Ditzo Basic Insurance Terms and Conditions 2019

Contents

1. Definitions

Pharmacy

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

Dispensing practitioner

The dispensing general practitioner or an established pharmacist registered in the register of established pharmacists, or a pharmacist who is assisted by registered pharmacists in their practice. The term dispensing practitioner shall also include legal entities that provide care through pharmacists that are registered in the foregoing register.

Company doctor

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

Treatment plan or care plan

A treatment plan or care plan consists of, among other things, a description of:

- the patient's prior history;
- the complaints;

- results of examinations carried out previously;
- the – probable – diagnosis;
- the proposed treatment: purpose, nature, frequency and duration of the treatment, the care providers involved and whether or not the patient is to be hospitalised;
- the expected outcomes of the treatment.

Pelvic therapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*, BIG) and who is also registered as a pelvic therapist in the Central Register for Quality Physical Therapy (*Centraal Kwaliteitsregister Fysiotherapie*, CKR) maintained by the Royal Dutch Society for Physical Therapy (*Koninklijk Nederlands Genootschap voor Fysiotherapie*, KNGF) or the Physiotherapy Accreditation Foundation (*Stichting Keurmerk Fysiotherapie*).

Special dentistry

Special dentistry 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 registered as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (*Registratiecommissie Geneeskundig Specialisten*, RGS) or who is registered as a Health and Society physician (*arts Maatschappij en Gezondheid*) in the Specialists Register maintained by the Royal Dutch Medical Association (*Nederlandsche Maatschappij tot bevordering der Geneeskunst*, KNMG) and established by the RGS, and who works as such in Youth Healthcare.

Contract rate

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

Emergency mental healthcare

Treatment for a patient who requires emergency assistance. This care is provided by a psychiatric care provider who works for a 24-hour emergency service. It is also referred to as emergency treatment. Emergency situations relate to situations where 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-reliance. 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 normal way of spending the day offered in a home/residential situation (with breakfast, lunch and dinner);
- welfare activities such as excursions, singing and bingo.

DTC Table of Mental Healthcare Professions

The mental healthcare professions framework issued by the Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*, NZa) that includes all professions whose practitioners are qualified to perform a role in the individual diagnosis-oriented treatment of clients in the mental healthcare sector. This professions framework identifies six clusters of professions: medical, psychotherapeutic, adult educational, psychological, specialised therapeutic and nursing professions.

DTC Care Product

A DTC Care Product describes the full path of specialist medical care or specialised mental healthcare using a performance code laid down by the Dutch Healthcare Authority (NZa). This covers the request for care, the type of care provided, the diagnosis and the treatment.
The DTC pathway commences at the time at which you submit a request for care (the DTC is opened) and is completed in accordance with the applicable regulations.

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 Health Care (Market Regulation) Act (*Besluit uitbreiding en beperking werkingssfeer Wet marktordening gezondheidszorg*), which has been established to ensure the provision of treatment by general practitioners in the evening, at night and at weekends, and which charges legally valid rates.

Dietician

A dietician who satisfies the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists (*Besluit diëtist, ergotherapeut, logopedist, mondhygiënist, oefentherapeut, orthoptist en podotherapeut*).

DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a classification system for psychiatric disorders. It contains cluster descriptions of all disorders based on symptoms.

Expensive medicines

Expensive medicines are medicines that are provided by an institution for specialist medical care and for which that institution can submit a declaration (if relevant agreements are in place), in addition to the DTC Care Products for which an institution for specialist medical care may submit a declaration. These are also known as Add On medicines.

Primary care admission

A temporary stay that is necessary on medical grounds in relation to medical care as generally provided by general practitioners.

Occupational therapist

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

EU and EEA States

In addition to the Netherlands, this shall mean the following countries within the European Union: Austria, Belgium, Bulgaria, Croatia, Cyprus (Greek), Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Sweden and the United Kingdom.

Switzerland has been given equal status under the relevant treaty provisions.
The EEA States (states that are party to the Agreement on the European Economic Area) are Iceland, Liechtenstein, and Norway.

Pharmaceutical care

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

Fraud

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

Physiotherapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered in the Central Quality Register for Physical Therapy maintained by the Royal Dutch Society for Physical Therapy or the Physiotherapy Accreditation Foundation. A remedial masseur as referred to in Section 108 of the Individual Healthcare Professions Act is also deemed to be a physiotherapist.

Birth centre

An institution for primary obstetric care (also known as a birth hotel or delivery centre), located in a hospital, which is able to provide acute obstetric care. New mothers will be able to stay at such an institution for childbirth and during their maternity period.

Contracted care

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

General Basic Mental Healthcare (*Generalistische Basis GGZ*)

The supplementary or other diagnostics and general treatment for minor to moderately severe, non-complex mental or stable chronic problems of insured persons aged 18 and over.

Geriatric physiotherapist

A physiotherapist who is registered as such in accordance with the requirements referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a geriatric physiotherapist in the Central Quality Register for Physical Therapy maintained by the Royal Dutch Society for Physical Therapy or the Physiotherapy Accreditation Foundation.

Specialised Mental Healthcare (*Gespecialiseerde GGZ*)

Diagnosis and specialist treatment of very complex mental disorders for insured parties aged 18 and over.

Healthcare psychologist

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

Mental healthcare institution

An institution 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 (*Wet toelating zorginstellingen*, WTZi). Based on the Quality Charter of the care provider, a distinction is made between independent practices and institutions.

Skin therapist

A skin therapist who is registered in accordance with the terms and conditions referred to in Section 34 of the Individual Healthcare Professions Act and in the Decree governing educational requirements and the discipline of skin therapists (*Besluit opleidingseisen en deskundigheidsgebied huidtherapeut*).

General practitioner

A doctor who is registered as a general practitioner in the register of accredited general practitioner established by the Commission for the Registration of Medical Specialists of the Royal Dutch Medical Association.

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 Ditzo Medical Aids Regulations 2010 (*Ditzo Reglement Hulpmiddelen 2019*) laid down by us regarding the requirements for consent, period of use and quantity.

Attempt at in vitro fertilisation

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

- stimulating the maturation of ova in the body of the female by means of hormone treatment;
- follicular aspiration;
- fertilising the ova and growing embryos in the laboratory;
- implanting one or two embryos in the womb, one or more times, in order to instigate pregnancy.

You

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

Youth healthcare physician

A physician who is registered as a youth healthcare physician in the Profile Register established by the Commission for the Registration of Medical Specialists (RGS) or who is registered as a Health and Society physician in the Specialists Register maintained by the Royal Dutch Medical Association and established by the RGS, and who works as such in Youth Healthcare.

Dental surgeon

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

Multidisciplinary care

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

Paediatric physiotherapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as a paediatric physiotherapist in the Central Quality Register for Physical Therapy maintained by the Royal Dutch Society for Physical Therapy or the Physiotherapy Accreditation Foundation.

Clinical psychologist

A healthcare psychologist who is registered in accordance with the terms and conditions referred to

in Section 14 of the Individual Healthcare Professions Act.

Maternity care agency

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

Maternity hotel

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

Maternity care

The care provided by a maternity care provider affiliated with a hospital, maternity centre or maternity hotel that provides the care generally provided by maternity nurses.

Laboratory tests

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

Speech therapist

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

Authorisation

The written statement that we provide you with in response to a request for care from a care provider. The authorisation confirms that:

- the requested care comes within your healthcare insurance cover;
- you can reasonably be deemed to depend on such care;
- you are entitled to full or partial compensation of the costs of such care in accordance with the policy conditions;

and states the requirements for compensation specific to the type of care involved.

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 Quality Register for Physical Therapy maintained by the Royal Dutch Society for Physical Therapy or the Physiotherapy Accreditation Foundation.

Maximum rate

The average rate that has been agreed on for your treatment with our contracted care providers.

Medical adviser

A physician who is registered 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 registered as a Health and Society physician 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 insurance company.

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 registered as a medical specialist in the Specialists Register established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical

Association.

Quality Charter Model

The Quality Charter Model is a field standard included as a professional standard in the National Health Care Institute's public register for quality standards, measurement tools and information standards and applies to all mental healthcare providers.

Dental hygienist

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

NZa

The Dutch Healthcare Authority (*Nederlandse Zorgautoriteit*, NZa), which is responsible for the regulation, supervision and implementation of healthcare.

Oedema therapist

A physiotherapist who is registered as such in accordance with the terms and conditions referred to in Section 3 of the Individual Healthcare Professions Act and who is also registered as an oedema therapist in the Central Quality Register for Physical Therapy maintained by the Royal Dutch Society for Physical Therapy or the Physiotherapy Accreditation Foundation.

Cesar/Mensendieck remedial therapist

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

Turnover cap

In order to control healthcare costs and keep premiums low, we apply a turnover cap to some contracted care providers. This means that we have made agreements with these care providers on a maximum amount that may be claimed per calendar year.

Admission

Admission in a hospital or rehabilitation centre for 24 hours or longer in the event that and insofar as, on medical grounds, nursing, examinations and treatment can only be offered in a hospital or rehabilitation centre, while uninterrupted treatment by a medical specialist is necessary.

Orthodontist

A dental specialist who is registered in the specialists register maintained by the Commission for the Registration of Dental Specialists.

Orthoptist

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

Chiropodist

A chiropodist who is registered in the Quality Register of Chiropodists (*KwaliteitsRegister voor Pedicures*, KRP) for treating patients with diabetes, rheumatism or medical chiropody.

Physician's assistant

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

Podiatrist

A podiatrist who meets the requirements laid down in the Decree governing dieticians, occupational therapists, speech therapists, oral hygienists, remedial therapists, orthoptists and podiatrists.

Mental healthcare sector privacy statement

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

Private clinic

A treatment centre either in the Netherlands or abroad without WTZi accreditation.

Psychiatrist

A physician registered as a psychiatrist in the Specialists Register established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical Association.

Psychotherapist

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

Rehabilitation

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

Rehabilitation institution

An institution authorised to provide inpatient or outpatient rehabilitation care. The healthcare institution must be accredited under the WTZi.

Second opinion

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

SOS International

SOS International provides 24/7 assistance to travellers in the event of illness or an accident abroad. Medical travel assistance can be requested via www.smartmelden.nl. You will receive a response within 15 minutes.

Geriatric specialist

A doctor who is registered as a geriatric specialist in the register of recognised geriatric specialists established by the Commission for the Registration of Medical Specialists and maintained by the Royal Dutch Medical Association.

Emergency care

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

Sports physician

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

Dentist

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

Prosthodontist

A prosthodontist who has been trained in accordance with the Decree governing educational requirements and the discipline of prosthodontics (*Besluit opleidingseisen en deskundigheidsgebied tandprotheticus*).

V&VN

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

Treaty country

A country that is not part of the European Union, an EEA Member State or Switzerland, with which the Netherlands has a treaty on social security in which regulations on the provision of medical care have been included. These are the following countries: Australia (only temporary stay), Bosnia and Herzegovina, Cape Verde, Macedonia, Morocco, Serbia and Montenegro, Tunisia and Turkey.

Obstetrician

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

Nurse specialist in mental healthcare

A nurse specialist in mental healthcare who is registered as such in one of the five statutory registers for nurses in accordance with Section 14 of the Individual Healthcare Professions Act.

Nurse

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

Nurse (higher professional education level)

A nurse or nursing specialist who completed their training at higher professional education (HBO) level, Dutch Quality Framework (NLQF) Bachelor's training profile or Nursing level 5 or 6 (Section 3.1 and 14 of the Individual Healthcare Professions Act/NLQF version 4.0).

Referral letter/referral

The recommendation of a healthcare professional or institution to an insured person to be admitted for treatment or for treatment to be continued by another healthcare professional or institution. A referral must be issued prior to the treatment. The referral must at least state: the name and address and date of birth of the insured person, name, job title, AGB code and stamp of the practice and/or signature of the referring party, date of issue, reason of referral and any other relevant details. A referral letter remains valid for a period of one year following the date of issue and should comply with the national laws and regulations.

Insured party

Any person who is designated as such in the healthcare policy, the policy endorsement or in the certificate of registration.

Policyholder

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

Waiting list mediation

If the healthcare institution has longer waiting times than the nationwide level, please contact us for waiting list mediation assistance. In such a case, you will always be referred to a different healthcare institution.

Wet BIG

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

District nurse

A nurse who completed training at higher professional education (HBO) level, diagnoses care and can provide care in domestic situations and the immediate environment (district, neighbourhood) of the client. The district nurse is the link in the neighbourhood, is freely accessible and operates independently.

We/us/our

ASR Basis Ziektekostenverzekeringen N.V.

Wlz

The Long-Term Care Act (*Wet langdurige zorg*, abbreviated to Wlz).

Wmo

The Social Support Act (*Wet maatschappelijke ondersteuning*, abbreviated to Wmo).

WTZi

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

Independent treatment centre (*Zelfstandig behandelcentrum*, ZBC)

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

Hospital

An institution for nursing, examining and treating sick people as referred to in the Care Institutions (Accreditation) Act.

Sensory impairment care

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

Health insurance company/health insurance provider

ASR Basis Ziektekostenverzekeringen N.V.

Zvw-pgb

Personal budget (*persoonsgebonden budget*, pgb) under the Healthcare Insurance Act (*Zorgverzekeringswet*, Zvw).

ZZP GGZ Care Product (ZZP GGZ)

ZZP GGZ is a complete intramural mental healthcare package involving treatment tailored to the patient's symptoms and specific care requirements (following 365 days in an institution). 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). You only qualify for reimbursement at an institution that has been specifically contracted for these products.

Article 2 Basis of the insurance

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

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

The insurance contract concerns hybrid care insurance, and is based on:

- the Healthcare Insurance Act (*Zorgverzekeringswet*) and accompanying notes;

- the Healthcare Insurance Decree (*Besluit zorgverzekering*) and accompanying notes;
- the Healthcare Insurance Regulations (*Regeling zorgverzekering*) and accompanying notes;
- the application form completed by the policyholder.

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

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

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

These policy terms and conditions state your policy cover entitlements. The extent of basic insurance cover is determined by the government. The relevant legislation states inter alia that the content and scope of your entitlement to care is determined by the current state of scientific research and current practice. If there is no such benchmark, the definition of 'prudent and appropriate care and services' in the relevant specialist area shall apply. You are only entitled to reimbursement of care if you can be reasonably considered to be dependent on the type and scope of care you have received.

We cannot conclude any basic insurance with you if the address you have provided does not appear in the Personal Records Database (*Basisregistratie Personen*) or if it differs from the address under which you are registered in the database. This rule does not apply if:

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

Article 3 Reimbursement of care

Commencement and termination of the reimbursement

The treatment and/or supply date as stated on the invoice is decisive in order to determine whether you qualify for reimbursement of care. In other words, the invoice date is not decisive. If a particular treatment is claimed in the form of a Diagnosis-Treatment Combination (DTC), your entitlement to reimbursement of care depends on the date on which the treatment commenced. You will not qualify for reimbursement unless you were insured with us on that date.

Choice of care provider

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

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

Reimbursement of contracted care

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

*A list of contracted care providers can be viewed at www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Reimbursement of non-contracted care

Statutory maximum rate

If you consult a care provider in the Netherlands with whom we have not agreed any rates, or have only done so to a limited extent, and a statutory maximum rate applies, we will reimburse 100% of your treatment up to the statutory maximum.
The following exceptions apply:

- expensive medicines;
- primary care admission;
- maternity care;
- speech therapy;
- independent rehabilitation centres;

In these five exceptions, we will reimburse your treatment/medicine up to our maximum rate, which we define as the average rate that has been agreed on for your treatment/medicine with our contracted care providers. In many cases, this results in 100% reimbursement, but you may sometimes need to pay part of the invoice yourself.

- mental healthcare (basic and specialist);

In the above cases, we will reimburse your treatment up to our maximum rate for mental healthcare, which is in line with the contracted rates agreed with comparable care providers.

- obstetric care;

In this case, we will reimburse your treatment up to our maximum rate for obstetric care.

- nursing and other care;

In the above cases, we will reimburse your treatment up to our maximum rate for nursing and other care.

*Our maximum rates can be found at www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*

Free rates

If you go to a care provider with whom we have not agreed any rates, or have only done so to a limited extent, and no statutory maximum rate applies, we will reimburse your treatment/medicine according to our set maximum rate, which we define as the average rate that has been agreed on for your treatment with our contracted care providers. In many cases, this results in 100% reimbursement, however you may sometimes need to pay part of the invoice yourself.

*Our maximum rates can be found at www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*

For nursing and care under the Healthcare Insurance Act Personal Budget Scheme (Zvw-pgb), the maximum rates will apply as stated in the Ditzo 2019 Zvw-pgb Regulations.

The Ditzo 2019 Zvw-pgb Regulations are available on www.ditzo.nl/zorgverzekering.

Additional conditions governing non-contracted care

We can only accept original invoices for processing that can contain all the relevant information. The information that is required is determined by the NZa and specified in the current policy rules, which are available on https://puc.overheid.nl/nza.

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

Your entitlement to reimbursement can only be transferred to a non-contracted care provider if either you or this care provider uses a deed of assignment to do so, which must comply with our rules. Further details about our rules on the use of a deed of assignment can be found on www.ditzo.nl/zorgverzekering/reglementen.

Urgent care (including urgent care abroad)

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. In the event of urgent care abroad, you should do so via SOS International. No referral is required for this type of care.

Crucial care guaranteed

In some cases, healthcare institutions may reach their turnover cap during the course of the year as a result of financial agreements between them and us. In such cases, crucial care for you is guaranteed (in other words, ambulance care, emergency assistance, acute maternity services and emergency mental healthcare), and so is regular care, in most cases, if you are already undergoing treatment at that healthcare institution. If the healthcare institution has longer waiting times than the nationwide

level, please contact us. We can provide waiting list mediation assistance. In such a case, you will always be referred to a different healthcare institution.

Overpayment

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

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

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

Authorisation policy

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

- stay in a primary care institution following three months of hospitalisation (Article 18.5);
- certain medicines (Article 18.8);
- non-contracted specialised mental healthcare treatment at a Mental Healthcare (GGZ) institution (Article 18.12);
- non-contracted medical aids (Article 18.14), as well as certain contracted medical aids ('Restitutie 2019' Medical Aids Regulations);
- plastic surgery treatment (Article 18.17);
- specific types of dental surgery (Article 18.18); see the limitative list of dental surgery authorisations;
- dental overview X-rays (Code X21) for insured persons up to age 18 (Article 18.18);
- rehabilitation at non-contracted independent treatment centres (Article 18.21);
- non-contracted nursing and care (Article 18.25);
- admission to sensory impairment care (Article 18.28).

The authorisation will state its period of validity. If the authorisation states a period that exceeds the term of the insurance, your new health insurer will take over the authorisation.

For more details about the backgrounds to this policy and the limitative list of dental surgery authorisations, please go to www.ditzo.nl/zorgverzekering/reglementen.

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

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

DTC Care Product claims

For reimbursement of the costs of care that involves a DTC Care Product, the DTC Care Product will

be apportioned to the year in which the DTC commenced. This means that the costs for the DTC opened in 2018 will be reimbursed by the 'old' insurer if you switch in 2019.

Example:
If your first contact with the specialist was in 2018, the specialist opens a DTC Care Product and the treatment or operation is performed in or continues into 2019, the reimbursement conditions and the compulsory/voluntary excess of 2018 will apply. If the specialist opens a new follow-up DTC Care Product in 2019, the follow-up product will be subject to the reimbursement conditions and the compulsory or voluntary excess of 2019.

Abroad

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

Article 4 Premium

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

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

The premium is equal to the premium base minus any discounts resulting from a voluntary excess.

Article 5 Compulsory excess

Compulsory excess amount

If you are 18 years of age or older, you must pay an obligatory excess of €385 per calendar year. Any care costs up to this amount are for your own account.

When does the compulsory excess apply?

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

- visits to your general practitioner. However, medicines prescribed by your general practitioner or laboratory tests ordered as part of the care from your general practitioner do fall under the obligatory excess;
- the costs of combined lifestyle intervention (Article 18.10);
- the costs of obstetric care and maternity care (Article 18.24);
- the costs of nursing and other care (Article 18.25);
- the costs of foot care for diabetes patients (Article 18.26);
- the costs of follow-up donor checks. The 13-week and 6-month follow-up checks are paid for by the donor's health insurance;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- the costs of multidisciplinary care in the case of diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);

- medical aids provided on loan or rented based on a loan arrangement;
- personal contributions (except for medicines) or private payments;
- mentoring programmes for quitting smoking carried out by your general practitioner.

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

Calculation of compulsory excess for a mid-year contract date

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

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

DTC Care Product (Diagnosis-Treatment Combination)

In order to determine the compulsory excess, the DTC Care Product will be apportioned to the year in which it was commenced. This means that the obligatory excess in 2018 will be charged to the 'old' insurer if you switch in 2019.

Example:
If your first contact with the specialist was in 2018, the specialist opens a DTC Care Product and the treatment or operation is performed or continues into 2019, the reimbursement conditions and the compulsory/voluntary excess of 2018 will apply. If the specialist opens a new follow-up DTC Care Product in 2019, the follow-up product will be subject to the reimbursement conditions and the compulsory or voluntary excess of 2019.

Article 6 Voluntary excess

Voluntary excess amount

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

When does the voluntary excess apply?

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

- visits to your general practitioner. However, medicines prescribed by your general practitioner or laboratory tests ordered as part of the care from your general practitioner do fall under the obligatory excess;
- the costs of combined lifestyle intervention (Article 18.10);

- the costs of obstetric care and maternity care (Article 18.24);
- the costs of nursing and other care (Article 18.25);
- the costs of foot care for diabetes patients (Article 18.26);
- the costs of follow-up donor checks. The 13-week and 6-month follow-up checks are paid for by the donor's health insurance;
- the costs of donor transport if they can be reimbursed to the donor under basic insurance;
- the costs of multidisciplinary care in the case of diabetes, vascular risk management or COPD;
- medication assessment for chronic use of prescription-only medicine(s);
- medical aids provided on loan or rented based on a loan arrangement;
- personal contributions (except for medicines) or private payments;
- mentoring programmes for quitting smoking carried out by your general practitioner.

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

Calculation of voluntary excess for a mid-year contract date

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

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

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

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

DTC Care Product (Diagnosis-Treatment Combination)

In order to determine the voluntary excess, the DTC Care Product will be apportioned to the year in which it was commenced. This means that the obligatory excess in 2018 will be charged to the 'old' insurer if you switch in 2019.

Example:
If your first contact with the specialist was in 2018, the specialist opens a DTC Care Product and the treatment or operation is performed or continues into 2019, the reimbursement conditions and the compulsory/voluntary excess of 2018 will apply. If the specialist opens a new follow-up DTC Care Product in 2019, the follow-up product will be subject to the reimbursement conditions and the

compulsory or voluntary excess of 2019.

Article 7 Privacy

Registration of personal details

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

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

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

For further information, please see the privacy statement at www.asrnederland.nl/privacyverklaring.

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

For further information, visit www.stichtingcis.nl.

Citizen Service Number

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

Notification

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

Article 8 Obligations

Insured parties and policyholders are obliged to:

- identify themselves using a driver's licence, passport or Dutch identity card when utilising healthcare services in a hospital or outpatients' department;

- ask the treatment provider or medical specialist to inform our medical adviser of the reason for your being admitted, upon request;
- cooperate fully with us in obtaining the information we need, with due observance of privacy legislation;
- inform us within 30 days in the event of your detainment. You must also inform us within 30 days of the cessation of your detainment;
- submit original invoices to us within three years of the date of treatment. The details on the invoices must allow us to determine whether you are entitled to a reimbursement, and the amount. Computer-generated invoices must be authenticated by the healthcare provider. Neither a payment overview, nor a quote, order confirmation, proof of advance payment or advance invoice count as an invoice.

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

Article 9 Recourse

Insured parties and policyholders are obliged to:

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

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

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

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

Article 10 Fraud

Duty of cooperation

Under the Healthcare Insurance Act and the Incidents Warning System for Financial Institutions Protocol (*Protocol Incidentenwaarschuwingssysteem Financiële Instellingen*), for the purposes of fraud investigation, we are allowed to monitor the content of your insurance application, your personal data in our systems and your claims. Under the Healthcare Insurance Regulations, health insurance providers are obliged to conduct material checks and fraud investigations in accordance

with the requirements in the Regulations. You are obliged to cooperate in this regard. If you refuse to cooperate, we will be unable to acknowledge your statements and will be required to draw unilateral conclusions.

Personal data

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

Health insurers actively collaborate on fraud management

The Healthcare Insurance Act, the Long-Term Care Act and the Health Care (Market Regulation) Act authorise health insurance providers to exchange information among themselves for monitoring and fraud management purposes. We also share certain indications with sector partners to combat fraud, such as the Dutch Healthcare Authority (NZa), the Social Affairs and Employment Inspectorate (iSZW) and the Fiscal Intelligence and Investigation Service (FIOD), with due observance of Article 6 of the General Data Protection Regulation (GDPR). This information exchange may take place directly, or via the Association of Dutch Health Insurers (*Zorgverzekeraars Nederland*, ZN). The General Data Protection Regulation sets out the way in which personal data may be processed.

Lapsed right to claims

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

Sanctions

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

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

Article 11 Unlawful registration

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

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

Article 12 Payment of premium and payment arrears

Payment of premium

You are obliged to pay the premium and the contributions arising from Dutch or international statutory regulations or provisions to us in advance. We have agreed with you that you will do so on a monthly or annual basis. You will only be able to pay premiums via direct debit. For monthly payments, we will debit the amount payable from your account every month around the same date. If the policy is backdated when drawn up, the outstanding premium will be collected as a lump sum within 30 days. The amount of the premium is shown on the policy schedule issued to you.

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

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

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

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

Payment reminders

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

Premium payment arrears

If you are two monthly premium payments in arrears, we will offer you a premium payment plan.
If your payment arrears amount to four monthly premiums, we will inform you that, should your arrears reach six monthly premiums, we will refer your case to the Central Administration Office (CAK) in connection with the levying of a premium under administrative law.

If your payment arrears amount to six monthly premiums or more, we will report the matter to the CAK and to you, the policyholder. From that point on, the Central Administration Office will collect the premium under administrative law from you, the policyholder, and you will no longer pay any nominal premiums to us. If we decide to take measures in order to collect our claim, all judicial and extrajudicial collection costs will be for your account. The relevant claims for costs will be submitted to Stichting e-Court (the e-court foundation) and/or the competent court.
In such cases, the statutory regulations concerning 'The consequences of non-payment of the premium and the premium under administrative law' (Sections 18a through 18g of the Healthcare Insurance Act) apply.
We are entitled to settle any payment arrears against sums that we still owe to you.

Stichting e-Court

If there is an outstanding amount in premiums or other costs, then proceedings may be initiated at the Stichting e-Court disputes committee. If we initiate such proceedings, you will have one month to submit a notice of objection to the proceedings at Stichting e-Court, counted from the date at which a notice of such proceedings has been issued by the bailiff. In that case, the proceedings will be put before the sub-district court, unless you put the dispute to the Dutch Health Insurance Industry Complaints and Disputes Authority (*Stichting Klachten en Geschillen Zorgverzekeringen*, SKGZ). The statutory rules and the applicable procedural rules that are listed on **www.e-court.nl** shall apply to proceedings at Stichting e-Court.

Suspension in the event of detention

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

Article 13 Claims and suspension of cover

Claims paid directly

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

Amounts owed

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

General claim

We will notify you of any amounts to be repaid by you; you will have to repay such amounts by the deadline stated in the notification. You are not permitted to use your existing credit with us to pay outstanding amounts.

Suspension

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

Article 14 Notification of relevant events

Changes to your personal situation

You are obliged to notify us within 30 days of all events that may be of significance for the proper implementation of this insurance, such as the end of your obligation to obtain health insurance, changes to your account number/IBAN, extended stays abroad, relocation, divorce, birth, death, etc.

18 years and over

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

Article 15 Revision of premium or conditions

Annual amendment

We are entitled to amend your premium and/or policy conditions every year, effective 1 January.

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

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

Letter of notification of changes

A revision of the premium base will take effect no sooner than seven weeks after the date upon which the policyholder was notified to this effect. Before we change anything, you will receive a letter from us containing information on the changes. Complaints regarding the implementation of the change will be subject to the customary complaints procedure.

Article 16 Commencement and termination of the insurance

Commencement of your basic insurance

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

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

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

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

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

Right of withdrawal

You (the policyholder) have 14 days after submitting an application for basic health insurance during which you may withdraw the application.

Termination of your basic insurance by notice of termination

Switching at the end of the year

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

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

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

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

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

Interim termination

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

- You (the policyholder) have insured someone other than yourself, who is insured under a separate basic insurance policy. In such cases, however, you must provide us with proof of

registration for the new insurance policy. If we receive the termination notice prior to the commencement date of the new basic insurance, the basic insurance will terminate on the day the insured party receives new basic insurance. In other cases, the termination date will be the first day of the second calendar month following the day on which you (the policyholder) submitted notice of termination.

- Changes to the premium base or policy conditions adversely affect you. In such cases, the basic insurance will terminate on the day on which the changes to your premium or conditions enter into force. You have 30 days from receiving notice of the changes in which to submit written notice of termination. This reason for termination will not apply if the premium or conditions change as the result of a statutory provision.
- You recently turned 18 and wish to transfer to a different insurance provider.
- The NZa has informed you that we have failed to meet the provisions of Section 15f of the Processing of Personal Data in Healthcare (Additional Provisions) Act (*Wet aanvullende bepalingen verwerking persoonsgegevens in de zorg*). In that case, we need to have received your notice of termination within six weeks of the NZa's message.

These termination options do not apply:

- during the period in which you (the policyholder) have failed to pay the premiums and any collection costs owed by the set deadline (see Article 12), unless we confirm your termination within two weeks;
- during the first 12 months of the insurance contract, if you are insured under the Central Administration Office (CAK) Regulations for the Non-insured.

Termination of your basic insurance by operation of law

We will terminate your basic insurance effective the day following the day on which:

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

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

Article 17 Reconsideration and complaint

This Agreement is governed by Dutch law.

Request for reconsideration

In the event that you do not agree with a decision made by us, you may request that we reconsider it. To do so, please send an email to zorg.medisch@ditzo.nl. Alternatively, you may send a letter to Ditzo, attn. Medical Department, PO Box 2072, 3500 HB Utrecht (the Netherlands) or call us on +31 (0)70 699 79 30.

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 Dutch Health Insurance Industry Complaints and Disputes Authority (*Stichting Klachten en Geschillen Zorgverzekering*, SKGZ). The SKGZ offers mediation services in order to solve problems. If mediation fails to produce satisfactory results, the Disputes Board of the SKGZ may issue a binding decision. You may also bring your request for reconsideration before the competent court.

Complaints

If you have a complaint, please use the online complaints form on My Ditzo. Alternatively, you can call us (+31 (0)30 699 79 30) or send a letter to Ditzo Complaints Office, PO Box 2072, 3500 HB Utrecht (the Netherlands).
If you are dissatisfied with the way your complaint was handled, please submit it to the SKGZ.
You may also bring your complaint before the competent court.

Complaints about standard forms

If you find our forms too complicated or superfluous, you may submit a complaint to the NZa, who will issue a binding opinion on the matter.

Article 18 Medical care

Article 18.1 Audiological care

Audiological care focuses on the prevention, examination and treatment of hearing disorders. It is a type of specialist medical care.

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

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

A referral by a general practitioner, company doctor, paediatrician, youth healthcare physician, clinical physicist, audiologist, infant welfare centre physician or ENT specialist is required. If you undergo inpatient treatment at an institution designated under the Long-Term Care Act, in addition to the referring specialists referred to above, a doctor for the intellectually disabled or a geriatric specialist may also issue the referral, provided they are acting as the coordinating treatment provider.

Article 18.2. Abroad

Submitting an invoice

The invoice should be submitted in one of the following languages: Dutch, German, English, French or Spanish. If the invoice is submitted in any other language, it is your responsibility to provide a translation produced by a certified translator.

If you live in the Netherlands and receive healthcare abroad

We provide the same level of reimbursement under the same terms and conditions that you would have received had you used a non-contracted care provider in the Netherlands, up to our set maximum rate.

*Our maximum rates can be found at www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*

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

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

If you live in another EU/EEA country or treaty country and are temporarily residing in the Netherlands or in another EU/ EEA country or treaty country, you have the following options:

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

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

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

Emergency care

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

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

Requesting non-emergency care in advance

Non-emergency care abroad will only be refunded (fully or partially) in specific cases. For non-emergency care abroad, you must contact us in advance to find out if – and if so, to what amount – you are eligible for reimbursement. We reimburse costs up to our set maximum rate.

European Health Insurance Card (EHIC)

The EHIC can be found on the back of your health insurance card. If you go on holiday to an EU/EEA country or Switzerland, you will be entitled to necessary medical care in the destination country. You can also use the EHIC in Australia for necessary medical care services. You may only use this EHIC if you are insured with us. If you use the EHIC with the knowledge that it is no longer valid, or if you should know that it is no longer valid, the costs of your care will be for your own account.

Payment

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

Article 18.3. Dialysis

There are two types of non-clinical dialysis: peritoneal dialysis and haemodialysis. Peritoneal dialysis involves cleaning your abdominal cavity with a fluid to purify your blood. Haemodialysis is a therapy in which filters take over your renal function. These filters are known as artificial kidneys. You can undergo dialysis in a dialysis centre or at home.

We reimburse the following dialysis centre costs:

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

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

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

Please note that you will need our prior permission for any adjustments to your home and for restoring your home to its original state.

Article 18.4. Dietetics

Dietetics is the provision of information about eating habits and food for a medical purpose. Dieticians provide advice on your eating pattern in order to promote your physical health.

We will reimburse a maximum of three hours of treatment per calendar year. This treatment must involve the care generally provided by dieticians and must have a medical purpose.

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

Article 18.5 Primary care admission (ELV)

There may be situations in which your general practitioner believes it is not sensible for you to stay at home, although there is no direct need for hospitalisation. In such a case, you may be admitted to a primary care institution, in consultation with your general practitioner. The purpose of such admission is for you to recover sufficiently to return to your own home environment.

Primary care admission focuses on recovery and return to your home environment or relates to palliative terminal care, in cases where life expectancy is an average of three months or less. During primary care admission, it may become clear that a return home is not medically justified; consequently, an indication under the Long-term Care Act (Wlz) will be requested. The care that you receive during primary care admission is a medical necessity in relation to care as generally provided by general practitioners.

During primary care admission, you will be monitored or have care close by you at all times, which may also be accompanied by nursing, care, psychological care (in accordance with Section 2.4 of the Healthcare Insurance Decree) or paramedical care that relates to the medical indication for primary care admission. The medical indication for primary care admission must be issued by a general practitioner, medical specialist, emergency department doctor or specialist geriatrician using an assessment instrument. If necessary, such a medical assessment will be conducted in consultation with the district nurse or transfer nurse.

You are not eligible for primary care admission if you have a medical indication for:

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

Maximum admission period

Because of the temporary nature of primary care admission, we will reimburse such a stay for a maximum period of three months. If you require primary care admission for longer than three months, then you must request an extension prior to the lapse of the three-month period. To do so, your care provider, in consultation with you as a patient, must submit an authorisation request for an extension of the primary care by a maximum period of three months.

The authorisation form is available on www.ditzo.nl/zorgverzekering.

Quality criteria for primary care admission providers

All providers must meet the following minimum criteria:

- The provider must have the relevant accreditation under the WTZi, concerning admission, treatment, nursing and/or other care, and must satisfy the requirements set out in the Act.
- The care supplied by the provider must be in line with the latest professional requirements and standards.
- Nurses must be available 24 hours a day, 7 days a week. A level-5 nurse will have primary responsibility, and will therefore also act as your primary point of contact.

- The care provider must make agreements (with your general practitioner, in any case) concerning the handover of medical data (medical policy) between the hospital and the primary care institution upon admission and discharge.

If you decide on a non-contracted provider

We will reimburse your stay up to our set maximum rate. In many cases, this results in 100% reimbursement, however you may sometimes need to pay part of the invoice yourself.

Note: please see Article 3 (Reimbursement of care) for 'Additional conditions governing non-contracted care'.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Article 18.6 Genetic testing and counselling

Genetic testing involves examining whether a congenital disorder or defect is hereditary. It is a type of specialist medical care.

Provided that a medical specialist has confirmed the medical necessity, we will reimburse the costs of central diagnostics and the coordination and registration of the blood and bone marrow samples submitted to a centre for genetic testing.
This care comprises:

- conducting research into hereditary diseases by means of:
    - genealogical research;
    - chromosome research;
    - biomedical diagnostics;
    - ultrasound testing;
    - DNA testing;

- genetic counselling and the necessary psychosocial support.

We also reimburse tests for other persons if this is necessary for the recommendation to be issued to you. This also includes potential counselling for these other persons.

You require a referral from your medical specialist.

Article 18.7 Occupational therapy

Occupational therapy helps you find practical solutions in your environment if performing daily activities becomes problematic for you due to a physical, mental, sensory or emotional disorder. You can also ask your occupational therapist for advice on the use of aids, or how to apply for them.

We reimburse a maximum of ten treatment hours per calendar year for consultation, instruction, training or treatment by an occupational therapist, either at the specialist's practice or at your home. This treatment must comprise the care generally provided by occupational therapists, for the purposes of promoting or restoring your self-reliance and ability to care for yourself. Treatment at locations other than the care provider's practice (e.g. at home or at a health institution) requires a

referral from a general practitioner or specialist.

Article 18.8 Pharmaceutical care

Pharmaceutical care relates to the use of drugs or medicines, as well as the supply of such drugs or medicines and providing advice and guidance on how to use them. Medicines come in a wide variety of forms, such as tablets, drinks, injections, etc. Medicines are substances that have a specific – ideally curative – effect on the body.

General

Pharmaceutical care consists of:

- the supply of medicines by dispensaries (pharmacists and dispensing practitioners); or
- consultation and support as generally provided by dispensaries for the medical assessment and responsible use of:
    - registered medicines from Appendix 1 to the Healthcare Insurance Regulations (*Regeling Zorgverzekering*) as stipulated by us;
    - the medicines listed in Appendix 1 that belong to the categories listed in Appendix 2 of the Healthcare Insurance Regulations. These medicines must also meet the criteria listed in the relevant category, and comply with the provisions in Article 5.3 of the Ditzo Pharmaceutical Care Regulations 2019 (*Ditzo Reglement farmaceutische zorg 2019*);
    - other medicines, provided they relate to rational pharmacotherapy as follows:
        - medicines prepared by or on assignment of a dispensary in a private pharmacy on a small scale and made available (in accordance with Section 40(3a) of the Medicines Act);
        - medicines brought into commercial circulation in accordance with established regulations and prepared by a manufacturer at the request of a doctor in the Netherlands. The medicines must be intended for use by individual patients of the doctor in question, and must have been prepared under the doctor's supervision according to his or her specifications (in accordance with Section 40(3)(c) of the Medicines Act (*Geneesmiddelenwet*));
        - medicines that were brought into commercial circulation in another Member State or a third country, have been imported or otherwise brought into the Netherlands at the doctor's request and are intended for a patient who is suffering from an illness that does not have a higher incidence in the Netherlands than 1 in 150,000 inhabitants (in accordance with Section 40(3)(c) of the Medicines Act);
    - polymeric, oligomeric, monomeric and modular dietary preparations in compliance with Section 1 of Appendix 2 to the Healthcare Insurance Regulations that furthermore comply with the provisions in Article 5.3 of the Ditzo Pharmaceutical Care Regulations 2019;

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

Appendices 1 and 2 of the Healthcare Insurance Regulations are available on www.wetten.overheid.nl.
The Ditzo Pharmaceutical Care Regulations 2019 (Ditzo Reglement farmaceutische zorg 2019) are available on www.ditzo.nl/zorgverzekering/reglementen.

Reimbursement

We reimburse the supply of medicines as generally provided by dispensaries. A statutory personal contribution of up to €250 applies to specific medicines. The Minister of Health, Welfare and Sport determines to which medicines this contribution applies. These medicines are listed in Appendix 1a to the Health Insurance Regulations.

Details about the personal contribution can be found in Article 5.1 of the Ditzo Pharmaceutical Care Regulations 2019 and on our website.

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

- the provision of medicines exclusively available on prescription;
- explanation of the new medicine and how it should be used.

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

Prescribing doctor

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

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

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

We do not reimburse:

- pharmaceutical care which the minister has decided does not qualify as insured care or which the minister has made subject to certain conditions that have not been met;
- medicines for travel-related risk of illness;
- medicines for examination or experimental use;
- medicines for which an application for market authorisation has been submitted to the Medicines Evaluation Board (*College ter Beoordeling van Geneesmiddelen*, CBG) or that are still undergoing clinical tests and which, in accordance with conditions established by a Ministerial Regulation, have been made available for compassionate use;
- personal contribution(s) for medicines up to €250;
- personal contribution(s) for medicines that fall under the excess;
- medicines that are equivalent or practically equivalent to any registered medicine that is not listed in the medicine reimbursement system (*geneesmiddelenvergoedingssysteem*, GVS);

- homeopathic and anthroposophical products and medicines;
- nutritional supplements and vitamins not registered as medicines;
- other costs (i.e. administrative or shipping costs).

Pharmaceutical Care Regulations

The Ditzo Pharmaceutical Care Regulations 2019 contain further conditions concerning the eligibility assessment of pharmaceutical care. These include:

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

The Ditzo Pharmaceutical Care Regulations 2019 are available on www.ditzo.nl/zorgverzekering/reglementen.

Article 18.9 Physiotherapy and remedial therapy

Physiotherapy and remedial therapy are types of treatment aimed at improving the way you move and your posture when you have physical complaints.

Parties under the age of 18

Physiotherapy and remedial therapy are reimbursed as follows:

- If your condition **is** listed in Appendix 1 of the Healthcare Insurance Decree:
    - You must be treated by a (paediatric) physiotherapist, Mensendieck/Cesar remedial therapist, pelvic therapist or oedema therapist. You require a statement from a general practitioner, a company doctor or a medical specialist. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist.

- If your condition is **not** listed in Appendix 1 of the Healthcare Insurance Decree:
    - A maximum of nine treatments per indication per calendar year will be covered. You must be treated by a (paediatric) physiotherapist, manual therapist, pelvic therapist, Mensendieck/Cesar remedial therapist or oedema therapist. Oedema therapy and scar therapy may also be provided by a skin therapist.
    - If the outcomes are not satisfactory, a maximum of nine **additional** treatments per indication per calendar year will be covered. You require a statement from a doctor or medical specialist.

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

Appendix 1 of the Healthcare Insurance Regulations can be consulted on www.ditzo.nl/zorgverzekering/reglementen.

Parties aged 18 or older

Physiotherapy and remedial therapy are reimbursed as follows:

- If your condition is listed in Appendix 1 of the Healthcare Insurance Decree:

    - the necessary treatment starting from the 21st treatment. You must be treated by a physiotherapist, manual therapist, Mensendieck/Cesar remedial therapist, pelvic therapist, oedema therapist or geriatric physiotherapist. You require a statement from a general practitioner, a company doctor or a medical specialist. The maximum treatment duration specified in Appendix 1 applies. Oedema therapy and scar therapy may also be provided by a skin therapist;
- up to nine pelvic therapy treatments for urinary incontinence. You must be treated by a pelvic therapist. You require a statement from a general practitioner, a company doctor or a medical specialist;
- up to the first 37 treatments for a medical diagnosis of intermittent claudication (stage-2 *claudicatio intermittens*) during a maximum period of 12 months. You require a statement from a general practitioner, a company doctor or a medical specialist;
- up to 12 remedial therapy sessions for arthrosis of the hip or knee over a period of up to 12 months;
- depending on your class, up to 5 (class A), 27 (class B) or 70 (class C and D) supervised remedial therapy treatments for COPD over a period of up to 12 months. If follow-up treatments are required after the year in which treatment was started, we will reimburse a maximum of 3 (class B) or 52 (class C and D) treatments per 12-month period. You will require a statement from a general practitioner, a company doctor or a medical specialist.

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

Appendix 1 of the Healthcare Insurance Regulations is available on www.ditzo.nl/zorgverzekering/reglementen.

Article 18.10 Combined Lifestyle Intervention

Combined Lifestyle Intervention consists of advice and guidance on nutrition, exercise and behaviour for patients with moderately elevated weight-related health risks. The objective of the care is to achieve a healthier lifestyle for the patient.

Reimbursement

We reimburse Combined Lifestyle Intervention care, but do not enter into contracts for partnerships or with individual care providers for that purpose. Reimbursement of this care takes place according to the policies of the Dutch Healthcare Authority.

In addition, we set the following conditions that:

- all Combined Lifestyle Intervention care providers with accreditation as a lifestyle coach must be registered in the register of the Professional Association of Lifestyle Coaches in the Netherlands (*Beroepsvereniging Leefstijlcoaches Nederland*, BLCN);
- a Combined Lifestyle Intervention care provider coordinates the care process and acts as the first point of contact for the insured party;
- a Combined Lifestyle Intervention care provider must notify us of the results of the Combined Lifestyle Intervention treatment on a quarterly basis, insofar as determined by the outcome of the relevant national agreements;

- there must be a valid medical indication in accordance with the policy of referral by a general practitioner (a demonstrable (moderately) elevated weight-related risk);
- the programme must have proven effective based on research and this must have been assessed and published as such by the National Institute for Public Health and the Environment (*Rijksinstituut voor Volksgezondheid en Milieu*, RIVM) in the Centre for Healthy Living (*Loket Gezond Leven*).

Article 18.11 Mental healthcare – General Basic Mental Healthcare (*Generalistische Basis GGZ*)

*Mental healthcare is the diagnosis and treatment of a psychiatric disorder, for the purpose of restoring or improving your mental health. General Basic Mental Healthcare does **not** involve hospitalisation.*

General

If you are aged 18 or over, we will reimburse General Basic Mental Healthcare for the diagnosis and online or regular treatment of, as well as recovery from, mental health problems that lead to a DSM classified disorder, or to prevent the exacerbation of such a disorder. The care must not involve Specialised Mental Healthcare (*Gespecialiseerde GGZ*) and must relate to care defined under or pursuant to the Healthcare Insurance Act.

Care from a non-contracted provider

If you use a non-contracted General Basic Mental Healthcare provider, the amount of the reimbursement will not exceed the maximum rate for General Basic Mental Healthcare set by us.

Note: please see Article 3 (Reimbursement of care) for 'Additional conditions governing non-contracted care'.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Referral

You will require a referral from your general practitioner, medical specialist, company doctor or coordinating treatment provider in Specialised Mental Healthcare.
Such a referral should meet the regulatory requirements in accordance with the Specialised Mental Healthcare Referrals Decision (*Besluit verwijzingen GGZ*) of the Ministry of Health, Welfare and Sport.

The text of this decision is available on www.rijksoverheid.nl/documenten/besluiten/2017/03/16/besluit-verwijzingen-ggz.

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

Care provider

Quality Charter

- The care provider offers care in accordance with its own Quality Charter registered as such with www.ggzkwaliteitsstatuut.nl. We only reimburse care supplied by care providers that satisfy the criteria in the Quality Charter Model.

Coordinating treatment provider

- A coordinating treatment provider is the care provider managing the care process as described in the mental healthcare Quality Charter Model and the Dutch Healthcare Authority regulations.
- The coordinating treatment provider is responsible for establishing and substantiating the diagnosis. To this end, he or she will contact you directly prior to treatment.
- In addition, the coordinating treatment provider is responsible for creating a treatment plan, evaluating the treatment and if necessary adjusting the treatment plan.
- The following General Mental Healthcare providers can act as coordinating treatment providers:

Independent	**Institution-based**
Healthcare psychologist	Healthcare psychologist
Psychotherapist	Psychotherapist
Clinical psychologist/clinical neuropsychologist	Clinical psychologist/clinical neuropsychologist
	Nurse specialist in mental healthcare
	Geriatric specialist or clinical geriatrician in accordance with the terms and conditions of the Quality Charter Model
	Addiction specialist (when addiction and/or gambling is the primary diagnosis) in the Profile Register maintained by the Royal Dutch Medical Association (KNMG)

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

Secondary medical specialists providing mental healthcare

Secondary medical specialists work under the responsibility of the coordinating treatment provider and are listed in the DTC Table of Mental Healthcare Professions.

We do not reimburse:

- Youth Mental Healthcare (under age 18), which is covered by the Youth Act;
- assistance in the event of work-related or relationship problems;
- treatment of adjustment disorders;

- psychosocial support;
- care in the treatment of learning and development disorders;
- excluded care specified in the Mental Healthcare Therapies List, including:
    - dyslexia;
    - fear of animals and flying; the treatment of these phobias falls under general practitioner care;
    - self-help;
    - neurofeedback;
    - psychoanalysis;
    - intelligence testing;
    - medical psychological care (which may form part of specialist medical care);
    - assistance of a non-medical nature, such as training programmes, courses, and counselling regarding parenting;
    - indexed prevention for cases of depression, panic disorders and problematic alcohol use. This falls under general practitioner care;
    - treatments that do not reflect the latest developments in science and practice.

An overview of all Mental Healthcare Therapies that do/do not reflect the latest developments in science and practice (formerly known as the 'dynamic list' of the Association of Dutch Health Insurers) can be found at www.ditzo.nl/zorgverzekering/reglementen.

Article 18.12 Mental healthcare – Specialised Mental Healthcare (*Gespecialiseerde GGZ*)

Specialised mental healthcare is the diagnosis and treatment of a complex psychiatric disorder, for the purpose of restoring or improving your mental health. Some psychiatric treatments require that you be admitted to a psychiatry clinic or to a psychiatric ward of a general hospital.

General

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

Care provider

Quality Charter

- The care provider offers care in accordance with its own Quality Charter registered as such with www.ggzkwaliteitsstatuut.nl. We only reimburse care supplied by care providers that satisfy the criteria in the Quality Charter Model.

Coordinating treatment provider

- A coordinating treatment provider is the care provider managing the care process as described in the mental healthcare Quality Charter Model and the Dutch Healthcare Authority regulations.
- A coordinating treatment provider is responsible for:
    - helping to assess, substantiate and confirm the diagnosis. This also applies to the case during the diagnosis phase;

    - drawing up the treatment plan aimed at responsible treatment according to the latest developments in science and practice and in accordance with mental healthcare guidelines;
    - evaluating and, if necessary, adjusting the treatment.
- The coordinating treatment provider is also responsible for:
    - the authorisation and competence of secondary medical specialists in relation to the independent implementation of the part of the treatment for which they are responsible;
    - meeting the statutory requirements with regard to record keeping. Secondary medical specialists have their own responsibilities in that regard;
    - being informed by secondary medical specialists and other professionals involved in the treatment in a timely fashion, as necessary for the responsible treatment of a patient. The coordinating treatment provider assesses whether or not the activities contribute to and align with the established treatment plan;
    - engaging in personal contact with the secondary medical specialists, as many times as your condition warrants;
    - engaging in effective communication with you and your next of kin (if applicable and with the patient's consent) regarding the progress of the treatment in relation to the treatment plan;
    - concluding the treatment in accordance with the DTC rules.
- The following Specialised Mental Healthcare providers can act as coordinating treatment providers:

Independent	Institution-based
Psychotherapist	Psychotherapist
Clinical psychologist/clinical neuropsychologist	Healthcare psychologist
Psychiatrist	Clinical psychologist/clinical neuropsychologist
	Psychiatrist
	Nurse specialist in mental healthcare
	Addiction specialist (when addiction and/or gambling is the primary diagnosis) in the Profile Register maintained by the Royal Dutch Medical Association (KNMG)
	Geriatric specialist or clinical geriatrician in accordance with the terms and conditions of the Quality Charter Model

- At Mental Healthcare Institutions, specialised mental healthcare is provided by multidisciplinary teams, which always include a psychiatrist or clinical psychologist.
- In cases of clinical admission, the coordinating treatment provider must generally be a psychiatrist or clinical psychologist/neuropsychologist. In consultation, it may be decided that the ambulatory coordinating treatment provider will remain the coordinating treatment provider for the duration of the patient's admission as well.
- If you commence treatment under the Youth Act and turn 18 while treatment is still ongoing, you may continue to receive care from the general remedial educationalist, post-master

remedial educationalist or paediatric/youth psychologist as part of the Specialised Mental Healthcare provisions. This only applies to treatments that are started prior to the patient's 18th birthday and completed after their 18th birthday. The Specialised Mental Healthcare provision must be opened consecutively following the patient's 18th birthday and will remain valid for a period of one year.

Secondary medical specialists providing mental healthcare

Secondary medical specialists work under the responsibility of the coordinating treatment provider and are authorised to allocate time within a Mental Healthcare DTC if they are listed in the DTC Table of Mental Healthcare Professions together with a description of their profession.

Care from a non-contracted provider

If you use a non-contracted Specialised Mental Healthcare provider, the amount of the reimbursement will not exceed the maximum rate for Specialised Mental Healthcare set by us.

Note: please see Article 3 (Reimbursement of care) for 'Additional conditions governing non-contracted care'.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Referral

You will require a referral from your general practitioner, medical specialist, company doctor or coordinating treatment provider in General Basic Mental Healthcare.
Such a referral should meet the regulatory requirements in accordance with the Specialised Mental Healthcare Referrals Decision of the Ministry of Health, Welfare and Sport.

The text of this decision is available on www.rijksoverheid.nl/documenten/besluiten/2017/03/16/besluit-verwijzingen-ggz.

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

Authorisation requirement for a non-contracted institution

We have concluded agreements with the majority of institutions. However, if you wish to attend a non-contracted mental healthcare institution without incurring high costs, either you or your care provider on your behalf must request our authorisation prior to commencing treatment. A separate authorisation request is required for every individual care programme. In principle, we do not reimburse treatments exceeding 6,000 minutes that are carried out by small-scale institutions. In addition, the 'somatic professions' (such as physiotherapists and dieticians) listed in the DTC Table of Mental Healthcare Professions cannot serve as secondary medical specialists in order to qualify for reimbursement.
In order for us to issue an authorisation, you or your care provider must submit:

- a letter of referral from your general practitioner, company doctor or medical specialist;

- in the event of admission: the clinical admission indication, in accordance with the guidelines laid down by the professional association, and the place where the treatment is going to be provided;
- the proposed treatment plan, with details on the number of treatment minutes and activities and procedures to be performed;
- the names and BIG registration numbers of the coordinating treatment provider and the secondary medical specialists involved in the provision of the care;
- the DTC expense claim code and the performance code.

We will treat your claim confidentially; please send it to our medical adviser:

Ditzo
Attn. Mental Healthcare (GGZ) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope, please state: 'Confidential'.
Or send an email to: zorg.medisch@ditzo.nl

Privacy statement

If you do not want a diagnosis code to appear on the claim, you must ensure that we have a privacy statement by no later than the submission of your first claim. We will not process claims without a diagnosis code for which a privacy statement has not been submitted in advance. This statement must be signed by you and the care provider, and sent to the following address:

Ditzo
Attn. Claims Handling Department
PO Box 2072
3500 HB UTRECHT
Or send an email to: zorg.medisch@ditzo.nl

We do not reimburse:

- Youth Mental Healthcare (under age 18), which is covered by the Youth Act;
- assistance in the event of work-related or relationship problems;
- treatment of adjustment disorders;
- psychosocial support;
- care in the treatment of learning and development disorders;
- excluded care specified in the Mental Healthcare Therapies List, including:
    - dyslexia;
    - fear of animals and flying; the treatment of these phobias falls under general practitioner care;
    - self-help;
    - neurofeedback;
    - psychoanalysis;
    - intelligence testing;
    - medical psychological care (which may form part of specialist medical care);

    - assistance of a non-medical nature, such as training programmes, courses, and counselling regarding parenting;
    - indexed prevention for cases of depression, panic disorders and problematic alcohol use. This falls under general practitioner care;
    - treatments that do not reflect the latest developments in science and practice;
- treatments by independent care providers totalling more than 6000 minutes;
- treatment at a non-contracted care provider without overnight stay.

An overview of all Mental Healthcare Therapies that do/do not reflect the latest developments in science and practice (formerly known as the 'dynamic list' of the Association of Dutch Health Insurers can be found at www.ditzo.nl/zorgverzekering/reglementen.

Specialised Mental Healthcare with and without admission

If you are aged 18 or over, we will reimburse specialised care in a Mental Healthcare Institution, psychiatric hospital or psychiatric ward of a hospital.
We also reimburse the necessary nursing, paramedic care,[1] medicines, medical aids and dressings, as well as Specialised Mental Healthcare by an independent psychiatrist, clinical psychologist/neuropsychologist or psychotherapist.
We will reimburse a period of admission in a Mental Healthcare Institution, psychiatric hospital or psychiatric ward of a hospital for a period of up to 1095 days. The care provided must be specialised psychiatric treatment, and admission must be necessary for the treatment.

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

Article 18.13 General practitioner

Your general practitioner is the first person to turn to if you have any questions about your health. Outside regular office hours, please contact your local after-hours clinic.

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

Article 18.14 Provision of medical aids

Medical aids are made to help you deal with a physical problem. There are all sorts of medical aids, for a wide variety of medical conditions. Examples include a hearing aid, a prosthetic arm or leg, test strips for diabetics or dressing materials.

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

We reimburse the costs of medical aids and dressings, subject to the further requirements and conditions of reimbursement listed in the Ditzo Medical Aids Regulations 2019. These regulations also specify whether the aids are given or loaned to you, and form part of this insurance policy.

*The Ditzo Medical Aids Regulations 2019 (*Ditzo Reglement farmaceutische zorg 2019*) can be found at www.ditzo.nl/reglementen.*

Authorisation

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

Usage costs

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

Suitability

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

Dressings

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

Aids on loan

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

We do not reimburse:

- aids and dressings that are also covered under the Long-Term care Act or the Social Support Act.

Article 18.15 Speech therapy

A speech therapist helps you diagnose and treat disorders in the functioning of your mouth organs. Such disorders may concern your breathing, voice, speech, language or hearing. Speech therapists also provide advice and information if you are the patient or a person caring for a patient.

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

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

Speech therapy treatment does not include the treatment of dyslexia or developmental language disorders in relation to a dialect or a foreign language.

Care from a non-contracted provider

If you use a non-contracted speech-therapy care provider, the amount of the reimbursement will not exceed the maximum set by us. In many cases, this results in 100% reimbursement, however you may sometimes need to pay part of the invoice yourself.

Note: please see Article 3 (Reimbursement of care) for 'Additional conditions governing non-contracted care'.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Article 18.16 Mechanical ventilation

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

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

You require a referral from your medical specialist.

Article 18.17 Specialist medical care (excluding mental healthcare)

In most cases, you receive specialist medical care from a medical specialist affiliated with a hospital. A medical specialist is a doctor who completed a specialist medical programme following his or her basic training and is registered as such. There are approximately 30 different medical specialities in the Netherlands, such as surgery, cardiology and neurology.

Referrals for specialist medical care

A referral by a general practitioner, company doctor, youth healthcare physician or other medical specialist is required to qualify for reimbursement of the costs of these types of care. This does not apply to emergency care. For specialist medical care in relation to pregnancy and/or childbirth, the referral can also be made by an obstetrician. This treatment must comprise the care generally provided by medical specialists. Oral care provided by a dental surgeon is covered in accordance with Article 18.18. A referral from a dentist is sufficient in such cases.
If you undergo inpatient treatment at an institution designated under the Long-Term Care Act, in addition to a general practitioner or a medical specialist, a doctor for the intellectually disabled or a geriatric specialist may also issue the referral, provided they are acting as the coordinating treatment provider.

Admission to hospital

We will cover your stay in the lowest class of a hospital or an independent treatment centre (ZBC) for an uninterrupted period of up to 1095 days. Your stay there must be medically necessary as described in this Article or in Article 18.18 (Oral care).

The following rules apply to calculating the 1095 days:
An interruption of no longer than 30 days is not viewed as an interruption, and these days will not be counted towards the 1095 days. Interruptions exceeding 30 days will reset the count at 0. If you are interrupting your admission for weekend or holiday leave, these days will be counted as part of the calculation.

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

Non-clinical specialist medical care

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

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

IVF (in vitro fertilisation attempts) or ICSI

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

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

Attempts do not count unless follicular aspiration (the collection of ova) has been successfully carried out. Only attempts that fail after this stage count towards the number of attempts.
The reinsertion of the/all embryo(s) obtained during an attempt (whether or not these have been frozen in the meantime) forms part of the attempt in which the embryos were obtained, provided there is no instance of a non-interrupted pregnancy. A new attempt following a non-interrupted pregnancy (either spontaneous or following IVF) counts as a new first attempt.
When a frozen embryo is returned to the womb, this will never qualify as a new IVF attempt. This means that, even after an uninterrupted pregnancy, reinsertion of a frozen embryo in the womb will not count as a new IVF attempt.
A maximum of one embryo will be implanted during the first and second attempts for women up to age 38. If a third attempt is made, a maximum of two embryos may be reinserted if necessary for medical reasons. If you are between 38 and 43 years old, a maximum of two embryos may be reinserted for all three attempts if necessary for medical reasons. An IVF attempt that commenced before you reached the age of 43 may be completed.

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

We do not reimburse:

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

Plastic surgery

We reimburse plastic surgery to correct:

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

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

*The Guide for the Assessment of Plastic Surgery Treatment (*Werkwijzer beoordeling behandelingen van plastisch chirurgische aard*) is available on www.ditzo.nl/zorgverzekering/reglementen.*

We do not reimburse:

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

Second opinion

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

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

Conditional admission

The Minister of Health, Welfare and Sport has made some forms of care provisionally admissible under basic insurance, as listed in Section 2.2 of the Health Insurance Regulations. These involve care whose effectiveness is still in doubt, or that has not yet been proven. This means that the full list of provisionally admitted treatments may change in the course of the year.

An updated version of the Healthcare Insurance Regulations is available on www.wetten.overheid.nl.

Article 18.18 Oral care

Oral care involves treatment by a dentist, dental surgeon, orthodontist, oral hygienist or prosthodontist, including those that work in a centre for special dental treatment. Your exact entitlement depends on whether you are 18 years old or above, or under 18.

Special dental treatment is oral care for people who cannot obtain the care they need from a regular dentist. Examples include cases of very serious overbite or a cleft palate.

General

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

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

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

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

a dentist, orthodontist or dental surgeon must be submitted alongside your application.

A list of procedures (codes) and rates is available on www.ditzo.nl/zorgverzekering/reglementen.

Treatment plan or care plan

If you need extensive dental treatment, your dentist will consult with you to prepare a suitable treatment plan and/or care plan. The purpose of such a plan is to solve a dental issue or prevent its becoming worse. Two important components of such a plan are information and consent.

During your conversation with the dentist about the treatment plan, the following subjects will be dealt with:

- a description of the condition;
- the proposed examination/treatment;
- the period after the examination/treatment;
- the costs of the treatment;
- our permission for the treatment;
- your consent to details being provided to third parties (if necessary);
- written information;
- preparing a dossier;
- other information.

Implant for the purpose of attaching a removable prosthesis

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

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

Orthodontics

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

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

Dental treatment for insured persons under the age of 18

If you are below the age of 18, then we will reimburse care as listed above under ‘General’. In addition, we will reimburse the care listed below:

- check-ups (periodic preventive dental examinations) once a year, and multiple times per year if dentally required;
- incidental consultations;
- tartar removal;
- fluoride application starting from the emergence of the first permanent tooth, up to twice per year and multiple times per year if dentally required;

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

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

The dentist should contact us for an authorisation to produce a dental overview X-ray (performance code X21) for insured persons up to age 18. This does not apply to dental overview X-rays made for the purpose of orthodontic treatment (performance codes F155A and 156A). The costs of such X-rays may be claimed without authorisation through supplementary insurance (if applicable).

Dental treatment for insured person over the age of 18

If you are aged 18 or over, we will reimburse the care under 'General' (see above). In addition, we will reimburse the care listed below:

- surgical dental treatment of a specialist nature and the accompanying X-rays, with the exception of periodontal surgery, the insertion of a dental implant and the extraction of teeth or molars without any complications;
- 75% reimbursement for the manufacture and placement of a removable complete immediate denture, removable complete overdenture or removable complete replacement for the upper and/or lower jaw that does not require an implant to be worn.
  A lower-jaw prosthesis requiring an implant to be worn attracts a personal contribution of 10% of the total costs of application (8% for the upper jaw). The personal contribution for a combination of a prosthesis onto implants on one jaw and a non-implant based prosthesis on the other jaw (code J50) is 17%. The placement of a removable complete denture onto dental implants also includes application of the fixed part of the superstructure
  repairing and rebasing an existing removable complete denture or an existing removable complete overdenture, which attracts a personal contribution of 10% of the costs.

Dental surgery requires our prior consent.
The replacement of removable complete replacement dentures within five years requires our prior consent. Your care provider will be able to submit a request for such treatment.

Personal contribution – Adults

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

Institution for specialist dental treatment

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

Article 18.19 Oncological care in children

For an effective treatment of cancer in children, it is crucial that the right diagnosis is made and that the extension of the disease and the type of tumour involved are analysed. SKION (the Dutch Childhood Oncology Group) analyses the blood, bone marrow and cerebrospinal fluid of these children.

We reimburse the costs incurred for central (reference) diagnostics conducted by, and the coordination and registration of the bodily material submitted to, SKION.

You require a referral from your medical specialist.

Article 18.20 Organ transplants

A transplant involves the full or partial replacement of a poorly functioning or non-functioning organ or tissue by that of a donor. Examples of organs and tissues that can be transplanted include the heart, skin, lungs, kidneys, pancreas, liver, bone and bone marrow.

As the recipient of the organ, you qualify for reimbursement of the costs of:

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

As the donor of the organ, you qualify for reimbursement of the costs of:

- the care related to the donor's admission, for selection and/or removal of the transplant material. The costs of this care and the donor's excess will be reimbursed up to 13 weeks after the admission period. A maximum period of six months applies to liver donors;
- the transport within the Netherlands that a donor who is uninsured in the Netherlands requires for:
    - selection, admission to and discharge from a hospital;
    - care up to 13 weeks (or 6 months for liver donors) following admission for transplant purposes.

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

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

residence abroad.

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

The transplant must be performed:

- in an EU Member State;
- in a state that is a party to the Agreement on the European Economic Area;
- in another state, if the donor resides in that state and is the spouse, registered partner or a blood relative in the first, second or third degree of the insured party;

We do not reimburse:

- the costs or excess of follow-up checks of the donor after 13 weeks (kidney donor) or 6 months (liver donor);
- accommodation costs in the Netherlands;
- possible loss of income.

If you are the donor yourself, the recipient's healthcare insurance will reimburse the costs under the same conditions.

Article 18.21 Rehabilitation

Specialist medical rehabilitation is meant for people who suffer an impairment as a result of an accident, medical intervention, serious illness or congenital disorder. The patient is treated by a multidisciplinary team led by a rehabilitation specialist.

Geriatric rehabilitation is meant for vulnerable elderly people following treatment in hospital, for example in connection with a stroke or a fracture. This type of rehabilitation is geared to the elderly patient's individual recovery potential and training speed, and also takes account of other, existing conditions (if applicable). The purpose of geriatric rehabilitation is to help elderly patients return to their home environment.

Specialist medical rehabilitation

We cover rehabilitation if:

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

Specialist medical rehabilitation may take place:

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

Specialist medical rehabilitation requires a referral from a general practitioner, company doctor,

youth healthcare physician or medical specialist. If you undergo inpatient treatment at an institution designated under the Long-Term Care Act, in addition to the referring specialists referred to above, a doctor for the intellectually disabled or a geriatric specialist may also issue the referral, provided they are acting as the coordinating treatment provider.

Geriatric rehabilitation

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

We reimburse geriatric rehabilitative care if:

- prior to receiving specialist medical care, you did not reside in an institution as described in Section 3.1.1 of the Long-Term Care Act; and
- the care is provided within one week after a stay as referred to in Article 18.17 (Specialist medical care); or
- the care is the result of an acute condition, resulting in acute impairment of your mobility or decrease of self-reliance, and you have received specialist medical care as referred to in Article 18.17.

We will reimburse geriatric rehabilitation for a maximum of six months. In special cases, we may grant permission for a longer period. Your care provider must submit a written statement in support of extension to our Medical care Department (zorg.medisch@ditzo.nl) 30 days before the 6-month period has lapsed.

Care from a non-contracted provider

If you use a non-contracted independent treatment centre for rehabilitation care, the amount of the reimbursement will not exceed the maximum set by us. In many cases, this results in 100% reimbursement, however you may sometimes need to pay part of the invoice yourself.

Note: please see Article 3 (Reimbursement of care) for ‘Additional conditions governing non-contracted care’.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under ‘Set maximum rates’ (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider’ (*zorgzoeker*).*

Authorisation requirement for specialist medical rehabilitation care at a non-contracted independent treatment centre

We have concluded agreements with numerous institutions. However, if you wish to attend a non-contracted mental healthcare institution without incurring high costs, either you or your care provider on your behalf must request our authorisation prior to commencing treatment. In order for us to issue the authorisation, please send us the following:

- a referral from a general practitioner, company doctor or medical specialist;

- in the case of hospitalisation: the clinical indication for hospitalisation in accordance with the established guidelines of the Dutch Association of Rehabilitation Specialists (*Nederlandse vereniging van revalidatieartsen*, VRA);
- the proposed treatment plan, with details on the period, number of treatment minutes and activities and procedures to be performed;
- the treatment providers involved in supplying the care;
- the DTC expense claim code and the performance code.

We will treat your claim confidentially; please send it to our medical adviser:

Ditzo
Attn. MSZ medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope, please state: 'Confidential'.
Or send an email to: zorg.medisch@ditzo.nl

Article 18.22 Quitting smoking

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

You may take part in a quit-smoking programme with:

- a general practitioner;
- a medical specialist;
- an obstetrician;
- a healthcare psychologist;
- care providers listed in the Quit-Smoking Quality Register (*Kwaliteitsregister Stoppen met Roken*).

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

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

Article 18.23 Thrombosis service

Thrombosis is a clot in a vein or artery. Patients suffering from thrombosis can take anticoagulants. The thrombosis service monitors patients using anticoagulants and provides advice.

We reimburse care by the thrombosis service.
This care consists of:

- the regular collection of blood samples;
- performance of laboratory tests if necessary to determine the clotting time of your blood;

- use of equipment and accessories capable of determining your blood's clotting time;
- training in the use of the equipment that measures your clotting time, and help with the measurements themselves;
- advice on the use of medicines that affect your clotting ability.

You require a referral from your GP and/or medical specialist.

Article 18.24 Obstetric care and maternity care

An obstetrician guides and monitors women during pregnancy and childbirth. A maternity nurse assists the obstetrician or doctor during childbirth. Maternity nurses also help to provide care for the mother and child after childbirth, usually for a week.

You (an insured female) and your child are entitled to reimbursement of the costs of obstetric care such as obstetricians generally provide, and to reimbursement of the costs of maternity care such as generally provided by maternity nurses.
The obstetric care may be provided by an obstetrician, general practitioner or medical specialist. The care may also be provided in combination with care by a maternity hotel. In this case, maternity care is defined as care provided by a maternity nurse who is:

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

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

Childbirth and postpartum care in a hospital on medical grounds

We reimburse specialist medical care and admission to hospital (in accordance with Article 18.17) for you and your child if you are required to give birth in a hospital for medical reasons. The care will commence on the day of the childbirth.

Childbirth and postpartum care in a hospital or birth centre without medical grounds

We reimburse nursing and maternity care for you and your child in the absence of medical grounds. The care will commence on the day of the childbirth.
A personal contribution of €17.50 each applies both to you (the mother) and to your child per day of admission. We will deduct this sum from your maximum reimbursement of €125 per day of admission, and the maximum payment of €125 for your child. If the hospital charges exceed €125 for you and €125 for your child, you must pay the excess amount yourself.
We will calculate the number of days of hospitalisation based on a statement issued by the hospital, birth centre or maternity care agency that is concerned with providing additional maternity care after discharge from the hospital.

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

Maternity care in a maternity hotel

We reimburse maternity care in a maternity hotel for you (the mother) and your child after childbirth in a hospital or maternity hotel. A personal contribution of €4.40 per hour applies to maternity care. The costs of the hotel are for your own account

Maternity care at home after childbirth in a birth centre, maternity hotel or hospital

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

Childbirth and postpartum care at home

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

- registration, intake (once-only, unless there are compelling reasons to decide otherwise) and childbirth assistance as established by the National Maternity Care Guidelines (*Landelijk Indicatie Protocol*);
- 24 up to 80 hours of maternity care divided across a maximum of ten days, counting from the day of delivery. The actual number of hours of maternity care depends on your (i.e. the mother's) needs and those of the child, and will be determined on the basis of the National Maternity Care Guidelines. A personal contribution of €4.40 per hour applies to maternity care.

Find the contracted or non-contracted maternity agency and maternity care of your choice via www.Ditzo.nl/zorgverzekering

Care from a non-contracted provider

If you use a non-contracted maternity care provider, the amount of the reimbursement will not exceed the maximum set by us. In many cases, this results in 100% reimbursement, however you may sometimes need to pay part of the invoice yourself.

Note: please see Article 3 (Reimbursement of care) for ‘Additional conditions governing non-contracted care’.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under ‘Set maximum rates’ (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Prenatal screening

We reimburse prenatal screening for female insured parties, comprising:

- counselling: this refers to the provision of information on the content and scope of prenatal screening for congenital defects (to enable you to take a considered decision). Your

healthcare provider must hold a licence under the Population Screening Act (*Wet op het bevolkingsonderzoek*);

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

Preconception consultation

We reimburse preconception consultations for female insured parties, as described in the 'Preconception Care' Guidelines by the Dutch College of General Practitioners (*Nederlands Huisartsen Genootschap*, NHG) and provided by an obstetrician who is authorised and sufficiently competent to do so. The obstetrician provides this care in consultation with the general practitioner.

IUD insertion by obstetricians not reimbursed

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

Article 18.25 Nursing and other care

Nursing and other care focuses on your physical health and on improving your self-reliance within your own residential and living environment.

Nursing and other care

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

- relates to the need for medical care or a high risk of such a need, as described under Articles:
    - 18.4 (Dietetics);
    - 18.7 (Occupational therapy);
    - 18.9 (Physiotherapy and remedial therapy);
    - 18.11 (General Basic Mental Healthcare);
    - 18.12 (Specialised Mental Healthcare);
    - 18.13 (General practitioner);
    - 18.15 (Speech therapy);
    - 18.17 (Specialist medical care);
    - 18.19 (Oncological care in children);
    - 18.20 (Organ transplants);
    - 18.21 (Rehabilitation);
    - 18.22 (Quit-smoking programme);
    - 18.23 (Obstetric care);
    - 18.28 (Sensory impairment care);
- is not already covered under the Social Support Act;

- is not part of hospitalisation as described in Article 18.5 (First-line admission), 18.12 (Specialised mental healthcare), 18.17 (Specialist medical care), 18.21 (Geriatric rehabilitative care) or at a Long-Term Care institution; and
- will only be reimbursed if the care is necessary due to complex somatic issues or a physical disability.

Qualifications

In order to determine how much care you require, a district nurse will make a diagnosis and will create a care plan on the basis thereof. There are a number of requirements for such a diagnosis and for the care plan.
The medical indication for both regular district nursing and Zvw-pgb:

- must be drawn up by a nurse or district nurse trained to at least higher professional education standard and registered under the BIG. Care indications for children up to age 18 are arranged through a nurse trained to at least higher professional education level (HBO) who holds a qualification in the specialisation necessary for the patient group they are nursing, namely children below the age of 18 (paediatric district nurse), and who must be registered in the BIG registry;
- is determined in accordance with the Nursing and Care Standards issued by the V&VN Dutch Nurses' Association;
- must be drawn up by a nurse who also works for an institution that has been accredited for the provision of personal care and nursing under the Care Institutions (Accreditation) Act. You may also consult a (paediatric) district nurse who is trained to at least higher profession level and who holds the KIWA certification mark for self-employed persons in the healthcare sector.

Based on the medical indication, the BIG-registered and HBO-qualified (paediatric) district nurse will draw up an up-to-date and dynamic care plan in consultation with you, the patient. This means that the care plan will be regularly evaluated and adjusted in cases where the care needs may change to address the relevant situation. The BIG-registered, HBO-qualified (paediatric) district nurse will be responsible for that care plan. The care plan must, in any case, contain information on the nature (care functions and activities), scope, duration and objectives of the care provided and the desired outcome. You or your (legal) representative and the care provider must sign the care plan. In the event of any major changes, the revised care plan must be signed again.
The care must be implemented by at least a level 3 care provider or by a nurse who is employed by a home-care organisation or works as a self-employed person without staff. In addition, the provision of ‘nursing and care for persons below the age of 18’ can only be claimed if such care was provided by a paediatric nurse.

We do not reimburse:

- care under the district nursing heading that is delivered by a non-contracted care provider who is also a family member in the first or second degree of the patient. The Zvw-pgb is available for this purpose, in accordance with the 'Ditzo 2019' Zvw-pgb Regulations.

Care from a non-contracted provider

We will reimburse the nursing care up to our set maximum rate for nursing and other care.

Note: please see Article 3 (Reimbursement of care) for 'Additional conditions governing non-contracted care'.

*Our maximum rates are available on www.ditzo.nl/zorgverzekering under 'Set maximum rates' (*vastgestelde maximale tarieven*).*
*A list of contracted care providers is available on www.ditzo.nl/zorgverzekering, see 'Find a care provider' (*zorgzoeker*).*

Nursing and care by non-contracted care providers

If you receive care from a non-contracted healthcare provider, you must request permission from us in advance as of 1 January 2019. The reason for this is that we have observed significant differences between care provided by contracted and non-contracted providers of district nursing and we wish to ensure that you receive effective and legitimate care from non-contracted care providers as well. We would emphasise that we have a sufficient number of contracted care providers, who provide district nursing services in all regions.
To request permission for non-contracted care, please use the 'Application for authorisation of non-contracted district nursing care' form, which is available on our website.

When submitting your authorisation request to us, please send us the following:

- the medical indication and the care plan (drawn up in accordance with the conditions listed above);
- the care institution and the type of care provider (including the level of qualification) that will be providing the care;
- the diploma of the BIG-registered, higher professional level qualified nurse who has made the medical indication;
- in the case of palliative care, please provide the statement that indicates an estimated lifespan of less than three months.

We will subsequently assess the effectiveness and legitimacy of your application. We will notify you of whether we have rejected or granted your request (either in full or in part).

If you were already insured at Ditzo in 2018 and were receiving care from a non-contracted care provider, you are not expected to request permission from us for the reimbursement of this care prior to 1 January 2019. We would, however, request that you submit the documents listed above to us by 1 April 2019, for us to assess whether the indication established previously is still accurate. This may result in a change in the medical indication.

Personal budget for nursing and care (Zvw-pgb)

If you wish to purchase nursing and care services yourself, you may request a Personal budget for nursing and care (Zvw-pgb) with us. The eligible target groups and applicable terms and conditions can be found in the Ditzo 2019 Zvw-pgb Regulations, which form part of this insurance policy.

The Ditzo 2019 Zvw-pgb Regulations are available on www.ditzo.nl/zorgverzekering/regulations.

Care for children with complex care needs

We will reimburse nursing and care for children up to the age of 18 who have complex care needs, where the care needs relate to the need for medical care or a high risk of medical care. If the care does not focus on the care needs, but rather on supporting and teaching skills that should lead to increasing the self-reliance of the child, the then care will be reimbursed under the Youth Act (*Jeugdwet*).

Day care nursing and stays in childcare homes

You are entitled to day care nursing and stays in a childcare home if you are less than 18 years of age and depend on care due to complex somatic issues or due to a physical disability. You also require permanent supervision or constant availability of care that involves one or more specific nursing activities.

In order to qualify for day care nursing or stays in childcare homes, you must have a referral from a medical specialist.

Day care nursing centre

This care can only be claimed for a minimum of six hours a day at a location equipped to provide nursing day care for intensive paediatric care, and includes the costs of accommodation, toys, food and drink, cleaning, linen, facilities (such as resources for general use), nursing and other care, and non-patient-specific materials such as dressings and incontinence materials.

Stay

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

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

Palliative terminal care

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

Collaboration with municipal authorities

We have made agreements with municipal authorities to organise care in your own environment as efficiently as possible. Certain aspects of this care are reimbursed by us, and other aspects by the municipal authority based on the Social Support Act. Under Section 14(a) of the Healthcare Insurance Act, we are obliged to make agreements to this effect with the municipalities. We have incorporated

these agreements into this policy where appropriate. If you receive care both through the municipality and through us, you will be able to contact us on the issue.

Article 18.26 Foot care for diabetes mellitus patients

One unpleasant complication that you may experience as a diabetic is diabetic feet. Foot care for diabetics also comprises the prevention or treatment of this condition.

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

Care profile 1:

- annual foot check-up, consisting of case history, physical examination and a risk assessment. This examination may be performed by a medical chiropodist, a certified diabetic foot care chiropodist, a podiatrist or a podiatrist who specialises in diabetes cases.

Care profiles 2, 3 and 4:

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

The foot care must be performed by, or under the supervision of, a diabetes-specialised or other podiatrist. The diabetes-specialised or other podiatrist may subcontract certain aspects of care to a medical chiropodist or a certified diabetic foot care chiropodist. This foot care will be claimed from us by the podiatrist or specialised podiatrist at a uniform rate per care class.

We do not reimburse:

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

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

Article 18.27 Patient transport

Ambulance transport covers both emergency transport (usually via 112) and pre-ordered transport. During ambulance transport, care is provided by nurses and drivers who have had special training for this purpose.

Seated patient transport is available in the event of specific medical indications. This may involve transport by car, public transport or some other means.

Ambulance transport

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

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

We do not reimburse:

- transport for attending an outpatients' clinic for half a day at an institution designated under the Long-Term Care Act.

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

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

- you require kidney dialysis;
- you must undergo oncological treatments involving chemotherapy, immunotherapy or radiotherapy. We also reimburse transport costs for consultations, (follow-up) check ups and (blood) testing;
- you are wheelchair-bound and require transport to and from a care provider or institution where you receive care that is covered under this policy;
- you are visually impaired and cannot travel unaccompanied, and therefore require transport to and from a care provider or institution where you receive care that is covered under this policy;
- you are aged under 18 and receive care under your district nursing entitlements (as part of intensive paediatric care), provided the transport is to and from a nursing day care centre and is required on medical grounds;
- transport for an attendant, if you require one or are aged under 16. In special cases, you may ask us in advance to permit two attendants.

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

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

Transvision can be contacted on 0900-33 33 33 0 (€0.15 per minute).

Seated transport hardship clause

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

We use the following formula to determine whether we can offer you reimbursement under the hardship clause: (no. of months (max. 12)) x (no. of trips/week) x (no. of weeks/month) x (no. of kilometres of a single journey) x 0.25 (= weighting factor). If the result is 250 or more, you are entitled to reimbursement for patient transport.

Note that you require our approval in advance. 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, you are entitled to reimbursement of the travel expenses. In example C, you are not.

Personal contribution

A statutory personal contribution of €103 per calendar year applies to seated passenger transport.

This does not apply to transport:

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

Kilometre allowance for private vehicle use

The allowance for use of your own vehicle is €0.30 per kilometre over the fastest common route. The distance is calculated using the Google Maps journey planner.

Other means of transport

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

Article 18.28 Sensory impairment care

Sensory impairment care is a type of treatment you receive if you are deaf or hearing-impaired, blind or vision-impaired or if you have serious speech and/or language problems due to a developmental language disorder. Multiple medical specialists (multidisciplinary care) are involved in the treatment.

General

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

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

The care provided comprises:

- diagnostic examinations;
- interventions aimed at psychologically learning to cope with a disability;
- interventions to resolve or compensate for the impairment and thus increase your level of self-reliance;

- admission in combination with extramural sensory impairment care.

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

Care provider

You may only consult one of the aural, visual or communication centres for this type of care, as stated on www.Ditzo.nl/zorgverzekering.

Criteria for medical indication

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

Referral

- Sensory impairment care for hearing and/or communication impairments requires a referral from a clinical physicist in audiology at an audiological centre or from a medical specialist based on diagnostic data demonstrating that you satisfy the inclusion criteria for the performance of the sensory impairment care to be insured (see Section 2.5(d) of the Healthcare Insurance Decree).
- For visual impairment care, you require a referral from a medical specialist on the grounds of the evidence-based NOG guideline on Viral diseases, rehabilitation and referral.
- If an audiological clinical physicist, ophthalmologist or medical specialist has already confirmed your sensory impairment in the past and you require related care that was not accompanied by any changes to the sensory impairment condition, you may also be referred by a general practitioner or youth care doctor. Visually impaired insured persons who have a straightforward rehabilitation demand (in line with Care Programme 11) do not need a new referral.

Medical responsibility

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

- For auditory and/or communication impairments:

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

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

The Healthcare Insurance Decree is available on www.wetten.overheid.nl.

Authorisation requirement in the event of admission

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

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

The application will be treated confidentially; please send it to our medical adviser:

Ditzo
Attn. Sensory impairment (ZG) medical adviser
PO Box 2072
3500 HB UTRECHT
On the envelope, please state: 'Confidential'.
Or send an email to: zorg.medisch@ditzo.nl

We do not reimburse:

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

Article 19 Exclusions

We do not reimburse:

- care that is covered by the Long-Term Care Act, the Youth Act, the Social Support Act or other statutory provision(s);
- personal contributions for your account under the Long-Term Care Act, the Social Support Act or for population screenings;
- pre-employment medical examinations and other examinations (for example for a driving or pilot's licence), certificates and vaccinations, unless the Healthcare Insurance Regulations specify otherwise;
- treatments in private clinics;
- flu vaccinations;
- alternative medicine/treatment;
- treatments against snoring with uvuloplasty;
- treatments aimed at the sterilisation of the insured party (man or woman);
- treatments aimed at reversing the sterilisation of the insured (man or woman);
- treatments aimed at the circumcision of the insured party, unless medically necessary;
- treatment of plagiocephaly and brachycephaly without craniosynostosis with a redression helmet;
- medicines for travel-related risk of illness;
- a maternity package, surgical cotton wool or sterile hydrophilic gauze for obstetric care;
- costs for failure to attend an appointment with a care provider;
- 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(*Wet op het financieel toezicht*, Wft);
- care resulting from one or more terrorist acts, if the total damage to be claimed in a calendar year as a result of such acts from non-life or life insurers, or insurers of funeral expenses and benefits in kind, to which the Financial Supervision Act applies, is expected by the Dutch Terrorism Risk Reinsurance Company (*Nederlandse Herverzekeringsmaatschappij voor Terrorismeschade N.V.*, NHT) to be higher than the maximum amount that this company has reinsured for a calendar year. In such cases, you will only be reimbursed a certain percentage, which will be the same for all insured parties and determined by the NHT. Under Sections 33 and 55 of the Healthcare Insurance Act, the government may decide to issue an additional contribution to health insurers and their insured parties in the event of a disaster, such as terrorist acts.

Terrorism clause

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

Contact details

Ditzo
www.Ditzo.nl/zorgverzekering
WhatsApp: +31 (0)6 516 777 01

SOS International
BV Nederlandse Hulpverleningsorganisatie SOS International
Hoogoorddreef 58, 1101 BE Amsterdam
Telephone: 31 (0)20 651 51 51
Email: info@sosinternational.nl

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