zorg*, abbreviated to Wlz].

Wmo

The Social Support Act [*Wet maatschappelijke ondersteuning,* abbreviated to Wmo].

WTZi

Care Institutions (Accreditation) Act [*Wet Toelating Zorginstellingen,* abbreviated to WTZi].

Independent treatment centre (ZBC)

A centre for specialist medical care (examinations and treatment) as referred to in or admitted under the Care Institutions (Accreditation) Act.

Hospital
An institution for nursing, examining and treating sick people as referred to in the Care Institutions (Accreditation) Act. This is also understood to include the Netherlands Asthma Centre in Davos [*Nederlandse Astma Centrum Davos*].

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

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

Zvw-pgb
Personal budget (*persoonsgebonden budget* or pgb) under the Healthcare Insurance Act.

ZZP GGZ care product/package
ZZP GGZ is a complete intramural mental healthcare package involving treatment tailored to the patient's symptoms and the type of care the patient needs. A ZZP GGZ package consists of a description of the patient type (patient profile), the number of hours of care that will be made available for this specific patient profile and a description of the care. It covers the following services: ZZP GGZ B3 through B7, including and excluding daytime activities and ZZP GGZ Intensive Clinical Treatment (KIB).

Article 2 Basis of the insurance

This basic insurance can be taken out by or on behalf of:

- any person who is subject to compulsory health insurance in the Netherlands; or
- any such persons residing abroad.

The insurance contract concerns non-contracted care insurance (‘Restitutie’), and is based on:

- the Healthcare Insurance Act [*Zorgverzekeringswet*] and accompanying notes;
- the Health Insurance Decree [*Besluit zorgverzekering*] and accompanying notes;
- the Healthcare Insurance Regulations [*Regeling zorgverzekering*] and accompanying notes; and
- the application form completed by the policyholder.

The insurance contract is stated on the policy schedule, which is sent annually to the policyholder.

We will also send you a health insurance card. Either the policy schedule or the health insurance card must be shown to the care provider when requesting healthcare services, after which you will be entitled to reimbursement of healthcare costs under the Healthcare Insurance Act.

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

These policy terms and conditions state your policy cover entitlements. The extent of basic insurance cover is determined by the government. This legislation states, among other things, that the content

and scope of your entitlement to care is determined by the current state of scientific research and current practice. If there is no such benchmark, the definition of 'responsible and effective care and services' in the relevant specialist area will apply. You are only entitled to reimbursement of care if you can be reasonably considered to be dependent on the type and scope of care you have received.

We cannot conclude any basic insurance with you if the address you have provided does not appear in the Persons Database [*basisregistratie personen*], or if it differs from the address under which you are registered in the database. This regulation will not apply if:

- you have presented a payslip or employer declaration which states that the person to be insured works and pays income tax in the Netherlands or on the continental shelf (see Section 1.1.1 of the Long-Term Care Act, *Wlz*). The declaration or payslip must state when the person to be insured commenced employment, and must not be more than one month old;
- you have submitted a declaration from the Social Insurance Bank, stating that the person to be insured is insured under the Long-Term Care Act; or
- you cannot be reasonably held at fault for the discrepancy regarding the address in the Persons Database.

Article 3 Reimbursement of care

Commencement and termination of the payment

We reimburse only insured care that commences during the term of this policy, and lasts until either the treatment stops or the DBC care product is discontinued.

Choice of care provider

This basic insurance policy entitles you to reimbursement of the costs of care. You are entirely free to select the care provider of your choice. You can make use of:

- care provided by a care provider that has entered into a contract with us (contracted care);
- care provided by a care provider that has not entered into a contract with us (non-contracted care).

Reimbursement of contracted care

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

A list of contracted care providers can be viewed on www.amersfoortse.nl/zorg, see 'Find a care provider'.

Reimbursement of non-contracted care

Statutory maximum rate

If you go to a care provider in the Netherlands with whom we have not agreed any rates and a statutory maximum rate applies, we will fully reimburse your treatment. In such cases, healthcare providers may not charge rates higher than the statutory maximum.

Free rates

If you go to a care provider with whom we have not agreed any rates and no statutory maximum rate applies, we will reimburse your treatment at prevailing market rates. In legal terms, this is defined as; the costs deemed reasonably appropriate given the current market conditions in the Netherlands. If a healthcare provider charges amounts higher than those deemed reasonably appropriate given the current market conditions in the Netherlands, we will therefore not be able to reimburse the higher portion.

*For our interpretation of prevailing market rates, please see www.amersfoortse.nl/zorg under '*indicatieve marktconforme tarieven*' (indicative market rates).*

For nursing and care under the Healthcare Insurance Act Personal Budget Scheme (Zvw-pgb), the maximum rates will apply as stated in the Zvw-pgb and/or Medical Specialist Care at Home (MSVT) Regulations under the 2017 'Restitutie' policy.

The Zvw-pgb and/or Medical Specialist Care at Home (MSVT) Regulations under the 2017 'Restitutie' policy can be viewed at www.amersfoortse.nl/zorg.

Additional conditions governing non-contracted care

We can only accept original invoices for processing that can contain the following information:

- your name;
- your address;
- your date of birth;
- the name of the treatment provider;
- the AGB code of the treatment provider. For nursing and other care (Article 18.24) this may not be the AGB code that is specific to the Personal Budget;
- the dates on which you were treated;
- the details of the treatment; and
- the amount per treatment.

The invoice must clearly state the amount that we are to pay. If you received the invoice from the care provider, it is your own responsibility to ensure that the care provider is paid on time.

Emergency care

In the event you need emergency care, we will act as though we have granted permission for the care even though you did not, of course, apply for it in advance. However, you are obliged to inform us of emergency care as soon as possible. No referral is required for this type of care.

Crucial care guaranteed

In some cases healthcare institutions may reach their turnover ceiling during the course of the year as a result of financial agreements between them and us. In such cases crucial care for you is

guaranteed (in other words ambulance care, emergency assistance, acute maternity services and emergency mental healthcare) but usually also if you are already undergoing treatment at a healthcare institution. If the care institution can only treat you later than you prefer, please contact the Care for Care Department who can assist with recommendations or mediation at the same or a different care provider.

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.

Care mediation

For care mediation, you may contact the experienced nursing staff of the Care for Care Department. Care Mediation involves nursing staff actively searching in order to find high-quality care for you within a reasonable period. You can also contact the department for waiting list mediation (quicker treatment in another hospital, possibly abroad or in an independent treatment centre), arranging the provision of medical aids and general information on health, disease and prevention.

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.

Overpayment

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

Reimbursement of the costs of care other than described in the policy

We also reimburse forms of care that are not stated in this policy, but which can be shown to achieve comparable results. You require our prior consent to claim these costs, and the form of care must not be excluded from reimbursement by law.

Authorisation policy

A number of reimbursement types are subject to an authorisation policy, which means that you must submit an application to obtain our permission prior to undergoing the treatment. This is governed by law. If we grant the necessary permission, you will receive the authorisation in writing.
This applies to:

- certain medicines (Article 18.8);
- Specialised mental healthcare requiring an admission period of more than 365 days (Article 18.11);
- non-contracted specialised mental healthcare (GGZ, Article 18.11);
- non-contracted medical aids (Article 18.13);
- some contracted medical aids (Medical Aids Regulations under the 2017 ‘Restitutie’ policy);
- rehabilitation at non-contracted independent treatment centres (Article 18.20).

Any authorisations we issue remain valid for the entire term of the insurance policy, unless affected by changes to legislation. If the authorisation states a period that exceeds the term of the insurance, your new health insurer will take over the authorisation.

More background information on this policy can be found at www.amersfoortse.nl/zorg.

Admission to a hospital in a class other than the insured class

If you are admitted to a hospital in a class other than that for which you are insured, you will be reimbursed according to the lowest class.

DBC Care Product claims

For reimbursement of the costs of care involving a DBC care product, the DBC care product will be apportioned to the year in which the DBC commenced. This means that the costs in 2016 will be reimbursed by the 'old' insurer if you switch in 2017.

> ***Example:***
> *If your first contact with the specialist was in 2016, the specialist opens a DBC care product and the treatment or operation is performed or continues into 2017, the reimbursement conditions and the compulsory/voluntary excess of 2016 will apply.*

Abroad

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

Article 4 Premium

As the policyholder, you must pay a premium for your basic insurance.

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

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

Article 5 Obligatory excess

Obligatory excess amount

If you are 18 years of age or older, you must pay an obligatory policy excess of €385 per calendar year. Any care costs up to this amount must be paid by you.

When does the obligatory excess apply?

Obligatory excess applies to all forms of healthcare in these policy terms and conditions, except:

- visits to your general practitioner. However, medicines prescribed by your GP or laboratory tests ordered as part of the care from your GP do fall under the excess;
- the costs of obstetric care and maternity care (Article 18.23);
- the costs of nursing and other care (Article 18.24);

- the costs of foot care for diabetes patients (Article 18.25);
- the costs of follow-up donor checks. The 13-week and 6-month follow-up checks must be paid for by the donor's health insurance;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- the costs of multidisciplinary care to treat diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);
- medical aids on loan;
- personal contributions or personal payments.

Only the costs that we reimburse under this basic insurance policy count towards the obligatory excess. Amounts billed to you personally therefore do not count.
Costs are first deducted from the obligatory excess, and afterwards from any voluntarily chosen excess.
If we reimburse your care costs to your care provider directly, we will charge you the payable obligatory excess amount separately.

Calculation of obligatory excess for a mid-year contract date

If your basic insurance does not start or end on 1 January, we will calculate your obligatory excess as follows:

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

DBC care product (Diagnosis-Treatment Combination)

In order to determine the obligatory excess, the DBC care product will be apportioned to the year in which it was commenced. This means that the obligatory excess in 2016 will be charged to the 'old' insurer if you switch in 2017.

> ***Example:***
> *If your first contact with the specialist was in 2016, the specialist opens a DBC care product and the treatment or operation is performed or continues into 2017, the reimbursement conditions and the compulsory/voluntary excess of 2016 will apply.*

Article 6 Voluntary excess

Voluntary excess amount

The default voluntary excess amount is €0.
If you are aged 18 or over, you can elect to pay a voluntary excess of €100, €200, €300, €400 or €500 per calendar year. This will result in a reduced premium, and the discount will be noted in your policy schedule.

When does the voluntary excess apply?

The voluntary excess applies to all forms of healthcare in these policy terms and conditions, except:

- visits to your general practitioner. However, medicines prescribed by your GP or laboratory

tests ordered as part of the care from your GP do fall under the excess;

- the costs of obstetric care and maternity care (Article 18.23);
- the costs of nursing and other care (Article 18.24);
- the costs of foot care for diabetes patients (Article 18.25);
- the costs of follow-up donor checks. The 13-week and 6-month follow-up checks must be paid for by the donor's health insurance;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- the costs of multidisciplinary care to treat diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);
- medical aids on loan;
- personal contributions or personal payments.

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

Calculation of voluntary excess for a mid-year contract date

If your basic insurance does not start or end on 1 January, we will calculate your voluntary excess as follows:

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

If the basic insurance does not start on 1 January and you had a basic insurance policy with us with a different voluntary excess immediately preceding it, then the total voluntary excess will be calculated as follows:

- the total voluntary excess amount x no. of days the voluntary excess was applicable during the preceding period and for the period after it was changed;
- these two amounts will be summed together and divided by the total number of days in the calendar year;
- the result will be rounded to whole euros.

DBC care product (Diagnosis-Treatment Combination)

In order to determine the voluntary excess, the DBC care product will be apportioned to the year in which it was commenced. This means that the obligatory excess in 2016 will be charged to the 'old' insurer if you switch in 2017.

Example:
If your first contact with the specialist was in 2016, the specialist opens a DBC care product and the treatment or operation is performed or continues into 2017, the reimbursement conditions and the compulsory/voluntary excess of 2016 will apply.

Article 7 Privacy

Registration of personal details

When you apply to us for insurance or financial services, we will ask you for personal details. These will be used for:

- entering into and performing contracts;
- informing you of relevant products and offering them to you;
- ensuring the security and integrity of the financial sector;
- statistical analysis;
- relationship management; and
- fulfilling statutory requirements.

We place great importance on protecting your personal information, and your medical details in particular. We therefore treat your information with the utmost care. Whenever we use your personal details, we are bound to strict legislation and the Code of Conduct governing the Processing of Personal Details by the Insurance Industry [*Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars*].

For further information, see the privacy statement at www.amersfoortse.nl/zorg.

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

For further information, visit www.stichtingcis.nl.

Citizen Service Number

We are required by law to record your Citizen Service Number [*Burgerservicenummer*, BSN] in our administration. Your care provider or institution is required by law to use your BSN in all forms of communication, as are other service providers offering care under the Health Insurance Act. We also use your BSN when communicating with these parties.

Notification

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

Article 8 Obligations

Insured parties and policyholders are obliged to:

- identify themselves using a driver's licence, passport or Dutch identity card when utilising healthcare services in a hospital or outpatients' department;
- ask the treatment provider or medical specialist for the reason for your being admitted and inform our medical adviser upon request;
- cooperate fully with us in obtaining the information we need, with due observance of privacy

legislation and regulations;
- inform us within 30 days in the event of your detainment. You must also inform us within 30 days of the cessation of your detainment;
- submit original invoices to us within three years of the date of treatment. The details on the invoices must allow us to determine whether you are entitled to a reimbursement, and the amount. Computer-generated invoices must be authenticated by the healthcare provider. Neither a payment overview, nor a quote, order confirmation, proof of advance payment or advance invoice count as an invoice.

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

Article 9 Recourse

Insured parties and policyholders are obliged to:
- provide us with information and lend their cooperation with regard to seeking recourse against a liable third party;
- contact us before reaching a settlement with a third party, or a party acting for or on behalf of the third party – including the health insurer of the third party – in relation to the damage suffered by him or her.

Under no circumstances are you permitted to reach a settlement with a third party or their representative without obtaining our prior written consent. This includes issuing notice of discharge (stating that a debt has been paid) that impinges upon our rights.

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

In the event that you must pay the obligatory or voluntary excess for medical assistance as a result of an accident involving an opposing party who is at fault, you must personally recover this sum from the opposing party.

Article 10 Fraud

Obligation to cooperate

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

Personal data

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

Health insurers actively collaborate on fraud management

The Healthcare Insurance Act, the Long-Term Care Act and the Healthcare Market (Regulation) Act authorise health insurers to exchange information among themselves for monitoring and fraud management purposes. We also share certain indications with sector partners to combat fraud, such as the Dutch Healthcare Authority (NZa), the Social Affairs and Employment Inspectorate (I-SZW) and the Fiscal Intelligence and Investigation Service (FIOD), with due observance of Section 8 of the Personal Data Protection Act. This information exchange may take place directly, or via the Association of Dutch Health Insurers [*Zorgverzekeraars Nederland*, ZN]. The Personal Data Protection Act prescribes how personal data may be processed.

Void right to claims

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

Sanctions

If you and any accessories/co-perpetrators are found guilty of fraud, we are entitled to:

- issue an official warning;
- place an internal alert;
- terminate your health/other insurance with immediate effect;
- register your personal data in the External Referral Register maintained by the Central Information System Foundation [*Stichting CIS*].
- register your personal data with the Insurance Fraud Bureau [*Centrum Bestrijding Verzekeringsfraude*] of the Dutch Association of Insurers;
- commence criminal proceedings by submitting a report to the police or other investigative body;
- refuse you a new basic insurance policy for a five-year period. Other health insurers will be obliged to accept your application for basic health insurance;
- refuse you any supplementary or other insurance policies from a.s.r. insurers for a period of eight years.

Article 11 Unlawful registration

If it transpires that you were not obliged to obtain health insurance, the basic insurance will become void with retroactive effect until the last time we were able to determine the existence of an insurance obligation.

If we draw up basic insurance for you based on the Central Administration Office (CAK) Regulations for the Non-insured, and it later transpires that you were insured elsewhere, our basic insurance will become void with retroactive effect.
In such a case, you must demonstrate to us and the CAK that you were insured elsewhere. You will have two weeks to do so, counting from the day the CAK informed you as such. The CAK implements regulations at the behest of the government.

Article 12 Payment of premium and payment arrears

Payment of premium

You are obliged to pay the premium and the contributions arising from international or other statutory regulations or provisions to us in advance. We have agreed with you that you will do so monthly, quarterly, half-yearly or annually. Have you authorised us to automatically debit your insurance premium from the account number you provided us? If so, we will debit the amount payable from your account every month around the same date. If the policy is backdated when drawn up, the outstanding premium will be collected as a lump sum within 30 days. The amount of the premium is shown on the policy schedule issued to you.

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

It is not permitted to use your existing credit with us to pay outstanding amounts.

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

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

Warnings

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

Premium payment arrears

If you are two monthly premium payments in arrears, we will offer you a premium payment plan.
If your payment arrears amount to four monthly premiums, we will inform you that, should your arrears reach six monthly premiums, we will refer your case to the Central Administration Office (CAK) in connection with the levying of a premium under administrative law.
If your payment arrears amount to six monthly premiums or more, we will report the matter to the CAK and to you, the policyholder. From that point on, the Central Administration Office will collect the premium under administrative law from you, the policyholder, and you will no longer pay any nominal premiums to us. If we decide to take measures in order to collect our claim, all judicial and

extrajudicial collection costs will be for your account. The relevant claims for costs will be submitted to the competent court.
In such a case, the statutory regulations concerning 'The consequences of non-payment of the premium and the premium under administrative law' (Sections 18a through 18g of the Healthcare Insurance Act) apply.
We are entitled to settle any payment arrears against sums that we still owe to you.

Suspension in the event of detention

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

Article 13 Claims and suspension of cover

Claims paid directly

We have the right to pay claims directly to healthcare providers that have been submitted by the healthcare provider to us. You are entitled to an itemised statement of the amounts paid.

Amounts owed

We will pay claims submitted to us to the care provider in full even if the claim is not entirely eligible for reimbursement, e.g. due to an outstanding policy excess amount or a limited reimbursement scheme. In such cases, you must pay the policy excess or payment amount(s) exceeding the reimbursement scheme back to us.

General claim

We will notify you of any amounts to be repaid by you, which you must do by the deadline stated in the notification. It is not permitted to use your existing credit with us to pay the outstanding amounts.

Suspension

If you fail to pay the amount due within the term specified, you will be issued a warning. If you then fail to pay the amount by the deadline stated in the written warning, or if you refuse to pay, we will suspend your policy. In such a case, we will not pay for any care that has taken place during the period stated in the warning, and you will still be liable to pay the premium owed, in addition to any costs and interest associated with recovery and collection. The cover will resume the day after we have received and accepted your full payment (including any costs and interest).

Article 14 Notification of relevant events

Changes to your personal situation

You are obliged to notify us within 30 days of all events that may be of significance for the proper implementation of this insurance, such as the end of your obligation to obtain health insurance,

changes to your account number/IBAN, extended stays abroad, relocation, divorce, birth, death, etc.

18 years and over

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

Article 15 Revision of premium or conditions

What if the premium and/or terms and conditions change?

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

You will receive a letter

We may alter both the premiums and the terms and conditions for all of the people we insure at the same time, including the general contractual terms and conditions. A revision of the premium base will take effect no sooner than six weeks after the date upon which the policyholder was notified to this effect. Before we change anything, you will receive a letter from us containing information on the changes. Complaints regarding the implementation of the change will be subject to the customary complaints procedure.

Article 16 Commencement and termination of the insurance

Commencement of your basic insurance

The basic insurance will commence on the date that is stated as the date of commencement on the policy schedule.

If you switch to us from your old insurer at the end of the year or before 1 February of the following year (if you have terminated your previous insurance), the start date will be 1 January of the new year.

In other cases, we will insure you with retroactive effect:

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

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

Right of withdrawal

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

Termination of your basic insurance by notice of termination

Switching at the end of the year

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

You (the policyholder) may terminate the insurance policy in the following ways:

- in writing, no later than 31 December;
- by making use of the transfer system prior to 31 December.

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

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

Premature termination

Termination during the course of a calendar year is only possible in the following cases:

- you (the policyholder) have insured someone other than yourself, who is insured under a separate basic insurance policy. In such cases, however, you must provide us with proof of registration from the new insurance policy. If we receive the termination notice prior to the commencement date of the new basic insurance, the basic insurance will terminate on the day the insured party receives new basic insurance. In other cases, the termination date will be the first day of the second calendar month following the day on which you (the policyholder) submitted notice of termination;
- changes to the premium base or policy conditions that adversely affect you. In such cases, the basic insurance will terminate on the day on which the changes to your premium or conditions enter into force. You have 30 days from receiving notice of the changes in which to submit written notice of termination. This reason for termination will not apply if the premium or conditions change as the result of a statutory provision;
- you (the policyholder) have a group insurance policy with us and start work with another employer who has different group basic insurance. You may cancel the old basic insurance up to 30 days after commencing your new employment contract. Your new group insurance will start on the day you commence employment with the new employer if it is the first day of the month; otherwise, it will start on the first day of the following month. Your old group

insurance will end on the same day. All rights to discounts and other entitlements under the group policy will cease to apply on termination of the policy;
- you recently turned 18 and wish to transfer to a different insurer.

These termination options do not apply:
- during the period in which you (the policyholder) have failed to pay the premiums and any collection costs owed by the set deadline (see Article 12), unless we confirm your termination within 2 weeks;
- during the first 12 months of the insurance contract, if you are insured under the Central Administration Office (CAK) Regulations for the Non-insured.

Termination of your basic insurance by operation of law

We will terminate your basic insurance effective the day following the day on which:
- we can no longer offer you basic insurance because our permit to do so has been modified or withdrawn. We will notify you at least 2 months in advance of any such case;
- the insured party dies. We must be notified of the death of the insured party within 30 days of the date of death;
- the obligation to obtain health insurance expires for persons no longer insured under the Long-Term Care Act, or if you enter military service. You must inform us of the above as soon as possible.

In the above cases, we will notify you as soon as possible of the termination date of the basic insurance, and the reasons why.

Article 17 Reconsideration and complaint

This Agreement is governed by Dutch law.

Request for reconsideration

In the event that you do not agree with a decision made by us, you may request that we reconsider it. To do so, please send an email to zorg.medisch@amersfoortse.nl. Alternatively, you may send a letter to De Amersfoortse, attn. Medical Department, PO Box 2072, 3500 HB Utrecht (the Netherlands) or call us on +31 (0)33 464 20 61.

SKGZ

If we fail to respond to your request for reconsideration within four weeks or have indicated the intention to adhere to our decision, you may turn to the Health Insurances Complaints and Disputes Organisation: *Stichting Klachten en Geschillen Zorgverzekeringen* (SKGZ). The SKGZ offers mediation services in order to solve the problem. If mediation fails to produce satisfactory results the Disputes Board of the SKGZ may issue a binding decision. You can also bring your request for reconsideration before a competent court.

Complaint

If you have a complaint, please contact your insurance adviser first, who will seek the most suitable solution for your problem, in consultation with us if necessary.

If you are unable to find a solution in consultation with your insurance adviser you may submit a complaint using the complaints form that can be filled in on www.amersfoortse.nl, or by sending a letter to De Amersfoortse Klachtenservice, P.O. Box 2072, 3500 AA Amersfoort. Alternatively, you may call us on (033) 464 20 61.

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

You can also bring your complaint before a competent court.

Complaints about standard forms

If you find our forms too complicated or superfluous, you may submit a complaint to the Dutch Healthcare Authority, which will issue a binding opinion on the matter.

Article 18 Medical care

Article 18.1 Audiological care

We pay for care provided by audiological centres, which provide the following care services:

- conducting hearing tests;
- advising you on the purchase of hearing aids;
- giving you information on the use of the hearing aid;
- provision of psychosocial care if required by your hearing impairment;
- diagnostic assistance in the case of speech and language impediments for your child.

A referral by a general practitioner, company doctor, paediatrician, youth healthcare physician, infant welfare centre physician or ENT specialist is required.

Article 18.2 Abroad

If you live in the Netherlands and receive healthcare abroad:

We provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands. We will reimburse you up to prevailing market rates.

*For our definition of prevailing market rates, please see www.amersfoortse.nl/zorg under '*indicatieve marktconforme tarieven*' (indicative market rates).*

If you live or reside in an EU/EEA country or treaty country other than the Netherlands, you may choose between the following options:

- We will pay the costs of your care in accordance with the statutory regulations of that country pursuant to the provisions of the EU Social Insurance Regulation or the treaty concerned; or
- We will provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands.

If you live in another EU/EEA country or treaty country and are temporarily residing in the Netherlands or in another EU/ EEA country or treaty country, you may choose between the following

options:

- We will pay the costs of your care in accordance with the statutory regulations of the country where you receive your care pursuant to the provisions of the EU Social Insurance Regulation or the treaty concerned; or
- We will provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands.

If you live or reside in a country that is not an EU/EEA country or treaty country:

We provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands.

Emergency care

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

SOS International can be contacted on +31 20 651 51 51 (this number is also given on the back of your health insurance card), by fax +31 20 651 51 09 or via www.smartmelden.nl.

Requesting non-emergency care in advance

Non-emergency care abroad will only be refunded (fully or partially) in specific cases. For non-emergency care abroad, you must contact the Care for Care Department in advance to find out if – and if so, to what amount – you are eligible for reimbursement. We will reimburse you up to prevailing market rates.

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.
*For our definition of prevailing market rates, please see www.amersfoortse.nl/zorg under '*indicatieve marktconforme tarieven*' (indicative market rates).*

Payment

We will pay your claim in euros according to the exchange rate applicable at the time when your claim is accepted for processing. Payment will be issued to the account number (IBAN) of the policyholder listed in our records, which must be an account number (IBAN) at a bank located in the Netherlands. We apply the exchange rate listed on www.oanda.com.

Article 18.3 Dialysis

We reimburse the following dialysis centre costs:

- haemodialysis due to kidney failure, and peritoneal dialysis without admission;
- medical specialist care that is necessary and consists of:
    - tests, treatment and nursing care associated with dialysis;
    - medicines necessary for treatment;
    - psychosocial support for you and those assisting with performing the dialysis.

If the dialysis takes place at your home, you are entitled to reimbursement of:

- the costs of training by the dialysis centre for those performing or assisting with the home

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

You require our prior approval for dialysis care at home or at a dialysis centre.

Article 18.4 Dietetics (information on diet and eating habits)

We will reimburse a maximum of 3 hours of treatment per calendar year. This treatment must involve the care generally provided by dieticians, for medical purposes.

You require a referral from a general practitioner, dentist, infant welfare centre physician, a company doctor, youth healthcare physician or a medical specialist.

Article 18.5 Primary care admission (ELV)

Primary care admission is intended for people who are temporarily unable or not yet able to live safely in their own living environment. This may involve indications for:

- medical specialist care (including Geriatric Rehabilitative Care);
- specialist mental healthcare;
- respite care under the Social Support Act (Wmo);
- admission under the Long-Term Care Act;
- admission related to maternity care (maternity hotel).

We reimburse primary care admission, provided it is to an institution that is necessary for the medical care generally provided by general practitioners. The general practitioner must establish the medical necessity for being admitted, which he/she may do in consultation with the district nurse/transfer nurse and/or the geriatric specialist.

During primary care admission you will have monitoring or care close by you at all times, which may also be accompanied by nursing, paramedic or other care. Primary care admission is aimed at helping you to recover and return to your own home, or may involve palliative terminal care.

Maximum admission period

Because of the temporary nature of primary care admission, we deem it valuable to reassess every three months whether the care is still of a temporary nature. Your care provider must contact the Care for Care Department for this purpose (in consultation with you).

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.

Right of transfer

A right of transfer applies to primary care admission, which means that a current treatment plan may be completed with the same care provider according to the indication issued by the Care Assessment Centre (CIZ) concerning its nature, scope and duration. As such, the right of transfer is dependent on the indication as issued by CIZ in 2016 (as of 31-12-2016, with a maximum of 3 months for basic/intensive primary care admission and a maximum of 3 years for palliative primary care admission).

Quality criteria for ELV providers

All providers must meet the following minimum criteria:

- The provider must have the relevant accreditation under the Care Institutions (Accreditation) Act (WTZi, concerning admission, treatment, nursing and/or other care) and satisfy the requirements set out in the Act.
- The care supplied by the provider must be in line with the latest professional requirements and standards.
- Nurses accredited at levels 4 or 5 must be available 24 hours a day, 7 days a week. A level-5 nurse will have primary responsibility, and will therefore also act as your primary point of contact.
- The care provider must make agreements (with your own GP, in any case) concerning the handover of medical data (medical policy) between the hospital and the primary care institution upon admission and discharge.

Article 18.6 Genetic testing and counselling

We will reimburse the costs of central diagnostics and the coordination and registration of the blood and bone marrow samples submitted to a centre for genetic testing.
This care comprises:

- conducting research into hereditary diseases by means of:
    - genealogical research;
    - chromosome research;
    - biomedical diagnostics;
    - ultrasound testing;
    - DNA testing; and
- genetic counselling and the necessary psychosocial support.

We also reimburse tests for other persons if necessary when issuing a recommendation to you. This also includes potential counselling for these other persons.

You require a referral from your medical specialist.

Article 18.7 Occupational therapy

We reimburse a maximum of 10 treatment hours per calendar year for consultation, instruction, training or treatment by an occupational therapist, either at the specialist's practice or at your home. This treatment must comprise the care generally provided by occupational therapists,

for the purposes of promoting or restoring your self-sufficiency and ability to care for yourself. Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a referral from a general practitioner or specialist.

Article 18.8 Pharmaceutical care

General

Pharmaceutical care comprises:

- the supply of medicines by dispensaries (pharmacists and dispensing practitioners) or;
- consultation and support as generally provided by dispensaries for the medical assessment and responsible use of:
    - registered medicines from Appendix 1 to the Healthcare Insurance Regulations [*Regeling Zorgverzekering*] as stipulated by us;
    - the medicines listed in Appendix 1 that belong to the categories listed in Appendix 2 of the Healthcare Insurance Regulations. These medicines must also meet the criteria listed in the relevant category, and comply with the provisions in Article 5.3 of the Pharmaceutical Care Regulations under the 2017 'Restitutie' policy [*Reglement farmaceutische zorg Restitutie 2017*];
    - other medicines, provided they relate to rational pharmacotherapy as follows:
        - medicines prepared by or on assignment of a dispensary in a private pharmacy on a small scale and made available (in accordance with Section 40(3a) of the Medicines Act);
        - medicines brought into commercial circulation in accordance with established regulations and prepared by a manufacturer at the request of a doctor in the Netherlands. The medicines must be intended for use by individual patients of the doctor in question, and must have been prepared under the doctor's supervision according to his/her specifications (in accordance with Section 40(3c) of the Medicines Act);
        - medicines brought into commercial circulation in another Member State or a third country and have at the doctor's request been imported or otherwise brought into the Netherlands and are intended for a patient that is suffering from an illness that does not have a higher incidence in the Netherlands than 1 in 150,000 inhabitants. (in accordance with Section 40(3c) of the Medicines Act);
    - polymeric, oligomeric, monomeric and modular dietary preparations in compliance with Section 1 of Appendix 2 to the Healthcare Insurance Regulations, and comply with the provisions in Article 5.3 of the Pharmaceutical Care Regulations under the 2017 'Restitutie' policy [*Reglement farmaceutische zorg Restitutie 2017*].

Appendices 1 and 2 of the Healthcare Insurance Regulations may be amended during the course of the year by the Ministry of Health, Welfare and Sport (VWS).

Appendices 1 and 2 of the Healthcare Insurance Regulations can be consulted at www.wetten.overheid.nl. The Pharmaceutical Care Regulations under the 2017 'Restitutie' policy can be viewed at www.amersfoortse.nl/zorg.

Reimbursement

We reimburse the supply of medicines as generally provided by dispensaries. A statutory personal contribution applies to specific medicines. The Minister of Health, Welfare and Sport (VWS) determines to which medicines this contribution applies. These medicines are listed in Appendix 1a to the Health Insurance Regulations.

Details about the personal contribution can be found in Article 5.1 of the Pharmaceutical Care Regulations under the 2017 'Restitutie' policy.

We also reimburse consultation and support services as generally provided by dispensaries. Advice and assistance includes the following:

- the provision of medicines exclusively available on prescription;
- explanation of the new medicine and how it should be used;
- instructions concerning a medical aid required for the medicine exclusively available on prescription;
- assessment of chronic medication exclusively available on prescription;
- pharmaceutical assistance during day treatment/outpatient clinic visits;
- pharmaceutical assistance during hospitalisation;
- pharmaceutical assistance in connection with discharge from hospital.

The polymeric, oligomeric, monomeric and modular dietary preparations must be supplied by a dispensary or a specialised supplier of medical aids.

Prescribing doctor

Unless otherwise agreed with your care provider, the medicines supplied must be prescribed by a:

- general practitioner;
- company doctor;
- youth healthcare physician;
- medical specialist;
- dentist;
- dental specialist;
- obstetrician;
- nursing specialist; or
- physician's assistant.

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

We do not reimburse:

- pharmaceutical care that the Minister has decided will not be covered under insurance;
- medicines for travel-related risk of illness;
- medicines for research or experimental use;
- medicines for which an application for market authorisation has been submitted or that is still undergoing clinical tests and which, in accordance with conditions established by a Ministerial Regulation, has been made available for compassionate use;
- personal contribution(s);
- medicines that are equivalent or practically equivalent to any registered medicine that is not

listed in the medicine reimbursement system (GVS);
- homeopathic and anthroposophic products and medicines;
- nutritional supplements and vitamins not registered as medicines;
- other costs (i.e. administrative or shipping costs).

Pharmaceutical Care Regulations

The Pharmaceutical Care Regulations under the 2017 'Restitutie' policy contain further conditions concerning the eligibility assessment of pharmaceutical care. These include:

- approval conditions;
- supply quantities;
- specific medicine-related provisions;
- reimbursement of medicines.

The Pharmaceutical Care Regulations under the 2017 'Restitutie' policy can be viewed at www.amersfoortse.nl/zorg.

Article 18.9 Physical therapy and remedial therapy

Parties under the age of 18

Physiotherapy and remedial therapy is reimbursed as follows.

- If your condition **is** listed in Appendix 1 of the Healthcare Insurance Decree [*Besluit Zorgverzekering*]:
    - the necessary treatment. You must be treated by a paediatric or other physiotherapist, Mensendieck/Cesar remedial therapist, pelvic therapist or oedema therapist. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist;
- If your condition is **not** listed in Appendix 1 of the Healthcare Insurance Decree:
    - a maximum of 9 treatments per indication per calendar year. You must be treated by a paediatric or other physiotherapist, manual therapist, pelvic therapist, Mensendieck/Cesar remedial therapist or oedema therapist. Oedema therapy and scar therapy may also be provided by a skin therapist.
    - if the outcomes are not satisfactory, a maximum of 9 **additional** treatments per indication per calendar year will be covered. You require a referral from your general practitioner or a medical specialist.

This treatment must comprise the care generally provided by physiotherapists and remedial therapists.
Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a referral from a general practitioner or specialist.

Appendix 1 of the Healthcare Insurance Regulations can be consulted at www.amersfoortse.nl/zorg.

Parties aged 18 or older

Physiotherapy and remedial therapy are reimbursed as follows.

- If your condition is listed in Appendix 1 of the Healthcare Insurance Decree [*Besluit Zorgverzekering*]:
    - the necessary treatment starting from the 21st treatment. You must be treated by a physiotherapist, manual therapist, Mensendieck/Cesar remedial therapist, pelvic

therapist or oedema therapist. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist;

- up to nine pelvic therapy treatments for urinary incontinence. You must be treated by a pelvic therapist, and require a referral from a general practitioner, a company doctor or a medical specialist;
- up to the first 37 treatments for an indication of intermittent claudication (stage-2 *claudicatio intermittens*) during a maximum period of 12 months.

This treatment must comprise the care generally provided by physiotherapists and remedial therapists.
Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a referral from a general practitioner or specialist.

Appendix 1 of the Healthcare Insurance Regulations can be consulted at www.amersfoortse.nl/zorg.

Article 18.10 Mental healthcare – General Basic Mental Healthcare [*Generalistische Basis GGZ*]

General

If you are aged 18 or over, we reimburse General Basic Mental Healthcare for the treatment of, recovery from or to prevent the exacerbation of a DSM disorder. The care must not involve Specialised Mental Healthcare [*Gespecialiseerde GGZ*], and must comprise care as generally provided by clinical psychologists. We also reimburse online treatments.

Referral

You require a referral from your general practitioner, medical specialist or company doctor.
The digital/physical referral letter must include at least the following information:

- the date of referral;
- the referrer's name and AGB code;
- your name and address details;
- a referral for General Basic Mental Healthcare (*Generalistische Basis GGZ*);
- reason for referral/questions concerning the suspected DSM condition.

No referral is required for emergency care, however a referral is required for any treatment that commences after the emergency situation has passed.

Care provider

Quality institution

- The care provider must have a Quality Charter [*Kwaliteitsstatuut*]. The care provided must meet the professional standards set out in the Register of the National Health Care Institute: the Quality Institution Model. We only reimburse care supplied by care providers that satisfy the criteria in the Quality Institution Model.

Coordinating treatment provider

- A coordinating treatment provider is the care provider managing the care process as described in the mental healthcare (GGZ) Quality Institution Model and the Dutch Healthcare Authority regulations.
- The coordinating treatment provider is responsible for establishing the diagnosis. To do so, the coordinating treatment provider will contact you directly prior to treatment. The following general mental healthcare providers can act as coordinating treatment providers:

Independent	Institution-based
Healthcare psychologist	Healthcare psychologist
Psychotherapist	Psychotherapist
Clinical psychologist	Clinical psychologist/clinical neuropsychologist
Clinical neuropsychologist	Nurse specialist in mental healthcare
	Geriatric specialist or clinical geriatrician (if dementia is the primary diagnosis)
	Addiction specialist (with addiction and/or gambling as the primary diagnosis)

- General Basic Mental Healthcare institutions always have a psychiatrist or clinical psychologist available for advice and consultation.
- If you commence treatment under the Youth Act and turn 18 while treatment is still ongoing, you may continue to receive care from the general remedial educationalist, post-master remedial educationalist or paediatric/youth psychologist. This only applies to treatments immediately following the patient's 18th birthday, which must conclude within a maximum period of one year and therefore will only apply to the initial Basic Mental Healthcare (BGGZ) treatment initiated for you after reaching the age of 18.

Secondary medical specialists providing mental healthcare

Secondary medical specialists work under the responsibility of the coordinating treatment provider and are listed in the DBC Table of Mental Healthcare Professions. Practitioners in the 'somatic' professions listed there (such as physiotherapists and dieticians) cannot serve as secondary medical specialists.

We do not reimburse:

- Youth Mental Healthcare;
- assistance in the event of work-related or relationship problems;
- treatment of adjustment disorders;
- psychosocial support;
- care in the case of learning and development disorders, including:
    - dyslexia;
    - fear of animals or flying (treatment for these phobias falls under general practitioner care);
    - self-help;
    - neurofeedback;
    - psychoanalysis;
    - intelligence testing;

    - school psychological care;
    - medical psychological care (which may form part of medical specialist care);
    - assistance of a non-medical nature, such as training programmes, courses and counselling regarding child upbringing;
- indexed prevention for cases of depression, panic disorders and problematic alcohol use; (this falls under the scope of medical care provided by general practitioners); or
- treatments that do not reflect the latest developments in science and practice.

*An overview of all psychological interventions that do/do not reflect the latest developments in science and practice (formerly known as the 'dynamic list' by the Association of Dutch Health Insurers [*Zorgverzekeraars Nederland*] can be found at www.amersfoortse.nl/zorg.*

Article 18.11 Mental healthcare - Specialised Mental Healthcare [*Gespecialiseerde GGZ*]

General

If you are aged 18 or over, we reimburse Specialised Mental Healthcare for the treatment of, recovery from or to prevent the exacerbation of a DSM disorder. Specialised mental healthcare is taken to mean: the diagnosis (establishing a condition) and specialist treatment of complex psychological conditions, and must comprise care as generally provided by clinical psychologists.

Care provider

Quality institution

- The care provider must have a Quality Charter [*Kwaliteitsstatuut*]. The care provided must meet the professional standards set out in the Register of the National Health Care Institute: the Quality Institution Model. We only reimburse care supplied by care providers that satisfy the criteria in the Quality Institution Model.

Coordinating treatment provider

- A coordinating treatment provider is the care provider managing the care process as described in the mental healthcare (GGZ) Quality Institution Model and the Dutch Healthcare Authority regulations.
- The coordinating treatment provider is responsible for establishing the diagnosis. To do so, the coordinating treatment provider will contact you directly prior to treatment. The following Specialised Mental Healthcare providers can act as coordinating treatment providers:

Independent	**Institution-based**
Psychotherapist	Psychotherapist
Clinical psychologist	Healthcare psychologist
Clinical neuropsychologist	Clinical psychologist/clinical neuropsychologist
Psychiatrist	Psychiatrist
	Nurse specialist in mental healthcare
	Geriatric specialist
	Addiction specialist (with addiction and/or gambling as the primary diagnosis) in the Profile Register maintained by the Royal Dutch Medical Association (KNMG)

	Clinical geriatrician (if dementia is the primary diagnosis)

- At Mental Healthcare (GGZ) Institutions, specialised mental healthcare is provided by multidisciplinary teams, which always include a psychiatrist or clinical psychologist.
- In cases of clinical admission, the coordinating treatment provider must generally be a psychiatrist or clinical psychologist. In consultation with the working psychiatrist or clinical psychologist, it may be decided for the ambulatory coordinating treatment provider to remain the coordinating treatment provider for the duration of the patient's admission.
- If you commence treatment under the Youth Act and turn 18 while treatment is still ongoing, you may continue to receive care from the general remedial educationalist, post-master remedial educationalist or paediatric/youth psychologist. This only applies to treatments immediately following the patient's 18th birthday, which must conclude within a maximum period of one year and therefore will only apply to the initial Specialised Mental Healthcare (BGGZ) treatment initiated for you after reaching the age of 18.

Secondary medical specialists providing mental healthcare

Secondary medical specialists work under the responsibility of the coordinating treatment provider and are authorised to allocate time within a Mental Healthcare DBC if they are listed in the DBC Table of Mental Healthcare Professions together with a description of their profession. Practitioners in the 'somatic' professions listed there (such as physiotherapists and dieticians) cannot serve as secondary medical specialists.

Referral

You require a referral from your general practitioner, medical specialist or company doctor.
The digital/physical referral letter must include at least the following information:

- the date of referral;
- the referrer's name and AGB code;
- your name and address details;
- a referral for General Basic Mental Healthcare (*Generalistische Basis GGZ*);
- reason for referral/questions concerning the suspected DSM condition.

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

Authorisation requirement for using a non-contracted institution

We have concluded agreements with numerous institutions, however if you wish to attend a non-contracted mental healthcare institution, either you or your care provider on your behalf must request our authorisation prior to commencing treatment. In order for us to issue the authorisation, please send us the following:

- a referral from a general practitioner, company doctor or medical specialist;
- in the event of admission: the clinical admission indication, in accordance with the guidelines laid down by the professional association;
- the proposed treatment plan, with details on the number of treatment minutes and activities and procedures to be performed;

- the coordinating and secondary treatment providers involved in providing the care;
- the DBC expense claim code and the performance code.

We will treat your claim confidentially, which can be sent to our medical adviser:

De Amersfoortse Verzekeringen
Attn.: Mental Healthcare (GGZ) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

Privacy declaration

If you do not want a diagnosis code to appear on the claim, you must ensure that we have a privacy declaration by no later than submission of your first claim. This declaration must be signed by you and the care provider, and sent to the following address:

De Amersfoortse Verzekeringen
Attn.: Mental Healthcare (GGZ) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

We do not reimburse:

- Youth Mental Healthcare;
- assistance in the event of work-related or relationship problems;
- treatment of adjustment disorders;
- psychosocial support;
- care in the case of learning and development disorders, including:
    - dyslexia;
    - fear of animals or flying (treatment for these phobias falls under general practitioner care);
    - self-help;
    - neurofeedback;
    - psychoanalysis;
    - intelligence testing;
    - school psychological care;
    - medical psychological care (which may form part of medical specialist care);
    - assistance of a non-medical nature, such as training programmes, courses and counselling regarding child upbringing;
- indexed prevention for cases of depression, panic disorders and problematic alcohol use; (this falls under the scope of medical care provided by general practitioners); or
- treatments that do not reflect the latest developments in science and practice.

An overview of all psychological interventions that do/do not reflect the latest developments in science and practice (formerly known as the 'dynamic list' by the Association of Dutch Health Insurers [Zorgverzekeraars Nederland] can be found at www.amersfoortse.nl/zorg.

Specialised mental healthcare including admission

If you are aged 18 or over, we will reimburse a period of admission in a Mental Healthcare (GGZ) Institution, psychiatric hospital or psychiatric ward of a hospital for a period of up to 1095 days. This care provided must be specialised psychiatric treatment, and admission must be necessary for the treatment.
We also reimburse the necessary nursing and other care, paramedic care,[1] medicines, medical aids and dressings during the period of admission.

The following rules apply to calculating the 1095 days:
An interruption of no longer than 30 days is not viewed as an interruption, and these days will not be counted towards the 1095 days. Interruptions exceeding 30 days will reset the count at 0. If you are interrupting your admission for weekend or holiday leave, these days **will** be counted as part of the calculation.
Entitlement to the above care may still exist after a period of 1,095 days under the Long-Term Care Act (Wlz).

NB: If you wish us to reimburse your Specialised Mental Healthcare costs for a period of more than 365 days, you (or your care provider on your behalf) must request authorisation from us in advance. The application for the authorisation must be submitted to us by no later than the tenth month of your uninterrupted stay. It must state why your admission period must exceed 365 days, and be accompanied by a treatment plan drawn up by the coordinating treatment provider.
We will treat your claim confidentially, which can be sent to our medical adviser:

De Amersfoortse Verzekeringen
Attn.: Mental Healthcare (GGZ) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

Specialised mental healthcare without admission

If you are aged 18 or over, we will reimburse specialised healthcare in a Mental Healthcare (GGZ) Institution, psychiatric hospital or psychiatric ward of a hospital.
We also reimburse the necessary nursing and other care, paramedic care,[2] medicines, medical aids and dressings, as well as Specialised Mental Healthcare by an independent psychiatrist, clinical neuro/other psychologist or psychotherapist.

Article 18.12 General practitioner

We reimburse medical care provided by a general practitioner, or by a care provider acting under

[1] Provided the condition is of a complex/extremely complex nature, for which paramedic care is recommended in the multidisciplinary guidelines as an integral component of treatment. Practitioners in the 'somatic' professions (such as physiotherapists and dieticians) cannot serve as secondary medical specialists.

[2] Provided the condition is of a complex/extremely complex nature, for which paramedic care is recommended in the multidisciplinary guidelines as an integral component of treatment for the mental disorder. Practitioners in the 'somatic' professions (such as physiotherapists and dieticians) cannot serve as secondary medical specialists.

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

Article 18.13 Provision of medical aids

We reimburse the costs of functional medical aids and dressings, subject to the further requirements and conditions of reimbursement listed in the Medical Aids Regulations under the 2017 'Restitutie' policy [*Reglement Hulpmiddelen Restitutie 2017*]. These regulations also specify whether the aids are given or loaned to you, and form part of this insurance policy.

The Medical Aids Regulations under the 2017 'Restitutie' policy can be viewed at www.amersfoortse.nl/zorg.

Authorisation

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

Usage costs

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

Suitability

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

Dressings

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

Aids on loan

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

We do not reimburse:

- Aids and dressings not covered under the Long-Term Care Act (Wlz) or the Social Support Act (Wmo).

Article 18.14 Speech therapy

We reimburse treatment by speech therapists. The treatment is expected to result in the improvement or recovery of speech or speech ability. This treatment must comprise the care generally provided by speech therapists for medical purposes.

You require a statement from your doctor, dentist or remedial educationalist stating the indication for speech therapy. Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a referral from a general practitioner or specialist.

Speech therapy treatment will not be understood to include the treatment of dyslexia or

developmental language disorders in relation to a dialect or a foreign language.

Article 18.15 Mechanical ventilation

We reimburse necessary mechanical ventilation in a ventilation centre or at home, along with the associated necessary medical specialist care. If you are ventilated at home under the supervision of a ventilation centre:

- the ventilation centre will provide the equipment required for each treatment in a ready-to-use state;
- the ventilation centre will provide the specialist medical care and pharmaceutical care associated with the mechanical ventilation.

You require a referral from your medical specialist.

Article 18.16 Specialist medical care (excluding mental healthcare)

Referrals for specialist medical care

A referral by a general practitioner, company doctor, youth healthcare physician or other medical specialist is required to qualify for reimbursement of the costs of these types of care. This does not apply to emergency care. For specialist medical care in relation to pregnancy and/or childbirth, the referral can also be made by an obstetrician. This treatment must comprise the care generally provided by medical specialists. Oral care provided by an oral surgeon is covered according to Article 18.17. A referral from a dentist is sufficient in such cases.
If you undergo inpatient treatment at an institution designated under the Long-Term Care Act (Wlz), in addition to a general practitioner or a medical specialist, a doctor for the intellectually disabled or a geriatric specialist may also issue the referral, provided they are acting as the coordinating treatment provider.

Admission to hospital

We will cover your stay in the lowest class of a hospital or an independent treatment centre (ZBC) for a period of up to 1095 days. Your stay there must be medically necessary as described in this Article or in Article 18.17 (Oral care).

An interruption of no longer than 30 days is not viewed as an interruption, and will not count towards the 1095 days. Interruptions on account of weekend and holiday leave **will** be included in the calculation of the 1095 days.

We also reimburse the necessary nursing and other care, paramedic care, medicines, medical aids and dressings during the period of admission.

Non-clinical specialist medical care

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

Our cover includes the costs of specialist medical treatment at the general practice of the medical specialist or elsewhere, along with the necessary medicines, medical aids and dressings relating to

the treatment.

IVF (in vitro fertilisation attempts) or ICSI

For women until the age of 43, we reimburse the first, second and third IVF or ICSI attempts for each intended non-interrupted pregnancy. Treatments must take place in a hospital with the proper licence to provide such treatment. We also reimburse the necessary medicines. We draw a distinction between two different forms of non-interrupted pregnancy:

- Physiological pregnancy: a spontaneous or other pregnancy lasting at least 12 weeks counted from the first day of the last menstrual cycle;
- Pregnancy after an IVF or ICSI treatment lasting at least 10 weeks from the follicular aspiration after the non-frozen embryo has been returned to the womb, or at least 9 weeks and three days after the frozen embryo has been returned to the womb.

Attempts do not count unless follicular aspiration (the collection of ova) has been successfully carried out. Only attempts that fail after this stage count towards the number of attempts.
The reinsertion of the/all embryo(s) obtained during an attempt (whether or not these have been frozen in the meantime) forms part of the attempt in which the embryos were obtained, provided there is no instance of a non-interrupted pregnancy. A new attempt following a non-interrupted pregnancy (either spontaneous or following IVF) counts as a new first attempt. A maximum of one embryo will be implanted during the first and second attempts for women until the age of 38. If a third attempt is made, a maximum of two embryos may be implanted if necessary for medical reasons. If you are aged between 38 and 43, a maximum of two embryos may be implanted for all three attempts if necessary for medical reasons. An IVF attempt that commenced before reaching the age of 43 may be completed.

You require our prior written consent to claim these costs.

<u>Explanation</u>

If any ova are found in the follicular fluid, the aspiration attempt is considered to have been successful, regardless of the quality of these ova. If no ova whatsoever are found in the follicular fluid, the attempt will not count.

We do not reimburse:

- treatments or medicines for the fourth or subsequent IVF attempt for each intended pregnancy. Prior to this, three attempts must have concluded between the initial successful follicular aspiration and an instance of a non-interrupted pregnancy. A ‘non-interrupted pregnancy’ is defined as: a pregnancy of ten weeks’ duration counted from the successful follicular aspiration (when using non-frozen embryos), or a pregnancy of nine weeks and three days’ duration counted from the implantation of the frozen embryo (when using frozen embryos);
- the first and second attempt at in vitro fertilisation up to the age of 38 if more than one embryo is returned to the womb;
- fertility-related care commencing at the age of 43 or older.

Plastic surgery

We reimburse plastic surgery to correct:

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

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

*The Guide for the Assessment of Plastic Surgery Treatment [*Werkwijzer beoordeling behandelingen van plastisch chirurgische aard*] can be viewed at www.amersfoortse.nl/zorg.*

We do not reimburse:

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

Second opinion

We will reimburse the costs of a second opinion, which must relate to medical care that is intended for you and that your initial treatment provider has discussed with you. You must return with the second opinion to your initial treatment provider. This person is authorised to direct the course of the treatment.

You require a referral from your general practitioner or a medical specialist.

Conditional admission

The Minister of Health, Welfare and Sport has made some forms of care provisionally admissible under basic insurance. These involve care whose effectiveness is still in doubt, or that has not yet

been proven. This means that the full list of provisionally admitted treatments may change over the course of the year.

An updated list of all provisionally admitted treatments can be viewed at www.amersfoortse.nl/zorg.

Article 18.17 Oral care

General

'Oral care' is defined as the care generally provided by dentists, and must entail the dental care necessary:

- due to a serious developmental disorder, growth disorder or acquired defect of the dental, jaw and mouth system such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- due to a non-dental physical or mental disorder such that, without this care, you would be unable to retain or attain a dental function equivalent to that which you would have had if the condition had not presented; or
- if, without this care, medical treatment would have a demonstrably insufficient result and, without this other care, you would be unable to retain or attain a dental function that is equivalent to that which you would have had if the condition had not presented.

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

Oral care also extends to admission to a hospital on medical grounds so that specialist dental surgery can be performed.

You require our prior consent. A written statement of the grounds for the treatment and a treatment plan drawn up by a dentist, dental surgeon or medical specialist must be submitted with your application.

A list of procedures (codes) and rates can be viewed at www.amersfoortse.nl/zorg.

Implant for the purpose of attaching a removable prosthesis

We reimburse dental implants in cases of a severely shrunken edentulous jaw and where the implant is for the purposes of attaching a removable complete overdenture.

You require our prior consent. A written statement of the grounds for the treatment drawn up by a dentist, dental surgeon or medical specialist must be submitted with your application.

Orthodontics.

We only reimburse orthodontic treatment in cases of very serious developmental or growth disorders affecting the teeth, jaw and/or mouth system. Such cases require co-diagnosis or co-treatment from disciplines other than dentistry.

You require our prior consent. A written statement of the grounds for the treatment drawn up by a

dentist, dental surgeon or medical specialist must be submitted with your application.

Dental surgery for insured persons under the age of 18 years

We reimburse oral care that does not fall under the description under 'General' (see above). This encompasses:

- check-ups (periodic preventive dental examinations) once a year, and more often if dentally required;
- incidental consultations;
- tartar removal;
- fluoride application starting from the emergence of the first permanent tooth, up to twice per year and more often if dentally required;
- sealing of grooves and pits in teeth and molars;
- gum (periodontal) treatment;
- anaesthetic;
- root-canal (endodontic) treatment;
- fillings (restoration of dental elements using plastic materials);
- treatment for problems with the jaw joint (gnathological treatment);
- removable prosthetics (e.g. dentures or plates);
- crowns, bridges and implants to replace one or more missing permanent incisors or canines which have failed to develop or which are absent due to an accident. This entitlement lasts until the age of 22 for incisors or canines that failed to develop entirely, or that were lost due to an accident before your 18th birthday. The cause of this loss must have been established prior to your 18th birthday;
- surgical dental treatment, with the exception of the insertion of a dental implant. You are only entitled to implants that replace one or more missing permanent incisors or canines that either failed to develop or that were lost as the direct result of an accident;
- X-rays, excluding X-rays for orthodontic treatment.

Implants require our prior consent. A written statement of the grounds for the treatment and a treatment plan drawn up by a dentist must be submitted with your application.

Dental treatment for insured persons over the age of 18 years

We reimburse oral care that does not fall under the description under 'General' (see above). This encompasses:

- surgical dental treatment of a specialist nature and the accompanying X-rays, with the exception of periodontal surgery, the insertion of a dental implant and the extraction of teeth or molars without any complications;
- 75% reimbursement for the manufacture and placement of a removable complete immediate denture, removable complete overdenture or a removable complete replacement for the upper and/or lower jaw that does not require an implant to be worn.
  A lower-jaw prosthesis requiring an implant to be worn attracts a personal contribution of 10% of the total costs of application (8% for the upper jaw). The placement of a removable complete denture onto dental implants also includes application of the fixed part of the superstructure;
- repairing and rebasing an existing removable complete denture or an existing removable

complete overdenture, which attracts a personal contribution of 10% of the costs.

Dental surgery requires our prior consent.
The replacement of removable complete replacement dentures within 5 years requires our prior consent.

Personal contribution – Adults

If you are aged 18 or over, the treatments listed under 'General' above that are not directly related to the medical indication for special dental treatment attract a personal contribution. This contribution is the amount we charge for treatment not conducted as part of special dental treatment.

Institution for specialist dental treatment

If you attend an institution for special dental treatment for oral care, you require our prior consent.

Article 18.18 Oncological care in children

We reimburse the costs incurred for central (reference) diagnostics conducted by, and the coordination and registration of the bodily material submitted to, the Dutch Childhood Oncology Group [*Stichting Kinderoncologie Nederland*, SKION]

You require a referral from your medical specialist.

Article 18.19 Organ transplants

As the recipient of the organ, we reimburse you for:

- the transplant of tissues and organs;
- the specialist medical care related to selecting the donor (the person donating the organ/tissue to you) and the surgical removal of the transplant material from the donor;
- the examination, preservation, removal and transportation of the post-mortal transplant material in connection with the transplantation.

As the donor of the organ, we reimburse you for:

- the care related to the donor's admission, for selection and/or removal of the transplant material. The costs of this care will be reimbursed up to thirteen weeks after the admission period. A maximum period of six months applies to liver donors;
- the transport within the Netherlands that a donor uninsured in the Netherlands requires for:
    - selection, admission to and discharge from a hospital;
    - care up to thirteen weeks (or six months for liver donors) following admission for transplant purposes.

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

We will also reimburse the donor's transplant-related costs if they are connected to the donor's

residence abroad.

If the donor has basic insurance in the Netherlands, the costs of this transport will be paid by the donor's basic insurance. If the donor is also an insured party under this basic insurance policy, the costs may be claimed against this basic insurance policy.

The transplant must be performed:

- in an EU member state;
- in a state that is party to the Agreement on the European Economic Area;
- in another state, if the donor resides in that state and is the spouse, registered partner or a blood relative once, twice or three times removed of the insured party.

We do not reimburse:

- accommodation costs in the Netherlands;
- possible loss of income.

You require our prior consent.

Article 18.20 Rehabilitation

Rehabilitation

We reimburse rehabilitation if:

- it has been designated as the most suitable method for preventing, ameliorating or overcoming your disability. In such cases, your disability must be the result of:
    - mobility disorders or restrictions;
    - a condition of the central nervous system that hampers communication, behaviour or cognitive ability;
- the care enables you to achieve or maintain a certain level of independence that is reasonably feasible given your limitation;
- the care is provided by a multidisciplinary team led by a medical specialist or rehabilitation specialist affiliated with a rehabilitation centre accredited by law.

Rehabilitation may take place:

- via part-time or day treatment (non-clinical);
- via admission for several days (clinical). This is only possible if the admission provides better and faster results.

Rehabilitation requires a referral from a general practitioner, company doctor, youth healthcare physician or medical specialist.

Geriatric rehabilitation

Geriatric rehabilitation relates to integrated and multidisciplinary rehabilitative care as generally provided by geriatric specialists. The care must be necessary in connection with physical frailty and complex multimorbidity and a reduced ability to learn and be trained, aimed at reducing your functional limitations to the extent that you can return to your own home.

We reimburse geriatric rehabilitative care if:

- the care is provided within one week after a stay as referred to in Article 18.16 (Specialist medical care), where your treatment comprised the care generally provided by medical specialists. Prior to your stay in the hospital, you must not have been residing in a nursing home as described in Section 3.1.1 of the Long-Term Care Act; and
- the commencement of the care is accompanied by a stay in a hospital or care institution as referred to in Article 18.16 (Specialist medical care).

We will reimburse geriatric rehabilitation for a maximum of six months. In special cases, we may grant permission for a longer period.

Authorisation requirement for rehabilitative care at a non-contracted independent treatment centre (ZBC)

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

- a referral from a general practitioner, company doctor or medical specialist;
- in the case of hospitalisation: the clinical indication for hospitalisation in accordance with the established guidelines of the Dutch Association of Rehabilitation Specialists (VRA);
- the proposed treatment plan, with details on the period, number of treatment minutes and activities and procedures to be performed;
- the treatment providers involved in supplying the care;
- the DBC expense claim code and the performance code.

We will treat your claim confidentially, which can be sent to our medical adviser:

De Amersfoortse Verzekeringen
Attn.: MSZ medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: ‘Confidential’.

Article 18.21 Quitting smoking

We reimburse a maximum of one quit-smoking programme per calendar year, which must comprise medical care, possibly in combination with medicines that support behavioural change for the purposes of quitting smoking.

You may take a quit-smoking programme with:

- *Rook Vrij! Ook jij?*;
- a general practitioner;
- medical specialist;
- obstetrician;
- healthcare psychologist;
- care providers listed in the Quit-Smoking Quality Register [*Kwaliteitsregister Stoppen met Roken*].

The Quit-Smoking *Quality Register can be consulted at www.KwaliteitsregisterStopmetRoken.nl.*

We only reimburse nicotine replacement products and medicines if they form part of the quit-smoking programme in order to support behavioural change.
The medicines must have been prescribed by the doctor, medical specialist, obstetrician or nursing specialist providing the treatment. Nicotine replacements may only be obtained from a pharmacist, with a 'quit-smoking' request form completed by your treatment provider, or if prescribed by your general practitioner with a special code on the prescription.

Article 18.22 Thrombosis service

We reimburse care by the thrombosis service comprising:

- the collection of regular blood samples;
- performance of laboratory tests if necessary to determine the clotting time of your blood;
- use of equipment and accessories capable of determining your blood's clotting time;
- training in the use of the equipment that measures your clotting time, and help with the measurements themselves;
- consultation on the use of medicines that affect your clotting ability.

You require a referral from your doctor.

Article 18.23 Obstetric care and maternity care

You (an insured female) and your child are entitled to payment of the costs of obstetric care such as obstetricians generally provide, and to payment of the costs of maternity care such as generally provided by maternity home-care assistants.
The obstetric care may be provided by an obstetrician, general practitioner or a medical specialist. The care may also be provided in combination with care by a maternity hotel. Here, maternity care is defined as: care provided by a maternity home-care assistant who is:

- affiliated with a hospital;
- affiliated with a maternity centre;
- affiliated with a maternity hotel;
- affiliated with a maternity care agency;
- independent.

The maternity carer cares for you and your child, and assists with the housekeeping where necessary. The following situations can be identified:

Childbirth and maternity care in a hospital necessary on medical grounds

We reimburse specialist medical care and admission to hospital (in accordance with Article 18.16) for you and your child if you are required to give birth in a hospital for medical reasons. The care will commence on the day of the childbirth.

Childbirth and confinement in a hospital without medical grounds

We reimburse nursing and maternity care for you and your child in the absence of medical grounds. The care will commence on the day of the childbirth.
An excess of €16.50 applies both you (the mother) and to your child per day of admission. We will

deduct this sum from your maximum payment of €119 per day of admission, and the maximum payment of €119 for your child. If the hospital charges exceed €119 for you and €119 for your child, you must pay this amount yourself.
We will calculate the number of days of hospitalisation based on a statement issued by the hospital, or by the maternity care agency that is concerned with providing additional maternity care after discharge from the hospital.

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

Maternity care in a maternity hotel

We reimburse maternity care in a maternity hotel for you (the mother) and your child after childbirth in a hospital or maternity hotel. An excess of €4.20 per hour applies to maternity care. The costs of the hotel are for your own account.

Maternity care at home following childbirth in a maternity hotel or hospital

If you receive maternity care at home following childbirth in a hospital or maternity hotel, we will deduct the number of days of hospitalisation from the maximum number of maternity care days (10) that we reimburse for childbirth and maternity care at home, as described below. We will calculate the number of days of hospitalisation based on a statement issued by the maternity hotel or maternity care agency that is concerned with providing additional maternity care after discharge from the maternity hotel.

Childbirth and confinement at home

We reimburse obstetric care (including prior and aftercare) at home.
We also reimburse:

- registration, intake and childbirth assistance as established by the National Maternity Care Guidelines [*Landelijk Indicatie Protocol*];
- maternity care for up to 10 days, counting from the date of delivery. The actual number of hours of maternity care depends on your (i.e. the mother's) needs and those of the child, and will be determined on the basis of the National Maternity Care Guidelines [*Landelijk Indicatie Protocol Kraamzorg*]. An excess of €4.20 per hour applies to maternity care.

You yourself may arrange for maternity care to be provided by the contracted or non-contracted maternity agency of your choice via www.amersfoortse.nl/zorg. Simply enter the words 'maternity care' in the 'Formulate your question' screen.
You can also apply for maternity care via TSN Kraamzorgbemiddeling*, tel. +31 (0)79 343 04 68 or +31 (0)33 464 28 84*

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Prenatal screening

We reimburse prenatal screening for female insured parties, comprising:

- counselling: this refers to the provision of information on the content and scope of prenatal screening for congenital defects (to enable you to take a considered decision). In such cases, your healthcare provider must hold a licence under the Population Screening Act [*Wet op het*

bevolkingsonderzoek];

- a structural ultrasound scan: Structural ultrasound scans are only reimbursed if your healthcare provider has a collaboration agreement with a Regional Centre for Prenatal Screening that holds a licence under the Population Screening Act [*Wet op het bevolkingsonderzoek*];
- a combined first-trimester screening test: reimbursement only if your medical history reveals a high risk of having a baby with Down syndrome, Edwards' syndrome or Patau syndrome.
- a non-invasive prenatal test (NIPT): reimbursement only if you have undergone a combined first-trimester screening test revealing a significant risk of a chromosomal abnormality;
- invasive diagnostics: reimbursement only if your medical history reveals a high risk of having a baby with Down syndrome, Edwards' syndrome or Patau syndrome, or if significant risk of a chromosomal abnormality has been established by a combined first-trimester screening test or NIPT. This concerns chorionic villus sampling and an amniotic fluid puncture.

Preconception consultation

We reimburse preconception consultations for female insured parties, as described in the 'Preconception Care' Guidelines by the Dutch College of General Practitioners (NHG) and provided by an obstetrician or general practitioner.

IUD insertion by obstetricians not reimbursed

We do not reimburse the insertion of an IUD (Intra-Uterine Device) by obstetricians. To get an IUD, please see your general practitioner or a medical specialist following a referral.

Article 18.24 Nursing and other care

Nursing and other care

We reimburse nursing and other care as generally provided by nurses, whereby such care:

- relates to the need for, or high risk of, medical care as described under Articles:
    - 18.4 (Dietetics);
    - 18.7 (Occupational therapy);
    - 18.9 (Physical therapy and remedial therapy);
    - 18.10 (General Basic Mental Healthcare [*Generalistische Basis GGZ*]);
    - 18.11 (Specialised mental healthcare [*Gespecialiseerde GGZ*]);
    - 18.12 (General practitioner);
    - 18.14 (Speech therapy);
    - 18.16 (Specialist medical care);
    - 18.18 (Oncological care in children);
    - 18.19 (Organ transplants);
    - 18.20 (Rehabilitation);
    - 18.21 (Quit-smoking programme);
    - 18.23 (Obstetric and maternity care);
    - 18.27 (Sensory impairment care).
- is not already covered under the Social Support Act [*Wet maatschappelijke ondersteuning*, Wmo];
- is not part of hospitalisation as described in Article 18.5 (First-line admission), 18.11 (Specialised mental healthcare), 18.16 (Specialist medical care), 18.20 (Geriatric rehabilitative

care) or at a Long-Term Care institution; and

- for insured parties aged under 18: the costs of care will only be reimbursed if the care is necessary due to complex somatic issues or a physical handicap and, additionally, if;
    - permanent supervision is required, or
    - care must be close at hand 24 hours a day and involves one or more specific nursing activities.

Qualifications

You require a medical indication from a (level-5) district or other nurse, determined in accordance with the Nursing and Care Standards issued by the V&VN Dutch Nurses' Association. The level-5 district/other nurse must draw up a dynamic care plan with you. This means that the care plan must be evaluated and modified to accommodate the actual situation whenever the need for care changes, under the supervision of a level-5 district nurse. The care plan must, in any case, contain information on the nature, extent, duration and objectives of care, and the desired results. You (or your representative) and the care provider must sign the care plan.

Nursing and Care Personal Budget (Zvw-pgb)

If you require nursing and other care without hospitalisation, you may apply to us for a personal budget under the Healthcare Insurance Act Personal Budget Scheme (Zvw-pgb). This will allow you to purchase nursing and other care yourself. The eligible target groups and applicable terms and conditions can be found in the Zvw-pgb and/or Medical Specialist Care at Home (MSVT) Regulations under the 2017 ‘Restitutie’ policy, which form part of this insurance policy.

The Zvw-pgb and/or Medical Specialist Care at Home (MSVT) Regulations under the 2017 ‘Restitutie’ policy can be viewed at www.amersfoortse.nl/zorg.

Intensive paediatric care

Daycare nursing centre

In addition to nursing and other care at home, it is also possible for insured parties aged under 18 who are eligible for intensive paediatric care to attend a nursing daycare centre.
This care can only be claimed for a minimum of six hours a day at a location equipped to provide nursing daycare for intensive paediatric care, and includes the costs of accommodation, toys, food and drink, cleaning, linen, facilities (such as resources for general use), nursing and other care, and non-patient-specific materials such as dressings and incontinence materials.

Admission

There may be an indication for admission to a location that provides intensive paediatric care if hospitalisation is not necessary or desirable but the home situation does not allow for adequate care. This may involve a temporary stay as respite care for the parents, or for palliative purposes (children's hospices).
The care can only be claimed if the patient spends the night at the institution, and is present before 20:00 at a location equipped to provide intensive paediatric care. An admission day is counted as the day on which the patient was admitted, plus the subsequent night.

Neither claim is covered under the Healthcare Insurance Act Personal Budget scheme (Zvw-pgb).

Palliative terminal care

As soon as the doctor providing the treatment has determined that you are expected to die within three months, the district nurse may issue an indication for terminal palliative care (potentially at the patient's home). If the care exceeds this three-month period, your care provider must contact the Care for Care Department for consultation.

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.

Collaboration with municipal authorities

We have made agreements with municipal authorities to organise care in your own environment as efficiently as possible. Certain aspects of this care are reimbursed by us, and other aspects by the municipal authority based on the Social Support Act [*Wet Maatschappelijke Ondersteuning*, Wmo]. Under Section 14(a) of the Healthcare Insurance Act, we are obliged to make agreements to this effect with the municipality. We have incorporated these agreements into this policy where appropriate. If you receive care both from us and from the municipality, it is wise to contact our Care for Care Department.

The Care for Care Department can be contacted during office hours on +31 (0)33 464 20 61 or via zorgadvies@amersfoortse.nl.

Article 18.25 Foot care for diabetes mellitus patients

We reimburse foot care if you suffer from diabetes mellitus, provided the care is preventive in nature and related to potential symptoms due to diabetes. You require a referral to a podotherapist from your GP, physician or geriatric specialist (nursing home doctor), who will determine your care profile based on the Simm's classification and any other medical risks. The podotherapist will then consult with you to draw up an individual treatment plan. The aspects of care that you are entitled to are set out in the 'Prevention of Diabetic Foot Ulcers Care Module'. The type of foot care you receive will depend on your care profile, which will fall into one of the following three categories:

Care profile 1:

- Annual foot check-up, consisting of case history, physical examination and a risk assessment. This examination may be performed by a medical chiropodist, a certified diabetic foot care chiropodist, a podotherapist or a diabetes-specialised podotherapist.

Care profiles 2, 3 and 4:

- More frequent targeted examination of the patient's feet including the resulting diagnostics and treatment of skin and nail problems and abnormalities in the shape and position of the feet, for patients with a moderately high (Simm's 1) or high (Simm's 2 or 3) risk of contracting ulcers;
- Treatment of risk factors in cases of a moderately high or high risk of contracting ulcers;
- Scheduling training sessions to modify your lifestyle in order to benefit your treatment.

The foot care must be performed by, or under the supervision of, a diabetes-specialised or other podotherapist. The podotherapist or diabetes-specialised podotherapist may subcontract certain

aspects of care to a medical chiropodist or a certified diabetic foot care chiropodist. This foot care will be claimed from us by the podotherapist or diabetes-specialised podotherapist at a uniform rate per care class.

We do not reimburse:

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

More information on Simm's classes and care profiles can be found at www.amersfoortse.nl/zorg, under 'Prevention of Diabetic Foot Ulcers Care Module'.

Article 18.26 Patient transport

Ambulance transport

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

- to a care provider or institution where you receive care that is covered wholly or in part by this policy;
- to an institution where your admission will be paid for under the Long-Term Care Act (Wlz);
- from a Wlz institution to a care provider or an institution where you will be undergoing an examination or treatment that is covered wholly or in part by the Long-Term Care Act (Wlz);
- from a Wlz institution to a care provider or institution for the purpose of measuring and fitting a prosthesis, the costs of which are fully or partly covered under the Long-Term Care Act (Wlz);
- (in the case of persons under 18) to an institution or care provider whose care is covered by the Youth Act and the costs of which are paid by the municipality;
- from the above-mentioned care providers and institutions to your home, or to another home if the care cannot reasonably be provided at your own home.

We do not reimburse:

- transport for attending an outpatients' clinic at a Long-Term Care (Wlz) institution.

Seated patient transport (public transport, taxi or private vehicle)

We reimburse transport to and from the care providers and institutions listed above under 'Ambulance transport' by taxi, lowest-class public transport or your own vehicle up to a maximum of 200 kilometres if:

- you require kidney dialysis;
- you must undergo oncological treatments involving chemotherapy, immunotherapy or radiotherapy;
- you are wheelchair-bound and require transport to and from a care provider or institution where you receive care that is covered under this policy;
- you are visually impaired and cannot travel unaccompanied, and require transport to and from a care provider or institution where you receive care that is covered under this policy;
- you are aged under 18 and receive care under your district nursing entitlements (as part of intensive paediatric care), provided the transport is to and from a nursing daycare centre and

is required on medical grounds;
- transport for an attendant, if you require one or are aged under 16. In special cases, you may ask us in advance to permit two attendants.

Seated patient transport requires our approval in advance, which in turn requires a statement from your doctor.
If we issue approval, we may set additional criteria for the mode of transport. We may also permit transport to a care provider or institution covering more than 200 kilometres.

In order to claim transport by taxi, please contact Transvision. Transvision will determine on our behalf whether you are entitled to the reimbursement of the costs of transport by taxi and will arrange the transport by taxi.

More information on Transvision is available at www.amersfoortse.nl/zorg.
Transvision can be contacted on 0900-33 33 33 0 (€0.15 per minute).

Seated transport hardship clause

If you do not fall under the aforementioned 'seated patient transport' criteria, you may be entitled to reimbursement for seated patient transport under the hardship clause. To do so, you must have a long-term illness or condition that makes you dependent on seated patient transport for an extended period of time, and means that refusal to provide this type of transport would be considered extremely unfair to you.

We use the following formula to determine whether we can offer you reimbursement under the hardship clause: (no. of months (max. 12)) x (no. of trips/week) x (no. of weeks/month) x (no. of kilometres of a single journey) x 0.25 (= weighting factor).
If the result is 250 or more, you are entitled to reimbursement for patient transport. You require our approval in advance. To this end, we will also need a statement from your doctor.

Examples of the application of the hardship clause

	A	B	C
No. of months	6	4	12
x No. of times per week	3	5	1
x No. of weeks per month	4	4	4
x No. of kilometres of a single journey	40	15	9
x Weighting factor	0.25	0.25	0.25
= Result	720	300	108

In examples A and B, you are entitled to reimbursement of the travel expenses. This is not the case in example C.

Excess

An excess of €100 per year applies to seated passenger transport.

This does not apply to transport:

- from one institution where you have been admitted, to another institution where you will be admitted to undergo specialised tests or treatment that is/are not available at the first institution, provided the costs of both admissions are covered by this basic insurance or under the Long-Term Care Act (Wlz);
- that is a return trip from an institution where you have been admitted to a person or institution to undergo specialised tests or treatment that is/are not available at the first institution, provided the treatment is covered by this basic insurance and the admission is covered by this insurance or under the Long-Term Care Act (Wlz);
- that is a return trip from an institution where you have been admitted to a person or institution to undergo dental treatment that is not available at the first institution, provided both the treatment and the admission are covered under the Long-Term Care Act (Wlz).

Kilometre allowance for private vehicle use

The allowance for use of your own vehicle is €0.28 per kilometre over the shortest common route. Distance is calculated using the ANWB journey planner.

Other means of transport

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

Article 18.27 Sensory impairment care (ZG-care)

General

We reimburse multidisciplinary care (i.e. care involving various specialists) for:

- hearing impairments (you are deaf or hard of hearing);
- visual impairments (you are blind or vision-impaired);
- communication impairments (you have a serious speech and/or linguistic impediment) resulting from a developmental language disorder and you are not aged over 23;
- at-home care provided to the patient by a care provider based on a travel allowance [*uittoeslag zorgverlener*];
- admission on medical grounds that is related to the sensory impairment care to be provided.

The care provided comprises:

- diagnostic examinations;
- interventions aimed at psychologically learning to deal with a disability;
- interventions to resolve or compensate for the impairment and thus increase your level of self-reliance;
- admission in combination with extramural sensory impairment care.

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

Criteria for medical indication

You must satisfy the following indication criteria:

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

Referral

- Sensory impairment care for auditory and/or communication impairments requires a referral from a clinical physicist in audiology at an audiological centre or from a medical specialist

based on diagnostic data demonstrating that a client satisfies the inclusion criteria for the performance of the sensory impairment care to be insured (see Section 2.5(d) of the Health Insurance Decree).

- For visual impairment care, you require a referral from a medical specialist on the grounds of the evidence-based NOG guideline on Viral diseases, rehabilitation and referral.
- If an audiological clinical physicist, ophthalmologist or medical specialist has already confirmed your sensory impairment in the past and you require related care that was not accompanied by any changes to the sensory impairment condition, you may also be referred by a general practitioner or youth healthcare physician.

Medical responsibility

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

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

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

The Health Insurance Decree can be found at www.wetten.overheid.nl.

Authorisation requirement in the event of admission

If admission is to form part of extramural care in connection with a sensory impairment, you (or your care provider on your behalf) must request an authorisation from us in advance. In order to issue the authorisation, the following information must be submitted to us:

- a referral letter as described above under ‘Referrals’;
- the proposed treatment plan;
- an explanation of the reason for admission according to the Sensory Impairment Treatment Guidelines [*Indicatieprotocol Zintuiglijk Gehandicapten*];
- the expected duration of the patient's stay.

Your application will be treated confidentially, and can be sent to our medical adviser:

De Amersfoortse
Attn.: Sensory impairment (ZG) medical adviser
PO Box 2072
3500 HB UTRECHT

On the envelope please state: ‘Confidential’.

We do not reimburse:

- aspects of care that are related to supporting social functioning;
- complex, long-term and life-encompassing support to deaf-and-blind adults and prelingual deaf adults (those who acquired a hearing impairment prior to the age of three years);
- care for insured parties in connection with a communication impairment arising from a developmental language disorder aged 23 or over.

Article 19 Exclusions

We do not reimburse:

- care that is covered by the Long-Term Care Act (Wlz), Youth Act (Jeugdwet), Social Support Act (Wmo) or other statutory provision(s);
- personal contributions for your account under the Long-Term Care Act (Wlz), Social Support Act (Wmo) or for population studies;
- pre-employment medical examinations and other examinations (for example for a driving or pilot's licence), certificates and vaccinations, unless the Healthcare Insurance Regulations specify otherwise;
- flu vaccinations;
- alternative medicine/treatment;
- treatments against snoring with uvuloplasty;
- treatments aimed at the sterilisation of the insured party (man or woman);
- treatments aimed at reversing the sterilisation of the insured party (man or woman);
- treatments aimed at the circumcision of the insured party, unless medically necessary;
- treatment of plagiocephaly and brachycephaly without craniosynostosis with a redression helmet;
- medicines for travel-related risk of illness;
- a maternity package, surgical cotton wool or sterile hydrophilic gauze for obstetric care;
- costs for failure to attend an appointment with a care provider;
- consultations, treatments, medicines or medical aids given, prescribed or provided by an insured party for him or herself or a member of their family, or vice versa, without obtaining our approval in advance;
- damage caused by or arising from armed conflict, civil war, rebellion, domestic unrest, rioting or mutiny as defined in Section 3.38 of the Financial Supervision Act;
- care resulting from one or more terrorist acts, if the total damage to be claimed in a calendar year as a result of such acts from non-life or life insurers, or insurers of funeral expenses and benefits in kind, to which the Financial Supervision Act applies, is expected by the Dutch Terrorism Risk Reinsurance Company [*Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade N.V.*, NHT] to be higher than the maximum amount that this company has reinsured for a calendar year. In such cases you will only be reimbursed a certain percentage, which will be the same for all insured parties and determined by the NHT. Under Sections 33 and 55 of the Healthcare Insurance Act [*Zorgverzekeringswet*, Zwv], the government may

decide to issue an additional contribution to health insurers and their insured parties in the event of a disaster, such as terrorist acts.

Terrorism clause

Under this insurance any damage or losses due to terrorist acts are covered by the Dutch Terrorism Risk Reinsurance Company (NHT).
The text of the terrorism cover clause is available from us upon request.

Contact information

General

www.amersfoortse.nl/zorg
Telephone number: +31 (0)33 464 20 61

Visiting address:
Archimedeslaan 10
3584 BA Utrecht

Mailing address:
Postbus 2072
3500 HB Utrecht

Acceptance Department:
Email: zorg.polis@amersfoortse.nl

Claims Handling Department:
Email: zorg.declaratie@amersfoortse.nl

Medical Care Department:
Email: zorg.medisch@amersfoortse.nl

Care for Care Department
Email: zorgadvies@amersfoortse.nl