DE AMERSFOORTSE
De Ondernemersverzekeraar

Health insurance Flexibel 2016 Policy Conditions

Contents

1. Definitions

Pharmacy

Pharmacy includes regular pharmacies, Internet pharmacies, chains of pharmacies, hospital 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 physician who is listed as a company doctor in the register established by the Commission for the Registration of Medical Specialists [*Registratiecommissie Geneeskundig Specialisten*, RGS] maintained by the Royal Dutch Medical Association (KNMG) and who acts on behalf of an employer or the Occupational Health and Safety Service [*Arbodienst*] to which the employer is affiliated.

Pelvic therapist

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

Register for Quality Physical Therapy [*Centraal Kwaiteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy or a similar register.

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 or on behalf of De Amersfoortse 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 DBC Table of Professions is linked to a nationally recognised classification of professions known as the professions framework set out by the Coordinating Body for Further Training in Mental Healthcare (CONO). The CONO professions framework includes all professions whose practitioners are qualified to perform a role in the (individual, diagnosis-oriented) treatment of patients in the mental healthcare sector.
The CONO professions framework distinguishes six clusters of professions: medical, psychotherapeutic, adult educational, psychological, specialised therapeutical and nursing professions. Practitioners in the professions cluster of 'somatic professions in metal 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 specialist 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 DCB pathway commences at the time at which the insured party submits 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 specialist mental healthcare).

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.

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.

DSM IV disorder

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

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 dispensing practitioners in the interests of medication assessment and responsible use, designated as such under or pursuant to the *Besluit Zorgverzekeringen* [Health Insurance Decree], with due observance of the Pharmaceutical Care Regulations stipulated by De Amersfoortse.

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. 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*], the health insurer is obliged to provide, or reimburse the costs of, by virtue of an agreement entered into between the health insurer and the care provider.

Invoiced rate

The amount charged by the care provider as stated on the relevant invoice.

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

The (supplementary) diagnostics and general treatment for minor to moderately severe, non-complex mental disorders.

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 a similar register.

Specialised Mental Healthcare [*gespecialiseerde* GGZ]

Diagnostics and specialist treatment for complex mental disorders requiring the involvement a specialist (psychiatrist, clinical psychologist or psychotherapist).

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.

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 2016 'Flexibel' health insurance policy [*Reglement Hulpmiddelen Flexibel*] laid down by the health insurer regarding the requirements for consent, period of use and quantity.

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 listed 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 Section 3 of the Individual Healthcare Professions Act and who is also registered s a paediatric

physiotherapist in the Central Register for Quality Physical Therapy [*Centraal Kwaiteitsregister Fysiotherapie*, CKR] maintained by the Royal Dutch Society for Physical Therapy or a similar register.

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 the health insurer. This is understood to include a maternity centre.

Maternity hotel

A place of accommodation 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 the health insurer.

Maternity care

The care provided by a maternity care provider affiliated to 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

An 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 (CKR) maintained by the Royal Dutch Society for Physical Therapy (KNGF).

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].

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 in the Central Register for Quality Physical Therapy (CKR) maintained by the Royal Dutch Society for Physical Therapy (KNGF) or a similar register.

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.

Admission

Admission to a hospital or rehabilitation centre for longer than 24 hours, 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.

Orthodonist

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.

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.

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

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,
fax +31 (0)20 651 51 09.

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.

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
For maternity care mediation. Telephone number: +31 (0)70 343 04 68.

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.

Treaty country
Each country with which the Netherlands has signed a convention on social security incorporating regulations for the provision of medical care, other than Member States of the European Union, a state which is party to the Agreement on the European Economic Area, or Switzerland. These countries are: Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Serbia and Monte Negro, Tunisia, Turkey and Australia (only during a temporary stay).

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
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).

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.

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 institution. A referral letter must contain the insured party's name and date of birth, the name and signature of his or her doctor, the date of issue, the reason for the referral and any other relevant information. 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 the health insurer.

Individual Healthcare Professions Act [*Wet BIG*]

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

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 the impairment to enable the insured party 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

Paragraph 1. This insurance contract is based on the Healthcare Insurance Act, the Healthcare Insurance Decree with the accompanying Healthcare Insurance Regulations, including the explanatory notes thereto, and the application form completed by the policyholder.
The sample contract, as referred to in Section 1(h) of the Healthcare Insurance Act, is set out in the health insurance policy certificate as referred to in Section 1(i) of the Healthcare Insurance Act. The health insurance policy (which has been laid down in the policy schedule) will be issued to the policyholder on an annual basis. In the event that the policyholder is someone other than the insured party, the policy schedule will be issued to the insured party.

Paragraph 2. In addition to the health insurance policy, the health insurer will also issue a Health Insurance Card [*Zorgpas*] which the insured party can furnish as proof of his or her entitlement to healthcare pursuant to this policy when requesting healthcare services from the healthcare provider(s) contracted by the health insurers.

Paragraph 3. The insured party can submit a claim to the health insurer to cover the costs of healthcare pursuant to this insurance policy, with the exception of the insured party's own contributions, unless an agreement has been concluded between the healthcare provider and the insurer in accordance with which the claim is submitted directly to the health insurer by the healthcare provider.

Insofar as specifically cited, the costs of healthcare pursuant to this insurance policy, with the exception of the insured party's own contributions, will be claimed directly from the health insurer by the healthcare provider in accordance with an agreement concluded between the parties. The agreement in any case includes agreements on the level of the price, quality and suitability of the care to be provided, the method of claiming and the conditions subject to which the care will be provided.

A list of contracted care providers is available on www.amersfoortse.nl/zorg.

Paragraph 4. The nature and extent of any entitlement to healthcare or reimbursement of healthcare costs, as described in this health insurance policy, will be determined by the state of the art in science and practice, or in the absence of such criteria, by what is deemed to constitute prudent and appropriate care and services in the relevant field of expertise.

Paragraph 5. The insured party will only be entitled to reimbursement of the costs of care insofar as this is deemed to be reasonable in terms of its nature and extent.

Article 3 Reimbursement of care

Paragraph 1. General

This care policy shall include entitlement to reimbursement of the costs of care. You are entirely free to select the care provider of your choice. You can make use of:

a. care provided by a care provider contracted by us.

b. care provided by a care provider that has not entered into a contract with us (non-contracted care) (see paragraph 3).

This health insurance policy may be taken out by or on behalf of any person who is subject to compulsory health insurance in the Netherlands, as well as any such persons residing abroad.

Paragraph 2. Reimbursement of contracted care

If you opt for contracted care, the costs will be reimbursed in accordance with the rates we have agreed. In that case, the payment is made directly to the care provider. You will be billed for the care you received. The statutory personal contribution (if applicable) will normally be charged to you separately by the care provider. It is also possible however that we will collect it from you. A list of contracted care providers can be viewed on www.amersfoortse.nl/zorg, see 'zoek een zorgverlener'.

Paragraph 3. Reimbursement of non-contracted care

Statutory maximum rate

If you decide to go to a care provider in the Netherlands with whom we have not agreed any rates and a statutory maximum rate applies, we will reimburse 100% of the costs of your treatment up to the statutory maximum rate, with the exception of the costs of mental healthcare (both specialised and basic), nursing and care, speech therapy, independent rehabilitation centres and maternity care. For these latter types of care, we will reimburse 100% of the costs up to the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section ‘marktconforme vergoedingen’).

Free rates

If you decide to go to a care provider with whom we have not agreed any rates and no statutory maximum rate applies, we will reimburse 100% of the costs of your treatment up to the prevailing market rates as determined by us. This could mean that your bill will not be fully reimbursed. All our

reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section 'marktconforme vergoedingen').

Paragraph 4. Additional conditions governing non-contracted care

We will only accept original bills which feature the name, address details and date of birth of the insured party, the name and AGB code of the treatment provider, the treatment dates, the nature of the treatment and the amount charged per treatment session. These bills must be itemised in such a way that the amount payable by us can be clearly identified without further inquiry. If you received the bill from the care provider, it is your own responsibility to ensure that the care provider is paid in time.

Paragraph 5. Urgent care

In the event you need urgent 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 urgent care as soon as possible. No referral is required for this type of care.

Paragraph 6. In some cases healthcare institutions may reach their turnover ceiling during the course of the year as a result of budget agreements. In such cases crucial care for insured parties is guaranteed (in other words ambulance care, emergency assistance, acute maternity services and emergency mental healthcare) as well as care for insured parties who are already undergoing treatment at a healthcare institution. If the healthcare institution can only treat new insured parties later than required, we request the insured party to contact the Care for Care Department for advice or mediation at this or another healthcare institution.

Paragraph 7. The insured party may also make a claim to mediation for reasons other than those referred to in paragraph 6. Further information on care mediation can be found in Article 20 of these policy conditions: Care for Care services.

Paragraph 8. If and insofar as the health insurer pays more than it is required to pay under the terms of this contract, the insured party/policyholder will be deemed to have authorised the health insurer to collect, in the name of the health insurer, the excess amount paid to the healthcare provider on behalf of/by the insured party.

Paragraph 9. Other reimbursement rules apply to costs incurred abroad. For more information, see Article 18.2 Abroad.

Article 4 Premium

Paragraph 1. Under the terms of the health insurance, a premium is payable by the policyholder.

Paragraph 2. No premium is payable by the insured party until the first day of the calendar month following the calendar month in which he or she reaches the age of 18 years.

Paragraph 3. The premium payable is equal to the premium base less a discount for any voluntarily chosen excess (see premium schedule). The discount applicable to the excess chosen will be deducted directly from the premium base.

Article 5 Compulsory excess

Paragraph 1. A compulsory excess of €385 applies to all insured parties aged 18 or above for the costs of care or other services that will remain for the account of the insured party.
The following costs do not apply to the compulsory excess:

- the costs of care as generally provided by general practitioners, with the exception of the costs of an examination in connection with this type of care that is carried out elsewhere and is charged separately, on condition that the person or institution concerned is entitled to charge the rate determined for this purpose by the Dutch Healthcare Authority.
- the costs of nursing and care referred to in Article 18.20;
- the costs of foot care for diabetes patients as referred to in Article 18.21;
- the costs of obstetric care and maternity care;
- the costs of follow-up checks for living kidney or liver donors after a kidney or liver transplant, insofar these checks are covered by the donor's health insurance policy and take place after a period of 13 weeks, or six months, respectively;
- the costs of multidisciplinary care to treat diabetes or COPD or for vascular risk management. Multidisciplinary care is defined as: 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;
- medication assessment exclusively for prescribed medicines.

In those cases in which, in accordance with one of the following articles, an amount remains that is payable by the insured party, this amount will not be included in the calculation of the compulsory excess.

Paragraph 2. In the event that the insurance policy is entered into, or terminated, in the course of a calendar year, the obligatory excess in that calendar year will be equal to the amount for the full year, multiplied by a fraction of which the numerator is equal to the number of days in the calendar year for which the health insurance was in force or will be in force and the denominator is equal to the total number of days in that calendar year.

Paragraph 3. The situation upon the date of commencement of the insurance or the situation as at 1 January of a given year will be decisive in determining the amount of the compulsory excess.
If the insured party turns 18 in the course of the calendar year, the obligatory excess will be calculated by multiplying the amount in the calendar year in question by a fraction with respect to which the numerator will be equal to the number of days in the calendar year over which premium is owed and the denominator will be the number of days in that calendar year.

Paragraph 4. In order to determine the compulsory excess, the DBC care product will be apportioned to the year in which it was commenced.

Example:
If you went to see a medical specialist in 2015 for the first time, were diagnosed and the specialist opened a DBC care product. And if the treatment or operation was performed in 2016 or continued in 2016. In that case, the reimbursement conditions and the compulsory excess of 2015 will apply.

Paragraph 5. In the event that the health insurer pays the costs of the care provided directly to the healthcare provider, the outstanding obligatory excess will, if necessary, be offset or reclaimed.

Paragraph 6. The costs of care that are refunded by the health insurance policy will first be deducted from the obligatory excess and thereafter incorporated in any calculation of the voluntarily chosen excess.

Article 6 Voluntarily chosen excess

Paragraph 1. The voluntarily chosen excess will be € 0, unless a higher excess has been agreed.

Paragraph 2. An insured party aged 18 years or above may agree to pay a voluntarily chosen excess of €100, €200, €300, €400 or €500 per calendar year.

Paragraph 3. In the event that an excess has been agreed, the premium discount stated on the premium schedule will apply.

Paragraph 4. The following costs do not apply to the obligatory excess:

- the costs of care as generally provided by general practitioners, with the exception of the costs of an examination in connection with this type of care that is carried out elsewhere and is charged separately, on condition that the person or institution concerned is entitled to charge the rate determined for this purpose by the Dutch Healthcare Authority;
- the costs of nursing and care referred to in Article 18.20;
- the costs of foot care for diabetes patients as referred to in Article 18.21;
- the costs of obstetric care and maternity care;
- the costs of follow-up checks for living kidney or liver donors after a kidney or liver transplant, insofar these checks are covered by the donor's health insurance policy and take place after a period of 13 weeks, or six months, respectively;
- the costs of multidisciplinary care to treat diabetes or COPD or for vascular risk management. Multidisciplinary care is defined as: 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;
- medication assessment exclusively for prescribed medicines.

In those cases in which, in accordance with one of the following Articles, an amount remains that is payable by the insured party, this amount will not be included for the calculation of the voluntarily chosen excess.

Paragraph 5. Costs of care that are refunded by the health insurance policy will first be deducted from the obligatory excess referred to in Article 5 and thereafter incorporated in any calculation of the voluntarily chosen excess.

Paragraph 6. In the event that the insurance policy is entered into, or terminated, in the course of a calendar year, thevoluntarily chosen excess in that calendar year will be equal to the amount for the full year, multiplied by a fraction of which the numerator is equal to the number of days in the calendar year for which the health insurance was in force or will be in force and the denominator is equal to the total number of days in that calendar year.

Paragraph 7. In the event that during the calendar year the voluntarily chosen excess amount applicable in that year changes and the policyholder or the insured party had already taken out a health insurance policy immediately prior to this change, the voluntarily chosen excess is calculated as follows:
a. each voluntarily chosen excess amount that was applicable or will be applicable in the calendar year concerned is multiplied by the number of days in that year for which that voluntarily chosen excess applied or will apply;
b. the amounts calculated on the basis of point a are added together, then divided by the number of days in the calendar year;
c. the result of this calculation is rounded off to the nearest euro.

Paragraph 8. In order to determine the voluntarily chosen excess, the DBC care product will be apportioned to the year in which it commenced.

Example:
If you went to see a medical specialist in 2015 for the first time, were diagnosed and the specialist opened a DBC care product. And if the treatment or operation was performed in 2016 or continued in 2016. In that case, the reimbursement conditions and the voluntary excess of 2015 will apply.

Paragraph 9. In the event that the health insurer pays the costs of the care provided directly to the healthcare provider, the outstanding voluntarily chosen excess will if necessary, be offset or reclaimed.

Article 7 General

Paragraph 1. Reimbursement of the costs of care other than described in the policy

In certain cases, the insured party can claim reimbursement of the costs of types of care other than those specified in this policy, if it has been established that it is generally agreed that the treatment concerned leads to a comparable result, and the health insurer has given its consent prior to the treatment and insofar as these types of care are not excluded by or pursuant to the law.

Paragraph 2. Admission to a hospital in a class other than the insured class

In the event of admission to a hospital in a class other than the insured class, the reimbursement will

be based on the charge applicable to the lowest class.

Paragraph 3. Commencement and termination of reimbursement

In the event that the insured party is entitled to the payment of costs incurred based upon the preceding provisions of this health insurance policy, the entitlement will only apply insofar as the care was received during the period in which this insurance is in force. For reimbursement of the costs of care that involves a DBC care product, the DBC care product will be apportioned to the year in which the DBC commenced.

Example:
If you went to see a medical specialist in 2015 for the first time, were diagnosed and the specialist opened a DBC care product. And if the treatment or operation was performed in 2016 or continued in 2016. In that case, the reimbursement conditions of 2015 will apply.

Paragraph 4. Registration of personal details

When applying for an insurance or a financial service, the health insurer will ask the applicant for personal details and other information. The insurer will use the information to enter into and perform the insurance contract or financial service, to manage the relationships arising as a result, for activities aimed at enlarging its customer database, for statistical analyses, to comply with statutory obligations and in connection with the security and integrity of the financial sector. For further information, see the privacy statement on www.amersfoortse.nl/zorg.

The Code of Conduct governing the Processing of Personal Details by the Insurance Industry [*Gedragscode Verwerking Persoonsgegevens Zorgverzekeraars*] applies to the processing of personal details. In connection with maintaining a responsible acceptance, risk and fraud policy we may consult these details at the Stichting CIS [Central Information System], Bordewijklaan 2, 2591 XR The Hague, c/o P.O. Box 91627, 2509 EE The Hague.

If the insurer has noted reprehensible or unlawful behaviour the insurer is entitled to record personal data in the External Reference Register in accordance with the regulations of the Incidents Warning System for Financial Institutions Protocol [*Protocol Incidentenwaarschuwingssysteem Financiële Instellingen*]. This register is used by financial institutions to assess the integrity of customers and business relations and can be accessed by the insurer via the central databank of Stichting CIS.

The goal behind processing personal data at Stichting CIS is to enable insurers to manage risks and combat fraud. For further information, visit www.stichtingcis.nl, where you can also find the applicable privacy regulations.

Paragraph 5. Personal Public Service Number

The health insurer is legally obliged to include the insured party's citizens service number [*burgerservicenummer*, BSN] in its records. The healthcare provider, the care assessment agency or the healthcare insurer are legally obliged to use this BSN when providing personal details. This only applies to the following:

- care needs assessments;

- care provision;
- care insurance.

Paragraph 6. Permission from the insurer

A number of claims are subject to an authorisation policy. In that case, prior to treatment we must have received an application and approved it by means of an authorisation. This applies in the event of specialised mental healthcare involving a stay of more than 365 days, non-contracted specialised mental healthcare (Article 18.7), non-contracted aids (Article 18.9) and non-contracted independent treatment centres for rehabilitation (Article 18.16).
For more information about the background to this policy, go to our website www.amersfoortse.nl/zorg.

Paragraph 7. Authorisation

An authorisation issued by the health insurer will only be applicable for the term of the insurance and will be issued subject to changes in legislation and regulations. If the authorisation states a period that exceeds the term of the insurance, the new health insurer will take over the authorisation.

Paragraph 8. Notification

Notices for the attention of the policyholder sent to his or her last known address, or to the address of the person through whose mediation the insurance has been taken out, are deemed to have reached the policyholder.

Article 8 Obligations of the policyholder/insured party

Paragraph 1. The policyholder/insured party is obliged to:
a. identify himself or herself by means of a valid form of identification, i.e. a driving licence, a passport or Dutch identity card, when seeking care at a hospital or an outpatients' department;
b. ask the doctor or medical specialist who is treating him or her to notify the medical adviser of the reason for his or her admission, if requested by the medical adviser;
c. assist the health insurer, its medical adviser or those responsible for monitoring the case, with obtaining all information that may be required, with due observance of privacy legislation and regulations;
d. to inform the health insurer within 30 days that the insured party has been detained. The insurer must also be notified of termination of the period of detention within 30 days. The foregoing relates to the statutory provision concerning the suspension of cover and obligation to pay premiums during the period of detention.

Paragraph 2. The insured party must submit the original invoices to the insurer within three years of the date of treatment. These invoices must be itemised in such a way that the amount payable by the health insurer can be clearly identified without further inquiry. 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 is considered an invoice.

Paragraph 3. In the event that the interests of the health insurer are prejudiced by a failure to comply with the aforementioned obligations, the insured party will not be entitled to reimbursement of the costs of healthcare and the insurer will be permitted to reclaim these costs.

Article 9 Recourse

The policyholder or insured party is obliged to:
a. provide the health insurer with information and lend his or her cooperation with regard to seeking recourse against a liable third party;
b. contact the health insurer 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 may the insured party reach any settlement with this third party or the party acting for or on behalf of this third party, including the granting of discharge, which would prejudice the rights of the health insurer, without the written consent of the health insurer.

In the event that the insured party fails to comply, or fails to fully comply with these provisions, he or she is obliged to compensate the health insurer for the damage suffered by the insurer as a result thereof.

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

Article 10 Fraud

If you commit fraud, your right to care or the costs of care will lapse. We will claim back any reimbursements paid. You are also obliged to pay the costs arising from the fraud investigation.

Should you commit fraud, we will register your personal data as well as those of your accessory or co-perpetrator in our Incident Register. which is managed by our Security Affairs Department. The incidents recorded in the Incident Register are reported to the Dutch Data Protection Authority [*College bescherming persoonsgegevens*].

Your personal data and those of your accessory or co-perpetrator may also be registered with:
- the Insurance Fraud Bureau [*Centrum Bestrijding Verzekeringsfraude*] of the Dutch Association of Insurers;
- the external referral register held by Stichting CIS.

We also report fraud to the police, the Ministry of Justice and Security, the Dutch Healthcare Authority (NZa) and/or the Social Affairs and Employment Inspectorate.

As a consequence of fraud relating to an insurance taken out with our company, we will terminate your health insurance(s) and may refuse to conclude a new health insurance for a period of five years. Your supplementary insurance(s) may similarly be terminated. In that case you may not conclude any supplementary insurances with any of the a.s.r. insurance companies for a period of eight years.

Article 11 Unlawful registration

Paragraph 1. In the event that an insurance contract is concluded for the benefit of the insured party in accordance with the Healthcare Insurance Act or an application via the Regulations for the Non-Insured of the National Health Care Institute and it later emerges that he or she was not under an obligation to obtain health insurance, the insurance contract will lapse with retrospective effect until such time as there was no obligation to obtain health insurance or this obligation ceased to exist.

Paragraph 2. If the insured party is insured on grounds of the National Health Care Institute Regulations for the Non-Insured, this person will be granted a term of two weeks, as from the date of notification by the National Health Care Institute, in which to rescind this policy, if the insured party is able to demonstrate to the National Health Care Institute and the insurer that he or she has been insured with another healthcare insurer during the period set out for this purpose in the National Health Care Institute Regulations.

Paragraph 3. The health insurer will offset any premiums charged from the date upon which the duty to obtain health insurance did not or ceased to exist for the insured party against any care received since then that is payable by the health insurer, and will refund or charge the balance to the insured party.

Article 12 Payment of premium and payment arrears

Paragraph 1. Payment of premium

a. The policyholder is obliged to pay the premium as well as the contributions arising from (foreign) statutory regulations or provisions in the agreed manner, i.e. monthly, quarterly, half-yearly or annually, in advance. 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.

In the event the insurance policy is changed during the course of a month, the health insurer is entitled to (re)calculate or refund the premium. The insured party is not permitted to offset the premium due against a payment to be claimed from the health insurer. If the insured party has chosen to pay the premium once a year, once every six months or once a quarter and payment was not received within 30 days, we retain the right to convert the payment term of the premium into a monthly payment term. Any right to a discount based on payment frequency will then lapse.

b. In the event of the death of the insured party, the premiums will be settled and/or refunded upon request with effect from the day following the date of death.

Paragraph 2. Payment arrears

If the policyholder fails to meet his obligation to ensure timely payment of the premium, statutory contributions and costs, we will be entitled to issue the policyholder a written warning after the premium due date urging him to effect payment within 14 days, counting from the day of the warning.

Paragraph 3. Consequences of payment arrears of two months or more

a. We will notify you as soon as your payment arrears have exceeded two monthly premiums and will offer a premium payment schedule. Once your payment arrears amount to four monthly premiums, we will inform you that we will report your case to the National Health Care Institute (Zorginstituut Nederland) in connection with the levying of a premium under administrative law. Once your payment arrears amount to six monthly premiums or more, we will report the matter to the National Health Care Institute and to you, the policyholder. From then on, the National Health Care Institute will collect the premium under administrative law from you, the policyholder. 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 will be submitted to the competent court.
b. 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.
c. The company will be authorised to set off the outstanding amount against any reimbursements due to be paid to the insured party.

Paragraph 4. Suspension of cover during detention

The insurance will be suspended by operation of law for any period during which the insured party is detained. The rights and obligations of the insured party will be reinstated as soon as the period of detention ends.

Article 13 Claims and suspension of cover

Paragraph 1. Claims paid directly

The health insurer has the right to pay the claims of healthcare providers, which have been submitted by the healthcare provider to the health insurer, directly to the healthcare provider. The policyholder is entitled to an itemised statement of the amounts paid by means of remittance advice.

Paragraph 2. Amounts due

The claim referred to in paragraph 1 will be paid in full by the health insurer to the healthcare provider, even if the claim is not eligible for full reimbursement, for example due to an outstanding excess amount or a limited payment scheme. The policyholder must pay the health insurer the policy excess or payment(s), insofar as these amounts exceed the limited payment scheme.

Paragraph 3. General claim

The amounts referred to in paragraph 2 will be payable as soon as the policyholder receives a communication in this regard. The policyholder must pay the health insurer the amounts owed within the term specified. The policyholder is not permitted to offset the amounts due against a payment to be claimed from the health insurer.

Paragraph 4. Suspension of cover

In the event that the policyholder fails to pay the amount due within the term specified, a written notice to pay will be issued. In the event that the policyholder fails or refuses to pay the amount due within the term stipulated in the written notice, the medical treatment and/or provisions that have taken place after the term stipulated in the written notice will not be covered by the insurance. It remains the duty of the policyholder to pay the premium, in addition to any costs and interest associated with recovery and collection. Cover will be reinstated with effect from the day following the date upon which the amount due is received and accepted by the health insurer.

Article 14 Notification of relevant events

Paragraph 1. Notification

The policyholder is obliged to notify the insurer within 30 days of all events that may be of significance for the proper implementation of this insurance, such as relocation, divorce, birth, death, etc.

Paragraph 2. When the insured party turns 18

The health insurer will approach the insured party or his or her policyholder at least six weeks before the first day of the month following the calendar month in which the insured party reaches the age of 18 years with the request to indicate which voluntarily chosen excess he or she wishes to opt for in relation to the premium that will be due as from that moment. In the event that the policyholder or the insured party fails to inform the health insurer of this choice in writing within the term stated in the request, a premium will be charged that is equivalent to a policy without a voluntarily chosen excess.

Paragraph 3. Attainment of the age of 27 by a child co-insured under a parent’s employer's group insurance policy

A child that is co-insured under a parent’s employer's group insurance policy is required to take out insurance independently from the first day of the month following the month in which the child reaches the age of 27. This does not apply to group insurance taken out via an association or a middleman group insurance policy. The insurer will inform the policyholder six weeks before that date.

Article 15 Revision of premium or conditions

The health insurer is entitled to revise the policy conditions and the premiums of its health insurance

policies collectively or according to groups. Such a revision will be effected for each insurance policy on a date to be determined by the health insurer. The health insurer will give notice of the intended revision, possibly on the premium receipt. 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.

Article 16 Commencement and termination of the insurance

16.1 Commencement of the health insurance

Paragraph 1. The health insurance will commence on the date that is stated as the date of commencement on the policy schedule. The date of commencement is the date upon which the health insurer received an application from the policyholder to enter into the insurance contract.

Paragraph 2. In the event that the person for the benefit of whom the health insurance has been taken out already has health insurance on the date upon which the health insurer receives the application referred to in paragraph 1, and the policyholder indicates that he or she wishes to have the insurance commence on a date specified by him or her, which is later than the date referred to in paragraphs 1 or 2, then the insurance will commence on this later date.

Paragraph 3. In the event that this health insurance commences within four months after an obligation to obtain health insurance comes into effect, it will apply, if necessary contrary the provisions of Section 925, Book 7 of the Netherlands Civil Code, retrospectively from the date upon which this obligation arose.

Paragraph 4. In the event that the health insurance commences within one month after a previous health insurance policy was terminated, with effect from 1 January of a calendar year or due to changes in the conditions (or premium), by giving notice, it will apply with retrospective effect from the day after the date upon which the previous health insurance policy terminated.

16.2 Term of the health insurance

Paragraph 1. The policyholder may cancel the health insurance before 31 December of each year with effect from 1 January of the subsequent calendar year. In the event that the policyholder does not cancel the insurance, the insurance will be extended automatically for a term of one calendar year.
The insurance policy may be terminated in the following manner:

- the policyholder terminates the policy in writing no later than 31 December;
- the policyholder makes use of the transfer system. If the policyholder takes out a new insurance policy for the following year no later than 31 December, the new insurer will cancel the old policy automatically.

Paragraph 2. The policyholder who has insured someone other than himself may cancel the insurance in the event that the insured party is covered under another health insurance policy.

Paragraph 3. The policyholder may cancel the health insurance in the event of a change in the premium base to the detriment of the policyholder. The policyholder may cancel the health

insurance with effect from the date upon which the change takes effect, within 30 days after he or she has been notified of the change.

Paragraph 4. In the event of a change in the insured party's entitlements to the detriment of the policyholder or the insured party, the policyholder may cancel the health insurance, unless this change arises directly from a change in any legal provision. The policyholder may cancel the health insurance with effect from the date upon which the change takes effect, within 30 days after he or she has been notified of the change.

Paragraph 5. The policyholder will be entitled to cancel the insurance before the end of the term, with effect from the date of termination of his or her previous employment in connection with entering into a new contract of employment, in the event that the reason for cancellation concerns a changeover from the one employment-related group insurance policy to the other employment-related group insurance policy. The policyholder may cancel the old health insurance up to 30 days after entering into the new contract of employment. Neither the cancellation nor the registration will apply retroactively, and both will take effect on the first day of the same calendar month.

Paragraph 6. All rights to discounts and other entitlements under the group policy will cease to apply on termination of the policy.

Paragraph 7. The cancellation referred to in paragraph 2 will take effect on the first day of the second calendar month following the day on which the policyholder cancelled the insurance.

Paragraph 8. Contrary to paragraph 7, a cancellation in accordance with paragraph 2 will take effect on the date upon which the insured party is covered under the other health insurance policy, in the event that this cancellation is received by the health insurer prior to the aforementioned date.

Paragraph 9. The cancellation options referred to in Article 16.2 will not apply during the period in which the policyholder has not paid the premium and any collection costs owed within the set term, as stated in Article 12. The above does not apply if the healthcare insurer confirms the cancellation to the policyholder within two weeks.

Paragraph 10. The cancellation options referred to in Article 16.2 will not apply during the first 12 months of the insurance cover for insured parties who are insured via the National Health Care Institute Regulations for the Non-Insured.

16.3 Termination by operation of law

Paragraph 1. The health insurance will terminate by operation of law on the day following the date upon which:

a. the insurer is no longer able to offer or provide health insurance as a result of an amendment to or revocation of its licence to conduct non-life insurance operations;

b. the insured party comes to reside outside of the area of operation of the insurer as a result of a change in the area of operation;

c. the insured party dies. The health insurer must be notified of the death of the insured party within

30 days of the date of death;
d. the obligation to be insured terminates due to the fact that the insured party is no longer insured in accordance with the Long-Term Care Act (Wlz) or is actively serving as a member of the armed forces.

Paragraph 2. The health insurance will terminate by operation of law on the first day of the second month following the day upon which the insured party, as a result of a relocation, comes to reside outside of a province in which his or her health insurer offers or implements the health insurance taken out on behalf of the insured party, without his or her obligation to have health insurance terminating.

Paragraph 3. The health insurer will give the policyholder a maximum of two months' notice before the termination of a health insurance policy pursuant to paragraph 1, under a or b, citing the reason for this termination and the date upon which the insurance will terminate.

Paragraph 4. The policyholder shall inform the health insurer immediately of all the facts and circumstances relating to the insured party that have resulted or may result in the termination of the health insurance pursuant to paragraph 1, under c or d, or paragraph 2.

Paragraph 5. In the event that the health insurer concludes, based on the fact referred to in paragraph 4, that the health insurance will terminate or has terminated, it will notify the policyholder of this immediately, citing the reason for this and the date upon which the insurance terminated or will terminate.

Paragraph 6. Cancellation or termination of the health insurance on account of non-payment of the premium due will not apply retrospectively.

Paragraph 7. It is expressly determined that the health insurer does not have the right to terminate the insurance, except in the event of fraud as defined in Article 10.

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 De Amersfoortse, 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 (033) 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 your have a complaint, please contact your insurance adviser first, who will seek the most suitable solution for your problem, in consultation with De Amersfoortse 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 HB Utrecht. Alternatively, you may call us on (033) 464 20 61.

If you are dissatisfied with the way your complaint was handled, you may consider submitting your complaint 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, who will issue a binding opinion on this matter.

Article 18 Medical care

Article 18.1 Audiological care

The insured party will be entitled to payment of the costs of care provided by a centre for audiological care that has been accredited as such in accordance with regulations laid down by or pursuant to the law, comprising:

- hearing tests;
- advice on the purchase of hearing aids;
- advice on the use of the hearing aid;
- any psychosocial care necessary in relation to problems arising from the hearing impairment;
- diagnostic assistance in the case of speech and language impediments for children.

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

Article 18.2 Abroad

Paragraph 1. Notification of emergency admission to hospital

Emergency care is taken to mean unforeseen care which cannot reasonably be postponed until the insured party returns to the Netherlands. In the case of emergency care, the insured party is obliged to ensure that SOS International is contacted immediately. In such case, the SOS International

physician will act on behalf of the health insurer's medical adviser.

Paragraph 2. Advice and mediation in the event of non-emergency care

If the insured party wishes to receive treatment abroad, he or she must take into consideration that the relevant treatment will not always be paid in accordance with the health insurance or that treatment will be more expensive than in the Netherlands, which means that the insured party will be required to pay the costs in full or in part. We would therefore advise you to contact the Care for Care Department beforehand via +31 (0) 33 464 20 61 or zorgadvies@amersfoortse.nl to learn in advance whether the costs will be reimbursed and, if so, the maximum amount of the reimbursement. De Amersfoortse has made agreements with a number of hospitals in Germany, Belgium and Spain. For details, please visit www.amersfoortse.nl/zorg.

Paragraph 3. General

An insured party who lives in the Netherlands and enjoys care provided in a country outside of the Netherlands is entitled to the same level of reimbursement under the same terms and conditions as the care the insured party would have received had he or she used a non-contracted care provider in the Netherlands.

Paragraph 4. An insured party who lives or resides in an EU/EEA country or treaty country other than the Netherlands can choose between the following options:

- entitlement to payment of the costs of 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
- the right to the same level of reimbursement under the same terms and conditions as the care the insured party would have received had he or she used a non-contracted care provider in the Netherlands.

Paragraph 5. An insured person who lives or resides in a country that is not an EU country or treaty country shall be entitled to payment of the costs of care in accordance with the health insurance:
has the right to the same level of reimbursement under the same terms and conditions as the care the insured party would have received had he or she used a non-contracted care provider in the Netherlands.

Paragraph 6. An insured party who lives in another EU/EEA country or treaty country and who is temporarily residing in the Netherlands or in another EU/ EEA country or treaty country can choose between the following options:

- entitlement to payment of the costs of 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
- the right to the same level of reimbursement under the same terms and conditions as the care the insured party would have received had he or she used a non-contracted care provider in the Netherlands.

Paragraph 7. Payment

Payment will be made in the Netherlands in Dutch legal tender taking into account the rate of exchange applicable on the date that the reimbursement is established by the health insurer.

Article 18.3 Dialysis

The insured party will be entitled to payment of the costs of non-clinical haemodialysis and peritoneal dialysis, as well as the related specialist medical care provided at a dialysis centre or at the home of the insured party, whether or not in combination with tests, treatment, nursing, medication required for the treatment and psychosocial counselling for the insured party as well as for persons who assist with the performance of the dialysis treatment somewhere other than a dialysis centre.

The entitlement to payment of costs for non-clinical haemodialysis and peritoneal dialysis at the home of the insured also includes:

- the costs in relation to the instruction provided by the dialysis centre for those who perform the dialysis treatment or who assist with this;
- the costs of lending out dialysis equipment and appurtenances, the costs of the regular monitoring and maintenance thereof (including replacement), and the costs of the chemicals and fluids required for the performance of the dialysis;
- the costs of making any adjustments in and to the home and of restoring it to its original condition, insofar as the health insurer deems these costs to be reasonable and no other statutory regulations provide for this;
- other costs that are directly related to home dialysis insofar as the health insurer deems these costs to be reasonable and no other statutory regulations provide for this;
- the costs of the required expert assistance provided by the dialysis centre for the dialysis;
- the other consumer items reasonably required in order to carry out the dialysis.

The insured party will only be entitled to reimbursement of the costs of this care if the consent of the health insurer has been provided in writing in advance.

Article 18.4 Genetic testing and counselling

The insured party will be entitled to payment of the costs incurred by a centre for genetic testing for central diagnostics and the coordination and registration of the blood and bone marrow samples submitted. The care comprises conducting research into hereditary diseases by means of genealogical research, chromosome research, biochemical diagnostics and ultrasound and DNA testing, providing genetic counselling and the psychosocial support in relation to this care. If necessary for the counselling of the insured party, the research may also include the testing of persons other than the insured. In this case, these persons may also receive counselling. A referral by a medical specialist is required for the care described above.

Article 18.5 Pharmaceutical care

Paragraph 1. Pharmaceutical care comprises the medicines provided by dispensing practitioners (pharmacists and dispensing general practitioners) or the advice and assistance as generally provided by pharmacists and dispensing general practitioners regarding medication assessment and the responsible use of the following:

a. the registered medicines designated by the health insurer pursuant to the Healthcare Insurance

Regulations stated in Appendix 1 to these Regulations published on the Dutch website http://wetten.overheid.nl.

b. the medicines, stated in Appendix 1 to these Regulations, classified in one of the medicine categories stated in Appendix 2 to these Regulations, if the conditions attached to these specific categories have been complied with, as published on the Dutch website: http://wetten.overheid.nl.

c. other medicines, as long as they relate to rational pharmacotherapy as follows:

1. in accordance with Section 40(3a) of the Medicines Act, medicines prepared by or on assignment of a dispensing practitioner in his pharmacy on a small scale and made available;
2. medicines brought into commercial circulation in accordance with the rules established under Section 40(3c), of the Medicines Act prepared by a manufacturer at the request of a doctor in the Netherlands. The medicines are intended for use by individual patients of that doctor and have been prepared under his supervision in accordance with his specifications;
3. medicines brought into commercial circulation in another Member State or a third country in accordance with rules established under Article 40, paragraph three (c), of the *Geneesmiddelenwet* [Medicines Act] 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;

d. polymeric, oligomeric, monomeric and modular dietary preparations if Part 1 of Appendix 2 of these Regulations has been complied with, see the Dutch website: www.overheid.nl.

Paragraph 2

a. You are entitled to reimbursement of the costs of the medicines referred to in Article 18.5(1) as generally supplied by dispensing practitioners. A statutory personal contribution applies to specific medicines stated under paragraph 1a. 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 published on the Dutch website: http://wetten.overheid.nl. Further details about the personal contribution can be found in Article 5.1 of the Pharmaceutical Care Regulations under the 2016 'Flexibel' policy.

b. With reference to the terms and conditions referred to in Article 18.5(1b), De Amersfoortse sets out in Article 5.3 of the Pharmaceutical Care Regulations under the 2016 'Flexibel' policy specific provisions for medicines classified in the categories stated in Appendix 2.

c. Appendices 1 and 2 of the Healthcare Insurance Regulations may be subject to change during the course of the year.

d. You are entitled to reimbursement of the costs of advice and guidance as generally provided by dispensing practitioners with respect to the medicines referred to in Article 18.5(1). 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.

e. The entitlement to the reimbursement of costs referred to in Article 18.5(2) does not apply to the following:

- pharmaceutical care in cases designated by a Ministerial Regulation;
- medicines for travel-related risk of illness;
- medicines for examination or experimental use;
- a medicine 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;
- the personal contribution as described in paragraph 2a;
- 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).

f. The polymeric, oligomeric, monomeric and modular dietary preparations must be supplied by a dispensing practitioner or a specialised supplier of medical aids. Article 5.3 of the Pharmaceutical Care Regulations under the 2016 'Flexibel' policy contains specific provisions for dietary preparations.

Paragraph 3

Unless the health insurer has concluded further agreements with the healthcare provider concerned, the medicines referred to in Article 18.5(1) must be prescribed by a doctor, company doctor, youth healthcare physician, medical specialist, dentist, dental specialist, an obstetrician, nurse specialist or a physician assistant. The provision of medicines must be carried out under the supervision of a dispensing practitioner.

Paragraph 4

The Pharmaceutical Care Regulations under the 2016 'Flexibel' policy contain further conditions regarding the suitability of pharmaceutical care, covering aspects such as consent requirements, quantities to be supplied, specific provisions for medicines and the reimbursement of medicines. Visit www.amersfoortse.nl/zorg to view the Pharmaceutical Care Regulations under the 2016 'Flexibel' policy or call us and we will send them to you.

Article 18.6 Mental healthcare – General Basic Mental Healthcare [*Generalistische Basis GGZ*]

Paragraph 1. General

The scope of the above healthcare will be limited to the care that psychiatrists, neurologists and clinical psychologists may be expected to provide. You are entitled to reimbursement of the costs of General Basic Mental Healthcare if you have a DSM IV disorder. Care focuses on the treatment of a DSM IV disorder, or recovery from or preventing deterioration of a DSM IV disorder, not being a specialised mental health disorder. The entitlement to reimbursement of the costs of care is subject to the provisions described in Article 2 (under 4 and 5).

If you receive Generalist Basic Mental Healthcare from a non-contracted care provider, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with

prevailing market rates are listed on www.amersfoortse.nl/zorg (section 'marktconforme vergoedingen').
Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 2. Referral

A referral letter from a general practitioner, medical specialist or a company doctor is required prior to treatment for General Basic Mental Healthcare (non-specialised mental healthcare). The referral letter must also indicate that the person concerned is (presumed to be) suffering from a DSM IV disorder and that the doctor is referring the insured party for General Basic Mental Healthcare treatment. A referral letter is not required for emergency mental healthcare, but is required for any treatment carried out when the crisis situation has passed. We may ask you to submit the referral letter when processing your claim.

Paragraph 3. Care provider

a. The main treatment provider

The main treatment provider bears ultimate responsibility for the treatment and has established that care is a medical necessity. The above specialist is directly involved in the diagnostics and treatment. A main treatment provider is taken to mean a healthcare psychologist, psychotherapist, psychiatrist, neurologist, clinical psychologist or a nurse specialist who works at an institution (see paragraph 4 for the Basic Mental Healthcare – 'Chronic' product).

b. Secondary medical specialists providing mental healthcare

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

Paragraph 4. Entitlement

People aged 18 and above are entitled to reimbursement of the costs of General Basic Mental Healthcare. This is taken to include primary psychological care. They are also entitled to reimbursement of the costs of Internet-based treatments. General Basic Mental Healthcare comprises four services and an Incomplete Treatment programme service. The four services are Basic Mental Healthcare - Short [*Basis GGZ Kort*], Basic Mental Healthcare - Medium [*Basis GGZ Middel]*, Basic Mental Healthcare - Intensive [*Basis GGZ Intensief*] and Basic Mental Healthcare - Chronic [*Basis GGZ Chronisch*].

Paragraph 5. Excluded treatments

Non-insured care under the Healthcare Insurance Act includes the following:
Youth Mental Healthcare, assistance in the event of work-related and relationship problems, the treatment of adjustment disorders, psychosocial support, care in the case of learning and development disorders, including dyslexia, self-help, neurofeedback, psychoanalysis, intelligence test, school psychological care, medical psychological care, assistance of a non-medical nature, such as training programmes, courses and counselling regarding child upbringing. Indexed prevention for cases of depression, panic disorder and problematic alcohol use are excluded from Mental Healthcare services and fall under the scope of medical care provided by general practitioners in accordance with Article 18.8.

Moreover, the costs of interventions that fail to meet the state of the art in science and in practice will not be reimbursed. The 'Dynamic List of psychological interventions that fail to meet the state of the art in science and in practice' issued by the National Health Care Institute as a guideline.

Article 18.7 Mental healthcare - Specialised Mental Healthcare [*Gespecialiseerde GGZ*]

Paragraph 1. General

The scope of the above healthcare will be limited to the care that psychiatrists, neurologists and clinical psychologists may be expected to provide. You are entitled to reimbursement of the costs of Specialised Mental Healthcare if you have a DSM IV disorder. Care focuses on the treatment of a DSM IV disorder, or recovery or preventing deterioration of a DSM IV disorder. Specialised mental healthcare is taken to mean: diagnostics (establishing a disorder), and the specialist treatment of complex psychological disorders. The entitlement to reimbursement of the costs of care is subject to the provisions described in Article 2 (under 4 and 5).

If you receive Specialised Mental Healthcare from a non-contracted care provider, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section 'marktconforme vergoedingen'). Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 2. Referral

A referral letter from a general practitioner, company doctor or medical specialist is required for specialised mental healthcare. The referral letter must also indicate that the person concerned is (presumed to be) suffering from a DSM IV disorder and that the doctor is referring the insured party for Specialised Mental Healthcare treatment. A referral letter is not required for emergency mental healthcare, but is required for any treatment carried out when the crisis situation has passed. We may ask you to submit the referral letter when processing your claim.

Paragraph 3 Care provider

a. The main treatment provider

The main treatment provider bears ultimate responsibility for the treatment and has established that care is a medical necessity. The above specialist is directly involved in the diagnostics and treatment. A main treatment provider is taken to mean a psychiatrist, neurologist, clinical psychologist and psychotherapist.

b. Secondary medical specialists

Secondary medical specialists work under the responsibility of the main 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 cannot serve as secondary medical specialists.

Paragraph 4. Specialised Mental Healthcare including admission

a. People aged 18 and above are entitled to reimbursement of the costs of Specialised Mental Healthcare with respect to admission to a mental healthcare institution, psychiatric hospital or psychiatric ward of a hospital for a maximum duration of 1,095 days. The entitlement comprises

specialised psychiatric treatment and the patient's admission, whether or not in combination with nursing and care. This includes any paramedical care, medication, medical aids and dressing materials used in the treatment throughout the admission period. Entitlement to the above care may still exist after a period of 1,095 days under the Long-Term Care Act (Wlz).
b. A stay is a requirement for the purpose of treatment.
c. The following rules apply to calculating 1,095 days:
1. If your stay is interrupted for no more than 30 days, that period (in days) will not be included in the calculation of 1,095 days. The days after the interruption will continue to be counted.
2. If your stay is interrupted for a period exceeding 30 days, calculation of the 1,095 days will start anew.
3. If your stay is interrupted due to weekend and holiday leave, these days of interruption will be counted as part of the 1,095 days.
d. On request the institution will provide the health insurer with a list of all care providers, including their BIG registration number (under the Individual Healthcare Professions Act).

NB: If the insured party wishes to be eligible for reimbursement of the costs of specialised mental healthcare exceeding 365 days, the insured party or the healthcare provider must request an authorisation prior to commencing treatment. The application for the authorisation must be submitted to us no later than the tenth month of the uninterrupted stay. The substantiated application must contain a treatment plan drawn up by the main treatment provider. The application will be treated as confidential. The insured party should send the application to the medical adviser.

De Amersfoortse Verzekeringen
Attn medisch adviseur
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

Paragraph 5. Specialised Mental Healthcare without admission

a. The insured party will be entitled to the reimbursement of costs for specialised mental healthcare in a mental healthcare (GGZ) institution, psychiatric hospital or psychiatric ward of a hospital for people aged 18 or above. The entitlement comprises the nursing received in relation to the treatment, as well as the paramedical care and medication, medical aids and dressing materials associated with the treatment. Furthermore, the insured party will be entitled to reimbursement of the costs of specialised mental healthcare provided by an independent psychiatrist, neurologist, clinical psychologist or psychotherapist.

Paragraph 6. Authorisation requirement for using a non-contracted institution

De Amersfoortse has concluded agreements with numerous institutions. If you nonetheless opt to use a non-contracted mental healthcare institution, in order to avoid high costs the insured party or the healthcare provider on the insured party's behalf must apply for an authorisation from us. In order to issue the authorisation the following information must be submitted to us:
1. a referral from his or her general practitioner, company doctor or medical specialist. 2. in the event of admission: the clinical admission indication, in accordance with the guidelines laid down by the

professional association;
3. the proposed treatment plan, including the number of minutes of treatment and the activities and procedures to be performed;
4. the names of the main treatment provider and the secondary medical specialists involved in providing the care;
5. the DBC claim and performance codes.
The application will be treated as confidential. The insured party should send the application to the medical adviser.

De Amersfoortse Verzekeringen
Attn medisch adviseur
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

Paragraph 7. Privacy statement
If an insured party does not want a diagnosis code to appear on the claim but does wish to submit it for reimbursement purposes, the insured party must send us a privacy statement prior to sending, or at the latest together with his or her first claim. The privacy statement must be co-signed by the insured party and the healthcare provider and sent to our Care Claims Handling Department.

Paragraph 8. Excluded treatments:
Non-insured care under the Healthcare Insurance Act includes the following:
Youth Mental Healthcare, assistance in the event of work-related and relationship problems, the treatment of adjustment disorders, psychosocial support, care in the case of learning and development disorders, including dyslexia, self-help, neurofeedback, psychoanalysis, intelligence test, school psychological care, medical psychological care, assistance of a non-medical nature, such as training programmes, courses and counselling regarding child upbringing. Indexed prevention for cases of depression, panic disorder and problematic alcohol use are excluded from Mental Healthcare services and fall under the scope of medical care provided by general practitioners in accordance with Article 18.8. Moreover, the costs of interventions that fail to meet the state of the art in science and in practice will not be reimbursed. The 'Dynamic List of psychological interventions that fail to meet the state of the art in science and in practice' issued by the National Health Care Institute as a guideline.

Article 18.8 General practitioner
The insured party is entitled to reimbursement of the costs of medical care provided by a general practitioner or a doctor/healthcare provider of similar standing who provides care under the supervision of a general practitioner. The extent of the care to be provided is limited to the care that general practitioners generally provide. The entitlement to reimbursement of the costs of care by a general practitioner also includes the associated tests, such as laboratory tests.

Article 18.9 Provision of medical aids
Paragraph 1. The insured party shall be entitled to reimbursement of the costs of functioning medical

aids and dressing materials. The extent of the entitlement to reimbursement of the costs will be determined by the Health Insurance Regulations (including the maximum amounts and personal contributions specified therein). The Medical Aids Regulations under the 2016 'Flexibel' policy specify the terms and conditions for the provision of medical aids and the specific requirements applicable per category of medical aid. The Medical Aids Regulations under the 2016 'Flexibel' policy further specify which aids qualify for reimbursement, and which will be provided on loan or must be purchased.

The Medical Aids Regulations under the 2016 'Flexibel' policy form part of this insurance contract. These can be consulted on www.amersfoortse.nl/zorg and will be sent upon request.

Paragraph 2. The prior consent of the health insurer will be required where stated in its 2016 Medical Aids Regulations under the 'Flexibel' policy for reimbursement of the costs of the provision, replacement, adjustment or repair of the medical aid concerned. Consent may be subject to additional terms and conditions.

Paragraph 3. Unless otherwise stated in the Health Insurance Regulations and/or the Medical Aids Regulations under the 2016 'Flexibel' policy, the costs of normal use of the medical aids are payable by the insured party. The costs of normal use include the costs of energy consumption and batteries.

Paragraph 4. The insured party will only be entitled to reimbursement of the costs of medical aids in the event that, in the opinion of the health insurer, they are necessary, efficient, and not unnecessarily expensive or complicated.

Paragraph 5. The insured party will only be entitled to reimbursement of the costs of dressing materials in the case of a serious condition requiring long-term medical treatment with these materials.

Paragraph 6. Medical aids and dressing materials for which entitlement exists by virtue of the Long-Term Care Act (Wlz) and Social Support Act (Wmo) fall outside the scope of the insurance cover.

Paragraph 7. Medical aids provided on loan may be subject to inspection. If the health insurer is of the opinion that the insured party in all reasonableness no longer is in need of the medical aid, the health insurer is entitled to demand that the medical aid be returned.

Article 18.10 Mechanical ventilation

The insured will be entitled to payment of the costs of necessary mechanical ventilation, as well as the costs of the related specialist medical care in a respiration centre. In the event that mechanical ventilation is carried out at the home of the insured party on behalf of and under the supervision of a respiration centre, the entitlement to payment of the costs of the care will include the following:

- the supply by the respiration centre to the insured party of the equipment necessary for each treatment, and the setting up thereof so that it is ready for use;
- the specialist medical and pharmaceutical care in relation to mechanical ventilation to be provided by or on behalf of a respiration centre.

A referral by a medical specialist is required for the care described above.

Article 18.11 Specialist medical care (excluding mental healthcare)

Paragraph 1. 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. In the event of specialist medical care in relation to pregnancy and/or childbirth, the referral can also be made by an obstetrician. The extent of the care to be provided will be limited to the care that medical specialists generally provide. With due observance of Article 18.12, entitlement will apply with regard to reimbursement of the costs of oral care provided by a dental surgeon. In this case, the dentist will be eligible to issue a referral if the insured party is to undergo dental surgery. As regards IVF or ICISI and plastic surgery-related treatments, insured parties are entitled to reimbursement of the costs taking into account the provisions under paragraph 2(c and d). In the event that the insured party is undergoing inpatient treatment in an institution designated under the Long-term Act (Wlz), in addition to a general practitioner or a medical specialist, a doctor for the mentally disabled and a geriatric specialist may also issue the referral if this person is the patient's main treatment provider.

Paragraph 2. Hospitals and independent treatment centres

a. Admission to hospital

The insured party will be entitled to payment of the costs of admission to a hospital of the lowest class for a period not exceeding 1,095 days. This concerns admission to a hospital on medical grounds so that medical care can be administered as referred to in Article 18.11 or in connection with specialist surgical dentistry treatment as referred to in Article 18.12.

An interruption of no more than 30 days will not be considered as an interruption and will not be included in the calculation of the 1,095 days. Interruptions on account of weekend and holiday leave will be included in the calculation of the 1,095 days. The entitlement comprises reimbursement of the costs of specialist medical treatment and the patient's stay in hospital, whether or not in combination with nursing and care. This will also include any paramedical care, medication, medical aids and dressing materials used in the treatment throughout the period of hospitalisation.

b. Non-clinical specialist medical care

The insured party will be entitled to reimbursement of the costs of specialist medical treatment in a hospital or in an institution that has been approved as a hospital. The entitlement comprises reimbursement of the costs of specialist medical treatment and nursing (day admission) received in relation to the treatment, as well as the medication, medical aids and dressing materials used in the treatment.

In addition, the insured party shall be entitled to payment of the costs of specialist medical care in independent treatment centres. The entitlement comprises the specialist medical treatment and the nursing received in relation to the treatment, as well as the medication, medical aids and dressing materials that are used in the treatment.

Furthermore, the insured party will also be entitled to payment of the costs of specialist medical treatment at the general practice of the medical specialist or elsewhere. The entitlement comprises payment of the costs of the specialist medical treatment, as well as the medication, medical aids and dressing materials used in the treatment.

c. IVF or ICSI

Entitlement to the payment of costs for the first, second and third IVF or ICSI attempts to achieve a non-interrupted pregnancy in a woman up to the age of 42 in a hospital licensed to provide such treatment. This includes the costs of the pharmaceutical care required in connection with the treatment. In the event of a physiological (spontaneously achieved) pregnancy, a non-interrupted pregnancy is defined as: a pregnancy of at least 12 weeks measured from the first day of the last menstruation. In the event of a pregnancy achieved through an IVF or ICSI treatment, a non-interrupted pregnancy is defined as: a pregnancy of at least ten weeks measured from the date of follicular aspiration or, if the IVF or ICSI was achieved through the introduction into the womb of cryopreserved embryos a pregnancy of at least nine weeks and three days measured from the date of the implantation.
An attempt only counts as an attempt if follicular aspiration (the collection of mature ova) has been successfully carried out. Only attempts that fail after this stage count towards the number of attempts. The replacing of the/all embryos obtained during an attempt (whether or not these have been cryopreserved in the meantime) forms part of the attempt in which the embryos were obtained. A maximum of one embryo will be implanted during the first and second attempts in insured women up to the age of 38. If a third attempt is made a maximum of two embryos may be replaced if there is a medical indication to do so. If the insured woman is between the ages of 38 and 42 a maximum of two embryos may be implanted for all three attempts if there is a medical indication to do so. An IVF attempt that commenced before reaching the age of 43 may be completed. The insured will only be entitled to payment for this care in the event that the consent of the health insurer has been provided in writing well in advance.

d. Plastic surgery treatments

The insured party will only be entitled to reimbursement of the costs of plastic surgery treatment in the event that this surgery is performed to correct:
- abnormalities in appearance that are linked to demonstrable functional abnormalities in the body;
- disfigurement resulting from a disease, an accident or medical treatment;
- weakened or loosened eyelids that are the result of a congenital abnormality or a chronic condition that was present at birth;
- the following congenital deformities: cleft lip, jaw and palate, malformations of the facial bones, benign tumours of the blood vessels, lymph vessels or connective tissue, birthmarks or malformations of the urinary tract and sexual organs;
- primary sexual characteristics where transsexuality has been diagnosed.

The insured will only be entitled to payment for this care in the event that the consent of the health insurer has been provided in writing well in advance. Applications for plastic surgery treatments are assessed according to the Guide for the Assessment of Plastic Surgery Treatment [*Werkwijzer beoordeling behandelingen van plastisch chirurgische aard*]. These can be consulted on

www.amersfoortse.nl/zorg and will be sent upon request.

e. Second opinion

The insured party will be entitled to payment of the costs of a second opinion upon referral by a general practitioner or medical specialist. A second opinion must relate to medical care provided to the insured party as already discussed with the first person to treat the complaint. The insured party is obliged to return with the second opinion to the first person to treat his or her complaint. This person is authorised to direct the course of the treatment.

f. Conditional admission

Paragraph 1

a. Until 1 January 2016 the insured party will be entitled to reimbursement of the costs of treatment of chronic a-specific lower back pains (complaints for which no clear cause can be identified) through the application of anaesthesiological pain alleviation techniques, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph. If treatment of chronic a-specific lower back pain commenced prior to 1 January 2014 through the application of radiofrequency denervation and was reimbursed under the Health Insurance, the insurer will reimburse the costs incurred for completing the treatment until 1 January 2016, if the medical grounds for the treatment and the treatment itself satisfy the conditions of the research proposal that is funded by the Netherlands Organisation for Health Research and Development [*Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie*, ZonMW].

b. Until 1 January 2017 the insured party will be entitled to reimbursement of the costs of treatment of therapy-resistant hypertension through the application of percutaneous renal denervation, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph. If treatment of therapy-resistant hypertension commenced prior to 1 January 2014 through the application of percutaneous renal denervation and was reimbursed under the Health Insurance, the insurer will reimburse the costs incurred for completing the treatment until 1 January 2017, if the medical grounds for the treatment and the treatment itself satisfy the conditions of the research proposal that is funded by ZonMW.

c. Until 1 January 2017 the insured party will be entitled to reimbursement of the costs of treatment of a stroke through the application of intra-arterial thrombolysis if the insured party is taking part in the 'Multicenter Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands' (MR CLEAN) or in an observational study as referred to in the second paragraph (b) on such care. If treatment of a stroke commenced prior to 1 January 2014 through the application of intra-arterial thrombolysis and was reimbursed under the Health Insurance, the insurer will reimburse the costs incurred for completing the treatment until 1 January 2017, if the medical grounds for the treatment and the treatment itself satisfy the conditions of the 'Multicenter Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands' (MR CLEAN).

d. Until 1 January 2018 the insured party will be entitled to reimbursement of the costs of the transluminal endoscopic step-up approach for patients with infected pancreatic necrosis, to the extent they are taking part in the research study on such care as referred to in the second paragraph.

e. Until 1 January 2018 therapy-refractory patients suffering from Crohn's disease will be entitled to reimbursement of the costs of autologous stem cell transplants to the extent they are taking part in

the research study on such care as referred to in the second paragraph.

f. Until 1 January 2019 the insured party will be entitled to reimbursement of the costs of treatment using belimumab for adult patients with highly active auto-antibody positive systemic lupus erythematosus and a history of treatment failure in standard therapies, to the extent they are taking part in the research study on the efficacy of such care or in the research study referred to in paragraph 2(b).

g. Until 01 July 2019 the insured party will be entitled to reimbursement of the costs of treatment using tumour-infiltrating lymphocytes of metastasised melanoma in non-resectable stages IIIc and IV, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph.

h. Until 01 October 2019 the insured party will be entitled to reimbursement of the costs of treatment of colon carcinoma using adjuvant hyperthermic intraperitonal chemotherapy, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph.

i. Until 01 January 2020 the insured party will be entitled to reimbursement of the costs of treatment of lumbosacral radicular syndrome for lumbar hernia using percutaneous transforaminal endoscopic discectomy, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph.

j. Until 01 April 2020 the insured party will be entitled to reimbursement of the costs of breast reconstruction following breast cancer using autologous fat transfer, to the extent that the insured party is taking part in the research study on such care as referred to in the second paragraph.

k. You are entitled to reimbursement of the costs of the treatment of functional urological and/or medical sexological disorders by a medical sexologist at De Boer Mannengezondheid en Zorg (www.dbmgz.nl). Functional urology comprises

1. bladder obstruction, for example in the case of benignant prostrate enlargement resulting in obstruction complaints such as a weak urinary stream, continued dribbling, difficulty starting urination and a feeling of incomplete bladder emptying after urination.
2. overactive bladder with retention issues such as frequent urination in small amounts, or great urgency to urinate.
3. pelvic floor issues: pain and infections of the urinary tract, prostrate inflammation, and
4. blood in urine or sperm. Medical sexology comprises sexual dysfunctions such as libido disorders, erection problems, problems in achieving orgasm, premature or slow ejaculation or pain and complete lack of orgasm during intercourse.

l. The Minister has laid down regulations governing the influx of expensive intramural medicines. Those medicines will be placed temporarily in what is known as a 'lock'. The lock period is then used to to assess the medicine and negotiate a reasonable price. After that, the Minister will decide whether the medicine can still be admitted to insured care. Those who need the medicine are entitled to reimbursement of the costs at all times, even during the lock period.

During the course of the calendar year, the Minister may decide to provisionally admit other treatments as well. This means that the full list of provisionally admitted treatments may change in the course of the year. An updated list of all provisionally admitted treatments can be viewed on www.amersfoortse.nl/zorg.

Paragraph 2

The following qualifies as a research study on care:
a. main study into the effectiveness of care funded by ZonWm, and
b. supplementary national observational research into care set up and performed in collaboration with the main study if:
1. the insured party, subject to the substantive care criteria, fails to satisfy the criteria for taking part in the main study;
2. the insured party has not taken part in the main study and inclusion in that study has ended; or
3. the insured party has taken part in the main study without having received the relevant care and the insured party's participation in the main study has been completed.

g. Excluded treatments

The insured party will not be entitled to reimbursement of the costs of:

- treatments – including the costs of the medication provided in relation to the treatment – aimed at a fourth or subsequent attempt at in vitro fertilisation for each pregnancy to be achieved, after three attempts have been terminated between the time of successful follicular aspiration and the achievement of a non-interrupted pregnancy of ten weeks calculated from the time of follicular aspiration, and if the implantation of cryopreserved embryos has not led to a non-interrupted pregnancy lasting nine weeks and three days from the date of implantation.
- treatment of weakened or loosened eyelids other than due to congenital abnormality or a chronic condition that was present at birth;
- liposuction of the stomach;
- an operation to insert or replace a breast prosthesis other than following a complete or partial mastectomy;
- the surgical removal of a breast prosthesis without medical grounds;
- treatments against snoring with uvuloplasty;
- treatments aimed at the sterilisation of the insured party (man or woman);
- treatments aimed at reversing the sterilisation of the insured (man or woman);
- treatments aimed at the circumcision of the insured party;
- treatment of plagiocephaly and brachycephaly without craniosynostosis with a redression helmet;
- the first and second attempt at in vitro fertilisation for insured women up to the age of 38 if more than one embryo is returned to the womb;
- fertility-related care for women over 43 years of age;
- Opdivo (nivolumab) to the extent it is provided in the treatment of lung cancer.

Article 18.12 Oral care

Paragraph 1. General

The entitlement to oral care will include the reimbursement of costs of care generally provided by dentists, on the understanding that this will only relate to dental care that is necessary:
a. if the insured party has such a serious development disorder, growth disorder or acquired defect of the dental, jaw and mouth system that without this care he or she would be unable to retain or attain a dental function that is equivalent to that which he or she would have had if the disorder had not occurred;

b. if the insured party has a non-dental physical or mental disorder and without this care he or she would be unable to retain or attain a dental function that is equivalent to that which he or she would have had if the disorder had not occurred; or
c. if a medical treatment without this care would have a demonstrably insufficient result and, without this other care, the insured party would be unable to retain or attain a dental function that is equivalent to that which he or she would have had if the disorder had not occurred.

The oral care can be provided by a dentist, dental 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.

The prior consent of the health insurer is required for this care. 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 the application.

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

Paragraph 2. Implants

The insertion of a dental implant and the insertion of the fixed part of the superstructure will also be included under the care referred to in paragraph 1, under a, in the event that there is a case of a severely shrunken edentulous jaw and the implant is for the purpose of attaching a removable complete overdenture.

The prior consent of the health insurer is required for this care. A written statement of the grounds for the treatment drawn up by a dentist, dental surgeon or medical specialist must be submitted with the application.

Paragraph 3. Orthodontics

Orthodontic treatment will only be included in the care referred to in paragraph 1 in the event of a very serious development or growth disorder affecting the dental, jaw and/or mouth system, whereby diagnosis or treatment by other medical disciplines is required in addition to dental treatment.

The prior consent of the health insurer is required for this care. A written statement of the grounds for the treatment drawn up by a dentist, dental surgeon or medical specialist must be submitted with the application.

Paragraph 4 Dental surgery for insured persons under age 18

For insured parties under the age of 18, the entitlement to reimbursement of the costs of oral care will include the following treatments in addition to the cases referred to in paragraph 1:
a. periodic preventive dental examinations once a year, unless the insured party is dependent upon having such dental treatment more than once per year;

b. incidental dental consultations;
c. the removal of plaque;
d. the application of fluoride to insured parties, commencing from the appearance of the permanent teeth, a maximum of twice per year, unless the insured party is dependent upon having such dental treatment more than twice per year;
e. sealing;
f. parodontal treatment;
g. anaesthetics;
h. endodontic treatment;
i. restoration of dental elements with plastic materials;
j. gnathologic treatment;
k. removable prosthetic devices;
l. tooth replacement treatment using non-plastic materials, in the event that this concerns the replacement of one or more missing permanent incisors or canines which have failed to develop or which are absent as a direct result of an accident;
m. surgical dental treatment, with the exception of the insertion of a dental implant;
n. x-rays, with the exception of x-rays for the purpose of orthodontic treatment.
In the event that the insured party is dependent on the treatment referred to under l, contrary to paragraph m, his or her entitlement to reimbursement of the costs shall include the insertion of a dental implant. The prior consent of the health insurer is required. A statement of the grounds for the treatment and a treatment plan drawn up in writing by the dentist must be submitted with the application.

Paragraph 5 Dental surgery for insured persons over age 18

For insured parties aged 18 years and above, the entitlement to payment of the costs of oral care will include the following treatments in addition to the cases referred to paragraph 1(a to c):

- surgical dental treatment of a specialist nature and the accompanying X-rays, with the exception of peridontal surgery, the insertion of a dental implant and the extraction of teeth or molars without any complications. The prior consent of the health insurer is required for surgical treatment;
- removable comprehensive prosthetic devices for the upper and/or the lower jaw.

Paragraph 6. Dental prosthesis

With regard to the manufacture and insertion of a removable complete denture for the upper and/or lower jaw, the insured party will be entitled to payment of the costs of a removable complete immediate denture, or a removable complete overdenture or a removable complete replacement.

75% of the costs of these treatments will be reimbursed.
The insured party will be entitled to a full payment of the costs of repairing and rebasing an existing removable complete denture or an existing removable complete overdenture.

The condition that the consent of the health insurer is necessary if the removable complete replacement denture is replaced within 8 years of purchase also applies.

Paragraph 7. Personal contribution towards implant-supported dentures

A personal contribution of € 125 per jaw shall be payable by the insured party for a full set of removable dentures and/or implant-supported dentures, which are provided in the context of the care referred to in Article 18.12(2).

Paragraph 8. Personal contribution of adults

Insofar as this concerns care as referred to in Article 18.3(1) that is not directly related to a disorder requiring special dental care, insured persons aged 18 and older are liable to pay a personal contribution equal to the amount that the relevant insured person would be charged if Article 18.3(1) were not applicable.

Paragraph 9. Institution for specialist dental treatment

The prior consent of the health insurer is required for entitlement to reimbursement of the costs of oral care, as referred to in paragraphs 1, 2, 3, 4 and 5, provided by an institution for specialist dental treatment.

Article 18.13 Oncological care in children

The insured party will be entitled to reimbursement of the costs incurred by the Dutch Childhood Oncology Group [*Stichting Kinderoncologie Nederland*, SKION] for central (reference) diagnostics and the coordination and registration of the bodily material submitted. A referral by a medical specialist is required for the care described above.

Article 18.14 Organ transplants

a. The entitlement to reimbursement of the costs of care includes the care required in connection with the selection of a donor, and in connection with the operation to remove the transplant material from the selected donor.
Furthermore, the entitlement to reimbursement includes the examination, preservation, removal and transportation of the post-mortal transplant material in connection with the intended transplantation.
b. Care only includes tissue and organ transplants if the transplant is performed in a member state of the European Union, a state that is party to the Agreement on the European Economic Area or in another state on the condition that 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.
c. The donor will be entitled to reimbursement of the costs of care in accordance with this policy, for a maximum of thirteen weeks, or six months in the case of a liver transplant, following the date of discharge from the institution to which the donor was admitted as a result of his or her selection or for the purpose of removing the transplant material, and only in the event that and insofar as the care provided was related to that admission.
d. Furthermore, with the exception of the cases in which the donor has taken out health insurance, the donor may be entitled to reimbursement of transport costs or the reimbursement of transport cost within the Netherlands by means of the lowest class of public transport, or - if and insofar as is necessary on medical grounds - by car, in relation to the selection, admission to and discharge from the hospital and in relation to the care referred to in the previous sentence. This entitlement to reimbursement will also extend to the costs of transport from and to the Netherlands of a donor

residing abroad in relation to the transplant of a kidney, bone marrow or liver into an insured party in the Netherlands, as well as the other costs associated with the transplant, insofar as these relate to the fact that the donor resides abroad.
In the event that the donor also is the insured party to this health insurance policy, the costs referred to may be claimed against this health insurance policy. These costs will not be deducted from the policy excess. The costs of accommodation in the Netherlands and any lost income will not be reimbursed under this insurance policy.

The insured party will only be entitled to reimbursement of costs in accordance with this article with the prior consent of the health insurer.

Article 18.15 Paramedical care

Paragraph 1. Paramedical care

The entitlement to reimbursement of the costs of paramedical care will include remedial therapy, occupational therapy, speech therapy and dietetics. Paramedical care will also include an entitlement to reimbursement of the costs of care provided by a physiotherapist. The extent of the care to be provided will be limited to the care that physiotherapists, remedial therapists, speech therapists, occupational therapists and dieticians generally provide.

Paragraph 2 Provision of physical therapy and remedial therapy to insured persons aged 18 and over

The provision of physiotherapy and remedial therapy to insured parties aged 18 years and above will include the necessary treatments by a physiotherapist, manual therapist, Mensendieck/ Cesar remedial therapist, pelvic therapist or oedema therapist, starting from the 21st treatment, in the event that the treatment relates to one of the conditions stated in Appendix 1 of the Health Insurance Decree and insofar as the duration of the treatment stated therein is not exceeded.

Oedema therapy and scar therapy may also be provided by a skin therapist.

Explanation
Appendix 1 of the Health Insurance Decree is available on request and can be consulted on www.amersfoortse.nl/zorg.

Paragraph 3. Provision of physical therapy and remedial therapy to insured persons under age 18

The provision of physiotherapy and remedial therapy to insured parties under the age of 18 will include the necessary treatments by a (paediatric) physiotherapist, Mensendieck/ Cesar remedial therapist, pelvic therapist or oedema therapist, in the event that the treatment relates to a condition stated in Appendix 1 of the Health Insurance Decree and insofar as the duration of the treatment stated therein is not exceeded. This appendix is available on request and can be consulted on www.amersfoortse.nl/zorg.

In the case of conditions other than those stated in Appendix 1 of the Health Insurance Decree, the provision of physiotherapy and remedial therapy to insured parties under the age of 18 will include a maximum of nine treatments by a (paediatric) physiotherapist, manual therapist, pelvic therapist, Mensendieck/ Cesar remedial therapist or oedema therapist per condition per calendar year. Upon

referral by a doctor or medical specialist, the insured party will be entitled to reimbursement of the costs of a maximum of nine additional treatments per indication per calendar year in the event that the result initially obtained is insufficient. Oedema therapy and scar therapy may also be provided by a skin therapist.

Explanation
Appendix 1 of the Health Insurance Decree is available on request and can be consulted on www.amersfoortse.nl/zorg.

Paragraph 4. Pelvic physiotherapy

Pelvic physiotherapy for urine incontinence for insured parties aged 18 and above comprises a maximum of nine treatment sessions by a pelvic physiotherapist. The costs of pelvic physiotherapy for urine incontinence will only be eligible for reimbursement following a referral by a general practitioner, company doctor or medical specialist.

Paragraph 5. Occupational therapy

The entitlement to occupational therapy will include advice, instruction, training or treatment for a maximum of ten hours of treatment per calendar year to be provided by an occupational therapist at his or her practice or at the home of the insured party, with the aim of improving or restoring the independence and self-sufficiency of the insured party.

Paragraph 6. Speech therapy

The entitlement to speech therapy will include treatment, upon referral by a doctor, dentist or remedial educationalist, by a speech therapist, insofar as this care has a medical objective and it is anticipated that the treatment will restore or improve the speech or the speech abilities of the insured party. Speech therapy treatment will not be understood to include the treatment of dyslexia and a developmental language disorder in relation to a dialect or a foreign language.

If you receive speech therapy from a non-contracted care provider, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section ‘marktconforme vergoedingen’).
Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 7. Dietetics

Dietetics comprises the care as generally provided by dieticians, provided that the care has a medical objective, up to a maximum of three hours of treatment per calendar year. The costs of dietary advice will only be eligible for reimbursement following a referral by a general practitioner, dentist, infant welfare centre physician, company doctor, youth healthcare physician or medical specialist.

Article 18.16 Rehabilitation

Paragraph 1. Rehabilitation

a. The insured party will be entitled to reimbursement of the costs of rehabilitation, but only if and insofar as:

- this type of care has been designated as the most effective for the insured for preventing, reducing or overcoming a disability which is the result of a disorder or a limitation of mobility, or a disability which is the result of a disorder of the central nervous system resulting in limitations in communication, cognitive ability or behaviour;
- this type of care will enable the insured to achieve or retain a certain degree of independence which is reasonably possible in view of his or her limitations;
- this type of care will be provided by a multidisciplinary team led by a medical specialist or rehabilitation specialist affiliated to a rehabilitation centre accredited in accordance with or pursuant to the regulations laid down by or pursuant to the law.

b. Rehabilitation can take place:

- in a clinical situation, involving admission for several days, provided that it is anticipated that in doing so, better results can be achieved more rapidly than if rehabilitation were to take place without admission;
- through treatment as a non-clinical patient (part-time or day treatment).

A referral by a general practitioner, company doctor, youth healthcare physician or other medical specialist is required for the payment of costs of rehabilitation as referred to under a and b.

Paragraph 2. Geriatric rehabilitation care

a. Geriatric rehabilitation includes integral and multi-disciplinary rehabilitation care as provided by specialists in geriatric medicine in connection with physical frailty and complex multimorbidity and a reduced ability to learn and be trained, aimed at the reduction of functional limitations to the extent that returning to the home situation is possible.

b. Geriatric rehabilitation care will only be included in the care as referred to under a if:

- the care is provided within one week after a stay as referred to in Article 18.11 in connection with medical care as generally provided by medical specialists, whereby this stay is not preceded by a stay and the associated treatment as referred to in Section 3.1.1 of the Long-Term Care Act (Wlz); and
- the care is initially provided in connection with a stay as referred to in Article 18.11.

The duration of the geriatric rehabilitation, as referred to under b, will not exceed six months. In special cases, the health insurer may grant permission for a longer period.

Paragraph 3. If you receive rehabilitation care from a non-contracted independent treatment centre, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section ‘marktconforme vergoedingen’).
Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 4. Authorisation requirement for rehabilitation care at a non-contracted independent treatment centre

De Amersfoortse has concluded agreements with numerous institutions and independent treatment centres.. If the insured party nonetheless opts to use a non-contracted institution, the insured party

or the healthcare provider on the insured party's behalf must apply for an authorisation from us in time. The authorisation must have been issued before the start of treatment, so as to prevent a high personal contribution.
The following information is required in the assessment of the authorisation:
1. a referral (copy) from the general practitioner, company doctor or medical specialist;
2. in the case of hospitalisation: the clinical indication for hospitalisation in accordance with the established guidelines of the Dutch Association of Rehabilitation Specialists (VRA);
3. the proposed treatment plan, with details on the period, number of treatment minutes and activities and procedures to be performed;
4. the treatment providers involved in the various specific types of care;
5. the DBC expense claim code and the performance code.
The application will be treated confidentially. The treatment provider, on behalf of the insured party, should send the application to the medical adviser.
De Amersfoortse Verzekeringen
Attn. Medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope please state: 'Confidential'.

Article 18.17 Stopping smoking

The stopping smoking programme comprises medical care for the purpose of changing behaviour, whether or not in combination with medicines, with the aim of stopping smoking. The care comprises following a treatment programme once per calendar year. The care may be provided by 'Rook Vrij! Ook jij?', the general practitioner, medical specialist, obstetrician, healthcare psychologist and care providers listed in the Quality Register for Stopping Smoking [*Kwaliteitsregister Stoppen met Roken*], which can be consulted on www.KwaliteitsregisterStopmetRoken.nl.

The costs of nicotine-replacement aids and medicines only qualify for reimbursement as part of the Stopping Smoking programme, to support behavioural change. The medicines must have been prescribed by the doctor, medical specialist, obstetrician or nursing specialist providing the treatment. To obtain nicotine-replacement aids you will have to go to a pharmacy and produce a Stopping Smoking application form filled out by your treatment provider.

Article 18.18 Thrombosis service

The insured party will be entitled to reimbursement of the costs of care provided by the thrombosis service by order of a doctor.
Care includes:
a. regularly taking blood samples from the insured party;
b. the performance of laboratory tests, by or under the supervision of the thrombosis service, to determine the clotting time of the blood of the insured party;
c. supplying equipment and appurtenances to the insured party to enable him or her to measure the clotting time of his or her blood;
d. training the insured party, referred to in paragraph c, to use the equipment referred to in that paragraph, as well as supervising the insured party whilst taking his or her measurements;

e. providing advice to the insured party with regard to the use of medication to influence blood clotting.

Article 18.19 Obstetric care and maternity care

Paragraph 1. An insured female and her child shall be entitled to payment of the costs of obstetric care such as obstetricians generally provide and payment of the costs of maternity care such as maternity home-care assistants generally provide.
The obstetric care may be provided by an obstetrician, a general practitioner or a medical specialist, on the understanding that such care must be provided in the manner generally provided by an obstetrician, whether or not in combination with care provided in a maternity hotel. In this context maternity care is defined as: the care provided by a maternity home-care assistant working independently or affiliated with a hospital, maternity centre or maternity hotel who cares for the mother and child, and assists with the housekeeping where applicable. The following situations can be distinguished in this regard:

a. Childbirth and maternity care in a hospital necessary on medical grounds

In the event and insofar as hospitalisation is necessary on medical grounds, in the opinion of the obstetrician, general practitioner or medical specialist, the mother and her child, with effect from the date of birth, will be entitled to reimbursement of the costs of specialist medical care as referred to in Article 18.11, whether or not in combination with a stay, care and nursing in hospital.

b. Childbirth and confinement in a hospital without medical grounds

In the event that childbirth and/or confinement take place in a hospital without medical grounds, the mother and her child, with effect from the date of birth) will be entitled to reimbursement of the costs of obstetric assistance and maternity care. An excess of €16.50 applies to the mother and to the child per day of admission. This sum will be deducted from the maximum payment of €119 for the mother and the maximum payment of €119 for the child. If the hospital charges exceed €119 for the mother and €119 for the child, this amount shall be payable by the insured party. The number of days of hospitalisation will be determined on the basis of a statement issued by the hospital, or by the maternity care agency that is concerned with providing any additional maternity care after the insured party is discharged from hospital.

Explanation: a birth in an outpatients' clinic is deemed to be equal to one day of hospitalisation.

c. Maternity care and/or childbirth in a maternity hotel or maternity care at home, after childbirth in a hospital

In the event that maternity care takes place in a maternity hotel after childbirth in a hospital or in a maternity hotel, the mother and her child will be entitled to reimbursement of the costs of maternity care. A personal contribution of €4.20 per hour applies to maternity care. The hotel costs remain for account of the insured party. The number of days of hospitalisation will be determined on the basis of a statement issued by the maternity hotel, or by the maternity care agency that is concerned with providing any additional maternity care after the insured party is discharged from the maternity hotel.

In the event that the maternity care takes place at home following childbirth in a hospital, the mother and her child shall be entitled to payment of the costs of maternity care as described in paragraph d, subparagraph c, on the understanding that in the event that part of the maternity care already took place in the hospital, the number of days spent in the hospital shall be deducted from the maximum period of ten days referred to in paragraph d, subparagraph c.

d. Childbirth and confinement at home

If childbirth and confinement take place at home, theinsured party will be entitled to:

1. payment of the costs of obstetric care (including prenatal and postnatal care).

They are also entitled to reimbursement of the costs of:

2. the registration, intake and childbirth assistance up to a maximum of three hours after delivery.

If childbirth takes place and maternity care is provided at home, entitlement shall also exist with regard to reimbursement of the costs of:

3. maternity care for no more than 10 days from the date of delivery. The actual number of hours of maternity care depends on the needs of the mother and the child and will be determined on the basis of the National Maternity Care Guidelines [*Landelijk Indicatie Protocol Kraamzorg*] and allocated by the maternity care agency in consultation with the health insurer.

The maternity care will be provided under the responsibility of a maternity agency. 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 ‘kraamzorg aanvragen’ in the 'Stel uw vraag' screen. You can also apply for maternity care via TSN Kraamzorgbemiddeling, tel. (079) 343 04 68 or (033) 464 28 84.

A personal contribution of €4.20 per hour applies to maternity care.

Paragraph 2. If you receive maternity care from a non-contracted care provider, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section ‘marktconforme vergoedingen’). Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 3. An insured female shall be entitled to the payment of costs for prenatal screening if these relate to:

- counselling: this refers to the provision of information on the content and scope of prenatal screening for congenital defects (to enable the insured party to take a considered decision). In this case the healthcare provider must hold a licence under the Population Screening Act [*Wet op het bevolkingsonderzoek*];
- a structural ultrasound scan: in this case the care provider must hold a licence under the Population Screening Act or have a collaboration agreement with a Regional Centre for Prenatal Screening that holds a licence, unless the case involves blood loss or growth retardation;
- a combined test: the insured party will only be entitled to reimbursement of this provision if the insured party's medical history shows that she has a high risk of having a baby with Down

syndrome, Edwards' syndrome or Patau syndrome;
- a non-invasive prenatal test (NIPT): the insured party is only entitled to reimbursement of this provision if the insured party has undergone a combined test, the medical results of which are positive or there is a considerable risk of a chromosomal aberration;
- invasive diagnostics: the insured party will only be entitled to this provision if the insured party's medical history shows that she has a high risk of having a baby with Down syndrome, Edwards' syndrome or Patau syndrome or a considerable risk of a chromosomal aberration has been demonstrated on the basis of a combined test or NIPT. This concerns chorionic villus sampling and an amniotic fluid puncture.

Article 18.20 Nursing and care

Paragraph 1. Nursing and care

Nursing and care comprises care as generally provided by nurses, whereby such care:
a. relates to the need for, or high risk of medical care. The care qualifies as medical care if it concerns care as described in Articles 18.6, 18.7, 18.8, 18.11, 18.13, 18.14, 18.15, 18.16 and 18.19.
b. does not involve admission as referred to in Articles 18.11(2) and 18.7(4); and
c. for patients under age 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.

If you receive nursing and care from a non-contracted care provider, the amount of the reimbursement will not exceed the prevailing market rate as determined by us. This could mean that your bill will not be fully reimbursed. All our reimbursements in accordance with prevailing market rates are listed on www.amersfoortse.nl/zorg (section ‘marktconforme vergoedingen’). Contracted care providers are listed on www.amersfoortse.nl/zorg.

Paragraph 2. Personal budget (pgb)

To the extent that the insured party requires nursing and care that does not involve admission as referred in paragraph 1, the insured party will be eligible for reimbursement on request in the form of a personal budget under the Healthcare Insurance Act. The amount and further conditions of the entitlement are set out in the Regulations concerning nursing and care based on a personal budget under the 2016 'Flexibel' policy. These Regulations form part of this insurance contract and can be viewed on www.amersfoortse.nl/zorg, or will be sent to you on request.

Paragraph 3. Medical indication and care plan

The insured party has a right to the reimbursement of the costs of care generally provided by nurses, as described in paragraph 1, if he or she has a medical indication from a nurse holding a Level 5 qualification. The medical indication is determined in accordance with the Nursing and Care Standards issued by the V&VN Dutch Nurses' Association. The nurse holding a Level 5 qualification draws up a care plan. The care plan in any case contains information concerning the nature, extent, duration and objectives of care, including the desired result. The care plan must be signed by the insured party or curator, where applicable, and by the care provider.

Paragraph 4. Palliative terminal care

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

Paragraph 5. Collaboration with municipalities

For the purpose of the provision of integrated care, we have made agreements with the municipalities (Section 14a of the Healthcare Insurance Act). Where relevant to the terms and conditions of the insurance policy, the agreements are incorporated in this policy. If you use integrated care (care from various fields), we would recommend that you contact us.

Article 18.21 Foot care for diabetes mellitus patients

Insured parties suffering from diabetes mellitus will be entitled to medically related preventive foot care for the following care components:

- Annual examination of the feet, consisting of anamnesis, 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. The general practitioner or medical specialist determines the patient's Simm's class, on the basis of which the care profile is determined.

Care classes 2, 3 and 4 entitle the patient to reimbursement of the following types of care:

- More frequent targeted examination of the patient's feet including the resulting diagnostics and treatment of skin and nail problems and deviations in the shape and position of the feet, for insured parties with a moderately high (Simm's 1) or high (Simm's 2 or 3) risk of contracting ulcers;
- Treatment of risk factors in patients with a moderately high or high risk of contracting ulcers;
- Education and the initiation of adjustments to lifestyle factors as part of the treatment cycle.

The following treatments are excluded:

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

Diabetes mellitus patients are eligible for the reimbursement of foot care only with a prior referral from a general practitioner or medical specialist and the care must be performed under the responsibility of a podotherapist or diabetes-specialised podotherapist. The podotherapist or diabetes-specialised podotherapist performs the treatment; special types of care may be subcontracted to a medical chiropodist or a certified diabetic foot care chiropodist. Foot care for patients with diabetes mellitus is claimed by the podotherapist or diabetes-specialised podotherapist with the healthcare insurer at a uniform rate per care class.

For more information about Simm's classes and care profiles, consult the 'Zorgmodule Preventie Diabetische Voetulcera' on www.amersfoortse.nl/zorg.

Article 18.22 Patient transport

Paragraph 1. General

With regard to the transport of patients, a distinction is made between transport by ambulance and seated patient transport. Seated patient transport concerns transport by a means of public transport, taxi or the insured party's own vehicle.

In cases where patient transport by ambulance, car or public transport is not possible, the health insurer may grant permission to use an alternative form of patient transport to be designated by the health insurer.

Paragraph 2. Transport by ambulance

The insured party will be entitled to reimbursement of the costs of transport by ambulance in the Netherlands on medical grounds, however, only in the event that and insofar as other transport (public transport, taxi or the insured party's own vehicle) is not considered to be safe on medical grounds, and over a distance of no more than 200 kilometres, unless the health insurer gives its consent for transport over a longer distance.

Paragraph 3

The entitlement to reimbursement of the costs encompasses:

- transport to the care provider or institution where the insured party will receive care, the costs of which - with due observance of any excess - will be covered in part or in full by this insurance;
- transport to an institution where the insured party will stay, the costs of which are partly or fully covered under the Long-Term Care Act (Wlz);
- transport from a Wlz institution to a care provider or an institution at which the insured party will be undergoing an examination or treatment, the costs of which will be fully or partly covered under the Wlz, as well as the costs of transport from a Wlz institution to a care provider or institution for the purpose of measuring and fitting a prosthesis, the costs of which will be fully or partly covered under the Wlz;
- the transport of persons under age 18 to an institution or care provider whose care is described in the Youth Act and the costs of which are paid by the municipality;
- transport from the above care providers and institutions to the home of the insured party or to another home if the insured party cannot reasonably receive care in his or her own home.

Paragraph 4

The entitlement to the reimbursement of costs does not include transport in connection with care provided in a Long-Term Care Act (Wlz) institution for only part of a day.

Paragraph 5. Seated patient transport

The insured party will be entitled to reimbursement of the costs of transport to and from the care providers referred to in paragraph 3 by taxi, by a means of public transport in the lowest class, or his or her own vehicle, over a distance of no more than 200 kilometres, and in the event that one of the following situations applies:

- the insured party must undergo haemodialysis;

- the insured party must undergo oncological treatments with chemotherapy or radiotherapy;
- the insured party is dependent on a wheelchair and must be transported to and from a care provider from whom, or an institution in which the insured party will receive care that is covered by this insurance;
- the vision of the insured party is impaired to such an extent that he or she cannot travel without assistance and must be transported to and from a care provider from whom, or an institution in which the insured party will receive care that is covered by this insurance.
- children who receive care under the district nursing heading (as part of intensive paediatric care) are entitled to reimbursement of the costs of transport to and from the daycare nursing centre, if medically necessary.

A request for consent for seated patient transport must be submitted in advance with a statement from the doctor treating the insured party. The consent granted by the health insurer for this purpose may be subject to additional terms and conditions with regard to the manner in which the transport is to take place. In the event that the health insurer has given its consent for the insured party to consult a certain care provider or institution whereby transport over a longer distance is required, the limitation of 200 kilometres does not apply.

In order to claim reimbursement of the costs of transport by taxi, the insured party can contact Transvision. Transvision will determine on behalf of the health insurer whether the insured party is entitled to the reimbursement of the costs of transport by taxi and will arrange transport by taxi. Further information on Transvision can be found on www.amersfoortse.nl/zorg. Transvision can be contacted on 0900-33 33 33 0 (€0.15 per minute).

Paragraph 6. Hardship clause

In addition to the above situations, the insured party may invoke the hardship clause in the event that he or she is dependent upon seated patient transport for a long period of time in connection with treatment for a long-term illness or disorder, and not providing seated transport would be considered as extremely unfair to the insured party.

To determine whether you can claim reimbursement of the costs of patient transport under the hardship clause we apply the following formula: (no. of months) x (no. of trips/week) x (no. of weeks/month) x (no. of kilometres of a single journey) x 0.25 (= weight factor). If the outcome is 250 or more, you can claim reimbursement of the costs of patient transport under the hardship clause. You do require our prior consent. To that end, we will also need a statement by 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 weight factor	0.25	0.25	0.25
= result	720	300	108

In examples A and B, the person involved is entitled to reimbursement of the travel expenses. In example C he is not.

Paragraph 7

Paragraph 7. In the event that seated patient transport by a means of public transport, taxi or the insured party's own vehicle is not possible, the prior consent of the health insurer can be requested for another means of transport.

Paragraph 8

Patient transport will also include the transport of a supervisor, in the event that supervision is necessary on medical grounds or if the insured party to be accompanied is under the age of 16. In special cases, it may be possible to request the health insurer in advance to allow the transport of two supervisors.

Paragraph 9

An amount of €98 per calendar year for seated patient transport does not qualify for reimbursement. The allowance for use of the insured party's own vehicle has been fixed at €0.30 per kilometre over the shortest common route. We calculate this distance via www.routenet.nl.
A personal contribution is not payable for the following:

- transport from an institution to which the insured party was admitted under his or her health insurance policy or under the Wlz to another institution to which the insured party was

admitted under his or her health insurance policy or under the Wlz for specialist examination or treatment that the first institution stated above is unable to provide;
- transport from an institution as referred to under a to another person or institution with the aim of undergoing specialist examination or treatment covered by the insured party's health insurance policy that the first institution stated above is unable to provide, including transport back to the institution;
- transport from an institution to which the insured party was admitted under the Wlz to a person or institution for dental treatment under the Wlz which the first institution stated above is unable to provide, including transport back to the institution.

Article 18.23 Sensory impairment care

The entitlement comprises reimbursement of the costs of multidisciplinary:
- care in connection with a visual impairment;
- care in connection with an auditory impairment;
- care in connection with a communication impairment arising from a developmental language disorder;
- at home care provided to the patient by a care provider based on a travel allowance [*uittoeslag zorgverlener*].

The care provided comprises:
- diagnostic examinations;
- interventions aimed at psychologically learning to deal with a handicap;
- interventions to resolve or compensate the impairment and thus increase the level of self-reliance.

The entitlement to reimbursement is limited to insured parties who satisfy the medical indication criteria set out below and where applicable the indirect system of 'co-treatment' of parents/carers, children and adults close to the person with a sensory disability.
The medical indication criteria are as follows:
- A visual impairment determined on the basis of the guidelines issued by the Netherlands Ophthalmological Society (*Nederlands Oogheelkundig Gezelschap*, NOG] setting out the following criteria:
  - visual acuity of <0.3 of the best eye and
  - a visual field of < 30 degrees, or
  - visual acuity between 0.3 and 0.5 of the best eye with the related serious impairments inhibiting the performance of daily activities.
- An auditory impairment determined on the basis of the guidelines issued by the Federation of Dutch Audiological Centres [*Nederlandse Federatie van Audiologische Centra*, FENAC) if:
  - the audiogram shows a threshold loss of at least 35dB resulting from averaging the loss of hearing in frequencies of 1,000, 2,000 and 4,000hz, or
  - if the threshold loss exceeds 25dB when measured according to the Fletcher index, the average loss in frequencies of 500, 1,000 and 2,000 hz.
- 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.
- A combination of the impairments listed above.

The relevant care may only be provided by one of the auditory or visual centres listed on www.amersfoortse.nl/zorg.

Sensory impairment care, specifically for those suffering from auditory and/or communication impairments, is only accessible on the basis of a referral from a clinical physicist in audiology at an audiological centre or from a physician based on diagnostic data demonstrating that a client satisfies the inclusion criteria for the performance of the sensory impairment care to be insured under (Section 2.5d) of the Health Insurance Decree.

Visual impairment care is only accessible on the basis of a referral from a medical specialist on the grounds of the evidence-based NOG guideline on Virus diseases, rehabilitation and referral.

Article 19 Exclusions

The insured party will not be entitled to reimbursement of the costs of:
- care that can be funded on the basis of another statutory provision. This also means that if care can be claimed on the basis of the Long-Term Care Act (Wlz) or the Social Support Act (Wmo), no claim can be made for reimbursement of comparable care based on the health insurance;
- the personal contribution pursuant to the Long-Term Care Act (Wlz) and the costs of national screening programmes;
- pre-employment medical examinations and other examinations (for example for a driving or pilot's licence), certificates and vaccinations, unless the Ministerial Regulation specifies otherwise;
- flu vaccination;
- alternative medicine/treatment;
- medicines for travel-related risk of illness;
- a maternity package, surgical cotton wool and sterile hydrophilic gauze for obstetric care;
- Charges incurred as a result of missing appointments;
- the costs of consultants, treatments, medicines and medical aids given, prescribed or provided by an insured party for him or herself or a family member, or vice versa, without the prior permission having being been obtained from De Amersfoortse;
- 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;
- if the need for care is the result of one or more terrorist acts and 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.] to be higher than the maximum amount that this company has reinsured for a calendar year, the insured party is only entitled to care or reimbursement of the costs of care up to a percentage, to be determined by that company, of the costs or the value of the care or other services.

In the event that, after a terrorist act, an additional contribution is made available to the insurer in accordance with Section 33 of the Healthcare Insurance Act or Section 3.16 of the Health Insurance Decree, the insured party has the right, in addition to the entitlements referred to in the first sentence, to entitlements the extent of which is determined in Section 33 of the Healthcare Insurance Act or Section 3.16 of the Health Insurance Decree.

Article 20 Care for Care services

For care mediation, the insured party 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 the insured party within a reasonable period. The insured party 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 telephone number +31(0)33 464 20 61 and by email at zorgadvies@nl.amersfoortse.nl.

Terrorism clause

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

Important information:
De Amersfoortse Verzekeringen:
www.amersfoortse.nl/zorg
Telephone number: +31 (0)33 464 20 61

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

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

Care for Care Department
Email: zorgadvies@amersfoortse.nl

These English policy conditions are a translation of the Dutch policy conditions. No rights may be derived from this translation. In the event of an irregularity between the Dutch and the English version of the policy conditions, the Dutch version is leading.