International essential medical insurance

General insurance conditions EMED-GIC-012026

Insured by

ANKER INSURANCE

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Information

General insurance conditions

Information

The Insurer

Anker Insurance Company n.v., having its registered office at Paterswoldseweg 812 at 9728 BM Groningen, in these policy conditions referred to as “Anker”. Anker is registered with the Autoriteit Financiële Markten (AFM) (the Dutch Authority for the Financial Markets) under number 12000661 and is authorised by De Nederlandsche Bank (“DNB”).

The Assistance Provider and Alarm Service

B.V. Nederlandse Hulpverleningorganisatie - SOS International, Rietbaan 40, 2908 LP, Capelle aan den IJssel, The Netherlands, is responsible for medical assistance during the insurance period or in the frame of other events enumerated in the insurance contract. The coverage and the conditions are determined by the insurance contract, any additional written agreements, the GIC’s as well as the applicable legal provisions in force.

The GIC’s are to be applied. On behalf and on request of the insurer, B.V. Nederlandse Hulpverleningorganisatie - SOS International provides emergency assistance and access to the insured persons.

Claims Department

De Goudse Verzekeringen, Bouwmeesterplein 1, 2801 BX Gouda, The Netherlands is responsible for handling the claims on behalf of the insurer.

Compliance

The insurer's products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void. The contract does not replace participation in a state-run or local health insurance scheme or compliance to any other legislative requirements of any country whatsoever. The policyholder/insured should not stop contributing to a state-run insurance scheme unless they have been given advice about the risks of doing so.

The insurer and policyholder/insured agree that, except as explicitly stated in the present general insurance conditions of the insurance contract, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation with this insurance contract.

Order of precedence of the clauses of the general insurance conditions

The general clauses are only valid insofar as they are not contradicted by or in conflict with the provisions and clauses of the different types of coverage. In case of contradictions or conflict, the clause of the specific coverage shall prevail over the general clause.

General insurance conditions

1. Insurance eligibility and acceptance

1.1 Eligibility

The insurance is for all foreign individuals residing in the EU/EEA and all EU/EEA residents going abroad excluding US Territories and Canada. The minimum age for being eligible for insurance coverage is 18 years of age. The maximum age of entry for being eligible for insurance is 49 years of age.

1.2 Acceptance

The insured is considered as accepted into the insurance once he has successfully applied the insurance, accepted the terms and conditions and paid the insurance premium before the start date of the insurance.

The insured is responsible to verify that the online purchase and transaction was successfully processed, that the insurance policy was issued and received by email and that the information on the insurance policy is accurate.

The insurer cannot be held responsible for any online technical errors.

2. Insurance territory

2.1 Area of coverage

The coverage is granted worldwide, with exclusions of the U.S. Territories and Canada. The benefits are applicable within the country of destination of the policyholder/insured mentioned on the policy certificate. Any treatments sought outside of your country of destination are subject to pre-approval by the insurer.

The right to benefits from the insurance coverage ceases as soon as the insured enters a territory excluded from the insurance contract or returns to his home country.

3. General provision

3.1 Key points

The insurance contract is a mutual agreement between the applicant and the insurer, covering all the key points of their relationship. The basis of this contract consists of the sum of declarations made by the policyholder, the insured person or a legal representative, and laid down in the contract or in further agreements.

The key points and criteria of the contract are the following:

a) The general insurance conditions must be taken into account and approved;

b) The insurer must explicitly accept the application for the policy to be concluded;

c) The insurer must have received the payment of the premium in full - all applicable bank fees, credit card fees or any other charges are at the expense of the policyholder/insured;

3.2 Insurance policy

An insurance policy is the document that confirms the existence of an insurance contract between the policyholder/insured and the insurer.

With this document, the insurer confirms his willingness to enter into an agreement with the insured provided that all the key points of the contract are fulfilled, particularly only after the insurance premium has been paid.

3.3 Modification of insurance coverage

In case the insured will modify the insurance coverage, a new insurance application is required.

3.4 Change of name/address

Any changes of name or address of the policyholder/insured have to be notified in writing within 30 days to the insurer. In the meantime the last known address will remain valid.

3.5 Right of cancellation

The insured can cancel the insurance and request a refund if both of the following conditions are met:

- The insurer will refund the premium if the insured or another eligible person can prove with official documents that the insured cannot travel. This includes:
  - a medical certificate,
  - a death certificate,
  - a summons from the police, court, or government,
  - or proof that the insured were denied a visa (such as a rejection letter from the embassy or consulate).
- The insured can only cancel the policy and request a refund before the coverage start date, shown on the insurance certificate. After that date, cancellation and refund are no longer possible.

If a refund is approved, it will be made using the same payment method and currency the insured has used. Any bank or credit card fees will not be reimbursed.

The policyholder/insured shall have a period of fourteen (14) calendar days to cancel the policy without penalty and without giving any reason. The period right of cancellation shall begin from the day of the conclusion of the online contract. The policyholder/insured will be entitled to the return of the full premium paid, on the condition that no claim has been submitted. The insurance policy cannot be cancelled after the start date of the policy.

For compliance with this deadline it is sufficient for the policyholder/insured to send his/her notice of withdrawal by post or e-mail to the insurer. There is no premium refund after the cancellation-period of fourteen calendar days.

3.6 Acceptance of medical service providers

Only invoices issued by qualified medical service providers, possessing recognized and valid diplomas of the country in which the insured is being treated and where they are authorized to practice will be taken into consideration.

3.7 Expenses covered

The services provided in the context of the insurance conditions should be effective, appropriate and economical. Effectiveness, adequacy and cost effectiveness have to be scientifically proven. If this is not the case the insurer reserves the right to reasonably reduce the benefits accordingly.

In- and outpatient treatment must be received in the appropriate medical facility, and experimental treatment is excluded.

The medical expenses must correspond to the expenses usually incurred by a similar service or supply and do not exceed the normal charges incurred under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing expenses charged can not be determined due to the unusual nature of the service or supply, the insurer will determine to what extent the charge is reasonable, taking into account:

- The complexity involved
- The degree of professional skill required
- All other relevant factors

The usual tariffs in the territory of the treatment define the amount and the duration of the insurance benefits.

If no special conditions have been negotiated such as the compulsory consultation of a predefined medical

network, the insured can be treated by a certified medical practitioner of choice.

3.8 Medical and assistance expenses

All benefits stated in the present insurance conditions and in the benefits overview are covered exclusively in cases of emergency.

All treatments received outside of the insurance period cannot be claimed and will not be covered or refunded by the insurer.

3.9 Partial benefits

If the insured does not benefit at all or only partially from the insurance policy, the insurer cannot be obliged to refund the benefits covered in kind. If the costs entailed by an occurrence are less than those set out in the insurance policy, the insured is not entitled to claim the difference.

A copayment means that a certain percentage of the coverage will be at the expense of the insured.

3.10 Maximum insured sum

An annual maximum insured sum is the maximum amount that is covered during the policy period.

The benefits list states the different maximum insurance benefits per policy period.

3.11 Subsidiarity

Coverage is subsidiary to any benefits that are provided by the compulsory social insurances, other insurance branches (e.g. accident insurance, health insurance of the home country), service agreements or associations to which the insured is a party or pays a contribution, whenever the latter do not offer the insured person sufficient protection.

4. Insurance start, duration, renewal and end date

4.1 Start date of insurance

The insurance cover shall enter into force, when the insurer has accepted the application and informed the applicant on which terms the insurance will be issued, and the agreed premium has been paid to the insurer.

4.2 Duration of insurance

The duration of coverage is stated in the insurance policy, the minimum duration is six (6) months and the maximum duration is eighteen (18) months.

The insurance begins on the effective date of the insurance, as indicated on the insurance policy and ends at the last date stated in the insurance policy.

The insured can purchase a new insurance policy for a new insurance period. The new application is subject to the general insurance conditions. All claims concerning the previous policy cannot be transmitted or covered under the newly purchased policy. This includes all conditions such as, waiting periods or pre-existing conditions.

4.3 End of insurance

The coverage expires on the same day that the insurance policy expires. All treatments received outside of the policy duration are not covered.

If an insured person is admitted to hospital and the coverage ends after the policy expires, there is coverage until the first possible date of return to the home country of the insured.

In any case, the insurance cover ceases once the insured returns to his/her home country stated in the passport.

For the Insured, the insurance under this policy shall automatically terminate:

- if it becomes unlawful for the insurer to provide any of the coverage available under this contract;
- if the insurer has been provided with misleading information or if information has been withheld that should have been provided and could have affected the Insurer's assessment of the risks to be insured under this contract;
- upon the death of the insured.

5. Premium payment

5.1 Payment of the insurance premiums

Receiving premium payment is an essential part of the insurance policy. The premium is to be paid in advance for the whole selected insurance period.

Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the policyholder/insured.

In any case, the insurance policy will only be issued after the payment is credited on the bank account of the insurer in full.

Withholding the payment of a premium in order to compensate for some outstanding benefits is not permitted.

The premium is calculated always for an entire selected insurance period.

5.2 Salvatory clause

The present invalidity or the future invalidation of one of the provisions to be found in the insurance conditions and the appearance of a legal gap (lacuna) do not have any effect on the validity of the other clauses.

In order to replace or add to the invalid or missing clause, the insurer will add a clause that makes sense and which will be within the realms of possibility and tolerance and the closest it can get to the original contents of the contract of the parties.

6. Obligations of the insured

6.1 Double insurance

If the same risk is covered for the same period of time by more than one insurer to the extent that the combined sums insured exceed the insurance value, the policyholder/insured are obliged to inform all insurers in writing immediately.

If the policyholder/insured has intentionally omitted to notify the insurer of these facts or taken out a double insurance in view of obtaining an illicit profit, the insurer shall henceforth automatically be relieved of any contractual obligations.

6.2 Increase of risk

An increase of risk is of significance if it affects the risk evaluation that has been established during the insurance contract. All factors that might influence the decision of the insurer to accept the contract or to accept it under the agreed conditions are important (especially important is the insured's state of health, illnesses can be considered a risk increase, or if he/she undertakes dangerous activities, etc.).

If the insured causes a significant increase of risk during the duration of the insurance, the insurer will cease to be bound by the insurance contract. The insured has the obligation to inform the insurer immediately in writing.

If the increase of risk is not caused by the insured this will only lead to an automatic cancellation of the policy if the insured has neglected to notify the insurer as stated above. If the insured provides such a notification the insurer reserves the right to terminate the policy following the notification.

Except for changes in the state of health of the insured incurred after acceptance into the insurance, the insured is obliged to inform the insurer of any change in circumstances or conditions that may increase the risk of illness or accidents (e.g. dangerous professional activity). The insurer may then propose new insurance conditions (within a period of one (1) month after having received notification of the increase of the risk) or cancel the insurance coverage, within one (1) month, retroactively as from the moment of the start of the increase of the risk.

6.3 Immediate notice/communication of a claim

In case of any imminent or declared incident all insured have the obligation to contact immediately the insurer.

Should verification of a claim no longer be possible due to the failure of the insured to notify the insurer in a timely way, and due to this late notification a claim can no longer be identified or verified, the Insurer will not reimburse the claim that cannot be identified or verified.

In case of medical assistance, it is mandatory to contact the 24/7 alarm center number as soon as possible after the incident has occurred.

Tel : +3150 520 9780

If the insured is entirely unable to notify the insurer immediately and it can be proven that a personal or indirect contact with the insurer prior to consulting a certified medical practitioner at the moment of the event was impossible because of the patient's life threatening situation, a notification in a timely manner by the policyholder/insured, the police, the hospital or any party to the incident, will be considered a valid notification.

All inpatient treatments (except emergency hospital admissions), are subject to pre-authorization by the Alarm Center or insurer.

In case of failure to comply with the pre-authorization requirement the insurer is entitled to reject the claim made. In case of an emergency hospitalization, the insurer has to be informed as soon as possible and at the latest before discharge from the hospital.

6.4 Obligation to minimize claims

The insured is obliged to take all reasonable steps to avoid or minimize any claims.

6.5 Consequences of the violation of the obligations

Besides the consequences of disregarding articles already mentioned above, upon infringement of the contractual obligations the following consequence can be applied to the insured:

Should the disregard of the obligations happen with the intention of defraud, the contract with the insured will automatically be null and void. The insurer will no longer be bound to provide services and benefits and can ask for a refund of the reimbursements already received by the insured. The insurer will not refund any premiums paid by the insured.

In the event of other violations or any disregard to the insured's obligations, the insurer has the right to reduce coverage proportionally to arising damages.

The policyholder/insured are solely responsible for the execution of the contractual obligations.

7. Inpatient treatment (Hospitalization)

7.1 Accommodation

The following costs for inpatient care in a hospital and in the contractual territory, are covered:

a) Inpatient treatment in a public or semi-private medical establishment;
b) Admission to a hospital or surgical establishment;
c) Medical costs arising during the hospital stay as an inpatient;
d) Intensive care in a public or semi-private medical establishment

e) Accommodation, operating theatre & recovery room in a public or semi-private medical establishment.

If no special conditions have been negotiated such as the compulsory consultation of a predefined medical network, the insured may choose between the public or private clinics, which are permanently staffed with qualified medical personnel, who can make a diagnosis and who have the necessary diagnostic and therapeutic means at their disposal and work with scientifically recognized methods.

Reimbursement of costs depends on the coverage and what has been agreed on in writing when the insured informs the insurer about the intention of inpatient treatment.

The insurer provides coverage for services for medical examinations, healing methods and medication generally accepted by conventional medicine. Coverage will also be provided for methods and medication that have proven to be effective in practice when conventional methods or conventional medications do not exist or cannot be applied. However, the insurer may reduce coverage to the amount by adjusting the coverage that should be paid as conventional methods and medication were used.

If it is considered a legal abortion according to the Criminal Code of the country in question and if the abortion is done on an emergency basis because of imminent danger to body and soul (profound distress) of the pregnant mother, the insurer will pay for the abortion and it will be considered an illness.

7.2 Inpatient psychiatric and similar treatment

The insurer will only reimburse the costs for inpatient psychotherapy if authorization has been given in advance in writing after having received an assessment by the insurer's own expert.
Psychiatry and psychotherapy refer to treatment of mental or nervous disorders, carried out by a psychiatrist or clinical psychologist. The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not triggered by a particular event such as bereavement, relationship or academic problems or acculturation.

The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the current International Classification of Diseases (ICD-10).

Psychotherapy is covered according to the insurance contract, provided the treatment is prescribed and performed by a certified medical practitioner.

7.3 Laboratory and x-ray expenses

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

The costs for lab examinations, x-rays, scans and MRIs, if prescribed by a certified medical practitioner for valid reasons are covered.

7.4 Organ transplant

The inevitable transplant of an organ is covered. However, the costs related to finding matching donor organs (organ bank) are not included in this coverage.

An organ transplant is the surgical procedure concerning the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and corneal transplants.

Expenses incurred for the acquisition of organs are not covered.

7.5 Medication

Medication approved by the state's authorities is covered according to the benefits list. Homeopathic treatments are also covered. Only medication prescribed during the inpatient treatment is covered.

Medication, wound dressings and medical equipment have to be prescribed by a certified medical practitioner or another agreed specialist. Certified medical practitioners who are next of kin of the insured or the policyholder will not be taken into consideration.

Medications that are not prescribed by an approved certified medical professional are not covered. When declaring the costs, you must submit a referral letter / recipe.

Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non-medical substances and therefore not covered.

7.6 Nursing at home

Nursing at home or in a convalescent home refers to nursing received instead of eligible inpatient or day-care treatment. The insurer will only pay the benefit where the treating certified medical practitioner decides (and the insurer agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Coverage is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care.

In replacement of an inpatient treatment in a hospital, a daily amount will be covered for each policy period.

7.7 Physiotherapy

Only physiotherapy prescribed during the inpatient treatment is covered.

Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a certified medical practitioner. Physiotherapy is initially restricted to 6 sessions, after which the referring medical practitioner must review the treatment. The maximum is 10 sessions a year.

Should further sessions be required, a progress report must be submitted to the insurer, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as rolfing, massage, pilates, fango and milta therapy.

7.8 Surgical/Medical appliances

Surgical and medical appliances are covered if prescribed by a medical provider and within the limitation and maximum sum defined in the insurance benefits list.

7.9 Mobility aids

Prescribed medical aid refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch-supports are covered. Medical aids that form part of palliative care or long term care are not covered.

7.10 Kidney dialysis

The insurer covers sudden kidney failure resulting from an illness or accident and within the limitation and maximum sum defined in the insurance benefits list.

8. Outpatient treatments

8.1 Emergency outpatient treatment

Emergency outpatient treatment is a treatment received in a casualty ward/emergency room following an accident or sudden illness, where the insured does not, out of medical necessity, be admitted in a hospital as an inpatient.

The treatment must be received within 24 hours of the emergency event.

8.2 Laboratory and x-ray expenses

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

The costs for lab examinations, x-rays, scans and MRI's, if prescribed by a certified medical practitioner for valid reasons are covered.

8.3 Medication

Approved medication by the state's authorities, homeopathic treatments, wound dressings and medical equipment are covered if prescribed by a certified medical practitioner or another agreed specialist.

The prescribed medication has to be bought at the pharmacy. The purchase of more than one package of the same medication has to be written on the certified medical practitioner's prescription.

Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non-medical substances and therefore not covered.

8.4 Medical aids/equipment

Prescribed medical aid refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch-supports are covered. Medical aids that form part of palliative care or long term care are not covered.

Prescribed aids such as bandages and supporting bandages, support stockings, orthopedic insoles, support plasters, correcting tapes, orthopedic equipment to support the upper body, the arms, the legs, hearing aids, electronic larynx, artificial arms, legs or feet are covered according to the insurance contract.

Costs for other prescribed medical aids and sanitary devices, such as any other equipment, orthopedic shoes, appliance for massage, inhalators, infrared and blue-light lamps for therapy as well as heating pads, their installation, use and maintenance, are not covered according to the insurance contract.

8.5 Emergency dental treatments

a. The insurer will reimburse the costs of dental assistance in the event of damage to natural teeth due to an accident. The insurer will only reimburse the costs if the treatment was given within 24 hours after the accident. The maximum reimbursement is stated in the Table of benefits. During the entire term of the insurance, the insured amount is insured a maximum of once.

b. The insurer will reimburse urgent dental care to natural teeth if it is necessary to relieve acute pain. The maximum reimbursement is stated in the Table of benefits.

Acute pain means that the treatment is necessary immediately. The invoice of the practitioner must show that it concerns an emergency treatment. Not insured are the costs of check-ups and planable treatments like filling cavities, placing a crown, etc.

9. Assistance

9.1 Assistance conditions

The insurer will assist the policyholder/insured within the legal and contractual scope during the contractual period. The policyholder/insured must notify immediately the insurer to obtain assistance. However, providing emergency assistance does not prejudice the insurer's decision concerning the financial coverage according to the present general insurance conditions.

9.2 Ambulance transport (air, sea or ground)

In case of a medical emergency, the insurer covers the transportation by air, sea or ground to the closest appropriate facility. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.3 Medical evacuation

Medical evacuation means that if the emergency treatment for which the insured is covered is not available

locally, the insured may be transported to the closest appropriate facility. Only the reasonable and customary costs of treatment and transport that have to be pre-authorized by the insurer are covered. Should it not be a medical emergency, the travel to and from the medical facility is not covered. In every case pre-authorization from the insurer is mandatory.

The insurer covers the costs per policy period for urgent medically indicated transportation so as to provide the insured with appropriate treatment at the nearest possible hospital or an approved medical service.

Medical evacuation related costs will only be reimbursed if the insured's state of health does not allow for use of public or private transportation.

Costs related to transportation per policy period are not covered, in the event of:

- An illness or accident intentionally provoked by the insured, self-mutilation or attempted suicide;
- Addiction (for example drugs) or alcoholism;
- Ethylic state, open drunkenness or if proven that the insured party while being involved in an accident had alcohol in his/her blood of more than 0,5 g/lt. Or if it has been proven that the insured person has used drugs in accordance with the statutory limits.

The insurer covers the transportation costs, the insurer's coverage is subsidiary to any other providers.

9.4 Medical repatriation

As soon as the insured's condition requires it, with authorization of the insured and with pre-authorization from the insurer, the insurer will arrange and pay for the repatriation to the home country. The limitation and maximum sum defined in the insurance benefits list is applicable.

The insurer has the right to choose the type of transportation deemed most appropriate (by air, sea or ground).

The insurer will cover reasonable and usual repatriation costs actually incurred by the transport. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.5 Repatriation of mortal remains

In the event of the death of the insured, the insurer will arrange for the repatriation of mortal remains from the place of his death to the funeral site within his/her country of destination mentioned on the policy certificate or home country. The repatriation is carried out in accordance with the applicable national laws and international conventions.

The insurer will cover the transfer costs of the mortal remains and will take care of all formalities required for the transportation of the mortal remains. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.6 Search and rescue

The insurer covers the costs for search and/or rescue incurred by the competent authorities up to the sum defined in the insurance benefits list.

10. Table of benefits

	Maximum insurance sum EUR 500'000
Inpatient treatments	**EMED**
Accommodation	Semi-Private
Physicians & Specialists	100%
Surgeons & anesthetist	100%
Nursing at home	100%
Medication	100%
Inpatient psychiatric treatment	100%
Organ transplant	EUR 150'000
Surgical/Medical appliances	100%
Physiotherapy	100%
Mobility aids	100%
CT, MRI and PET scans	100%
Kidney dialysis	EUR 15'000
Treatment for cancer	EUR 100'000

Outpatient treatments	
General practitioner consultations Specialist, X-ray, Laboratory Tests Prescribed medication	EUR 5'000
Medical aids/equipment	EUR 300
Emergency dental treatment	EUR 500

Assistance	
Ambulance transport (air, sea or ground)	EUR 10'000
Medical repatriation	EUR 30'000
Evacuation	EUR 30'000
Search and rescue	EUR 10'000
Repatriation of mortal remains	EUR 30'000
Assistance 24 / 7	included

11. Definitions

11.1 Inpatient treatment (Hospitalization)

Admission to a hospital establishment for medical intervention for a period of at least 24 hours.

Hospital accommodation refers to a general ward or semi-private room.

Deluxe, executive rooms and suites are not covered. Accommodation includes charges for services, such as general nursing care, that occur in connection with the hospital stay.

Hospital also includes clinics and medical units that are managed by certified medical practitioners and medical staff who treat ill or injured patients.

Not included are wellness hotels and thermal baths, establishments for elderly and chronically ill individuals as well as socio-medical and similar establishments that are not suited for the treatment of acute illness.

11.2 Outpatient treatment

Outpatient treatment refers to treatment provided in the practice or surgery of a certified medical practitioner, therapist or specialist that does not require the patient to be admitted to a hospital.

Outpatient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or outpatient department that does not require the patient to be admitted in a hospital.

11.3 Stabilization center

The place where the insured is taken to following an incident in order to prepare for transfer or repatriation.

11.4 Emergency

An emergency constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment occurring within 24 hours of the emergency event will be covered.

In addition, they must be:

- Essential to identifying or treating a patient's condition, illness or injury.
- Consistent with the patient's symptoms, diagnosis or treatments of the underlying condition.
- Consistent with the diagnosis and customary medical treatment for a covered illness or injury
- In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
- Required for reasons other than the comfort or convenience of the patient or his/her physician.
- Proven and demonstrated to have medical value.
- Considered to be the most appropriate type and level of service.
- Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
- Provided only for an appropriate duration of time.
- The charges are fair and reasonable for the treatment.
- The treatment may not be of experimental, investigational or research nature.

As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration.

11.5 Accident

An accident is an injury which is the result of an unexpected event, independent of the will of the insured and which arises from a cause outside of the insured's control. The cause and symptoms must be medically and objectively definable, allowing for a diagnosis and requiring therapy.

11.6 Sudden illness

Any unintended negative change in health that requires professional examination, treatment or medical care and which is not due to an accident or a pre-existing condition.

11.7 Chronic condition

A chronic condition is defined as a sickness, illness, disease or injury, which has one or more of the following characteristics:

- Is recurrent
- Is without a known, generally recognized cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Requires prolonged supervision or monitoring
- Leads to permanent disability

11.8 Acute medical condition

A medical condition that is likely to respond quickly to treatment which aims to return the insured to the state of health he/she was in immediately before suffering from the disease, illness or injury, or which leads to full recovery.

11.9 Consultation

A consultation is any consultation or discussion with a certified medical practitioner or specialist and the issue of any prescriptions.

11.10 Certified medical practitioner

A medical practitioner who holds primary degrees in medicine or surgery as recognized by the World Health Organization and who is legally licensed to practice in the country where treatment is provided.

Certified medical practitioner fees refer to non-surgical treatment performed or administered by a certified medical practitioner.

11.11 Specialist

A certified medical practitioner qualified, duly licensed and recognized as such by the relevant officials of the country in which the treatment is being given.

11.12 Anesthetist

An anesthetist is a certified medical practitioner or a technician trained to administer anesthetics.

11.13 Medication

Drugs, medicine and corrective devices (including prosthesis when used as an integral part of a surgical procedure) prescribed by a certified medical practitioner or specialist.

11.14 Pathology

Tests carried out to help determine or assess the nature of disease and the changes in structure and functions brought about by disease.

11.15 Psychiatric illness

Treatment of a mental disorder carried out by a clinical psychologist. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (employment).

The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.

The disorder must meet the criteria for classification under an international classification system such as Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

11.16 Treatment

Any emergency surgical procedure or medical intervention required to cure or provide relief of an acute medical condition.

Complementary treatment means therapeutic and diagnostic treatments that exist outside the institutions where conventional western medicine is taught. Such medicine includes chiropractic treatment, osteopathy, homeopathy and acupuncture as practiced by approved therapists.

Oncology treatment refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis on.

11.17 War and Terrorism

War :

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- also considered as acts of war are: all similar actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends.
- civil war: armed conflict between two (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil War are: an armed rebellion, revolution, sedition, insurrection, a coup d'état, the consequences of martial law and border closings ordered by government or by local authorities.

Terrorism :

- any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption;
- commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not;
- robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorist acts.

Terrorism shall include any act that is verified or recognized by the (relevant) government as an act of terrorism.

Description of benefits :

With respect to the risks and consequences of War and Terrorism, all consequences of active participation of the insured in operations of war and terrorism are explicitly excluded from all coverage. In case the insured is victim of acts of war and terrorism without any active involvement on behalf of the insured or his/her beneficiaries in these acts, the insured is covered within the limits and the ceilings of the cover. The optional insurance covers (accidental death and disability) are not valid when the insured (or covered dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of war or civil war at the time damages (bodily injury, or death) to the insured or his/her covered dependents happen. In the event the insured, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) war or warlike situations and acts, the insurance coverage remains valid for fourteen (14) days starting from the beginning of the hostilities.

11.18 Pre-existing conditions

A pre-existing condition is defined as any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application for the insurance or at any time during the six months prior to the effective date of the insurance, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date of the insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from.

It is strongly recommended that the insured undergoes, at his/her own expense, a thorough medical check-up prior to taking out an insurance coverage.

11.19 Policyholder

The policyholder is the physical person or legal entity concluding the insurance policy on his own behalf or on behalf of another person and who as a result is liable to pay the premiums. In the event the insurance is concluded by the policyholder on behalf of another person, the insured is considered the sole beneficiary of any insurance benefits and can claim accordingly.

11.20 Insured

The insured is a physical person who is the beneficiary of the insurance covers within the insurance contract.

11.21 Age limitations

Individuals can only apply and conclude an insurance contract after having reached the age of 18 years old.

Applications and conclusions are only accepted until the age of 49 years old.

11.22 Next of kin

A next of kin is a person who has a close relationship with the insured, whilst not necessarily being related.

11.23 Third party

A person who is not in any way related to the insured, nor a spouse or a flat mate, nor in a work relationship nor an organ of a relevant legal entity.

11.24 Home country

The home country is the country in which the insured has had permanent or habitual residence before leaving to the country of destination, as mentioned in the policy.

11.25 Country of destination

The country of destination is the place where the insured intends to travel to during the trip.

11.26 Negative travel advice

Are you going to a travel destination where a negative travel advice (code orange or red) is issued by the Ministry of Foreign Affairs in the Netherlands? Then there is no coverage on your insurance if you decide to go anyway. Are you at a travel destination where a negative travel advice (code orange or red) is issued by the Ministry of Foreign Affairs in the Netherlands? And are you sick? Then you have coverage for the medical costs until you can leave the area. The costs for repatriation to your home country are not insured.

12. Exclusions

The following events are not covered :

- If the insured commits a crime, an offence or acts in a rash way that leads to the claim;
- If the insured takes drugs and/or alcohol and/or hallucinogenic products and toxic substances which lead or contribute to the incident
- If there are harmful effects to the insured's health that resulted from the production and the use, intentionally or unintentionally, of chemical, biological, bio-chemical, electro-magnetically substances meant to be used as a weapon (independently from any possible concurring causes), as well as damages due to nuclear or any other form of radiation.
- If the incident occurred outside the territory fixed in the insurance policy or insurance policy or outside the effective period of coverage.
- If the insured participates in sports as listed:
    - extreme sports: bungee jumping, caving, canoeing or extreme kayaking (on torrents above class V, rivers above class II, on seas and oceans more than two miles from the coast),

sailing (transoceanic, solo navigation more than 20 miles from a shelter), base jumping,
- mountain sports: mountaineering, climbing (except artificial support with safety), rock climbing, solitary hiking above 3000 meters, ski jumping, bobsleigh, skeleton, skiing outside of marked territories (off-piste), and tobogganing off open marked trails to the public, rafting, canyoning,
- aerial sports: aerobatics, gliding, parachuting, microlight, hang gliding, paragliding, skysurfing, hot air ballooning,
- water sports: scuba diving as part of a sporting competition or for leisure by a person who does not hold a PADI certificate or equivalent and not accompanied by a professional, jet skiing, competitive surfing, hydro speed, kitesurfing ,
- competitive defense and combat sports,
- motor sports: car, motorcycle or karting driving,
- air navigation accidents unless the insured person is a simple passenger and is on board a device for which the owner and pilot have all the authorizations and licenses,
- participation in all sports competitions and training, practicing sports within the framework of a club or federation on a professional basis;

- Practicing sports professionally or as part of an official competition organized by a sporting association for which a license is issued, plus training in view of entering competitions;

- Ignoring official prohibitions or official rules concerning the safe practice of a given sports and/or leisure activity;

- Taking part in a motor racing at any level.

- Disease/Disorder including their consequences from an accident due to war or warlike conditions or those stemming from military service in a country not specifically listed;

- Illnesses or accidents and their consequences intentionally provoked;

- Treatments by certified medical practitioners, dentists and hospitals that have been explicitly excluded from the service package that are notified to the insured or to the person taking decisions on his behalf.

- Outpatient treatment in a spa or hot spring resort.

- Care and treatment provided by the spouse, by in-laws or by offspring, or by a next of kin;

- Any cosmetic surgeries, the consequences or complications thereof;

- Expertise, certificates, written evidence, opinions, instructions or estimates issued by the provider to the extent that they have to be submitted by the insured to the insurer;

- In the event that the services provided are deemed not efficient, appropriate, and economic by an independent medical expertise sought by the insurer.

- Aptitude testing, educational testing and services.

- Services for mental disorders or illnesses that are not deemed as emergencies.

- Services related to drug and alcohol abuse, including private or special nursing, or services rendered by a physician.

- Chronic brain syndrome, senility, mental retardation.

- In the event that the provided services for treatment or any other care exceed the real necessary medical costs, the insurer may reduce the benefits in such a way as to reach an acceptable amount. The insurer has also the right to reduce the benefits if other types of medical care, less expensive, would have been just as appropriate.

- Any fertility/infertility services, tests, treatments, drugs and/or procedures and pregnancy arising from such treatment.

- Any expenses related to pregnancy, maternity (including prenatal, childbirth and postnatal care), abortion (voluntary or therapeutic), and any complications thereof, as well as the use of or complications resulting from contraceptive, sterilisation, or abortion measures.

- All dental treatments (excepted emergency dental treatments).
- All pre-existing conditions are excluded.
- Accidents caused by the symptoms of epilepsy;
- Epidemics and pandemics

13. Claim

Considered as a claim are all unintentional events that occur within the period of coverage and under the conditions specified in the insurance contract and which causes the insurer to fulfill the obligation to provide benefits to the insured within the legal and contractual obligations.

All outpatient treatments will need to be paid in advance and can be claimed afterwards. The insurer shall reimburse the covered, reasonable and customary medical expenses up to the limits defined in these general insurance conditions following the receipt of the claim form and the relevant and complete written evidence of the medical expenses. Reimbursements shall be made to the insured, but if the insured has deceased, payment shall be made at the sole discretion of the insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment. Benefits may be directly assigned to hospitals.

13.1 What to do in case of an emergency?

The Alarm Service is for emergency situations only. You can contact us for example in case of the event of repatriation, accidents, (outpatient) clinical treatment in a hospital, hospitalization and your return on medical indication.

Alarm service
Phone: +31 50 520 9780
Email: alarmservice@anker.nl

It will be available for you 24/7. We will offer advice concerning the steps to be taken and we will organise the necessary support.

Claims Department
The Claims Department hands your claims. For visiting a doctor when you are ill.

You can report the damage in your personal account online at www.swisscare.com or use the app. Always report damage as soon as possible.

Phone: +31 50 520 9974
Email: swisscare@goudse.com

We are available from Monday to Friday during office hours. We will advise on how to report a claim and what details need to be handed over.

In order to benefit from the advice and services of this insurance, the Alarm Service must be contacted immediately after the incident and prior to any consultation.

This prior telephone call has to be made immediately since it is one of the fundamental obligations the insured has to fulfil. The insured hereby acknowledges and agrees that the insurer, the Alarm Service, or any third party that is mandated by the insurer, will provide advice, and / or other services, such as insurance benefits. Failure to comply with this requirement shall entail a forfeit of the insured's or any beneficiary's rights to claim or benefits.

If the insured is entirely unable to notify the insurer immediately and it can be proven that a personal or indirect contact with the Alarm Service prior to consulting a doctor at the moment of the event was impossible because of the insured's life threatening situation, a reasonable speedy notification by the insured, the policyholder, the police, the hospital or any party to the incident will considered a valid notice.

Advanced payment of all expenses
All expenses for claims must be paid in advance before the insurer will proceed to the reimbursement except:

- Admission in a hospital for inpatient treatments
- Search and rescue

In the above cases, the insurer must be provided immediately with the complete contact details of the hospital or authorities in order to establish a guarantee of payment. The insurer claims are reimbursed only to bank accounts. The insured is required to mention on the claim form the bank details to which the insurer is to reimburse.

IMPORTANT: All documents that are to be provided must be translated into English. The insurer reserves the right to refuse refunds if the required documents are not translated.

Furthermore, the insured and the policyholder have to provide the insurer – on their own initiative – with any other information and proof relating to the accident, which might help with clarifying the circumstances of the incident/claim and help with estimating the extent of the consequences, providing the ought to know of this information.

All bills and honorary fees have to be submitted to the insurer immediately upon receipt.

The insurer has the right to reimburse the authorized bearer or sender of the correct and complete documents.

Costs of treatments in a foreign currency will be converted at day's value (date of receipt) in EUR. Expenses such as inherent costs of transmissions and translations will be deducted from the benefits. Money transfer fees or taxes are not covered by the insurer.

Medical confidentiality
At the request of the insurer or the medical adviser of the claims handler, the insured person may be asked to issue an authorization for obtaining medical information from the treating physician.

Sanctions in case of failure to meet the obligations
a) The policyholder cannot derive any rights from this insurance if he and/or the insured person fail to meet one or more of his or her obligations with respect to Anker and as a result thereof harms Anker's interests. The policyholder and the insured person are in any event obliged to fulfil the obligations incorporated in these policy conditions and in the Claims Procedure.

b) If Anker is not harmed in a reasonable interest as a result of the aforementioned policyholder's and/or insured person's failure to meet obligations, Anker may nevertheless deduct any loss and/or damage sustained, or the costs incurred as a result thereof, from the insurance payment.

c) If the policyholder or the insured person fails to meet his or her obligations with respect to Anker, intending thereby to deceive it, all rights to insurance benefits and/or provision of services will lapse, unless the deception does not justify the loss of rights.

13.2 Documentation

Any documents have to be submitted to the insurer as soon as possible, however at the latest 365 days after the occurrence of the incident, proven by postal stamp or official certification, the insured must spontaneously and at his/her own expense, provide the insurer with the requested documents listed below. Beyond the delay of 365 days, no claim shall qualify for reimbursement and consequently the insured forfeits the right for reimbursement.

In case of an accident the insured must provide an accident report and/or statements drawn up by the police authorities, fire department or any other emergency service as well as:

- date and detailed description of circumstances and place of the accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

Medication and other prescriptions for the pharmacy;

Invoices for the medical treatments undergone by the insured, any stay in a hospital and purchases of medication;

Furthermore, the insured and the policyholder have to provide the insurer with any other information and

proof relating to the incident, which might help to clarify the circumstances of the incident/claim and allow an estimate of the extent of its consequences, provided they ought to know of this information.

In view of clarifying the circumstances of the announced incident, and in order to estimate the extent of its consequences and verify its veracity the insurer reserves the right to request, from the insured and at the latter's expense, supplementary information, facts and proof. If the insurer formulates this request in writing a delay of at least thirty days can be granted (formal notice) in order to receive these documents. If the insured lets the time elapse, all rights to the claim will have been forfeited.

On the insurer's request, the insured has to undergo a medical check-up done by a certified medical practitioner appointed and paid for by the insurer.

13.3 Non transferability of claims

Claims of the insured arising or likely to arise from the insurance contract can neither be transferred nor held as a deposit. Especially rights to benefits stemming from the insurance contract cannot be transferred to a next of kin, a hospital, debt collecting agency, a company, an insurance taker, a work colleague or an authority, etc.

13.4 Subrogation

The Insurer has full rights of subrogation for any benefits paid within the framework of this insurance contract. The rights and claims of any natural person or legal entity that benefits in whole or in part from the coverage provided in the insurance contract as stated in the conditions of insurance against the third party responsible for the event shall pass to the insurer up to the level of compensation and costs paid by the insurer in view of fulfilling this insurance contract.

Should the insured have a right to compensation by a third party and notwithstanding the contractual subrogation, this right has to be passed on in written form to the insurer up to the level of the amount of the benefits the insured is likely to receive from the third party. Thus, this right will pass to the insurer. If the insured waives the right to compensation or its relative security, without prior agreement of the insurer, the latter will be released from all obligations up to the sum the insured would have received or could have been entitled to by the third party.

Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third party any amount paid or which will be paid by the Insurer to the Insured or expenses made on behalf of the Insured, the Insured shall be obliged to provide this confirmation in writing to the Insurer.

Any defense inherent in the insurance policy, which the Insurer may raise against the Policyholder may also be raised against the Insured, whoever he/she may be.

13.5 Coordination of benefits - other insurances

If the insured is entitled to a reimbursement by another insurer or social security system, the coverage will be applied on the difference between the eligible medical expenses and the reimbursement made by the other insurer. However, in case the insurance is offered as a supplementary insurance, the amount reimbursed by the other insurance will be deducted from the amount of reimbursement. In any case, the insured has to attach copies of the pertaining medical bills and the settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned. Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the insured.

13.6 Medical confidentiality

At the request of the insurer or the medical adviser of the claims handler, the insured person may be asked to issue an authorization for obtaining medical information from the treating physician.

13.7. Data processing and data protection – inquiries

The policyholder/insured entitles the insurer to process all necessary data for his database and the data required for claim handling. The insurance contract is subject to compliance with the General Data Protection Regulation (GDPR). This regulation applies in relation to any personal data processed in connection with this insurance contract. All involved parties will provide sufficient guarantees in respect of the technical and organizational measures governing the data processing to be carried out, and will

therefore operate technical and organizational measures to protect against unauthorized or unlawful processing of such data and against accidental loss or destruction of or damage to such data.

The insurer collects and maintains personal information in order to underwrite and administer the insurance contract. All personal information is treated with the utmost confidentiality and with appropriate levels of security. The information will be protected from accidental or unauthorized disclosure. The insurer will only reveal the information if the law allows it, if it is authorized by the insured, or in order to prevent fraud.

Any inaccurate or misleading data will be corrected as soon as possible. The above principles apply regardless of if the information is digital or analog.

14. Termination of the contract

Besides the legal and contractual clauses that make it possible to declare/render the contract invalid, to terminate it retroactively, to terminate it with immediate effect and to terminate it within a certain different delay, an unintentional culpable attitude of the policyholder/insured will entitle the insurer to terminated the insurance policy within one (1) month from the moment of the insurer's becoming aware of the irregularity.

When the insured returns to live and/or to work in his/her home country, thereby ending the period of residing abroad, the policyholder/insured has to notify the insurer in writing by letter or e-mail, of the exact date of relocation to the home country. The insurance contract and the coverages are automatically terminated the day the insured relocates definitively to his/her home country also if the insurer was not properly informed.

15. Applicable law

The parties agree that the insurance policy will be governed by the law of the Netherlands as long as another law which applies according to national regulations does not contain conditions which are not compatible with the law of the Netherlands.

The benefits of this insurance do not hinder the applicability of legal statutes and of the compulsory basic health care legislation pertaining to the host country to which the present conditions of insurance refers to and which are thus part and parcel of the insurance contract within the limits of these references.

Conciliation
Before taking any judicial or arbitral action, each party agrees to contact the other party, in writing, within ten (10) days of the beginning of the dispute, to find an amicable settlement. In the event that the conciliation was unsuccessful, the insurer undertakes to put a free internal opposition proceeding at the insured's disposal. The commencement of this proceeding does however not suspend the course of any legal or contractual delays or deadlines.

Complaints procedure
If you have any complaint regarding the standard of service received under this insurance policy, the following instance can be contacted:

Anker Insurance Company n.v.
P.O. Box 8002
9702 KA Groningen
Netherlands

Telephone: +31 50 520 99 74
Email: complaints@anker.nl

Kifid for private policyholders
Has your complaint not been solved to your satisfaction by us? Then you can send your complaint within three months after our final response to your complaint to the independent Financial Services Complaints Institute (Kifid).

Address details:
KIFID
PO Box 93257
2509 AG The Hague
Phone number: +3170 333 8 999

An insured can also submit the difference of opinion to a court of law. Disputes will then be submitted to a competent Court in the Netherlands.

In the event of legal proceedings, the dispute regarding the interpretation and execution of this agreement shall fall within the exclusive jurisdiction of the Netherlands. This does not affect the application of mandatory, conventional or legal provisions regarding the place of jurisdiction. In addition, the parties are free, by written agreement, to make use of the possibility of arbitration by one or three arbitrators.

Sanction clause
The insurer shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the Netherlands, the European Union, United Kingdom or United States of America.

Sanction List
The insurer is obliged to verify whether the policyholder and/or the insured person(s) under this insurance contract appear on national or international sanctions lists. In such case, the insurer is not permitted to enter into or continue the contractual relationship. Verification may be carried out retrospectively.

The insurance contract shall only be valid once the insurer has established that no sanctions have been imposed on the policyholder and/or the insured person(s). The contract shall then take effect from the starting date stated on the policy. Should the policyholder and/or the insured person(s) appear on a sanctions list, the insurer shall notify the policyholder accordingly. In such case, the insurance contract shall be deemed never to have existed and no rights to coverage or compensation may be derived therefrom.

16. Validity

The present insurance conditions are valid from 01.2026 and replace all previous conditions governing the same product.