

Policy terms and conditions Confior ZorgPlan

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ARTICLE 1 ABBREVIATIONS AND DEFINITIONS

The following abbreviations are used in this model agreement:

AWBZ	Algemene Wet Bijzondere Ziektekosten [National Act on Exceptional Medical Expenses]
NZa	Nederlandse Zorgautoriteit [Dutch Healthcare Authority]
WVG	Wet Marktordening Gezondheidszorg [Healthcare (Market Regulations) Act]
Zvw	Zorgverzekeringswet [Health Insurance Act]

The following definitions are used in this model agreement:

Work-related disorders

Disorders arising from a stress which has principally taken place during work or under working conditions and which would not have arisen had the work not been carried out.

Medical adviser

The medical doctor assigned by the insurer to advise the insurer on medical matters.

Premium due date

The first day of the period for which premium is due.

Consent

Written consent (authorization) from health insurance company based on the strength of which insured is entitled to insured benefits as determined in this model agreement.

Referral

Referral by a provider prior to the procurement of care or other services from another provider.

Insured

Person designated as such on the health insurance policy.

Policyholder

Person who concluded the health insurance with the insurer.

Person accountable for insurance

Person who, on the strength of article 2 of the Zvw, is obliged to be insured for health insurance.

Health insurance policy

The contract (the policy document) in which the health insurance concluded between the policyholder and the insurer is recorded.

Health insurer

Confior Zorgverzekeraar N.V.

Health insurance

An indemnity insurance concluded between insurance company and policyholder on behalf of a person accountable for insurance, which meets the requirements of the Zvw and of which the insured benefits do not exceed that determined in the Zvw.

ARTICLE 2 BASIS OF THE INSURANCE

The Zvw, the implementing decisions based on the Zvw and the application form completed by the policyholder form the basis of this health insurance. The contents of the insurance agreement are reproduced in the model agreement and in the health insurance policy. These comply with the Zvw. In case of conflict the provisions of the Zvw apply.

ARTICLE 3 SCOPE OF THE INSURANCE

This health insurance may be concluded by or on behalf of persons accountable for insurance and resident in the Netherlands, and persons accountable for insurance and resident overseas.

ARTICLE 4 COMMENCEMENT, DURATION AND TERMINATION OF THE HEALTH INSURANCE

Commencement date of the health insurance

- a The health insurance commences on the day on which the insurer receives the application referred to in article 3, first paragraph, Zvw and, where the second or fifth paragraph of the same article applies, the variant chosen by the policyholder.
- b Should the insurer be unable, based on the application referred to in article 3, first paragraph, Zvw, to determine whether or not he is obliged to provide insurance for the prospective insured, and if he invites the prospective insured to provide the necessary information in order to be able to make this decision, then the health insurance commences, contrary to that specified in a, on the day on which the previously mentioned person complied with this request.
- c Insurer will promptly provide person who makes application, referred to in article 3, first paragraph, Zvw, or person on whose behalf the application is made, with:
 - i proof of application, referred to in article 3, first paragraph, Zvw, on which date of receipt is stated;
 - ii proof of receipt of information, referred to in article 3, second paragraph, Zvw, on which date of receipt is stated;
- d Should, on the day on which the application, referred to in article 3, first paragraph, Zvw, is received, the person on whose behalf the health insurance is to be concluded already be insured on the strength of another health insurance, and the policyholder declares that he wishes the health insurance to commence on a date later than the date referred to in article 3, first or second paragraph, Zvw, then the insurance will commence on that later date.
- e Should the health insurance commence within four months of obligation to take out health insurance then it is retroactive, where necessary contrary to article 925, first paragraph, book 7 of the Dutch Civil Code, to the first day of obligation.
- f Should the health insurance commence within one month of termination of a previous health insurance as of 1 January of a calendar year or of termination due to changes in terms and conditions in accordance with article 940, fourth paragraph, book 7 of the Dutch Civil Code, then this is retroactive, where necessary contrary to article 925, first paragraph, book 7 of the Dutch Civil Code, to the day following termination of the previous insurance.

Duration of the health insurance

- g The health insurance is repeatedly effected for a period of one calendar year. Should the health insurance commence during a calendar year then it will be effected for the remainder of that calendar year.
- h The health insurance will be renewed tacitly on 1 January each year for a period of one calendar year, unless the policy has been rightfully terminated.
- i The policyholder may end the insurance before 31 December each year with effect from 1 January of the following calendar year. This must be done in writing. In case of cancellation the policyholder must specify in writing the name of the person or persons insured for whom the agreement is to be ended.
- j A policyholder who has insured a person other than himself may end the health insurance should the insured person concerned be insured on the strength of another health insurance. Cancellation takes effect from the first day of the second calendar month following the date of cancellation. Contrary to that specified in the previous sentence, cancellation takes effect on the day on which the insured becomes insured on the strength of another health insurance, should notification of cancellation be received by the insurer before the previously mentioned date.

Cancellation or annulment by insurer

Insurer is authorised to cancel or annul the health insurance:

- k If the policyholder has deliberately misled the insurer or if the insurer, had he been fully aware of the circumstances, would not have concluded the health insurance.
- l If the premium, following reminders, remains unpaid.

- m If a reclaimed personal excess, or other outstanding claim, following reminders, remains unpaid.
- n If a false claim for compensation is made.
- o In the case of serious misbehaviour on the part of an insured person (such as coercion or intimidation).

Legal termination

- p This insurance legally ends on the day following the day on which:
 - i insurer, as a result of a change to or withdrawal of its license to provide indemnity insurance, is no longer allowed to offer or provide health insurance;
 - ii as a result of a change in work location, the insured moves to an area outside the insurer's area of activity;
 - iii insured dies;
 - iv insured is no longer obliged to hold insurance.
- q The health insurance legally ends on the first day of the second month following the day on which the insured, his insurance obligation not having ended, moves to live outside a province in which the insurer offers or provides the health insurance variant concluded on his behalf.
- r Insurer will inform policyholder of termination at least two months before a health insurance is ended on grounds of sub-sections p, i or ii, and will give the reason why and the date on which the insurance is to be terminated. The policyholder will also receive an offer for a policy variant or for policy variants provided by the insurer in the province in which the insured will come to live.
- s Policyholder will immediately inform insurer of all facts and circumstances regarding insured which, under sub-sections p, iii or iv, or under paragraph q, have led or may lead to termination of the health insurance.
- t Should the insurer conclude, based on the information referred to in paragraph s, that the health insurance will terminate or has been terminated, he shall immediately inform the policyholder of such, and the reason why and the date on which the insurance is to be or has been terminated.

Termination due to new employment

- u The policyholder is entitled to end the insurance for all insured persons before the end of the insurance period, as of the last day of employment in connection with new employment, as long as the reason for ending the insurance is a transfer from one employer collective insurance scheme to another employer collective insurance scheme. Policyholder may end old health insurance up to 30 days after commencing new employment. It is not possible to end or begin the insurance retroactively, and both have effect from the first day of the same calendar month.

ARTICLE 5 PREMIUM

- a Policyholder is obliged to pay premium on the strength of the health insurance.
- b The nominal premium for the health insurance is stated on the health insurance policy.
- c The premium payable is equal to the nominal premium, less any discount due to a personal excess or due to participation in a collective insurance scheme.
- d No premium is payable for an insured person until the first day of the calendar month following the calendar month in which he reaches the age of eighteen.
- e Unless cancellation or annulment takes place with the intention to mislead the insurer, the premium will be reduced in the case of cancellation or annulment prior to the renewal date as is considered reasonable.
- f Policyholder is obliged to pay the premium prior to the premium due date.
- g The policyholder is not entitled to balance the premium to be paid with any benefits to be paid by the insurer.

- h Should, the premium due date having passed, the policyholder fail to pay the premium within a period of at least 14 days of receipt of a summons, counted from the day following summons, then the right to compensation will lapse starting on the first day the premium was due. From this date insured has no right to compensation for insured benefits used in the period of suspension of cover. The policyholder remains bound to settle the premium.
- i The right to compensation, under possible specific administrative conditions, will again be effective on the day following the day on which full payment of amount owed and costs referred to in j are received by the insurer, unless the health insurance has already been terminated by the insurer as a result of non-payment. There is no entitlement to compensation for costs made in the period in which the entitlement to compensation had lapsed. This is also true in the case of insurer haven already given consent (authorization) and/or written consent.
- j Should the insurer take steps to collect overdue premium, all collection costs are to be borne by the policyholder. Insurer will also claim reimbursement of statutory interest charges.
- k Insurer may conclude a collective insurance scheme discount with an employer or a corporate body (other than the employer) representing an individuals interests.

ARTICLE 6 CHANGES TO TERMS AND CONDITIONS AND PREMIUM

- a Insurer is entitled to change terms and conditions of the health insurance and the premium and/or discounts based on the premium at any time.
- b A change in the nominal premium will not become effective earlier than six weeks following the day on which the policyholder receives notification.
- c Should the insurer change the terms and conditions of the agreement, including a change in the nominal premium and any applicable discounts based on the nominal premium, to the disadvantage of the policyholder or insured, then the policyholder is entitled to end the health insurance as of the day on which the change takes effect, and in any case for a month after receipt of notification of the change.
- d Contrary to that specified in c the policyholder is not entitled to end the health insurance should any change in insured benefits to the disadvantage of the policyholder or insured be a direct consequence of a change in articles 11 to 14 of the Zvw regulations.

ARTICLE 7 THE INSURED RISK

The risk insured under the health insurance is the need for:

- a medical care, including primary health care as provided by general practitioners and midwives;
- b dental care;
- c pharmaceutical care;
- d medical aids;
- e nursing;
- f care, including maternity care;
- g hospital stay in connection with medical care;
- h transportation in connection with receipt of care or services referred to in sub-sections a to g, or in connection with a claim based on the AWBZ.

ARTICLE 8 INSURED BENEFITS

Article 8.1

Insured is entitled to care or other services as described in articles 8.4 to 8.17.

Article 8.2

The content and scope of the form of care on which entitlement to care is based is partly determined by current scientific and practical standards and, in the absence of such a benchmark, by that which is considered in the medical specialisation concerned to be adequate care and services.

Article 8.3

Should the Minister of Finance make use of the authority given in article 18b, paragraph one of the Emergency Act on Financial Transactions, and the need for care or other services is a result of one or more terrorist acts referred to in the Act, then the insured is only entitled to one or more benefits in as far as the costs of such benefits do not exceed that determined by the Minister of Finance.

Article 8.4 Medical care

- 1 Medical care includes care such as that provided by general practitioners, medical specialists and midwives, including the associated laboratory tests, and excludes care such as that provided by dental specialists, as well as paramedical care as referred to in section 8.6, provided that:
 - a the care does not include:
 - 1 the influenza vaccination;
 - 2 prenatal screening for congenital defects other than by echoscopy in the second trimester of the pregnancy, should the insured person be less than 36 years of age and there is no medical indication;
 - 3 the fourth or subsequent in vitro fertilisation treatment per planned pregnancy;
 - b plastic surgery is only covered for the correction of:
 - 1 defects in appearance combined with proven physical functional disorders;
 - 2 mutilation caused by disease, an accident or a medical operation;
 - 3 paralysed or weak upper eyelids resulting from a congenital defect or a chronic complaint present at birth;
 - 4 the following congenital abnormalities: cleft lip, cleft palate, facial bone deformities, benign tumours of blood vessels, lymphatic vessels or connective tissue, port wine stains and abnormalities of the urinary tract and genital organs;
 - 5 external sexual characteristics in the case of diagnosed transsexuality;
 - c tissue and organ transplant is only covered in the case of:
 - 1 bone marrow transplantation;
 - 2 bone transplantation;
 - 3 cornea transplantation;
 - 4 skin grafting;
 - 5 kidney transplantation;
 - 6 heart transplantation;
 - 7 liver transplantation, together with removal of the recipient's own liver;
 - 8 lung transplantation;
 - 9 heart and lung transplantation;
 - 10 kidney and pancreas transplantation.
- 2 Should forms of care such as that provided by medical specialists not be included in the Regeling Zorgverzekering (Health Insurance Regulations), then that which is determined in the Regeling Zorgverzekering should be regarded as part of this agreement. The Regeling Zorgverzekering can be found on the insurer's website and is obtainable on request.
- 3 Artificial respiration includes necessary artificial respiration as well as the associated medical specialist and pharmaceutical care, accommodation, nursing and care in a respiratory care unit. Should respiration be provided by and under the responsibility of a respiratory care unit at the insured's home then cover includes the preparation of and availability of the necessary equipment and the associated medical specialists and pharmaceutical care provided by the respiratory care unit for artificial respiration for each session.
- 4 Medical care includes central diagnostics and reference diagnostics, coordination and registration of bodily material sent in, by the Stichting Kinderoncologie Nederland (Dutch Childhood Oncology Group).
- 5 Medical care provided by the thrombosis service includes:
 - a taking of insured's blood for blood tests;
 - b necessary laboratory tests to determine coagulation time of insured's blood, carried out by, or under the responsibility of, the thrombosis service;
 - c equipment and accessories with which insured can measure the coagulation time of his blood;

- d training of insured, referred to in sub-section c, regarding the use of equipment referred to in that sub-section, as well as guidance of insured regarding his results;
 - e advice for insured regarding use of medication with influence on blood coagulation.
- 6 Medical care covers, in the case of genetic examination:
- a central diagnostics, coordination and registration of blood and bone marrow samples sent in;
 - b examination into and of genetic hereditary disorders by means of examination of the family tree;
 - c examination of chromosomes, biochemical diagnostics, ultrasound examination and DNA-tests;
 - d genetic consultancy and the socio-psychological counselling related to this care;
 - e if necessary for advising the insured, the examination, besides the insured, may also include other persons, who may be advised as well.
- 7 Medical care includes the following aural care:
- a hearing tests;
 - b advice on hearing aids to be purchased;
 - c information about the use of the hearing aid;
 - d where necessary, socio-psychological care in connection with the hearing impairment;
 - e help in reaching a diagnosis in the case of speech and language disorders in children up to the age of seven.
- 8 Medical care includes rehabilitation care if, and for as long as, this care is considered to be the most effective form of care in order for the insured to avoid, reduce or overcome a handicap that is caused by disorders or restrictions of the locomotor apparatus or a handicap that is caused by a disorder of the central nervous system leading to reduced communication, cognition or behaviour skills and, with the care, the insured will reach or maintain a degree of independence which is, considering the insured's restrictions, reasonable to expect. Rehabilitation may take place in a clinical situation (admission), where admission for several days is possible only if admission gives better prospects that rehabilitation without admission, or in an outpatient situation (treatment for a day or part thereof).

<i>For the above-mentioned insured benefit:</i>	<i>Medical care as provided by general practitioners.</i>
<i>Insured should approach:</i>	<i>A general practitioner or equivalent doctor/care provider working under the responsibility of a general practitioner, such as a medical nurse, nurse practitioner or specialised nurse.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Medical care as provided by medical specialists, excluding DBC section B and plastic surgery.</i>
<i>Insured should approach:</i>	<i>Medical specialist and a multidisciplinary team of experts, headed by a medical specialist, attached to an accredited rehabilitation institute.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner, medical specialist, midwife, dental surgeon, nursing home doctor or company doctor (for work-related disorders).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Medical care as provided by medical specialists, including DBC section B and excluding plastic surgery.</i>
<i>Insured should approach:</i>	<i>Medical specialist.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner, medical specialist, midwife, dental surgeon, nursing home doctor or company doctor (for work-related disorders).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

Insured should obtain medical care belonging to DBC section B from a care provider contracted by the insurer (see article 11 a). Should the insured obtain medical care from a care provider not contracted by the insurer, compensation will be set according to the Verzekeringsreglement zorg (Insurance Regulations for Health). These regulations can be found on the insurer's website and are obtainable on request. The amount referred to in article 11, f, is then not applicable.

<i>For the above-mentioned insured benefit:</i>	<i>Plastic surgery.</i>
<i>Insured should approach:</i>	<i>Medical specialist.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner, medical specialist or nursing home doctor and prior consent from insurer.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Care as provided by midwives.</i>
<i>Insured should approach:</i>	<i>- Midwife; - General practitioner (active in obstetrics).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Aural care.</i>
<i>Insured should approach:</i>	<i>Audiology centre.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner or medical specialist.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

Article 8.5 Tissue and organ transplant

The medical care referred to in article 8.4, first paragraph, sub-section c, also includes compensation for the following costs:

- a specialist medical care in connection with donor selection;
- b specialist medical care in connection with removal of transplant material from selected donor;
- c examination, preservation, removal and transport of post-mortem material, in connection with proposed transplantation;
- d the care to which the donor is entitled on the basis of this article, for a period of a maximum of thirteen weeks following discharge from the institute to which the donor was admitted for selection or removal of transplant material, provided the care is connected to the transplant in question;
- e transport of the donor in the lowest class of a form of public transport within the Netherlands or, where medically necessary, transport by car within the Netherlands, in connection with the selection, the admission to and discharge from the hospital and with the care, referred to in sub-section d;
- f transport of a donor resident in a foreign country to and from the Netherlands, in connection with a kidney or bone marrow transplant for an insured person resident in the Netherlands, and other costs associated with the transplant which stem from the fact that the donor is resident in a foreign country, excluding accommodation expenses in the Netherlands and loss of income.

<i>For the above-mentioned insured benefit:</i>	<i>Transport (e and f).</i>
<i>Insured should approach:</i>	<i>A transport company.</i>
<i>On the condition that:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

Article 8.6 Paramedical care

- 1 Paramedical care includes physiotherapy, remedial therapy, speech therapy, occupational therapy and dietary advice.
- 2 Physiotherapy or remedial therapy includes care provided by physiotherapists and remedial therapists for the treatment of the disorders described in appendix 1 of the Besluit zorgverzekering (Health Insurance Resolution), on the condition that the specified period is not exceeded. The first nine treatments are not included for insured persons of eighteen years and older. Appendix 1 of the Besluit zorgverzekering can be found on the insurer's website and will be sent on request.
- 3 For insured persons younger than eighteen physiotherapy and remedial therapy also includes, for cases other than those specified in the second paragraph, a maximum of nine treatments for the same disorder per year, to be extended by a maximum of nine treatments in the case of inadequate result.
- 4 Speech therapy includes care as provided by speech therapists, if there is a medical purpose and if the treatment is expected to result in recovery or improvement in the speech function or ability.
- 5 Occupational therapy includes care as provided by occupational therapists, if it aims to promote and restore the insured's self-care and independence, up to a maximum of ten treatment hours per calendar year.
- 6 Dietary advice includes counselling with a medical purpose regarding food and eating habits, as provided by a dietician, up to a maximum of four treatment hours per calendar year.

<i>For the above-mentioned insured benefit:</i>	<i>Physiotherapy.</i>
<i>Insured should approach:</i>	<i>- Child physiotherapist, physiotherapist, manual therapist, oedema therapist, pelvic floor therapist; - Skin therapist in the case of lymphedema.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner, medical specialist, company doctor (for work-related disorders found on the list of chronic disorders) or dentist; Referral is not required for treatment by a physiotherapist included in the list of Direct Toegankelijke Fysiotherapeuten (Directly Accessible Physiotherapists). This list can be found on the insurer's website and is obtainable on request.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

Insured should initially obtain physiotherapeutic care from a care provider contracted by the insurer (see article 11 a). Should the insured obtain physiotherapeutic care from a care provider not contracted by the insurer, compensation will be set according to the Verzekeringsreglement zorg (Insurance Regulations for Health). These regulations can be found on the insurer's website and are obtainable on request. **The amount referred to in article 11 f, is then not applicable.**

<i>For the above-mentioned insured benefit:</i>	<i>Cesar/Mensendieck remedial therapy.</i>
<i>Insured should approach:</i>	<i>Cesar remedial therapist, Mensendieck remedial therapist.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner or medical specialist, dentist or company doctor (for work-related disorders).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Speech therapy.</i>
<i>Insured should approach:</i>	<i>Speech therapist.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner, medical specialist or dentist.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Occupational therapy.</i>
<i>Insured should approach:</i>	<i>Occupational therapist.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner or medical specialist.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Dietary advice.</i>
<i>Insured should approach:</i>	<i>Dietician.</i>
<i>On the condition that:</i>	<i>Referral by general practitioner or medical specialist.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Article 8.7 Dental care

- 1 Dental care includes care such as that provided by dentists, on the understanding that it only includes medically necessary dental care:
 - a should the insured have such a serious development disorder, growth disorder or acquired defect of the masticatory system that without this care he is unable to maintain or achieve normal dental function, equal to that had the disorder not arisen;
 - b should the insured have a non-dental physical or mental handicap and without this care is unable to maintain or achieve normal dental function, equal to that had the disorder not arisen; or
 - c should medical treatment be shown to have an inadequate result without the dental care, and the insured be unable to maintain or achieve normal dental function, equal to that had the disorder not arisen.
- 2 The insurer's Verzekeringsreglement zorg (Insurance Regulations for Health) also apply to dental care and are also part of this agreement. These regulations can be found on the insurer's website and are obtainable on request.
- 3 The care referred to in the first paragraph, sub-section a, also includes the insertion of a dental implant and the insertion of the fixed part of the suprastructure should there be serious resorption of the toothless jaw, and should this be required for the fixing of a removable prosthesis.
- 4 Orthodontic treatment is only covered by the care, referred to in the first paragraph, in the case of a severe development disorder or growth disorder of the masticatory system, whereby it is necessary to obtain diagnostics or treatments from another medical specialisation.
- 5 For insured persons under the age of eighteen dental care includes, in cases other than described in the first paragraph, sub-sections a to c:
 - a regular preventative dental examination, once per year, unless the insured is referred more often per year for this dental care;
 - b incidental dental consultation;
 - c oral hygiene;
 - d fluoride treatment for insured persons older than six years, a maximum of twice per year, unless the insured is referred more often per year for this dental care;
 - e sealing;
 - f periodontal care;
 - g anaesthesia;
 - h endodontic care;
 - i tooth restoration using plastic materials;
 - j gnathologic care;
 - k the provision of removable prosthetics;

- l tooth replacement using non-plastic materials and insertion of dental implants, in the case of the replacement of one or more missing, and not previously replaced, adult incisor or canine teeth, or where the absence of the tooth or teeth is a direct result of an accident;
 - m dental surgical care, excluding the insertion of dental implants;
 - n X-rays, excluding X-rays for orthodontic treatment.
- 6 An insured person younger than eighteen is only entitled to dental treatment outside regular surgery hours if the treatment cannot reasonably be delayed.
 - 7 For insured persons of eighteen years and older dental care includes, in cases other than those described in the first paragraph, sub-sections a to c:
 - a specialist dental surgical care and the associated X-rays, excluding periodontal surgery and the insertion of dental implants;
 - b provision of removable complete upper or lower jaw prosthetics.
 - 8 Own contribution:
Insured is obliged to pay an own contribution for the care referred to in the first paragraph, sub-sections a, b or c, and the seventh paragraph, sub-section b if and in as far as this is specified in the Regeling zorgverzekering (Health Insurance Regulations), which are regarded as a part of this agreement. The Regeling Zorgverzekering can be found on the insurer's website and is obtainable on request.

<i>For the above-mentioned insured benefit:</i>	<i>Dental treatment as referred to in article 8.7 paragraph 1, paragraph 5, paragraph 7 sub-section b.</i>
<i>Insured should approach:</i>	<i>Dentist.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement Zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Orthodontic treatment as referred to in article 8.7, paragraph 1, sub-section a.</i>
<i>Insured should approach:</i>	<i>Orthodontist.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement Zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Dental surgery as referred to in article 8.7 paragraph 1 sub-section a, paragraph 5 sub-section l and m, paragraph 7 sub-section a.</i>
<i>Insured should approach:</i>	<i>Dental surgeon working in a hospital contracted by insurer.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Dental care in special cases referred to in article 8.7 paragraph 1 sub-sections a, b and c.</i>
<i>Insured should approach:</i>	<i>Centre for dental care in special cases.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Removable complete prosthetics for the upper and/or lower jaw as referred to in article 8.7 paragraph 5 sub-section k and paragraph 7 sub-section c.</i>
<i>Insured should approach:</i>	<i>Dental prosthetist.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Article 8.8 Pharmaceutical care

- 1 Pharmaceutical care includes supply of:
 - a registered medicines allocated by the Regeling zorgverzekering (Health Insurance Regulations), if also allocated by the insurer;
 - b other medicines that are allowed to be supplied in the Netherlands on the basis of the Wet op de Geneesmiddelenvoorziening (Supply of Medicines Act), should it concern rational pharmacology;
 - c polymeric, oligomeric, monomeric and modular dietary preparations as specified in part 1, appendix II of the Regeling zorgverzekering (Health Insurance Regulations).
- 2 The Regeling zorgverzekering, referred to in the first paragraph in sub-sections a and c, is part of this agreement. Allocation of medicines by the insurer and specific conditions are detailed in the insurer's Verzekeringsreglement zorg (Insurance Regulations for Health), which is also part of this agreement. The Regeling zorgverzekering and the Verzekeringsreglement zorg are to be found on the insurer's website and can be obtained on request.
- 3 Pharmaceutical care does not include:
 - a pharmaceutical care indicated as such in the Regeling zorgverzekering (Health Insurance Regulations);
 - b medicines required as a result of travel;
 - c medicines referred to in articles 54 and 55 of the Besluit bereiding en aflevering van farmaceutische producten (Decision Preparation and Supply of Pharmaceutical Products), unless the insured suffers from an illness affecting less than 1 in 150,000 people in the Netherlands;
 - d medicines equivalent or closely equivalent to non-allocated, registered medicines.
- 4 The allocation by the insurer is intended to ensure that of all the active ingredients present in the allocated medicines included in the Regeling zorgverzekering, at least one medicine is available to the insured.
- 5 Pharmaceutical care also includes medicines allocated by the Regeling zorgverzekering but not by the insurer, if treatment with the medicine allocated by the insurer is not medically responsible in the case of the insured concerned.

- 6 Should the medicines indicated in the Regeling zorgverzekering, referred to in the first paragraph, sub-section a, be classified in groups of interchangeable medicines and if a compensation limit is set for a group of interchangeable medicines, the insured may be obliged to pay an own contribution. This applies to a medicine included in a group of interchangeable medicines should the cost price be higher than the compensation limit. An own contribution also applies if a medicine is prepared using another medicine for which an own contribution is payable. For calculation of the own contribution please refer to the Regeling zorgverzekering, which is part of this agreement. The Regeling zorgverzekering and the Verzekeringsreglement zorg are to be found on the insurer's website and can be obtained on request.

<i>For the above-mentioned insured benefit:</i>	<i>1. a. the supply of registered medicines allocated by the Regeling zorgverzekering (Health Insurance Regulations) where also allocated by the insurer.</i>
<i>Insured should approach:</i>	<i>Pharmacy or dispensing general practitioner.</i>
<i>On the condition that:</i>	<i>Prescription from general practitioner, medical specialist, dentist, midwife or GGD (Municipal Health Service) doctor and further conditions as specified in the Verzekeringsreglement zorg.</i>
<i>How to find which medicines are allocated by insurer:</i>	<i>Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>1. b. the supply of other medicines which are allowed to be supplied in the Netherlands on the basis of the Wet op de Geneesmiddelenvoorziening (Supply of Medicines Act), should it concern rational pharmacology.</i>
<i>Insured should approach:</i>	<i>Pharmacy or dispensing general practitioner.</i>
<i>On the condition that:</i>	<i>Prescription from general practitioner, medical specialist, dentist, midwife or GGD (Municipal Health Service) doctor.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>1. c. polymeric, oligomeric, monomeric and modular dietary preparations.</i>
<i>Insured should approach:</i>	<i>Pharmacy, dispensing general practitioner or contracted supplier of polymeric, oligomeric, monomeric and modular dietary preparations.</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>How to find further stipulations:</i>	<i>See Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Article 8.9 Medical aid care

- 1 Medical aid care includes the medical aids and dressing materials allocated by the Regeling zorgverzekering (Health Insurance Regulations), which can be used to determine:
 - a in which cases the insured is entitled to the care;
 - b the compensation of the costs allocated by the regulation in connection with dialysis at home.

The Regeling zorgverzekering, referred to in the first sentence, is considered part of this agreement. The insurer's Verzekeringsreglement Zorg (Insurance Regulations for Health) also applies to medical aid care, and also forms part of this agreement. The Regeling zorgverzekering and the Verzekeringsreglement zorg are to be found on the insurer's website and can be obtained on request.

- 2 The costs of normal use of medical aids are to be borne by the insured, unless otherwise indicated in the Regeling zorgverzekering (Health Insurance Regulations).
- 3 An own contribution is payable by the insured for a medical aid if and in as far as this is specified in the Regeling zorgverzekering (Health Insurance Regulations), which forms part of this agreement. The own contribution amounts to:
 - a the difference between the purchase price and the amount specified for the medical aid, which can vary according to the group of insured persons to which the insured belongs;
 - b an additional specified amount due to cost reduction.
- 4 Contrary to that determined in article 11, sub-section a of this agreement, the insurer will, on request, provide insured with a personal budget for medical aids described in article 2.9 of the Besluit zorgverzekeringen (Health Care Insurance Decree), required by the insured in the case of a serious visual handicap. The insurer's Verzekeringsreglement zorg (Insurance Regulations for Health) also apply to the provision of a personal budget and are also part of this agreement. The Verzekeringsreglement zorg can be found on the insurer's website and are obtainable on request.

<i>For the above-mentioned insured benefit:</i>	<i>Medical aid care.</i>
<i>Insured should approach:</i>	<i>Medical aid suppliers who meet the requirements specified in the insurer's Verzekeringsreglement Zorg (Insurance Regulations for Health).</i>
<i>On the condition that:</i>	<i>Further conditions as specified in the insurer's Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Insured should initially obtain medical aid care from a care provider contracted by the insurer (see article 11 a). Should the insured obtain medical aid care from a care provider not contracted by the insurer, compensation will be set according to the Verzekeringsreglement zorg (Insurance Regulations for Health). These regulations can be found on the insurer's website and are obtainable on request. The amount referred to in article 11, f, is then not applicable.

Article 8.10 Accommodation

- 1 Accommodation includes a continuous stay of a maximum of 365 days, medically necessary for the medical care referred to in article 8.4, whether or not coupled with nursing, care or paramedical care.
- 2 A break of a maximum of thirty days will not be considered as such, though the days will not contribute to the calculation of the 365 days.
- 3 Contrary to the second paragraph, breaks due to weekend and holiday leave do contribute to calculation of the 365 days.

<i>For the above-mentioned insured benefit:</i>	<i>Accommodation.</i>
<i>Insured should approach:</i>	<i>Hospital.</i>
<i>On the condition that:</i>	<i>Specialist medical treatment.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

<i>For the above-mentioned insured benefit:</i>	<i>Accommodation.</i>
<i>Insured should approach:</i>	<i>Rehabilitation centre.</i>
<i>On the condition that:</i>	<i>Prior consent from insurer. This consent is given on the condition that</i> <i>- this care is considered to be the most effective care in order to avoid, reduce or overcome a handicap that is caused by a disorder or a restriction of the locomotor apparatus or a handicap that is caused by a disorder of the central nervous system leading to reduced communication, cognition or behaviour skills and</i> <i>- with the care, the insured will reach or maintain a degree of independence which is, considering the insured's restrictions, reasonable to expect.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Article 8.11 Nursing

In addition to the nursing referred to in article 8.10, nursing also includes care such as that provided by midwives, not coupled with hospital admission, and which is necessary in connection with specialist medical care.

Article 8.12 Maternity care

- 1 In addition to the nursing referred to in article 8.10, nursing also includes care such as that provided by maternity nurses for mother and child in connection with a delivery, for a maximum of ten days, counted from the day of delivery.
- 2 The Landelijk Indicatieprotocol Kraamzorg (Maternity Care National Indication Protocol), obtainable from the insurer, applies.
- 3 Should it be specified in the Regeling zorgverzekering (Health Insurance Regulations) that the insured should pay an own contribution for the care referred to in the first paragraph, then that specified in the Regeling zorgverzekering should be considered part of this agreement. The Regeling Zorgverzekering can be found on the insurer's website and is obtainable on request. **Insured pays the own contribution owed on the strength of the Regeling zorgverzekering (Health Insurance Regulations) to the care provider.**

<i>For the above-mentioned insured benefit:</i>	<i>Maternity care.</i>
<i>Insured should approach:</i>	<i>A qualified maternity nurse attached to a hospital, maternity centre or maternity hotel.</i>
<i>On the condition that:</i>	<i>Please register on time, preferably before the 20th week of the pregnancy, using the insurer's Maternity Care Helpline: telephone number 0900 202 5003.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Website. List of contracted care providers will be sent on request.</i>

Article 8.13 Ambulance transport

- 1 Transportation includes transport of the insured by ambulance as referred to in article 1, first paragraph, of the Wet ambulancevervoer (Ambulance Transport Act), over a distance up to 200 kilometres:
 - a to a person or institution where he will receive care for which the costs are completely or partially compensated by the health insurance;
 - b to an institution where he will stay either completely or partially at the expense of the special medical insurance as referred to in the Algemene Wet Bijzondere Ziektekosten (AWBZ);
 - c from an institution, referred to in sub-section b, to:
 - 1 a person or institution where he will undergo examination or treatment completely or partially at the expense of the special medical insurance;
 - 2 a person or institution for fitting or adapting a prosthesis which is to be provided completely or partially at the expense of the special medical insurance;
 - d to his home or another house, should he be unable to reasonably receive the necessary care at his own home, and should he come from one of the persons or institutions referred to in sub-sections a, b or c;
 - e transportation in connection with treatment in an AWBZ institution for part of a day is not included in the cover.
- 2 Should the insurer give consent for the insured to receive treatment from a particular person or institution, then the 200 kilometre limitation does not apply.

<i>For the above-mentioned insured benefit:</i>	<i>Ambulance transport.</i>
<i>Insured should approach:</i>	<i>License holder indicated by province.</i>
<i>On the condition that:</i>	<i>Transport by order of the central ambulance communication centre.</i>
<i>Benefit type:</i>	<i>In-kind.</i>

Article 8.14 Seated patient transport other than ambulance

- 1 Transportation also includes transportation of the patient by car, other than by ambulance as referred to in article 1, first paragraph, of the Wet ambulancevervoer (Ambulance Transport Act), or transport in the lowest class of public transport from and to a person, institution or home as referred to in article 8.13, first paragraph, over a single distance of up to 200 kilometres if:
 - a insured is to undergo kidney dialysis;
 - b insured is to undergo oncological treatment with chemotherapy or radiotherapy;
 - c insured can only travel with the aid of a wheelchair;
 - d insured's sight is so limited that he cannot travel unescorted;
- 2 Should transportation, referred to in the first paragraph, be by private car, then compensation is given on the basis of a kilometre price as specified in the Regeling zorgverzekering (Health Insurance Regulations).
- 3 Contrary to the first paragraph, sub-sections a to d, transportation also includes other types of transport should the insured require transport on a long-term basis in connection with treatment of a long-term illness or disorder and the unavailability or non-compensation of that transport would result in unreasonable suffering for the insured.
- 4 Should the insurer give consent for the insured to receive treatment from a particular person or institution, then the 200 kilometre limitation does not apply.

<i>For the above-mentioned insured benefit:</i>	<i>Transport.</i>
<i>Insured should approach:</i>	<i>Transport company or individual not conducting professional service.</i>
<i>On the condition that:</i>	<i>Prior consent from insurer using application form for seated transport and explanatory notes from treating doctor and further conditions as specified in the insurer's Verzekeringsreglement zorg (Insurance Regulations for Health).</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Given on approval (authorization).</i>

Insured should initially obtain transport from a provider contracted by the insurer (see article 11 a). Should the insured obtain transport from a provider not contracted by the insurer, compensation will be set according to the Verzekeringsreglement zorg (Insurance Regulations for Health). **These regulations can be found on the insurer's website and are obtainable on request. The amount referred to in article 11 f, is then not applicable.**

Article 8.15 Other transport and escort

- 1 Should transport of patient by car or public transport not be possible, the insurer may permit transport of patient to take place using another form of transport, to be determined by the insurer.
- 2 Transport of a patient also includes transport of an escort, should escort be necessary, or when accompanying children younger than sixteen years old. In special cases the insurer may give permission for the transport of two escorts.

<i>For the above-mentioned insured benefit:</i>	<i>Other form of transport.</i>
<i>Insured should approach:</i>	<i>Transport company.</i>
<i>On the condition that:</i>	<i>Prior consent from insurer.</i>
<i>Benefit type:</i>	<i>In-kind.</i>
<i>Where to find contracted care providers:</i>	<i>Given on approval (authorization).</i>

Article 8.16 Own contribution for transport

Should it be specified in the Regeling zorgverzekering (Health Insurance Regulations) that an own contribution for transportation, other than transport by ambulance as referred to in article 1, first paragraph, of the Wet ambulancevervoer (Ambulance Transport Act), is payable by the insured, up to a maximum determined by the regulation, then that which is specified in the Regeling zorgverzekering should be considered part of this agreement. The Regeling zorgverzekering can be found on the insurer's website and is obtainable on request.

Article 8.17 Compensation of care other than that specified in this agreement

Should the occasion arise, entitlement exists to forms of care other than specified in this agreement, or to compensation for the cost of this care, when it is firmly established that the treatment concerned is generally accepted to produce a comparable result, and the insurer has given prior consent, and where these forms of care are not excluded by law. Experimental care is also excluded.

ARTICLE 9 CONFLICT AND TERRORISM

There is no entitlement to compensation should the need for care of other services result from:

- a major conflict (such as armed conflict, civil war, revolution, inland riots, revolt and mutiny). These 6 forms of conflict and their definitions as filed by the verbond van Verzekeraars in Nederland (Association of Insurers in the Netherlands) with the District Court in The Hague on 2 November 1981 under number 136/1981, form part of this agreement.
- b one or more terrorist acts and the total damages in a calendar year as a result of such acts which are to be claimed from indemnity, life or in-kind funeral insurers, to which the Wet toezicht verzekeringsbedrijf 1993 (1993 Insurance Supervision Act) or the Wet toezicht natuura-uitvaartverzekeringsbedrijf (Insurance Supervision (Benefits in Kind for Funerals) Act) applies, is expected by the Nederlandse Herverzekeringsmaatschappij voor Terrorisemeschaden N.V (Netherlands Reinsurance Company for Losses from Terrorism) to be higher than the maximum amount that this company has reinsured for a calendar year. Insured is only entitled to care or compensation of costs for such care up to a maximum percentage of the costs or value of the care or other services, as determined by the company. In the event that, after a terrorist act, an extra contribution is made available to the insurer by virtue of article 33 of the Zorgverzekeringswet (Zvw) or article 3.16 of the Besluit zorgverzekeringen (Health Care Insurance Decree), the insured has the right, in addition to the entitlements within the meaning of the first sentence, to entitlements the size of which are determined in article 33 of the Zorgverzekeringswet or article 3.16 of the Besluit Zorgverzekeringen.

ARTICLE 10 ENTITLEMENT TO CARE

- a Without prejudice to that determined in article 8, the insured is only entitled to a form of health care in as far as is, in content and scope and with regards to suitability, reasonable.
- b The decision as to whether an insured person requires a specific form of care or other service will only be made based on care criteria.
- c Should insured require insurer's authorization or should a referral or prescription from an expert be required in order to receive an insured benefit, and the insured has already received this authorization, referral or prescription from another insurer, then this authorization, referral or prescription qualifies the insured to obtain the insured benefit for the period over which the authorization had been given or the referral or prescription was valid, and the insurer will not again require authorization or a referral or prescription to be produced.

ARTICLE 11 CARE IN-KIND AND COMPENSATION OF COSTS

General

- a Insured should initially obtain care or other services to which he is entitled under the health insurance, from provider contracted by the insurer to provide such care.
- b Should insured obtain care or other service from a non-contracted provider, he is entitled to compensation of the costs of this care or other service in accordance with that determined below in 'Compensation from non-contracted provider'.
- c Should forms of care or other services be allocated by the regulation referred to in article 12, paragraph 1, Zvw, for which the insurer may only compensate the costs on the proviso that an agreement is concluded between him and the provider, the insured is only entitled to care obtained from a contracted provider.

Notice of contracted care and providers

- d Insurer will inform policyholder and/or insured person concerned of contracted providers either verbally or in writing, by or on behalf of the insurer, either by publication on the insurer's website or by another means.

Compensation from non-contracted provider

- e Insurer compensates the cost of care provided by a non-contracted provider in accordance with the WTG (National Health Tariffs Act) tariff, and, if such a tariff does not exist, in as far as the costs are considered reasonable by prevailing market standards in the Netherlands. Insurer includes in his assessment the costs charged by the provider concerned, the prevailing costs charged by such providers and what is considered reasonable given the circumstances.
- f A discount of 10% will be applied to the amount given in e, to a maximum of € 200 per insured person per calendar year. This discount does not apply:
 - i to unexpected and emergency care;
 - ii should there be a waiting list longer than the 'Treeknorm' (waiting list norm);
 - iii should the insured care, or the type of provider provided under this insurance, not be contracted or not be accessible within a reasonable distance of the insured.
- g That determined in f is not applicable in cases where compensation on the strength of articles 8.4, 8.6, 8.9, 8.14 or 8.15 is set according to the Verzekeringsreglement zorg (Insurance Regulations for Health).

ARTICLE 12 LIABILITY

- a Insurer is not responsible for losses suffered by policyholder or insured as a result of any treatment or failure on the behalf of a provider whose care policyholder of insured made use of within the framework of the health insurance.
- b The insurer's responsibility for any loss as a result of shortcomings of the insurer in the execution of the insurance is limited to the costs to the insurer should the insurance have been executed properly.

ARTICLE 13 FOREIGN COUNTRIES

Emergency care during holiday or temporary stay

Emergency care is unforeseen care which cannot be reasonably delayed until return to the land of residence. To obtain medical care call the Alarmcentrale, telephone number +31 317 455 555. Insurer advises calling the Alarmcentrale especially in the case of emergency care when high costs are to be suspected, such as for hospital treatment or admission.

Emergency care during holiday or temporary stay in EU/EEA country or treaty country other than country of residence of insured, should insured be a resident of the Netherlands or another EU/EEA country or treaty country.

- a An insured person resident in the Netherlands or other EU/EEA or treaty country, and who is temporarily staying in an EU/EEA or treaty country other than his or her land of residence, is entitled to the following emergency care:
 - i care according to the statutory scheme of that country on the strength of that determined in the EU Regulation 1408/71 or a social security regulation, should the following apply to insured;
 - ii care provided by an institution or provider which is contracted by the insurer in the land;
 - iii compensation of costs of care as included in this model agreement, to a maximum of the WMG (National Health Tariffs Act) tariffs valid in the Netherlands. In the absence of valid WMG tariffs, the costs will be compensated in as far as the costs are no higher than that considered reasonable by market standards in the Netherlands.

Emergency care during holiday or temporary stay in EU/EEA country or treaty country, should insured be a resident of a country other than an EU/EEA country or treaty country.

- b An insured person resident in a country other than an EU/EEA or treaty country, and who is temporarily staying in an EU/EEA or treaty country, is entitled to the following emergency care:
 - i care provided by an institution or provider which is contracted by the insurer in the land;
 - ii compensation of costs of care as included in this model agreement, to a maximum of the WMG (National Health Tariffs Act) tariffs valid in the Netherlands. In the absence of valid WMG tariffs, the costs will be compensated in as far as the costs are no higher than that considered reasonable by market standards in the Netherlands.

Emergency care during holiday/temporary stay in a country other than an EU/EEA or treaty country

- c An insured person temporarily resident in a country other than the country of residence, which is not an EU/EEA or treaty country, is, for emergency care, entitled to care or the compensation of costs of care as described in b.

Non-emergency care during holiday or temporary stay in a country other than the country of residence

- d Insured person temporarily staying in a country other than the country of residence is entitled to the following non-emergency care:
 - i care according to the statutory scheme of that country on the strength of that determined in the EU Regulation 1408/71 or a social security regulation, should the following apply to insured;
 - ii care provided by an institution or provider which is contracted by the insurer in the land;

- iii compensation of costs for care obtained from a provider or institution not contracted to the insurer, according to that determined in article 11.

Resident abroad

Insured resident in an EU/EEA or treaty country other than the Netherlands

- e Insured person resident in an EU/EEA or treaty country other than the Netherlands, is entitled to the following care:
 - i care according to the statutory scheme of that country on the strength of that determined in the EU Regulation 1408/71 or a social security regulation, should the following apply to insured;
 - ii care provided by an institution or provider contracted by the insurer;
 - iii compensation of costs for care obtained from a provider or institution not contracted to the insurer, to a maximum of the WMG (National Health Tariffs Act) tariffs valid in the Netherlands. In the absence of valid WMG tariffs, the costs will be compensated in as far as the costs are no higher than that considered reasonable by market standards in the Netherlands;
 - iv compensation of costs for care obtained outside the country of residence of the insurer from a provider or institution not contracted to the insurer, according to that determined in article 11.

Insured resident in country other than an EU/EEA or treaty country

- f An insured person resident in a country other than an EU/EEA or treaty country is entitled to the following emergency care:
 - i care provided by an institution or provider contracted by the insurer;
 - ii compensation of costs for care obtained in the country of residence of the insured from a provider or institution not contracted to the insurer, to a maximum of the WMG (National Health Tariffs Act) tariffs valid in the Netherlands. In the absence of valid WMG tariffs, the costs will be compensated in as far as the costs are no higher than that considered reasonable by market standards in the Netherlands;
 - iii **compensation of costs for care obtained outside the country of residence of the insurer from a provider or institution not contracted to the insurer, according to that determined in article 11.**

Prior consent requirement for care in foreign countries

- g The following applies to all the situations given above: in order to obtain intramural care, i.e. medical care on admission to an institution, in a country other than the country of residence, prior consent from the insurer is required, apart from in the case of emergency care.

Referral and/or authorization requirement

- h Should, for certain forms of care, specific referrals and/or authorization be required in addition to prior consent for obtaining the care, this will be stated in the article in which the particular form of care is described, or in the insurers Verzekeringsreglement zorg (Insurance Regulations for Health).

ARTICLE 14 SUBMITTING INVOICES

Should an insured person be entitled to compensation of costs, an invoice will only be considered for compensation under the following conditions:

- a An original invoice (not a copy or reminder) from the provider is submitted.
- b The invoice is clearly written such that the insurer is easily able to determine whether or not the invoice qualifies for compensation.
- c Invoices of unclear origin ('computer invoices') are authenticated by the care provider.
- d The invoice is received by the insurer within 12 calendar months of the end of the calendar year in which the care and/or service was provided.
- e Submitted invoices will not be returned to the policyholder.
- f **Should the insurer deem it necessary, an invoice written in a foreign language is to be translated by a sworn translator. The costs for translation are to be borne by the insured.**

ARTICLE 15 NO CLAIM SCHEME

- a Should the value of the insured benefits provided in one calendar year on behalf of an insured person total less than € 255, then the insured is entitled to receive an amount from the insurer, the no-claim refund, equal to the difference between € 255 and the value previously referred to.
- b Insured persons who, on the 31 December of the year referred to in the first paragraph, were younger than eighteen years old, have no entitlement to a no-claim refund.
- c Should the health insurance not commence or terminate on the 1 January of a calendar year and the policyholder did not have a health insurance with the insurer directly previously to the commencing date or directly following the termination date, or should the insured turn eighteen during the calendar year, then the amount specified in a is to be multiplied by a fraction in which the numerator is equal to the amount of days in the calendar year over which the insurance was valid or, if the insured turned eighteen, the premium was payable, and the denominator equal to the number of days in the calendar year.
- d Should c apply, the no-claim refund will be calculated by subtracting the value of the insured benefits provided from or up to the day on which the health insurance commenced or terminated, from the amount determined in accordance with c.
- e Maternity care and care provided during pregnancy and childbirth and by a general practitioner, with the exclusion of the costs of examination associated with general practitioner care which is carried out elsewhere and separately invoiced, on the condition that the person involved is authorized to charge the tariff as set by the CTG (Healthcare Charges Board) for that care, is not included for the determination of the no-claim refund.
- f Costs of care or another service will be ascribed to the calendar year in which the care or service was provided, on the understanding that the costs of care or another service made use of in two consecutive years and singularly charged by the care provider or other service provider, will be ascribed to the calendar year in which the invoiced care or service commenced.
- g Amounts referred to in article 11, third paragraph, Zvw, which are to be paid by insured, or costs which, based on article 13, first paragraph, Zvw, remain to be paid by insured, are, for determination of the no-claim refund and the determination as to whether or not a valid personal excess has been exceeded, not included.
- h The no-claim refund, referred to in article 22 of the Zvw, will be paid directly to the insured's bank account, no later than 31 March of the calendar year following the year for which the no-claim refund applied.
- i Should it become apparent that care was provided, the costs of which the insurer was unable to take into account when calculating the no-claim refund, then the no-claim refund will be corrected, no later than 31 March of the second calendar year following the year for which the no-claim refund applied.

ARTICLE 16 PERSONAL EXCESS

- a The personal excess is € 0, unless a higher personal excess is agreed and specified on the health insurance policy.
- b Insured persons older than eighteen may elect a personal excess of € 100, € 200, € 300, € 400 or € 500 per insured person per calendar year. The discount on the nominal premium is specified on the health insurance policy.
- c The personal excess applies to the insured benefits to which entitlement exists according to the insurance agreement.
- d Insurer will only reduce the costs of care or other services by the personal excess valid for that year, when these costs exceed the amount specified in the previous article, under a, or the amount calculated for that calendar year, based on article 22, third paragraph, Zvw.

- e Amounts referred to in article 11, third paragraph, Zvw, which are to be paid by insured, or costs which, based on article 13, first paragraph, Zvw, remain to be paid by insured, are, for determination of the no-claim refund and the determination as to whether or not a valid personal excess has been exceeded, not included.
- f The costs of registration with a general practitioner or an institute providing general practitioner care are excluded from the personal excess. Costs of registration include the costs of registering a patient, up to a maximum of the beschikbaarheidstarief (availability rate) as determined on the strength of the WMG (National Health Tariffs Act), and costs associated with the provision of medical care in the general practitioners surgery or in the institution, with marking the patient's file or with the location of the surgery or institution, in as far as these costs are agreed between the insurer and the general practitioner or institution and the general practitioner or institution is entitled to make these charges on the grounds of the previously referred to agreement in registering an insured person.
- g Should the health insurance not commence or terminate on the 1 January of a calendar year, then the personal excess for that calendar year is equal to that for the whole calendar year, multiplied by a fraction in which the numerator is equal to the amount of days in the calendar year over which the insurance will be or was valid, and the denominator equal to the number of days in the calendar year.
- h Contrary to that specified in g, the personal excess for the calendar year, should it change during the calendar year and the policyholder immediately previous to the change had already concluded an insurance agreement with the insurer, is calculated as follows:
 - i each personal excess amount which was or will be valid for the calendar year concerned, is multiplied by the number of days for which that excess was or will be valid during that year;
 - ii the amounts calculated based on sub-section i are summed;
 - iii the amount calculated based on sub-section ii is divided by the number of days in the calendar year;
 - iv the amount calculated based on i or ii is rounded to whole euros.
- i That which does not qualify for compensation is also not included in the personal excess.
- j Should direct payment be made to the provider and the personal excess is not deducted from the amount paid, then the policyholder is obliged to pay the personal excess not deducted to the insurer.

ARTICLE 17 PAYMENT OF COMPENSATION

As insured is entitled to compensation of costs, the insurer is entitled to pay costs eligible for compensation directly to the provider, or to a third party to whom the provider has transferred all its accounts. This payment having been made, the entitlement to compensation no longer exists.

ARTICLE 18 OBLIGATION TO COOPERATION

Policyholder and insured are obliged to:

- a cooperate with insurer, insurer's medical adviser or those otherwise entrusted, in providing all required information;
- b ask the attending doctor or medical specialist to inform the medical adviser of the reason for admission;
- c cooperate should insurer make an investigation into possible fraud by a provider;
- d assist insurer in the case of possible recovery of damage suffered by the insurer for which a third party can be made liable. **Insured is bound to promptly inform insurer in the case of disease or damage as a result of an accident for which a third party may be liable. Insured will provide insurer with information that insurer reasonably requests for the assessment of possible third party liability. Without insurer's written authorisation, it is on no account allowed to make any settlement with the third party or his representative, including his insurance company, whereby the interests of insurer may be damaged;**

- e communicate in writing to insurer every change that influences the rights and the duties ensuing from the supplementary insurance at his earliest convenience, but no later than 30 days after the time the change occurred. Such changes may be, amongst others:
 - i moving house;
 - ii birth;
 - iii death;
 - iv change of bank account number or Post Office account number;
 - v taking up residence outside the Netherlands;
 - vi entering active military service;
 - vii starting and ending prison sentence;
 - viii no longer satisfying the requirements for collective insurance.
- f to provide the insurer with the name and address of the general practitioner or general practitioners with whom the insured persons named on the insurance policy are registered.
- g if taking up insurance with another insurance company, to provide the name of this insurer.

ARTICLE 19 FRAUD PREVENTION

- a There is no entitlement to benefits should insured attempt to mislead insurer by making false statements or by withholding facts and circumstances from insurer relevant for the assessment of entitlement to compensation.
- b **In the case of fraud or abuse of the entitlement provided by the health insurance agreement, the details of insured and/or third parties will be registered in the relevant system, according to the Protocol Fraudebestrijding van het Verbond van Verzekeraars (Association of Insurers' Protocol for Fraud Prevention). These registers aim to promote the integrity and safety of the insurance trade and to prevent fraud and abuse. In addition, in the case of proven fraud, the insurer will prosecute.**
- c **The insurer is entitled to claim the costs of investigation into proven fraud from the policyholder.**
- d **Misuse of the health insurance identity card is regarded as fraud.**

ARTICLE 20 COMPLAINTS AND DISPUTES

- a **Should the policyholder or insured not agree with a decision made by the insurer in connection with the execution of the insurance agreement, he may request that the insurer reconsiders this decision. Such a request should be sent to the insurer's Complaints Department.**
- b **Should the insurer not react to the request for reconsideration within 30 days, or should the insurer uphold the original decision, then the policyholder or insured may present the dispute to the Health Insurance Disputes Board. The board's judgement is a binding recommendation, in compliance with that determined in the regulations applicable to the board.**
- c **Should the policyholder or insured have any complaints about the service he can submit his complaint to the Health Insurance Ombudsman.**
- d The address of the Health Insurance Disputes Board and the Health Insurance Ombudsman is: Stichting Klachten en Geschillen Zorgverzekeringen (SKGZ), Postbus 291, 3700 AG, Zeist.
- e Should the policyholder or insured have any complaints about the forms used by the insurer, he can submit his complaint to the Nza. Examples of such complaints may refer to forms which are, in the opinion of the complainant, unnecessary or too complicated. The decision of the Nza is binding for insurer, policyholder and insured.

ARTICLE 21 OTHER CONDITIONS

- a **The personal information required upon application for a health insurance and any further requested information is used by the insurer for accepting the application, the execution of the health insurance and to comply with statutory regulations. This data is also used for other activities in support of business management, such as prevention of fraud, statistical analyses or to inform about relevant products and services.**
- b **Policyholder and insured are assumed to have given permission to insurer, together with third parties (such as providers, factoring agencies, debt collection agencies, assets recovery agencies and fraud investigation agencies), for the use, electronic or otherwise, of personal information (such as name, address, policy, premium and compensations), in execution of the health insurance.**
- c **If and in as far as the insurer reimburses the provider in excess of the insured costs, the policyholder is assumed to have given the insurer the authority to reclaim this amount.**
- d **Costs of care or another service will be ascribed to the calendar year in which the care or service was provided, on the understanding that the costs of care or another service made use of in two consecutive years and singularly charged by the care provider or other service provider, will be ascribed to the calendar year in which the invoiced care or service commenced.**
- e Cancellation of the health insurance agreement is to take place in writing.
- f **Notifications sent to the policyholder at the address last known to insurer are assumed to have reached policyholder and insured.**
- g **A claim can only be made on the strength of authorization by telephone or word of mouth if insurer has confirmed this authorization in writing.**
- h Lists of contracted providers are not a part of the health insurance.
- i **Dutch law applies to this agreement.**



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