Rijksdienst Caribisch Nederland
Zorgverzekeringskantoor

Information brochure healthcare insurance

for the insured of the Healthcare insurance Bonaire, Saba and St. Eustatius.
As per January 1, 2011

In this brochure you will find comprehensive information about the healthcare insurance coverage rights the insured on Bonaire, Saba and St. Eustatius are entitled to. Go through this brochure thoroughly and save it.
In case of doubt and/or disputes concerning your health care insurance rights, the text of the Order in Council Healthcare Insurance BES (Algemene maatregel van bestuur zorgverzekering BES) and the Ministerial Regulation Healthcare Insurance Rights BES (Ministeriële regeling zorgaanspraken BES) determine healthcare entitlements.

Chapter 1 General

1.1 Introduction

As of January 1, 2011 a new mandatory healthcare insurance is provided for all residents of the islands of Bonaire, Saba and St. Eustatius (hereinafter: the Dutch Caribbean); the Dutch Caribbean Healthcare Insurance (hereinafter: Healthcare Insurance). An uniform insurance for all residents serves the equality of rights and prevents that some people remain uninsured.
As per January 1, 2011, the RCN- unit Healthcare Insurance Office (hereinafter: 'ZVK') implements the public healthcare insurance as regulated in the Healthcare Insurance Decree (Besluit zorgverzekering BES). The healthcare insurance includes both the medical care ('cure') as well as the long-term care ('care' formerly AVBZ).

1.2 Principles

The Healthcare Insurance is based on the Healthcare Decree (Besluit zorgaanspraken BES hereinafter: the Decree) and the Regulation Healthcare coverage claims (Regeling zorgaanspraken BES hereinafter: the Regulation).[1]

1.3 Intention

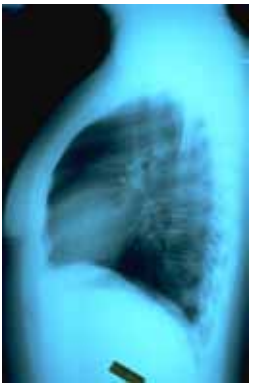
The healthcare insurances on the Netherlands Antilles are currently accommodated in various regulations targeting specific groups of individuals. These regulations are among others the "Ziektewet" – Sickness Benefits Act and the "Ongevallenwet" – Accidents and Injuries Act, national and island healthcare cost regulations including the AVBZ and various private insurances.
As of January 1, 2011 the Healthcare Insurance replaces all existing regulations and private insurances to the extent that these cover the same as the Healthcare Insurance.

The insurance provides for both the section curative care and the section long-term care in an income dependent premium that all insured with an income above the tax free allowance ($ 9,750 - $ 12,250) are subjected to. Employers must also pay premiums for their employees. These premiums are levied and collected by the Tax Authority.

[1] In the course of December 2010, the Order in Council Healthcare Insurance (Besluit Zorgverzekering BES) and Ministerial Regulation Healthcare Insurance (Ministeriële regeling zorgaanspraken BES) is available on our website: www.RijksdienstCN.com

Chapter 2 The healthcare insurance office (ZVK)

2.1 What is the 'ZVK'?



Het ZVK is het onderdeel van de RCN dat ten behoeve van de Minister van Volksgezondheid, Welzijn en Sport (hierna: Onze Minister) ten dienste staat aan de uitvoering van het Besluit.

Het motto van het ZVK is: 'Zorg voor mensen in een gezonde samenleving'

Het ZVK streeft naar een optimale dienstverlening. De klanten mogen verwachten dat het ZVK:

- goed bereikbaar is via internet, telefoon, balie en post;
- begrijpelijk communiceert in zijn contacten en beslissingen;
- snel zaken afhandelt

2.2 What does the 'ZVK' do?

The main task of the 'ZVK' is the implementation of the Healthcare Insurance Decree (Besluit Zorgverzekering BES). Its tasks can be described as follows.
The 'ZVK':

- contracts healthcare providers to provide care to the insured;
- publishes a list of healthcare providers that the insured can go to for treatment;
- makes payments to the healthcare providers and possibly to the insured;
- provides information to the insured, healthcare providers and employers;
- authorizes healthcare providers prior to certain types of treatments;
- investigates the quality of care.

The tasks of the 'ZVK' are herewith not exhaustive.

2.3 How do I contact the 'ZVK'?

2.3.1 Locations

The 'ZVK' has locations on Bonaire, St. Eustatius and Saba.

Bonaire

Healthcare Insurance Office Bonaire
Centrumgebied Kralendijk z/n
Kralendijk
(former SVB office)
Temporary general telephone number: +599 717 83 33
Fax number: +599 717 83 30
E-mail: infoZVK@RijksdienstCN.com or infoBonaireZVK@rijksdienstCN.com
www.RijksdienstCN.com

Sint-Eustatius
Healthcare Insurance Office St. Eustatius
Mazinga Complex A, B
Fort Oranjestraat
Oranjestad
(RCN office)
General telephone number: +599 318 33 70
E-mail: infoZVK@RijksdienstCN.com or infoBonaireZVK@rijksdienstCN.com
www.RijksdienstCN.com

Saba
Healthcare Insurance Office Saba
The Bottom
Saba
(RCN office)
General telephone number: +599 416 39 34
E-mail: infoZVK@RijksdienstCN.com or infoBonaireZVK@rijksdienstCN.com
www.RijksdienstCN.com

2.3.2 Opening hours (temporary)

The offices are open for the public on working days from Mondays through Fridays:

Bonaire:	08.00-12.00	13.00-17.00
St. Eustatius	09.00-13.00	
Saba	08.00-12.00	13.30-16.00

The offices can be reached by telephone on working days from Mondays through Fridays:

Bonaire	08.00-12.00	13.00-17.00
St. Eustatius	09.00-13.00	14.00-15.30
Saba	08.00-12.00	13.30-16.00

Chapter 3 The insured and the insured administration

The healthcare insurance is applicable to everybody without distinction: young and old, employee or self employed or benefit recipient. Nobody can evade it. To this end, it is not important whether someone has or doesn't have the Dutch nationality.

3.1 Who are insured?

Insured by virtue of law are those lawfully residing on Dutch Caribbean territory as well as those lawfully working on Dutch Caribbean territory.
The group of insured individuals is extended with individuals who have a permanent residence permit based on the Admittance and Deportation Act BES (Wet toelating en uitzetting BES). Also students, younger than 30 years, who leave the Dutch Caribbean territory with the only purpose to study elsewhere, are insured. Beside that are insured the employees of employers residing or established on Dutch Caribbean territory that are deployed outside Dutch Caribbean territory.

3.2 Who are not insured?

Not insured are individuals younger than 30 years who reside on Dutch Caribbean territory only to study. The same applies to trainees and lab trainees who reside on Dutch Caribbean territory. These people therefore must have a private healthcare insurance or a social insurance from the country of origin that has coverage on Dutch Caribbean territory.
Individuals residing on Dutch Caribbean territory but who are employed by a Dutch public entity or of an employer residing or established in the Netherlands, are also not insured. The same applies to individuals who work outside the Dutch Caribbean for at least three consecutive months unless they are employed by an employer in the Dutch Caribbean.

3.3 How does this work in practice?

3.3.1 The insured administration

Anyone registered in the Public registry regarding population of Bonaire, Saba or St. Eustatius can apply for an ID "sedula". Upon showing this ID to the contracted healthcare providers the insured can claim his rights to care.
For this, the ‘ZVK’ has an insured administration. The healthcare providers have access to this insured administration and can check if someone is indeed insured.
The healthcare provider does not charge the insured for the treatments or as the case maybe operations but sends the invoice to the ‘ZVK’ for payment. The ‘ZVK’ pays the costs to the healthcare provider.

3.3.2 Proof of insurance: special group of insured individuals

General

The insured is entitled to treatment and/or operations by a contracted healthcare provider upon showing his or her ID, 'the sedula'.

Children

The insured under 12 years of age does not have a 'sedula' yet but is still insured. To that end his parents must show the healthcare providers their 'sedula'. This way the healthcare provider can check the information of the child via the insured administration.

Students

If the insured, younger than 30 years, leaves the island only to study, he remains insured at the 'ZVK'. The student will be issued a guarantee letter by the 'ZVK' to that end if necessary. The student can apply for the letter at the 'ZVK'.

Travelers

If the insured goes on vacation outside the Dutch Caribbean he is also insured. Healthcare abroad is covered if it could not reasonably be postponed until return. The compensation is in principle not more than it costs in the Dutch Caribbean. The 'ZVK' advises travelers to always get travel insurance.

3.3.3 Sometimes permission prior to treatment required

For some treatments and/or operations the 'ZVK' must give prior permission to the healthcare provider or as the case may be to the insured. The permission must be applied for by a healthcare provider. This can be done by submitting an application form via e-mail at the 'ZVK'.
As soon as the 'ZVK' receives this e-mail the authorized employee will start processing the application. The applicant of the permission will receive a decision within a maximum of 3 days via e-mail regarding the submitted application.
The cases in which the 'ZVK' must give permission are further described in chapter 4.
The 'ZVK" may approve that in some cases the application for permission can be omitted..

Chapter 4 Health care claims package

The insured are entitled to medical care as regulated in the Decree and in the Regulation. For the details on the claims package you are referred to the relevant articles from the Regulation. The claims package is not a static but can be adjusted by the Minister whenever there may be reason to do so based on developments within the healthcare system.
Prior to certain claims or types of treatment the 'ZVK' must give permission.[2] The cases in which the 'ZVK' must give this consent are further indicated in this chapter per type of claim.

The claims package encompasses in any case:

4.1 General Practitioner Care

The insured is entitled to medical and surgical care to be provided by a general practitioner.
General Practitioner Care entails:

- the consultation;
- the visit;
- the medical prescription.

Moreover, the insured is entitled to additional laboratory, radiological, function and pathological-anatomical tests upon referral of the general practitioner.
Medical examinations and alternative cure methods are not included in the general practitioner care and are therefore not included in the claims package.

4.2 Primary Psychological care

The insured is entitled to treatment by an independently established psychologist prescribed by a general practitioner, specialist or nursing general practitioner. This includes a maximum of 9 treatments including the intake session.

4.3 Specialist –Medical Care

Specialist medical care concerns medical care, specialist mental care by a medical specialist, a psychiatrist, a hospital, an audiological center, a dialysis centre or a thrombosis center. . The insured is entitled to this care only upon referral from a general practitioner or a specialist. An obstetrician may also refer to obstetric care by a gynecologist.

Furthermore the specialist medical care encompasses the following treatments within the scope and subject to the further conditions of the Regulation.

[2] See paragraph 3.3.3. for the procedure of permission.

Various forms of transplantation transplant of tissues and organs:

- bone marrow transplant;
- bone e transplantationgraft;
- cornea transplant;
- skin tissue transplant;
- kidney transplant;
- heart transplant;
- liver transplant, coupled with the removal of the recipient's own liver;
- lung transplant;
- heart – lung transplant;
- kidney pancreas transplant;

This, as long as it concerns the indication area that is generally accepted for the relevant form of transplant.

Treatment of plastic-surgery nature for the correction of :

- abnormalities in the appearance that are coupled with demonstrable physical function disorders;
- disfigurations that are the consequence of a disease, accident or medical operation;
- paralyzed or drooping eyelids that are the consequence of a congenital defect or a chronic disorder present at birth;
- the following congenital malformations: lip, jaw and split palates, deformities of the facial bone structure, benign proliferations of blood vessels, lymphatic vessels or connective tissues, birth marks and malformations of the urinary tract and genitals;
- external sexual characteristics of a set transexualism.

Treatment of plastic-surgical nature does not include:

- treatment of paralyzed or drooping eyelids that are not the consequence of a congenital anomaly or a chronic disease present at birth;
- abdominoplasty and liposuction of the abdomen;
- the surgical placement of a breast prosthesis other than after state in case of a full or partial mastectomy;
- the surgical removal and placement of a breast prosthesis after the treatment referred to under sub c;
- treatments against snoring with uvular correction;
- treatments aimed at circumcision.

Permission of the 'ZVK'.

The costs of all treatments of plastic-surgery are only covered by the 'ZVK' after prior permission.

Second opinion from a qualified healthcare provider in the region in case of :

- a life threatening condition;
- a doubt in connection with urgency of a treatment;
- a surgery with irreversible consequences;
- a well founded doubt about the payment method;

Medically required UVB light therapy.

Assistance Audiological center

The insured is entitled to audiological assistance for up to a maximum of 6 weeks.

This assistance includes:
§ examination of the hearing function;
§ advice on the hearing aids to be purchased;
§ information on the use of the aids;
§ psychosocial assistance if necessary in connection with problems with hearing dysfunction.

permission of the 'ZVK'.
The 'ZVK' must give permission if the audio logical assistance must be provided for more than 6 weeks

Assistance Genetic Counseling
Assistance within the scope of genetic counseling includes research in and of genetic anomalies through genealogical research, chromosome research, biochemical diagnostics, ultra sound research and DNA-testing, providing genetic advice and related psychosocial assistance.

Outpatient hemodialysis
The outpatient hernodialysis includes:
§ the required hemodialysis for the insured, the related medical examination, treatment and pharmaceutical assistance of which; the required erythropoietin for the insured;
§ coverage of the costs related to the psychosocial assistance of the insured and/ or of persons who are involved in the performing of the dialysis elsewhere than at the dialysis center, some to be provided by experts associated with the dialysis center.

There must be a medical indication for outpatient dialysis.

Chronic Intermittent Insufflation
The chronic intermittent insufflation includes:
§ the regular stay for less than 24 hours in a respiration center for mechanical insufflation;
§ the use of mechanical insufflation equipment at the home of the insured, or in a specially equipped premises, if the insufflation takes place there and under the responsibility of a respiration center as referred to under sub a.

Permission of the 'ZVK'.
The 'ZVK' must give permission prior to the assistance from chronic intermittent insufflation. The application for permission must be accompanied by a motivation of the attending physician.

Assistance by a Thrombosis service
The assistance by a Thrombosis service includes the care upon prescription of the attending physician:
regularly taking blood samples from the insured;
§ the performance of or else having the necessary laboratory tests performed under the responsibility of the service to determine the blood clotting time;
§ making equipment and supplies available to the insured with which he can measure the clotting time of his blood;
§ training the insured, referred to in sub c, in the use of the equipment mentioned in that sub, as well as the assistance of the insured with his measurements;
§ giving advice to the insured regarding the application of the drugs to influence coagulation.

4.4 Hospital Care

The insured is entitled to hospitalization. In connection with obstetric care both the mother and the child are entitled to hospitalization.
The insured will be hospitalized in all cases in the third class, in a space with an adequate climate control system and insect repellant system. Hospitalization to a higher class is only covered if this is medically required. The attending healthcare provider determines in which cases placement in a higher class is medically required.

4.5 Paramedical Care

The insured is entitled to the following paramedical care within the scope and subject to the conditions of the Regulation.

- § physiotherapy and exercise therapy by Ceaser and Mensendieck physical therapists and exercise therapists with the objective of cure, improvement, reducing pain than conservation of an as fit as possible physical condition up to a maximum of 9 treatments per indication per calendar year;**;**
- § speech therapy; with the purpose of recovery or improvement of the speech function or the speech ability ;
- § occupational therapy with the objective of stimulating the self care and self reliance of the insured up to a maximum of 10 hours per calendar year;
- § dieticians' treatment regarding education with a medical objective on nutrition and eating habit up to a maximum of 4 hours per calendar year;
- § podological treatment, podology soles and podiatry;
- § medical pedicures for people with diabetic feet;

The physio therapy includes the the pelvic physiotherapy in connection with urinary incontinence.

The physiotherapy and the exercise therapy can be extended with a maximum of 9 treatments based on revised treatment plan.

The insured is not entitled to chiropractic treatment or electric hair removal.

Speech therapy
The 'ZVK' must give permission prior to a speech therapy treatment. The application for permission must be accompanied by a proper motivation of the referring physician or dental specialist.

Medical Pedicure
The insured is entitled to medical pedicure in connection with diabetic feet only after permission of the 'ZVK'.

4.5.1 treatments physical therapy and exercise therapy

If the insured suffers from one of the following chronic disorders that are coupled to disorders that lead to severe limitations in basic mobility skills, the personal care or the mobility, he may claim physiotherapy or exercise therapy treatments than mentioned in paragraph 4.5.

1. one of the following disorders of the nervous system:

1°. cerebrovascular accident;
2°. spinal cord disease;
3°. multiple sclerosis;
4°. peripheral nerve disease in case of motor loss;
5°. extra pyramidal disorder;
6°. motor retardation or a developmental disorder of the nervous system and he is younger than 17 years;
7°. congenital anomaly of the central nervous system;
8°. cerebellar disorder;
9°. loss of function caused by a tumor in the brain or spinal cord or as a result of brain damage;
10°. radicular syndrome with motor loss; for a maximum period of three months;
11°. muscle disease;
12°. myasthenia gravis, or

2. or one of the following disorders of the musculoskeletal:

1°. congenital anomaly;
2°. progressive scoliosis;
3°. juvenile osteochondrosis and he is younger than 22 years;
4°. reflex dystrophy;
5°. vertebral fracture due to osteoporosis;
6°. fracture due to morbus Kahler, bone metastasis or morbus Paget;
7°. frozen shoulder (capsulitis adhaesiva); for maximum period of 12 months
8°. rheumatoid arthritis or chronic rheumatism;
9°. chronic arthritis;
10°. ankylosing spondylitis (morbus Bechterew);
11°. reactive arthritis;
12°. juvenile chronic arthritis;
13°. hyperostotic spondylosis (morbus Forestier);
14°. collagen diseases;
15°. status after amputation;
16°. whiplash; for a maximum period of 3 months. If after this there is still a situation of the triad motion loss, loss of stamina (condition loss) and cognitive impairment this period may be extended by up-to 6 months;
17°. post-partum pelvic instability; for a maximum period of 3 months;
18°. fractures, if these are treated conservatively, for a maximum period of 6 months after conservative treatment;

3. or one of the following heart conditions:

1°. myocardial infarction (AMI);
2°. status after coronary artery bypass- surgery (CABG);
3°. status after percutaneous transluminal coronary angioplasty (PTCA);
4°. status after cardiac surgery;
5°. status after surgically corrected congenital defects, or

4. or one of the following conditions:

1°. chronic obstructive pulmonary disease if there is a FEV1/VC less than 60%;
2°. congenital anomaly of the respiratory tract;
3°. lymph edema
4°. scar tissue of the skin after a trauma or otherwise;
5°. status after admission to a hospital, a nursing facility or an institution for rehabilitation or else after a day treatment at an institution for rehabilitation and the assistance intends to accelerate the recovery after discharge to home or the termination of day treatment; for a maximum period of 12 months following discharge or termination of the treatment;
6°. intermittent claudication (vascular) grade 2 or 3 Fontaine; for a maximum period of 12 months;
7°. soft tissiue tumoren;
8°. diffuse interstitial lung disease in case of respiratory limitation and diffusion impairment.

4.6 Dental Care

The insured individual younger than 18 years (juvenile) is entitled to dental care by an institute for juvenile dental care; by a dentist or by dental specialist.
The dental care for the insured juvenile encompasses the following treatments within the scope and subject to the conditions of the Regulation.

- § periodic preventive dental examination once a year unless more care is required from a dental care perspective;
- § incidental consultation;
- § the removal of tartar;
- § fluoride application from the age of 6 up to a maximum of twice a year,. In special cases there can be a claim to fluoride application more than twice a year;
- § sealing;
- § periodontal support (assistance with inflammation surrounding tooth);
- § anesthesia;
- § endodontic treatment (assistance with root canal inflammation);
- § restoration of teeth elements with plastic materials;
- § gnathological assistance (assistance with mandibular joint and muscles);
- § removable prosthetic devices;
- § tooth replacement assistance with non-plastic materials if this concerns the replacement of one or more missing, permanent incisive or eye teeth that are not in place or else because the absence of that tooth or those teeth is the direct result of an accident;
- § dental surgery assistance, except for the fitting of a dental implant;
- § X-ray exam, except for X-ray exam for orthodontic assistance.

Orthodontics except for esthetic orthodontics is partially covered for insured individuals younger than 18 years. The coverage amounts to US$ 2,500 for the entire term of the insurance (contract) for fixed equipment and US$ 500 for removable devices.

The insured of 18 years and older (adult) is entitled to:
§ Removable full prosthetic devices for the upper and lower jaw
§ Dental surgery and the related x-ray exam, with the exception of periondontal surgery, straightforward extractions and the placement of a dental implant
§ The placement of a dental implant and the related surgical assistance if it concerns a severely atrophied toothless jaw and the application serves the placement of a removable prosthesis.

The adult is entitled to a one-time remediation. The remediation consists of an x-ray, anesthesia, restoration of the teeth elements with plastic materials and extractions.

The insured has other than the abovementioned treatments, if those treatments are necessary in view of a severe congenital or acquired dental, physical or mental disorder, and that without that care he will not be able to maintain or acquire dental function.

The dental care takes place in a practice space set up by the dentist and within the regular practice hours. In special cases exceptions may be made. If the assistance is provided outside the regular practice hours the insured must pay a contribution equivalent to the amount of additional costs.

The dental care does not include treatment that is unnecessarily costly, unnecessarily complicated or that is dentally ineffective.

permission of the 'ZVK'.
The insured younger than 18 years needs permission of the 'ZVK' prior to the following treatments.
§ periodontal surgery (surgery on inflammation surrounding tooth);
§ extraction under general anesthesia;
§ osteotomy;
§ placing of a dental implant.

The 'ZVK' must give permission for other treatments related to severe congenital or acquired dental, physical or mental disorders.

4.7 Pharmaceutical care

The insured is entitled to:
§ advice and guidance from the pharmacists regarding medication and the responsible use of medicines;
§ polymer, oligomer, monomer and modular diet preparations if the insured cannot manage with adjusted standard nutrition and other products of special nutrition.

The pharmaceutical care also includes the flu vaccine.

The insured is only entitled to pharmaceutical care that has been prescribed by a physician, dentist, obstetrician, or a person or institution that provides care of specific medical, specific behavioral scientific or specific paramedical nature.

In the pharmaceutical care, in principle, only generic medicines will be prescribed based on a list to be published.

The insured up to 21 years of age also have the right to contraceptives. These contraceptives are the contraceptive pill, the (hormone) IUD, the contraceptive implant, the diaphragm, and the morning-after pill. The insured is entitled to contraceptives if this medication serves to treat endometrioses, or the medication is intended to treat menorrhagia involving anemia.

Per prescription only the amount of medication required for a maximum period of 1 month is provided. Exceptions are oral contraceptives: one year, medicines for chronic illnesses except for hypnotics and anxiolytics: 3 months, antibiotics or chemotherapeutic agents: fifteen days.

The insured is entitled to repeat prescriptions. The pharmaceutical care does not include the coverage of simple painkillers.

The insured has no right to drugs as a precaution or prevention of a disease in connection with a trip, regular dietary supplements and/or drugstore products.

4.8 Auxiliaries (Medical Aids)

The coverage of auxiliaries includes the provision of an adequately at all time functional device within the scope and subject to the conditions of the Regulation.
The auxiliaries that the insured is entitled to, are the following.

- prostheses for shoulder, arm, hand, leg or foot
- breast prostheses if their use is appropriate to replace a part or almost entirely missing breast;
- facial prostheses in order to cover the face or a portion thereof, including nose and ears;
- eye prosthesis; full eye prosthesis when the eyeball is lacking; sclera scales; sclera lenses involving a severe malformed eye or after a traumatic change of one eye;
- orthoses for torso, arm, leg, foot, head or neck such as orthopedic shoes;
- vision auxiliaries like glasses and contact lenses up to a maximum of US$ 170 per two years for insured 18 years and older and per year for insured younger that 18 years and their replacement;
- hearing aids (individual contribution due);
- care products such as urine collection bags, provisions for ostomy patients, catheters and incontinence products;
- devices for contraceptive purposes, such as diaphragms and IUDs;
- aids to the mobility of persons such as crutches, walking aids, walkers, blind canes and – after permission - wheelchairs;
- wigs up to a maximum of US$ 510 if the insured experiences such psychological problems from a permanent or long term, full or partial baldness, that the use of hair-ware is reasonably appropriate.;
- syringes and accessories
- external devices to be used in the prolonged compensating for loss of function of blood vessels in the transportation of blood and the loss of function of lymphatic vessels for the transport of lymph;
- tools such as blood sampling equipment for diabetes, blood glucose test meter, test strips and infusion pumps;
- positive exhalation pressure devices;
- portable external infusion pumps and accessories;
- footwear provisions other than orthoses, such as bandage footwear and allergen-free shoes);
- devices for administering food;
- allergen free and dust-proof covers such as mattress, duvet and pillow shams;

§ tools for communication, information provision and signaling;
§ prosthetic devices for the lower or upper jaw unless covered under dental care;
§ oxygen devices or oxygen concentrators, with accessories;
§ lung vibrators;
§ nebulizers and accessories;
§ screen magnifiers;
§ external electro stimulators for chronic pain and accessories;
§ devices for continuous positive air pressure during breathing (CPAP equipment) with accessories;
§ solo equipment and accessories;
§ tactile reading equipment with accessories;
§ replacement of hearing aids that can be connected to an implanted bone conductor (BAHA hearing aid);
§ devices for the mobility of persons, such as tripping chairs and walking frames.
§ design elements for homes such custom adjusted furniture, anti-decubitus cushions, - beds and - mattresses.

The coverage of auxiliariss also includes modifications or repair thereof except if this is a result of undeniable careless use, training use, energy costs of certain equipment.
The 'ZVK' decides if certain aid devices are provided as property or on loans.

Permission of the 'ZVK'.
The 'ZVK' must give permission for the purchase of a wheelchair.

4.9 Obstetric Care

§ The insured is entitled to the following obstetric care.
§ assistance in childbirth and maternity costs coverage
§ prenatal care
§ postnatal care
§ gynecologist on medical grounds
§ hospitalization for 3 days unless more days are medically necessary
§ use of delivery room
§ medical and nursing supplies
§ coverage of laboratory costs

In case of a home birth the costs of the obstetrician will be covered.

4.10 Maternity Care

The insured mother and child are entitled to maternity care at home (24 -49 hours) or in a maternity home (up to 3 days) by a maternity nurse or by an organization that aims to provide maternity care.
Moreover, the insured is entitled to the maternity package, medical and nursing supplies, and on referral of the obstetrician or the maternity consultation clinic, on a lactation consultant.

4.11 Patient Transport

The insured is entitled to patient transport within the scope and subject to the conditions of the Regulation:
Patient transportation includes the following provisions and or cases:

- Medically necessary ambulance transportation to or from a care institution or from the residence;
- Transport compensation other than per ambulance to in case:
  - the insured must undergo kidney dialysis;
  - the insured must undergo oncological treatments with chemo therapy or radio therapy;
  - the insured can only move around with a wheelchair;
  - the vision of the insured is so limited to the extent that he cannot move around without assistance.
- "Air"- ambulance in case of an emergency due to illness or injury related to medical treatment missions abroad;
- Transportation costs related to medical treatment abroad from the place of stay to destination and vice versa.

Permission of the 'ZVK'.
The 'ZVK' must give permission before the compensation of the transportation. This may vary per island. The transport of a guiding person will also be covered if that is necessary in the opinion of the attending physician or if it regards a minor.

4.12 Repatriation Costs of the Deceased

If the insured passes away during a medical treatment abroad at the place of stay, the family is entitled to coverage of the repatriation costs. That means that they are entitled to full coverage of the transportation costs of the corps from the place of stay to the place of residence of the deceased on Dutch Caribbean territory.

4.13 Long-term care

The insured with a limitation of his self-reliant ability is entitled to personal care, nursing or assistance by an institution for home care, a nursing home, convalescent home or institution for the disabled. If the insured requires a protected living environment, therapeutic living environment or permanent supervision, he is entitled to admission and further stay in a nursing home, convalescent home or institution for the disabled. The spouse of the insured may also stay in the institution.

Permission of the 'ZVK'
The 'ZVK' must give permission upon request of the attending physician – possible afterwards –for the long term care.

4.14 Medical treatment abroad

The insured is entitled to a medical treatment abroad at a physician the 'ZVK' has a direct or indirect agreement with.
In case of medical treatments abroad, the insured must make his own travel and accommodation arrangements unless these are provided by the 'ZVK'
In 2011 the office will still book or have the airline tickets and hotels for the insured booked..

The following costs are covered for the insured that is sent abroad for treatment:
Beside the costs of treatment the following costs are covered for the insured sent abroad for treatment:

- daily allowance for the insured and, if applicable, his supervisor;

§ airport taxes;
§ transportation costs to the airport of departure and from the airport of arrival to the destination and vice versa;
§ hotel costs;
§ accommodation costs for staying at family members.

The 'ZVK' fixes the amount of the allowance per island. Usually the 'ZVK' will book the airplane tickets and hotels for the insured.

Permission of the 'ZVK'
The 'ZVK' must give permission before sending the insured abroad for medical treatment. The prior permission can be omitted in case of acute emergencies. The 'ZVK' then afterward assesses the legitimacy and effectiveness of the medical treatment abroad.

When the 'ZVK' gives permission, there is also coverage of:
§ medical treatment abroad by a non-contracted healthcare providers;
§ supervision during medical treatments abroad. The travel and accommodation costs of the supervisor will only be covered if the insured is younger than 18 years, or is mentally disabled, or is physically disabled and uses a medical aid device for mobility or is visually impaired or is severely ill and that according to the judgment of the attending physician or specialist it is impossible to travel without supervision.
§ Supervision by both parents in case of medical treatment abroad of a sick minor who is in a terminal phase of his illness or who is being treated with cytostatics or who suffers from leukemia or a similar disease or who is experiencing special cases of life threatening nature.
§ Longer stay abroad during medical treatment due to medical reasons.
§ extension of care abroad

Special cases
In bringing claims to assert, some special rules are applied.
The range and quality of care in the Dutch Caribbean are still under development. This means it is not yet possible to always provide exactly the desired care. For this, the regulations states that the right to transport and/ or care can only be claimed if this can be reasonably provided.
It's also defined that care abroad is only covered if it is medically necessary. And if an insured applies for a non-contracted healthcare provider, the coverage of the costs is limited.

The special rules are:
a. the right to care or transport can only be claimed to the extent that the insured, from the perspective of effective care, reasonably requires this based on the nature, content and scope thereof. (art. 6, sub 6 CN Healthcare Insurance Decree);
b. the right to care or transport on the islands can, in principle, only be claimed so far this care can reasonably be provided. (art. 6, sub 7 CN Healthcare Insurance Decree);
c. the permission to a healthcare provider who is not contracted by the Healthcare Insurance Office is subjected to the condition that a compensation is given afterwards of a maximum of 80% of the fee that the Healthcare Insurance Office pays to a contracted healthcare provider;
d. when staying off the territory of the islands, other than during medical treatment abroad, and care is claimed at a non-contracted healthcare provider, this care will only be covered if that care could not reasonably be postponed until return;

e. the coverage referred to under sub d. is not more than the prevailing rate on these island. If no rate has been determined, the usual rate in the country of treatment will be applicable. If that rate is also not determined, the maximum rate charged in the European Netherlands will be applied.

So far, your healthcare claims package. You can always contact the 'ZVK' if you have questions about your healthcare claims package.

Chapter 5 Legal protection

5.1 Rights and Obligations

The insured is entitled to the rights stated in the Decree, the related regulations and the CN Civil Code.
The insured has rights towards both the 'ZVK' and the healthcare provider. If the insured is not satisfied or disagrees with an action and/or decision of the 'ZVK' or of a healthcare provider he has various possibilities to file a complaint or to object. There are five possibilities to do this that are further discussed in the following paragraphs.

5.1.1 Right of the insured

The insured is entitled to be treated adequately by the employees of the 'ZVK'. Moreover, the insured has a right to privacy and he may expect that the employees of the 'ZVK' will respect this and will treat his data with complete discretion.

The insured has the right to be properly by the healthcare provider. Furthermore, the insured is entitled to information on the nature, objective, consequences and risks of a test and/or treatment by the healthcare provider. The insured also is entitled to information on the state and perspective of his health condition. The healthcare provider is not allowed to give information about the insured to third parties unless the insured explicitly gives authorization to do so. The insured is entitled to privacy towards a healthcare provider.

5.1.2 Obligations of the insured

The insured is obliged to inform the 'ZVK' about any circumstances or changes that may be of importance for the implementation of the Decree and the Regulation. The insured has no more healthcare claims than those derived from the Decree and Regulation. Moreover. the insured must behave well and must not abuse the healthcare claims he is entitled to.

5.2 Complaint procedure

The 'ZVK' has a complaint procedure. If the insured thinks that he has not been treated appropriately by an employee of the 'ZVK' he may file a complaint about this at the 'ZVK'. The insured can file his complaint verbally or in writing. The 'ZVK' will start processing the complaint as soon as possible and the insured will receive an answer within reasonable time.
If the insured is not satisfied with the handling of the complaint he can approach the National Ombudsman (see 5.3).

Each healthcare provider should have a complaint procedure. If an insured individual feels he has not been treated appropriately by a healthcare provider or its employee, he may file a complaint with the healthcare provider.
If the insured is not satisfied with the handling he can apply for an independent complaints committee to which the healthcare provider must be associated.

5.3 National Ombudsman

If the insured is not satisfied with the settlement of the complaint or the handling of the complaint by the 'ZVK', the insured may relay to the National Ombudsman. The National Ombudsman tries as much as possible to reach an agreement between the 'ZVK' and the insured. If necessary, the ombudsman shall give an advice on the matter.
For the islands of Bonaire, Saba and St. Eustatius, the National Ombudsman can be reached through the 'Rijksdienst Caribisch Nederland'. A complaint may also be filed on www.nationaleombudsman.nl. You can find more information on the subject on the website of the National Ombudsman.

5.4 Objection

The insured may object to the head of the 'ZVK' concerning a given or denied permission regarding a healthcare claim. The insured may also object against an imposed contribution. The deadline for filing an objection is maximum 6 weeks. The insured may request the 'ZVK' to write down the prior decision. If necessary the ZVK can reverse this decision than.

The objection letter should consist of the following :

- Your name and address;
- The date and signature of the party concerned;
- A description of the decision you are filing an objection against;
- The reasons why you don't agree with this decision.

If the insured does not file this objection within the set term, the 'ZVK' will declare the objection inadmissible.

The 'ZVK' processes the notice of objection as soon as possible however within a maximum of 4 months. For a proper handling of the objection the 'ZVK' can hold a hearingsession.
The 'ZVK' can declare the objection well-founded, unfounded, partially well-founded or partially unfounded.

5.5 Appeal in court and Disciplinary Proceedings

If the insured is not satisfied with the decision or the handling of the objection by the 'ZVK' he can appeal at Court of First Instance (Het Gerecht in Eerste Aanleg) of Bonaire, St. Eustatius or Saba. After that he may also appeal at Joint Court of Justice (Het Gemeenschappelijke Hof van Justitie) of Curaçao, Aruba, St. Maarten, Bonaire, St. Eustatius and Saba.

If the healthcare provider does not act in accordance with the rules of conduct of his profession, the insured can also file a complaint with the Medical Disciplinary Tribunal ('Medisch Tuchtcollege'). This may be the case if the healthcare provider acted negligently, intervened too slowly or provided too little information.