Regulations on Personal Care Budgets under the Dutch Health Insurance Act for Nursing and Other Care

Valid from 1 January 2027

This version replaces the previous version of the Regulations on Personal Care Budgets under the Dutch Health Insurance Act (‘Zorgverzekeringswet’, Zvw)

575.784.000.000.2650

Contents

Definitions 1
Article 1: Introduction 2
Article 2: Target group for the Personal Care Budget under the Dutch Health Insurance Act 2
Article 3: Qualifying criteria for a Personal Care Budget under the Dutch Health Insurance Act 3
Article 4: Grounds for refusal 4
Article 5: Application for a Personal Care Budget under the Dutch Health Insurance Act 5
Article 6: Allocation decision 8
Article 7: Claiming healthcare costs 9
Article 8: Obligations 11
Article 9: Revision or revocation 13
Article 10: Termination of the Personal Care Budget under the Dutch Health Insurance Act 14
Article 11: Claiming back the budget 15

Conscious-choice consultation
This is a consultation between you and us, either over the telephone or in person, allowing you to provide further details of your application. Our adviser will explain the implications of choosing a Personal Care Budget under the Dutch Health Insurance Act ('Zvw-pgb'). They will ask you a few questions about yourself, about your healthcare need and about what kind of healthcare you intend to procure. You will also have a chance to ask us any questions you may have.

Partner
Your spouse, registered partner or other life partner.

Representative
A representative is:

a. the legal representative; or
b. the partner; or
c. a relative (by consanguinity or marriage in the 1st or 2nd degree) who you appoint as your representative and who does not meet the definition of 'legal representative'.

We will assess whether or not you, through this representative, will be able to responsibly fulfil the tasks and obligations that come with the Personal Care Budget under the Dutch Health Insurance Act.

See article 4.7 for the grounds based on which we may reject a representative.

Legal representative
For persons aged under 18, a legal representative can be either a parent (provided the parent has not been removed from parental responsibility) or a guardian. For persons aged 18 and over, a court-appointed curator, mentor or administrator can be a legal representative.

In-kind healthcare
In the event of in-kind healthcare, the healthcare provider that we have contracted for this provides and organises the healthcare and takes care of all associated administrative tasks. We often refer to this as healthcare contracted by us.

Healthcare provider
By healthcare provider we mean all parties you have contracted to provide healthcare.

Article 1: Introduction

1.1 Why these regulations?

These regulations on the personal care budget for nursing and other care are intended to further clarify clause B.26 on district nursing in the terms and conditions of insurance. For certain nursing and other care needs, there is the option to apply for a personal care budget for nursing and other care that lets you procure care yourself. This option is subject to certain conditions. We will set this budget based on the required number of hours of nursing and other care specified in the care needs assessment. This number of hours will be the decisive factor in setting the budget. In these regulations, you will find further information on the Personal Care Budget under the Dutch Health Insurance Act, the qualifying criteria, how to apply for it, how to claim healthcare expenses and when and how the budget will be reviewed. These regulations are part of your terms and conditions of insurance.

1.2 Basis for these regulations

You are entitled to nursing and other care as specified in clause B.26. of the terms and conditions of insurance for your health insurance policy.

Article 13a of the Dutch Health Insurance Act (‘Zorgverzekeringswet’, Zvw) is the basis for allocation of a personal care budget. We reserve the right to make interim changes to these regulations as and when necessitated by changes in legislation. We will inform you as necessary.

1.3 Administrative agreements on the Personal Care Budget under the Dutch Health Insurance Act

The conditions and agreements that we have included in these Regulations are based on the most recent administrative agreements on the principles and content of the Personal Care Budget under the Dutch Health Insurance Act as agreed between the Dutch Ministry of Health, Welfare and Sport, ‘Zorgverzekeraars Nederland’ (the umbrella organisation of ten health insurers in the Netherlands), the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN), and Per Saldo (the association for people with a personal care budget).

Article 2: Target group for the Personal Care Budget under the Dutch Health Insurance Act

2.1 You qualify for a Personal Care Budget under the Dutch Health Insurance Act if you need the kind of nursing and other care as provided by nurses, whereby the care relates to a need for medical care or a high risk of needing medical care, and such care does not require admission to hospital and is not obstetric care either.

a. Healthcare as specified above in Article 2.1 does not include care activities for minors aimed at addressing a lack of independence in carrying out Activities of Daily Living (ADLs).

Aside from that, you must:

2.2 need the nursing and/or care in the long term, i.e. for over a year, or;

2.3 need palliative care. This means that your estimated life expectancy as determined by your attending doctor is under three months.

Article 3: Qualifying criteria for a Personal Care Budget under the Dutch Health Insurance Act

You must meet all the criteria below. If we do not consider you able to meet all the criteria, we will either deny you access to a Personal Care Budget under the Dutch Health Insurance Act or specify additional requirements that you must meet to qualify for a Personal Care Budget under the Dutch Health Insurance Act after all or again:

3.1 you have been issued a care needs assessment for nursing and other care as specified in Article 2.1 of these regulations. For the conditions that apply to the care needs assessment, please refer to Article 5 of these regulations and clause B.26. of the terms and conditions of insurance. The care needs assessment showing the medical grounds for nursing and other care must not be over three months old when we receive the application for a personal care budget;

3.2 we consider you able to fulfil the tasks and obligations that come with a Personal Care Budget under the Dutch Health Insurance Act either independently or with the help of a legal or other representative. In assessing your ability in this respect, we look at aspects such as the following:

a. you failed to meet the obligations that came with a previous personal care budget that you were allocated under the Dutch Health Insurance Act (‘Zvw)’, the Dutch Exceptional Medical Expenses Act (‘AWBZ’), the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz), the Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo), or the Dutch Youth Act (‘Jeugdwet’);
b. within a period of five years before submitting the application for a Personal Care Budget under the Dutch Health Insurance Act, you were involved in a case of deliberate deception in relation to a health insurance policy you had taken out or that had been taken out on your behalf;
c. there is an investigation ongoing into possible unlawful use of a previously allocated Personal Care Budget under the Dutch Health Insurance Act or under the Dutch Social Support Act, the Dutch Youth Act, the Dutch Long-Term Care Act and/or the Dutch Exceptional Medical Expenses Act;
d. you are at least four months behind on your premium payments or you were during the last six months;
e. you are enrolled in the debt restructuring programme for natural persons under the Debt Restructuring (Natural Persons) Act (‘Wet schuldsanering natuurlijke personen’, Wsnp), or a request to that effect has been submitted to a court;
f. you have applied for a suspension of payments order, are bankrupt or have been declared bankrupt.

If one of the situations under a to f applies, you will not be granted a Personal Care Budget under the Dutch Health Insurance Act;

3.3 we consider you able to manage the healthcare providers you have selected and align their care services in such a way that ensures responsible and high-quality healthcare either independently or with the help of a legal or other representative. ‘Responsible’ means that the situation at home is safe. A home situation will be considered ‘safe’ if there is, for example, sufficient supervision by carers and the healthcare provided is well aligned with the healthcare need. Care will be considered to be high quality if it is safe, effective (good outcome) and appropriate (not too costly). The healthcare is client-driven: you receive the healthcare at the right time and it is the healthcare you need;

3.4 we consider you able to effectively acquire adequate healthcare or other good-quality services using the Personal Care Budget under the Dutch Health Insurance Act;

3.5 we consider you able to explain why you want a Personal Care Budget under the Dutch Health Insurance Act and why you believe that you can get the healthcare you need through a Personal Care Budget under the Dutch Health Insurance Act, either independently or with the help of a legal or other representative.

Article 4: Grounds for refusal

You will not receive a Personal Care Budget under the Dutch Health Insurance Act if one of the following grounds for refusal exists:

4.1 you do not meet the conditions of Article 2 and/or Article 3 of these regulations;

4.2 you were previously awarded a Personal Care Budget under the Dutch Health Insurance Act and turned out not to be able to fulfil the tasks and obligations that come with a Personal Care Budget under the Dutch Health Insurance Act either independently or with the help of a legal or other representative;

4.3 you do not have a home address according to the Persons Database (‘Basisregistratie Personen’, BRP);

4.4 you are in custody;

4.5 you refuse to have a (or another) ‘conscious-choice consultation’ and/or to cooperate in a home visit that we may organise;

4.6 your application form or conscious-choice consultation and/or home visit shows that you only want to use your Personal Care Budget under the Dutch Health Insurance Act to procure healthcare or other services from healthcare providers with whom we have a contract for the provision of healthcare or other services;

4.7 your legal or other representative (if you need his or her help to meet the qualifying criteria specified in Article 3):

a. has failed to guarantee compliance with the obligations associated with previously allocated personal care budgets where he/she acted as an agent or legal or other representative;
b. does not have a home address according to the Persons Database (‘Basisregistratie Personen’, BRP);
c. is in custody;
d. is enrolled in the debt restructuring programme for natural persons under the Debt Restructuring (Natural Persons) Act (‘Wet schuldsanering natuurlijke personen’, Wsnp), or a request to that effect has been submitted to a court;
e. has applied for a suspension of payments order, is bankrupt or has been declared bankrupt;
f. is otherwise unable to provide sufficient security for compliance with the obligations that come with the personal care budget.
g. receives payment for managing your Personal Care Budget under the Dutch Health Insurance Act, or wants to be paid for this from the Personal Care Budget under the Dutch Health Insurance Act;

4.8 you have multiple care needs assessments for the healthcare as specified in Article 2.1. Your entire need for healthcare as specified in Article 2.1 must be captured in one single care needs assessment;

4.9 the healthcare is already reimbursed under other healthcare categories, such as specialist medical healthcare covered as part of a Diagnosis-Treatment Combination (‘Diagnose Behandel Combinatie’, DBC), so as to rule out duplicate cover and thus avoid unlawful healthcare.

4.10 the Personal Care Budget under the Dutch Health Insurance Act may only be spent on nursing and/or other care. The Personal Care Budget under the Dutch Health Insurance Act may not be used to pay for support (such as the costs involved in processing payments) in your duties as employer or client of a healthcare provider.

4.11 If you have a representative who takes care of managing and implementing the Personal Care Budget under the Dutch Health Insurance Act (not including nursing and other care) for you, your representative must be:

a. your legal representative, and/or
b. a 1st-degree or 2nd-degree relative by consanguinity or marriage, and/or
c. your spouse, and/or
d. your registered partner, and/or
e. another life partner.

It is not permitted to have a person other than those specified above in these Regulations on Personal Care Budgets under the Dutch Health Insurance Act act as your representative.

Article 5: Application for a Personal Care Budget under the Dutch Health Insurance Act

5.1 Your application for a Personal Care Budget under the Dutch Health Insurance Act will be assessed based on the fully completed set of Personal Care Budget under the Dutch Health Insurance Act application forms, including appendices (Part I: the part for the nurse, and Part II: the part for the insured person). A conscious-choice consultation is part of the application procedure, unless we decide otherwise. If the conscious-choice consultation shows that you meet the criteria specified in Articles 2 and 3 of these regulations, you will get an allocation decision for a Personal Care Budget under the Dutch Health Insurance Act. The application form for a Personal Care Budget under the Dutch Health Insurance Act is available for download from our website. Alternatively, you can call us or write to us to request the application form.

5.2 When it comes to making a care needs assessment for an application for a Personal Care Budget under the Dutch Health Insurance Act, we make the following distinction:
a. for an application for adults from the age of 18, you need to have a care needs assessment made by a nurse who at least has a degree from higher professional education (level 6 or higher) and is registered in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG), and who has made the care needs assessment in accordance with the standards for care needs assessment and nursing and other care organisation in the home environment (‘Normenkader voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving’), as drawn up by the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN), and in your presence;

b. the nurse (level 6 or higher) who assessed your care needs must be able to show proof of professional competence[1] in care needs assessment under the Dutch Health Insurance Act (‘Zorgverzekeringswet’) (article 2.10 of the Health Insurance Decree (‘Besluit zorgverzekering’)), within the field of expertise of their training, and must also meet one or several of the following conditions:

- nurses with a nursing degree from higher professional education (bachelor);
- nurses with a master’s degree;
- nurses with a district nursing diploma (social healthcare degree from higher professional education);
- nurses registered as district nurses in the quality register of the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN);
- nurses who have completed relevant further nursing training at level 6 of the Dutch qualification framework (‘Nederlands kwalificatieraamwerk’ (NLQF)).

b. for an application for children aged under 18, you need to have a care needs assessment made by a children’s nurse with at least a degree from higher professional education (level 5) who is registered in accordance with the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG) and/or a nursing specialist who has a children’s nurse qualification, and who has also taken the mandatory training on care needs assessments for home-based children’s healthcare (‘Handreiking Indicatieproces Kindzorg’-training) and has a valid certificate to prove it. The nurse making the care needs assessment must work for a BINKZ-affiliated healthcare provider (BINKZ is the sector organisation for integral paediatric medicine). In accordance with the standards for care needs assessment and nursing and other care organisation in the home environment (‘Normenkader voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving’), as drawn up by the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN), and the Guidance on the Assessment Process in Paediatric Medicine (‘Handreiking Indicatieproces Kindzorg’, HIK), this assessment must

[1] See also: ‘Statement of competence in care needs assessment under the Health Insurance Act’ issued by the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN), version of 14 May 2024

be drawn up in the home situation in the presence of yourself (the child) and your legal representative (parent(s), curator, administrator, mentor). If you are unable to procure healthcare for your child aged under 18, please contact us to find a suitable solution.

Both a and b are also subject to the following condition: the person making the care needs assessment must be part of the network (such as a district social support & care team, partnership of home care organisations and general practitioners and hospital) that organises healthcare and support in the insured person's local area.

5.3 In assessing care needs, the specialist making the care needs assessment must use the quality standard regarding the use of interpreters for non-Dutch speakers in healthcare ('Kwaliteitsnorm tolkgebruik voor anderstaligen in de zorg') to determine whether an interpreter is needed.

5.4 If there are reserved or high-risk activities involved, you must be able to show, as and when requested by us, that these have been ordered by a doctor.

High-risk activities

In case of a high-risk activity, the nature, scope and specifics of the healthcare must be worked out in the care plan.

Reserved activities

If a treatment involves reserved activities by a formal healthcare provider, your healthcare provider must be licensed and competent to perform these activities. You must be able to show, as and when asked by us, a request from a doctor for these activities to be performed and be able to show that they are in line with the manual for reserved activities in (district) nursing and other care ('handleiding voorbehouden handelingen in de (wijk) verpleging & verzorging' (ActiZ, 2019).

In case of informal healthcare providers, you must be able to show, as and when requested by us, that the doctor deems the healthcare provider to be adequately aware and competent to be able to perform the activity in a responsible manner.

5.5 If you need palliative care, you will need to enclose a statement by your attending doctor saying that your estimated life expectancy is under three months.

5.6 The care needs assessment must be made independently. The district nurse making the care needs assessment must, therefore, not:

- be your legal or other representative, your partner, or a first-degree or second-degree relative by consanguinity or marriage; and/or
- provide the healthcare to you himself or herself; and/or
- work for or have a partnership with a healthcare provider that will provide some of the healthcare to you, unless this is a healthcare provider that we have contracted for this healthcare.

5.7 In the care needs assessment, the district nurse must assess what the insured person and their network can and are willing to take care of themselves based on the standards for care needs assessment and nursing and other care organisation in the home environment ('Normenkader voor indiceren en organiseren van verpleging en verzorging in de eigen omgeving') drawn up by the Dutch Professional Organisation for Nurses and Professional Carers ('Verpleegkundigen & Verzorgenden Nederland', V&VN). This means, among other things, that the district nurse identifies the insured person's network and then assesses what healthcare this network can and cannot be expected to provide based on their capacity and the care burden involved. The district nurse will subsequently agree with the insured person and their network what the network is willing and able to contribute to the care. The care that the network can and is willing to provide will not be included in a care needs assessment for district nursing and you will not get a personal care budget for that part. The district nurse must include his or her rationale in the care needs assessment.

The conceptual framework of the Dutch Professional Organisation for Nurses and Professional Carers ('Verpleegkundigen & Verzorgenden Nederland', V&VN) defines 'network' as 'loved ones and carers'

such as the insured person's partner, children, members of the insured person's household, family and friends.
In the care needs assessment, the district nurse assesses based on the complete context of the insured person, i.e. the person needing healthcare, how to resolve the healthcare need or perform the intervention. Independence (together with the insured person's own network) is the starting point for the V&VN's standards.

5.8 The care needed according to the care needs assessment may be care that we deem not to come under the entitlement to nursing and other care, that we deem not to be appropriate and/or where the care needs assessment does not meet the standards ('Normenkader') of the Dutch Professional Organisation for Nurses and Professional Carers ('Verpleegkundigen & Verzorgenden Nederland', V&VN). We will in that case contact the district nurse who made the care needs assessment and ask for further details and the rationale behind the assessment. If, after liaising with the district nurse, we deem the healthcare not to come under the entitlement to nursing and other care, deem the healthcare not to be appropriate, or deem the care needs assessment not to meet the standards, we will not allocate a Personal Care Budget under the Dutch Health Insurance Act, or we may allocate a budget that does not extend to all the hours of care needed according to the care needs assessment. In that case, we will state our reasons for not accepting the care needs assessment in full. We may also seek re-evaluation of the care needs assessment in this kind of situation.

We may ask a second, independent district nurse to re-evaluate the current care needs assessment (re-evaluation). The first district nurse will retain control of the care needs assessment. After evaluation, the second district nurse's opinion/advice must be submitted to the first district nurse. After both district nurses have discussed the case (peer review), the first district nurse will assess whether the re-evaluation necessitates amendment of the care needs assessment and, if so, substantiate why.

You can also seek re-evaluation of the care needs assessment, albeit only with our approval. We may withhold such approval if you, for example, have already had a care needs assessment from multiple healthcare providers for the same period before you requested re-evaluation.

5.9 If you state on your application form that you will be using only one single healthcare provider, you must also specify how and with the help of which healthcare provider(s) you will meet your care needs in the event that the healthcare provider you intend to contract is or suddenly becomes unavailable due to illness, holiday or otherwise. You must also enter into a healthcare agreement with a replacement healthcare provider.

5.10 If you are staying at a facility on medical grounds to receive medical care as specified in the Dutch Health Insurance Act or have been admitted to a facility for a short-term stay (first-line stay), you can revert to your current care needs assessment after you have been discharged and returned home. You will then not have to submit a full application again, unless the nature, extent or estimated duration of your healthcare need has changed.
A new application will be required if you have been admitted to a facility providing care under the Dutch Long-Term Care Act ('Wet langdurige Zorg', Wlz), such as a nursing home, for longer than 60 days, or if you have been staying at a facility to receive medical care as specified in the Dutch Health Insurance Act for longer than 60 days.

This can be a hospital, facility for first-line in-patient care or a rehabilitation centre.

5.11 A combination of healthcare contracted by us (in-kind healthcare) and a Personal Care Budget under the Dutch Health Insurance Act is possible, but only on the following conditions:

a. if you intend to use in-kind healthcare in combination with care covered by a Personal Care Budget under the Dutch Health Insurance Act to cover your nursing and other care, you must state this on the application form. The nurse must then draw up one single care needs assessment that specifies both the in-kind healthcare and the healthcare covered by the Personal Care Budget under the Dutch Health Insurance Act. The healthcare providers we have contracted provide only in-kind healthcare and not healthcare covered by a Personal Care Budget under the Dutch Health Insurance Act;

b. if you want to spend your Personal Care Budget under the Dutch Health Insurance Act only on healthcare providers we have contracted for nursing and/or other care, we will deny you a Personal

Care Budget under the Dutch Health Insurance Act (Article 4.6). After all, the in-kind healthcare will then cover all your care needs;

c. if you go to a healthcare provider contracted by us for part of the healthcare you need, this healthcare will be provided as in-kind healthcare. You can then procure the remaining part of the healthcare using a Personal Care Budget under the Dutch Health Insurance Act, provided that you have our approval for that. On the application form, please state the healthcare providers you intend to use for the healthcare covered by your Personal Care Budget under the Dutch Health Insurance Act and the healthcare provider you intend to use for in-kind healthcare.
Not having our approval for reimbursement of in-kind healthcare in combination with a Personal Care Budget under the Dutch Health Insurance Act will affect the reimbursement;

d. if you have our approval for a Personal Care Budget under the Dutch Health Insurance act, you can pay non-contracted healthcare providers only out of this budget. We will not approve any procurement of non-contracted healthcare that does not use the Personal Care Budget under the Dutch Health Insurance Act. Only the combination of a Personal Care Budget under the Dutch Health Insurance Act and, in addition, healthcare contracted by us (in-kind healthcare) is possible.

Article 6: Allocation decision

6.1 The effective date for the Personal Care Budget under the Dutch Health Insurance Act is the date on which we receive your fully completed and signed application. You can also ask for the Personal Care Budget under the Dutch Health Insurance Act to take effect on a later date.

6.2 If your allocation decision has expired, you can only keep your Personal Care Budget under the Dutch Health Insurance Act by reapplying for it. Your new Personal Care Budget under the Dutch Health Insurance Act will then take effect at the earliest on the date when we receive the fully completed application form from you. You should therefore ask your district nurse to complete the new application in time before your current allocation decision expires. We need to have the fully completed and signed application forms, including the required enclosures, at least 6 weeks before your current allocation decision expires.

6.3 In the event of an interim revision of the care needs assessment, you can only keep your Personal Care Budget under the Dutch Health Insurance Act by reapplying for it. Your new Personal Care Budget under the Dutch Health Insurance Act will then take effect at the earliest on the date when we receive the fully completed application form from you.

6.4 We will record the duration of your Personal Care Budget under the Dutch Health Insurance Act in the written allocation decision that we will send to you.

a. Your Personal Care Budget under the Dutch Health Insurance Act will be valid for a maximum of 2 years from the date on which you were allocated the Personal Care Budget under the Dutch Health Insurance Act and as long as you have a valid care needs assessment. If you want to continue to receive a Personal Care Budget under the Dutch Health Insurance Act after this period, you can ask your district nurse to draw up a new care needs assessment and then submit a new application for a Personal Care Budget under the Dutch Health Insurance Act to us as specified in Article 5.
b. If a Personal Care Budget under the Dutch Health Insurance Act has been previously allocated by us, it may be possible in specific individual situations to allocate a Personal Care Budget under the Dutch Health Insurance Act with a term of up to 5 years, in accordance with the Guidance on Extended Allocation of a Personal Care Budget under the Dutch Health Insurance Act (‘Handreiking verlengde toekenning Zvw-pgb’).

6.5 In setting your Personal Care Budget under the Dutch Health Insurance Act, we look at the number of hours for which you are applying for a Personal Care Budget under the Dutch Health Insurance Act that fit within the hours of nursing and other care that the nurse deems necessary as specified in the care needs assessment.

6.6 The budget will be calculated for an entire calendar year and will expire on 31 December of the calendar year for which the Personal Care Budget under the Dutch Health Insurance Act has been provided.

6.7 If your health insurance policy or your Personal Care Budget under the Dutch Health Insurance Act is terminated before the end of the calendar year, your Personal Care Budget under the Dutch Health Insurance Act will be prorated to the part of the year for which it was provided. After such a proportional reduction, your Personal Care Budget under the Dutch Health Insurance Act will amount to: (the original personal care budget) times (the number of days during which your personal care budget and insurance policy were in effect during the calendar year) divided by (365). If you have submitted claims that exceed the reduced personal care budget, you will be required to pay back any amounts reimbursed in excess of the personal care budget.

In the event of an interim revision of the care needs assessment, your Personal Care Budget under the Dutch Health Insurance Act will be reduced or increased accordingly. After such a proportional reduction, your Personal Care Budget under the Dutch Health Insurance Act will amount to (the original personal care budget) times (the number of days during which your personal care budget and insurance policy were in effect during the calendar year) divided by (365). If you have submitted claims that exceed the reduced personal care budget, you will be required to pay back any amounts reimbursed in excess of the personal care budget.

6.8 You will receive written notice of allocation and termination of the Personal Care Budget under the Dutch Health Insurance Act, as well as of revocation of the allocation decision for the Personal Care Budget under the Dutch Health Insurance Act.

6.9 If the care for which you have applied for a Personal Care Budget under the Dutch Health Insurance Act is already covered by the healthcare contracted by us (in-kind healthcare) that you are receiving, or if you are already entitled to reimbursement of the costs of this care when you submit your application for a Personal Care Budget under the Dutch Health Insurance Act, it will be your responsibility to terminate this care. This must be done before the Personal Care Budget under the Dutch Health Insurance Act as specified in the allocation decision takes effect. This does not apply if you have stated on your application form that you will continue to procure your care from this/these healthcare provider(s).

Article 7: Claiming healthcare costs

7.1 Conditions for claiming healthcare costs

7.1.1 You can start submitting bills to claim healthcare costs from the effective date of the Personal Care Budget under the Dutch Health Insurance Act stated in your allocation decision.

7.1.2 Only you or your legal representative can submit bills to claim healthcare costs under the Personal Care Budget.

7.1.3 To submit a claim, use either our claim form for formal healthcare providers or our claim form for informal healthcare providers. These claim forms are available for download from our website. Alternatively, you can request a claim form from us by calling or writing to us. We have separate claim forms for care provided by formal healthcare providers and care provided by informal healthcare providers.

When you receive a bill from the healthcare providers with whom you have entered into an agreement based on your Personal Care Budget under the Dutch Health Insurance Act, make sure you check it and keep it for your records. Sending the ‘pgb’ claim form will suffice. Claims are only accepted for care provided that is in accordance with the care needs assessment, the application for the Personal Care Budget under the Dutch Health Insurance Act and the allocation decision.

7.1.4 Healthcare costs can only be claimed in retrospect. By sending us the claim forms, you confirm that these claim forms and hours of care provided are accurate.

7.1.5 A fixed monthly wage cannot be claimed as healthcare costs. Claims will only be accepted for care actually provided in hours and minutes (rounded off to units of 5 minutes).

7.1.6 To claim reimbursement of healthcare costs, please submit bills to us within three months of the care in question being provided. This is necessary so as to be able to keep track of your use of your Personal Care Budget under the Dutch Health Insurance Act.

7.1.7 The care needs assessment and evaluation of the healthcare need as described in Article 2.1, case management, and childcare with nursing and admission in case of intensive care for children are not reimbursed through the Personal Care Budget under the Dutch Health Insurance Act. Depending on your policy, such care will be provided as in-kind healthcare or reimbursed on a refund basis as regular district nursing.

7.2 Claim level and scope

7.2.1 Claims for care provided by formal healthcare providers are subject to the following maximum rates:

Type of healthcare	Hourly rate	Per 5-minute unit
Personal care	42,72	3,56
Nursing	63,24	5,27

7.2.2 Claims for care provided by informal healthcare providers are subject to the following maximum rates:

Type of healthcare	Hourly rate	Per 5-minute unit
Personal care	27,96	2,33
Nursing	27,96	2,33

7.2.3 Formal healthcare providers are healthcare providers who:
a. have an AGB code from one of the following categories:
• 41 self-employed district nurses/personal care budget providers/managing foundations
• 42 nursing homes
• 75 home care organisations
• 91 nurses
• 98 claimants/service agencies/health insurers; and

b. work independently or on behalf of the organisation stated under a. as a district nursing specialist, district nurse, nurse with a degree from intermediate professional education, level-3 individual healthcare carer (‘verzorgende 3IG’) or level-3 carer and who meet quality standards with respect to professional experience and expertise. We may ask you for proof of your formal healthcare provider’s qualification, based on which we can verify whether or not your healthcare provider is authorised to provide nursing or other care based on the formal rate.

Your parent, carer, 1st-degree or 2nd-degree relative by consanguinity or marriage or your partner (spouse, registered partner, or other life partner) will never be eligible for the formal rate.

For care provided by formal healthcare providers, the rate you can claim is subject to the maximum rates specified in Article 7.2.1. To be able to claim for care provided by a formal healthcare provider, you must state your healthcare provider’s AGB code (administrative code assigned to healthcare professionals in the Netherlands) in your application for the Personal Care Budget under the Dutch Health Insurance Act and on every claim you submit.

7.2.4 Informal healthcare providers are in any case healthcare providers who:
a. are parents, carers, a partner (spouse, registered partner or other life partner) or a 1st-degree or 2nd-degree relative by consanguinity or marriage of yours/the personal budget holder’s (these persons can never be designated as formal healthcare providers for you/the personal budget holder) and/or;
b. are a care assistant up to qualification level 3 and/or;
c. are not registered as a nurse in the register specified in Article 3 of the Dutch Individual Healthcare Professions Act (‘Wet op de beroepen in de individuele gezondheidszorg’, Wet BIG) to practice a profession in the healthcare sphere, and/or;
d. are not registered in the Trade Register or not registered in the Trade Register with SBI codes 86, 87 or 88 as a healthcare-providing organisation.

These healthcare providers are never eligible for the formal rate.

7.2.5 Rates for formal and informal healthcare are ‘all-in rates’, which means you cannot claim back any other costs on top of these rates, such as employer’s contributions, travel expenses, holiday pay, days of holiday leave and medical aids.

7.2.6 Healthcare providers who are registered in the External Reference Register (‘Extern Verwijzingsregister’) or for whom there is a serious suspicion of fraud may, following an investigation, be excluded from reimbursement under the Personal Care Budget under the Dutch Health Insurance Act. Applications with care needs assessments drawn up by healthcare professionals registered in the External Reference Index (EVR) may be rejected for this reason.

7.3 Other provisions for claiming healthcare costs

7.3.1 You are personally responsible for on-time payment of healthcare providers you have contracted. If you fail to comply with a contractual payment obligation on time, any additional costs (such as those of collection and statutory interest) cannot be claimed back from the Personal Care Budget under the Dutch Health Insurance Act.

7.3.2 We reserve the right to check whether care for which a claim has been submitted has actually been provided by the healthcare providers you have contracted and is in line with your care needs assessment. Aside from that, we may also audit the appropriateness and quality of the care provided. Where applicable, we can help you with advice on how to use this care even more appropriately.

7.3.3 Any unused funds in your budget will not be carried over to the next period after termination of the period for which it was allocated.

7.3.4 We will not reimburse you for healthcare procured in excess of the maximum of the budget for nursing and/or the maximum budget for other care.

7.3.5 In addition to the conditions specified in this article, submission of bills and payments for healthcare are also governed by the general terms and conditions of your health insurance policy.

7.3.6 You cannot use your Personal Care Budget to pay for support in your duties as employer or client of a healthcare provider and/or to pay for payment support.

7.3.7 If you are staying outside the Netherlands on a temporary basis and want to hire foreign healthcare providers for this period, please notify us in advance in writing. After you have received our written permission, you can claim the costs of healthcare provided by foreign healthcare providers.

7.3.8 The costs referred to in Article 4.10 of these regulations cannot be claimed.

Article 8: Obligations

8.1 You are required to record any arrangements made with your healthcare providers in writing in healthcare agreements. A healthcare agreement must at least specify the following:

- the insured person’s name and address details;
- the healthcare provider's name and address details;
- the relationship between the insured person and the healthcare provider;
- the term of the agreement;
- the care that will be provided;
- the number of hours of care that will be provided and when;
- the payable rate;
- the AGB code, if the healthcare provider is a formal healthcare provider;
- and it must be signed by the insured person or a legal or other representative and the healthcare provider.

For a sample healthcare agreement, please go to www.svb.nl (in Dutch).

8.2 As an insured person, it is your responsibility to ensure that the partner or first-degree or second-degree relative by consanguinity or marriage with whom you enter into an agreement does not work

for more than 48 hours a week. For the purposes of determining whether or not this maximum is exceeded, all work performed by this person will be taken into account, regardless of whether it is performed under an employment contract, on a self-employed basis or on any other basis.
The healthcare provider must be at least 15 years of age.

8.3 You are under an obligation to cooperate with the evaluation of your healthcare need as and when requested by the district nurse who made your care needs assessment. If such an evaluation shows that your healthcare need has increased or decreased, you are subsequently required to complete and submit a new application form for a Personal Care Budget under the Dutch Health Insurance Act together with the district nurse. In the case of a care needs assessment that is covered using a Personal Care Budget under the Dutch Health Insurance Act, the nursing process will be the decisive factor in determining your healthcare need. You are under an obligation to cooperate in a multidisciplinary meeting organised by the district nurse.

8.4 As the insured person, you are responsible for the quality of the healthcare you procure. Your health insurer will not be liable for any errors made by healthcare providers contracted by you.

8.5
a. In the event that the nature, scope or estimated duration of your healthcare need changes, the nurse will need to make a new care needs assessment. This may be necessary either when your health worsens or when your health improves. You must then immediately request a new care needs assessment and submit a new application for a Personal Care Budget under the Dutch Health Insurance Act.

b. The nurse who made your care needs assessment can also opt to perform a check once a year or more often to see whether the care needs assessment is still in line with your healthcare need and therefore still accurate. If such a check leads to a new care needs assessment, you will also have to submit a new application for a Personal Care Budget under the Dutch Health Insurance Act.

Monitoring and evaluation are part of the care needs assessment process. Changes in the care needs may lead to changes to the Personal Care Budget under the Dutch Health Insurance Act.

c. In the case of a review that shows that the healthcare need extends to more than 24 hours per week, the district nurse can always, prior to issuing the care needs assessment, convene a multidisciplinary meeting to discuss the healthcare to be provided with the various professionals involved, as also specified in the reporting guidelines of the Dutch Professional Organisation for Nurses and Professional Carers (‘Verpleegkundigen & Verzorgenden Nederland’, V&VN).

d. The district nurse will cease to be in control if he or she decides that his or her expertise is no longer needed, given the insured person’s medical situation, or if he or she deems that his or her interventions no longer serve to achieve a nursing goal for the insured person. If nursing expertise is no longer needed, any remaining healthcare need can be handed over to the network or another domain. The current care needs assessment will then cease to be valid.

e. You will be required to submit a new application for a Personal Care Budget under the Dutch Health Insurance Act within four weeks when you change healthcare providers or switch from having the healthcare provider provide healthcare contracted by us (in-kind healthcare) to having the healthcare provider provide healthcare under the Personal Care Budget under the Dutch Health Insurance Act or vice versa. Where applicable, the budget will be adjusted accordingly based on the new application. The old Personal Care Budget under the Dutch Health Insurance Act will be (re)calculated as specified in Articles 6.6 and 6.7. The new Personal Care Budget under the Dutch Health Insurance Act will be calculated as of the start date of this new Personal Care Budget under the Dutch Health Insurance Act.

8.6 You are personally responsible for ensuring that the spending of your budget and/or the hours are in line with the allocation decision issued by us.

8.7 You are under an obligation to keep a record and retain it for at least five years after termination of the Personal Care Budget under the Dutch Health Insurance Act. This record must at least contain the following:

a. a court decision if you have a legal representative, unless you are the legal representative ipso jure;

b. all application forms for the Personal Care Budget under the Dutch Health Insurance Act including appendices and healthcare agreements;
c. invoices or time sheets stating the name of the healthcare provider(s) and specifying hourly pay, units, type of care provided and further details of the care received;
d. proof of payment through bank statements (receipts for cash payments will not be accepted) or wage statements issued by the 'Sociale Verzekeringsbank' (SVB);
e. copies of bills issued by healthcare providers and copies of claims submitted for healthcare costs;
f. your healthcare plan and records of your objectives and evaluation reports.

8.8 You are furthermore required to send us information from your records as soon as possible as and when requested by us. Even if the 'Sociale Verzekeringsbank' (SVB) pays your healthcare providers directly, you still have to update your records.

8.9 Under current privacy regulations (GDPR, Dutch Health Insurance Regulations ('Regeling zorgverzekering')), we are authorised to contact the nurse and/or general practitioner to access your medical and other data regarding the application for a Personal Care Budget under the Dutch Health Insurance Act and care needs assessment for nursing and other care, as and when needed for a correct assessment. Such access will be the responsibility of our medical adviser or nursing adviser. We, or a party contracted by us, are also authorised to access and check records regarding your Personal Care Budget under the Dutch Health Insurance Act, in compliance with the Dutch Health Insurance Regulations.

8.10 You are under an obligation to cooperate in a conscious-choice consultation. Such a conscious-choice consultation will be held with the person needing the healthcare and/or his/her legal representative.

We reserve the right to have a third party perform home visits on our behalf. Such a third party will be selected with due care, as they will be authorised to, on our behalf, access and check your personal and medical data. They will do so with great care as per our privacy statement, which you can find on our website.

8.11 If you switch to another health insurer and still have a valid allocation decision, your new health insurer will honour the valid allocation decision (up to the expiry date of the care needs assessment) in terms of the number of hours allocated for nursing and other care (contact your new health insurer about this). However, the extent of the reimbursement paid for these hours can vary due to the fact that each health insurer has different rates. We advise you to keep this allocation decision for as long as it is valid and to send a copy to your new health insurer. Your new health insurer may ask you for it.

8.12 If you procure healthcare only from informal healthcare providers and the number of hours of nursing and other care per week exceeds 24 hours (especially in case of complex medical conditions), we may, for reasons of quality of care, make reimbursement conditional on part of the healthcare being provided by a formal healthcare provider. One opportunity to discuss this condition is during the conscious-choice consultation, whereby customisation is always the starting point. In exceptional situations, we may also make the provision of nursing and other care for fewer than 24 hours a week conditional on part of the healthcare being provided by a formal healthcare provider and/or the healthcare being evaluated in the interim. For a care need of fewer than 24 hours of nursing and other care per week, we, the nurse and you/the personal budget holder will consult to determine the reasons for deviating from this threshold.

Article 9: Revision or revocation

Your Personal Care Budget may be revised or revoked with retrospective effect from the date of the allocation decision:

a. if you no longer meet the criteria for allocation of the personal care budget;
b. if one of the grounds for refusal applies in your case;
c. if you fail to fulfil the obligations specified in these regulations;
d. if you are entitled to healthcare under the Dutch Long-Term Care Act ('Wet langdurige zorg', Wlz);
e. if you have requested termination of the Personal Care Budget under the Dutch Health Insurance Act;

f. if you are staying in a facility for over two months to receive care that is covered by your general health insurance policy;
g. as of the effective date of the allocation decision if the budget has been allocated based on incorrect or incomplete information provided by you and the decision would have been different if you had provided accurate or complete information;
h. if you fail to provide information requested by us, or fail to do so in a timely manner;
i. if you fail to allow us to audit your records;
j. if an audit of your records has identified irregularities based on current legislation and/or regulations;
k. if you fail to abide by the regulations;
l. if you appoint a new legal or other representative during the term of the Personal Care Budget under the Dutch Health Insurance Act, or appoint a legal or other representative for the first time, and your health insurer is of the opinion that you, with this representative, will not be able to fulfil the tasks and obligations that come with the Personal Care Budget under the Dutch Health Insurance Act in a responsible manner. You must notify us without delay when you change legal or other representatives or appoint one for the first time, using the change form for the Personal Care Budget under the Dutch Health Insurance Act, which is available for download from our website;
m. if you use in-kind healthcare provided by a healthcare provider not specified on your application form.

Article 10: Termination of the Personal Care Budget under the Dutch Health Insurance Act

10.1 Your entitlement to a Personal Care Budget under the Dutch Health Insurance Act will end automatically as of the day on which:

a. you are no longer in the specific target group referred to in Article 2;
b. the costs of the care you need can be covered by a legal provision other than the Dutch Health Insurance Act (‘Zorgverzekeringswet’), such as the Dutch Long-Term Care Act (‘Wet langdurige zorg’, Wlz) or the Dutch Social Support Act (‘Wet maatschappelijke ondersteuning’, Wmo);
c. you are declared bankrupt or enrolled in the debt restructuring programme for natural persons under the Debt Restructuring (Natural Persons) Act (‘Wet schuldsanering natuurlijke personen’, Wsnp);
d. you no longer have a home address according to the Persons Database (‘Basisregistratie Personen’, BRP);
e. you have been taken into custody;
f. you use your Personal Care Budget under the Dutch Health Insurance Act solely to procure healthcare from healthcare providers with whom we have a contract for the provision of healthcare;
g. if you have requested termination of the Personal Care Budget under the Dutch Health Insurance Act;
h. the validity term of your allocation decision has expired;
i. your health insurance policy expires.

10.2 The health insurer reserves the right to discontinue your entitlement to a Personal Care Budget under the Dutch Health Insurance Act:

a. as of the day on which you are no longer able to independently meet the qualifying criteria specified in Article 3 and do not have a representative to assist you;
b. as of the day on which your representative, if you need his or her help to meet the qualifying criteria specified in Article 3:
    1. is no longer your curator, administrator, mentor, guardian, partner or first-degree relative by consanguinity or marriage;
    2. has failed to guarantee compliance with the obligations associated with other personal care budgets where he/she acted as an agent or representative;
    3. no longer has a home address according to the Persons Database (‘Basisregistratie Personen’, BRP);
    4. has been taken into custody;
    5. is declared bankrupt or enrolled in the debt restructuring programme for natural persons under the Debt Restructuring (Natural Persons) Act (‘Wet schuldsanering natuurlijke personen’, Wsnp);
    6. is otherwise no longer able to provide sufficient security for compliance with the obligations that come with the Personal Care Budget under the Dutch Health Insurance Act;
    7. is your healthcare provider but not also your partner or first-degree or second-degree relative by consanguinity or marriage;
c. as of the day on which you cease to fulfil the obligations that come with the Personal Care Budget under the Dutch Health Insurance Act;
d. as of the day on which it is no longer sufficiently plausible that the Personal Care Budget under the Dutch Health Insurance Act is or will be used to fund sufficient good-quality and/or effective care. Care will in any case be considered not to be of good quality if the way in which the care is provided exposes you to health risks. Effective care is considered care funded by the Personal Care Budget under the Dutch Health Insurance Act aimed at improving, maintaining, or reducing the worsening of your health. This checks whether the way in which you intend to use your care is effective given the care need;
e. as of the day on which it is no longer sufficiently plausible that the continuity of the healthcare to be provided will be guaranteed sufficiently in situations where your healthcare provider will be unable to provide care due to illness, holiday or otherwise;
f. as of the effective date of the allocation decision if the budget has been allocated based on incorrect or incomplete information provided by you and the decision would have been different if you had provided accurate or complete information;
g. as of the day on which one of the situations specified in Article 4 occurs after all.

Article 11: Claiming back the budget

If you fail to abide by these Regulations in spending the Personal Care Budget under the Dutch Health Insurance Act, we may claim back all or part of the funds paid out under the Personal Care Budget under the Dutch Health Insurance Act.