Consumer Information COVRD.EE

General Customer Information

We, DR-WALTER GmbH, want to provide you as our customer with the following comprehensive information about the involved insurance company and the underlying insurance policy. These insurance policies are offered exclusively through DR-WALTER GmbH and its distribution partners.

COVRD.EE is an international travel group health insurance policy developed and concluded by DR-WALTER GmbH (policyholder) for members of Living Abroad Community e. V. (LAC e. V.) with the participation of DR-WALTER Versicherungsmakler GmbH.

The Risk carrier is Barmenia Krankenversicherung AG.

1. Type of insurance contract

COVRD.EE is an international travel group health insurance.

2. Identity of the companies involved

To offer you these insurance policy, DR-WALTER GmbH has teamed up with a renowned insurance company.

Insurance coverage is provided by the insurer:

Barmenia Krankenversicherung AG
Barmenia Allee 1
42119 Wuppertal, Germany

Headquarters: Wuppertal

District Court Wuppertal HRB 28475

Contract and service management is provided by:

DR-WALTER GmbH
Eisenerzstraße 34
53819 Neunkirchen-Seelscheid, Germany

Headquarters: Neunkirchen-Seelscheid

District Court Siegburg HRB 4701

DR-WALTER GmbH acts as an insurance agent for one or multiple clients in accordance with section 34d (1) Industrial Code. The competent authority is IHK Bonn/Rhein-Sieg, Bonner Talweg 17, 53113 Bonn, T +49 228 2284 -0, F +49 228 2284 -170, info@bonn.ihk.de, www.ihk-bonn.de.

DR-WALTER GmbH is registered in the register of insurance intermediaries under the number D-QAMW-L7NVQ-57. This entry can be reviewed online at www.vermittlerregister.info or in the Register of Insurance Brokers (Versicherungsvermittlerregister) at Deutscher Industrie- und Handelskammertag (DIHK) e. V., Breite Straße 29, 10178 Berlin, T +49 180 600 585-0, (landline price €0.20 / call; mobile phone prices maximum €0.60 / call). DR-WALTER GmbH has a direct interest of 100% in the voting rights of DR-WALTER Versicherungsmakler GmbH. No insurance company or parent company of an insurance company has a direct or indirect interest of more than 10% in voting rights or capital of DR-WALTER GmbH.

3. Authorized representatives of the companies involved

The legal representative of Barmenia Krankenversicherung AG is the Management Board as follows: Dr. Andreas Eurich (CEO), Frank Lamsfuß, Ulrich Lamy, Carola Schroeder; Chairman of the Board: Dr. h. c. Josef Beutelmann.

Legal representatives of DR-WALTER GmbH are the managing directors.

4. Main business activity of the insurers

Barmenia Krankenversicherung AG offers all types of health and long-term care insurance.

Legal and financial supervision is carried out by the Bundesanstalt für Finanzdienstleistungsaufsicht (Federal Financial Supervisory Authority), Graurheindorfer Str. 108, 53117 Bonn, Germany.

5. Guarantee and security fund

Medicator AG, Gustav-Heinemann-Ufer 74c, 50968 Cologne, Germany, in agreement with the Federal Financial Supervisory Authority, protects policyholders from the consequences of the insolvency of a health insurance company.

6. Key features of the benefits

Contract basis

The General Insurance Conditions describe type and scope of the insurance benefits and contain all other regulations. The entire content is derived from the following documents:

- Insurance Conditions COVRD.EE (DW-WP), of Barmenia Krankenversicherung AG,
- General Customer Information,
- Inurance Product Information Document,
- The insurance policy documents the concluded insurance contract.

The data to be provided by you and any documents to be submitted serve in particular to specify the desired insurance coverage. Collateral agreements (e.g. verbal commitments made by your insurance agent) are only binding if they are confirmed in writing by DR-

WALTER GmbH or the insurance company involved.

7. Total price of insurance

The premium is a monthly premium. This is due in advance at the beginning of each insured calendar month. The total premium is stated on the basis of your selection on our website, as well as in the consultation protocol and your insurance confirmation.

The premiums for health and long-term care insurance are free of tax in accordance with section 4 no. 5 Insurance Tax Act (VersStg).

8. Taxes, fees and expenses

In the event that you fall behind with your payments, the dunning costs specified in §§ 37 and 38 VVG as well as late payment fines, may be incurred. There are no other taxes, fees or charges.

9. Details of payment of premiums

(1) The premium is a monthly premium. It is payable in advance and due on the first of each month.

(2) The first premium is to be paid immediately after the expiry of two weeks following the delivery of the insurance confirmation.

(3) §§ 37 to 39 VVG shall apply in the event that a party is in default or if it becomes necessary to send the party a reminder.

(4) The premium shown are free of insurance tax. If such tax becomes due due to legal requirements, it must be paid separately. The premium is to be paid to the office designated by the insurer.

(5) The obligation to pay premiums has been transferred from the policyholder to the main insured persons. The regulations concerning the policyholder apply equally to the main insured persons.

(6) The insurer shall annually compare the calculated insurance benefits with the insurance benefits actually provided and adjust the premiums as necessary. The premium adjustment shall take effect at the beginning of the following insurance year. The prerequisite is that the policyholder has received the notification of the premium adjustment at least one month in advance.

10. Obligations

(1) The main insured person and the co-insured person named as being entitled to receive such information must, at the insurer's request, provide any information required to establish the insured event or the insurer's obligation to pay benefits and their scope.

(2) At the request of the insurer, the insured person is obliged to be examined by a doctor appointed by the insurer.

(3) The insured person shall, as far as possible, take care to mitigate the damage and refrain from all actions that impede recovery.

11. Consequences of a breach of obligations

(1) The insurer shall be wholly or partially exempt from the obligation to perform, subject to the restrictions prescribed in § 28 par. 2 to 4 VVG, if one of the obligations specified in Clause 10 is breached.

(2) The knowledge and fault of the co-insured person are equal to the knowledge and fault of the main insured person.

12. Obligations and consequences of a breach of obligations in the event of claims against third parties

(1) If the main person insured or a co-insured person has claims for compensation against third parties, there is, irrespective of the legal subrogation in accordance with § 86 VVG, the obligation to assign these claims to the insurer in writing up to the amount in which compensation (reimbursement of expenses as well as material and services) is paid under the insurance contract.

(2) The main person insured or a co-insured person has to assert his/her claim for compensation or any right to secure this claim properly and in due time and assist the insurer, as far as necessary, in enforcing such claim for compensation.

(3) If the main person insured or a co-insured person intentionally breaches the obligations set out in Clause 10 subsection 1 and 2, the insurer is not obliged to perform to the extent that he cannot obtain compensation from the third party as a result. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the fault.

(4) If the main person insured or a co-insured person has a claim for repayment of charges paid without legal cause against the provider of benefits for which the insurer has provided reimbursement on the basis of the insurance contract, subsection 1 to 3 shall apply accordingly.

(5) Insofar as third parties are liable to pay benefits in case of an insured event or benefits can be claimed from insurance contracts with other insurance companies, their obligations to pay benefits shall take precedence; this shall also apply if only subordinated liability is also agreed in an insurance contract. The claims of the insured person shall remain unaffected thereby. If the insured event is first reported to the insurer, the insurer will make an advance payment and settle the claim in accordance with the agreed terms and conditions.

(6) The policyholder must inform the insurer immediately about the conclusion or existence of other insurance contracts that have the same subject matter of insurance as this group insurance contract.

13. Validity of the information provided

The information provided is generally not limited in time.

14. Conclusion of the contract

Once we have received your necessary data, we can accept your application to join within six weeks. This period begins on the day of the declaration of accession. If the insured person receives the insurance confirmation within the acceptance period, the insurance contract is concluded without any further declaration of intent. In order to be able to decide on the insurability of a person to be insured, he/she undergoes a health check during the application process.

For persons to be insured who do not fulfil the condition of insurability, membership shall also not be established by payment or receipt of the premium.

15. Information on the right of revocation in accordance with section 8 (2) no. 2 German Insurance Contract Act (VVG)

You will find the complete right of revocation on the following pages.

16. Contract period

This contract is not limited in time.

The minimum contract period is 12 months.

17. Information on the termination of the contract

The insured person may terminate the insurance relationship at the end of any month after expiry of the minimum contract period.

18. Applicable law and place of jurisdiction

The contract is subject to German law and German jurisdiction. Should it ever be necessary to resolve a dispute in court, you can file suit in the courts with the following local jurisdiction:

- Your place of residence or habitual residence,
- Wuppertal as the headquarters of Barmenia Krankenversicherung AG for lawsuits against Barmenia Krankenversicherung AG,
- The court of your place of residence or habitual residence shall have jurisdiction over any action brought against you,
- In the event of departure to a foreign country outside the European Union / European Economic Area, the place of jurisdiction shall be Wuppertal for lawsuits against Barmenia Krankenversicherung AG. The same applies if your place of residence or habitual residence is unknown.

19. Languages

Our correspondence with you can be in English or German.

20. Appeal proceedings

In the event of a disagreement, please contact DR-WALTER GmbH.

Our contact data are

DR-WALTER GmbH
Eisenerzstraße 34
53819 Neunkirchen-Seelscheid
Germany

T +49 22 47 91 94 -0
F +49 22 47 91 94 -40

Email: beschwerde@dr-walter.com

We will try to find a mutually acceptable solution as quickly as possible. If we don't succeed in this endeavor, you can also contact an extra-judicial arbitrator.

For complaints that affect your health or long-term care insurance, please contact the

Ombudsmann für private Kranken- und Pflegeversicherungen (ombudsman for private health and long-term care insurance)
Postfach 060222
10052 Berlin

T +49 800 2 55 04 44 (free of charge from German telephone networks)
F +49 30 20 45 89 31

Email: ombudsmann@pkv.de

For more information, please go to www.pkv-ombudsmann.de

This ombudsman is both responsible for extra-judicial arbitration in the event of a dispute arising from insurance contracts with consumers and between insurance brokers and policyholders. The policyholder's right to take legal action shall remain unaffected hereby.

Conciliation body of the European Commission

Consumers who have concluded their contract online (e.g. via a website) can also submit their complaint online via the platform http://ec.europa.eu/consumers/odr/. Your complaint will then be sent to the ombudsman for private health and long-term care insurance.

In addition, you can file a complaint with the

Bundesanstalt für Finanzdienstleistungsaufsicht (Federal Financial Supervisory Authority)
Graurheindorfer Straße 108
53117 Bonn
Germany

T +49 228 41080
F +49 228 4108 1550

Email: poststelle@bafin.de

Information on the right of revocation

Section 1

Right to revoke, consequences of revocation and special notes

Right of revocation

You can revoke your contractual declaration in writing (e.g., letter, fax, email) without giving reasons within 14 days after conclusion of the contract.

Your revocation period starts after you have received

- **the insurance policy,**
- **the policy provisions,** including the General Insurance Conditions applicable to the contractual relationship, which in turn include the tariff provisions,
- **this information sheet,**
- **the fact sheet about the insurance products,**
- **and the other information listed in section 2**

in each case in writing.

Timely sending of the revocation statement is sufficient for complying with the revocation period. Please send your revocation to:

Barmenia Krankenversicherung AG, c/o DR-WALTER GmbH, Eisenerzstraße 34, 53819 Neunkirchen-Seelscheid

If you wish to send your revocation by fax, please send it to the following fax number: **+49 22 47 91 94-40**

If you wish to send your revocation by email, please send it to the following email address: vertrag@dr-walter.com

Consequences of revocation

In the event of an effective revocation, the insurance coverage shall end and the insurer shall reimburse you for the portion of the premiums attributable to the period after receipt of the revocation if you have agreed that the insurance coverage shall commence before the end of the revocation period. In this case, the insurer may retain the part of the premiums attributable to the period up to the receipt of the revocation; this is an amount equal to the number of days during which insurance coverage existed multiplied by 1/365 of the annual premium. The insurer shall reimburse any amounts to be repaid without delay, no later than 30 days after receipt of the revocation.

If insurance coverage does not commence before the end of the revocation period, the effective revocation shall result in any benefits received being returned and any benefits derived (e.g., interest) being reimbursed. If you have effectively exercised your right of revocation with regard to the insurance contract, you shall also no longer be bound by any contract related to the insurance contract. A related contract exists if it is related to the revoked contract and concerns a service provided by the insurer or a third party on the basis of an agreement between the third party and the insurer. A contractual penalty may neither be agreed upon nor demanded.

Special notes

Your right of revocation expires if the contract has been completely fulfilled by both you and the insurer at your express request before you have exercised your right of revocation.

Section 2

Further information required for the start of the deadline

With regard to the further information referred to in section 1 sentence 2, the information requirements are detailed below:

Subsection 1

Information requirements for all classes of insurance

The insurer is required to provide you with the following information:

1. the identity of the insurer and of the branch, if any, through which the contract is to be concluded; the commercial register in which the legal entity is registered and the corresponding registration number must also be provided;

2. the address for service of the insurer and any other address relevant to the business relationship between the insurer and you, in the case of legal persons, associations of persons or groups of persons also the name of an authorized representative; insofar as the notification is made by transmitting the contractual provisions including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;

3. the insurer’s principal business activity;

4. information on the existence of a guarantee fund or other compensation arrangements; the name and address of the guarantee fund must be provided;

5. the essential features of the insurance benefit, in particular information on the type, scope and due date of the insurer’s benefit;

6. the total price of the insurance, including all taxes and other price components, with the premiums shown individually if the insurance relationship is to comprise several independent insurance contracts, or, if an exact price cannot be stated, information on the basis of its calculation, enabling you to verify the price;

7. details regarding payment and fulfillment, in particular the method of payment of premiums;

8. the time limit of the validity of the information provided, for example, the validity period of limited offers, especially with regard to the price;

9. information on how the contract was drafted, in particular on the start of the insurance and the insurance coverage, as well as the duration of the period during which the applicant is to be bound by the application;

10. the existence or non-existence of a right of revocation as well as the conditions, details of the exercise, in particular the name and address of the person to whom the revocation is to be declared, and the legal consequences of the revocation, including information on the amount you may have to pay in the event of revocation; insofar as the notification is made by transmitting the contractual provisions, including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;

11. a) information on the contract period;
b) information on the minimum term of the contract;

12. information on the termination of the contract, in particular on the contractual terms of termination including any contractual penalties; if the notification is made by transmitting the contractual provisions including the General Insurance Conditions, the information shall be provided in a prominent and clearly designed form;

13. the member states of the European Union whose law the insurer uses as a basis for establishing relations with you before concluding the insurance contract;

14. the law applicable to the contract;

15. the languages in which the terms and conditions of the contract and the advance information referred to in this subsection will be communicated and the languages in which the insurer undertakes, with your consent, to communicate during the term of this contract;

16. possible access for you to an extrajudicial complaint and appeal procedure and, if applicable, the conditions for such access; it must be expressly stated that this does not affect the possibility for you to take legal action;

17. name and address of the competent supervisory authority and the possibility of lodging a complaint with this supervisory authority.

Insurance conditions COVRD.EE (DW-WP)

Contents from the Group Insurance Contract relevant to you

Status 01.12.2022

1. Insured persons

(1) All persons who are members of DIA e. V. or LAC e.V. and stay abroad are eligible for insurance as (main-) insured persons. Abroad in this context means all countries with the exception of the one which the insured person declares as his/her home country.

The home country is the country to which an insured person is returned in the case of a medically necessary return transport or death. The insured person must have either citizenship or a permanent residence permit for the specified home country. The time limit of the insurance coverage per calendar year mentioned under clause 3 subsection 5 applies.

(2) Eligible for insurance as (co-)insured persons are Family members – spouse, life partner, and children – who accompany the person referred to in clause 1 subsection 1 abroad or live there together or visit the person there, are insurable (family members, like the persons referred to in clause 1 subsection 1, must be registered in each case in accordance with clause 2 and the persons leaving the insurance must be de-registered).

(3) The contracting parties agree that the rights and obligations arising from this contract exist exclusively between the policyholder and the insurer. At the time of conclusion of the contract, the policyholder can only be a company with its registered office in Germany. All correspondence shall be conducted exclusively between the contracting parties.

2. Registration and de-registration and medical examination

(1) The reporting of the insured persons by name is waived. Instead, the policyholder undertakes to report the current number of insured persons as a lump sum per settlement number by the 10th of each month.

(2) The notification is made by list with the following data of the insured persons: Surname, first name, date of birth, gender, home country, start of insurance.

(3) The minimum contract period is 12 months.

(4) Any changes to the above data must be communicated immediately.

(5) To be able to decide on the insurability of a person to be insured, he or she needs to undergo a medical examination during the application process. Therefore, the health questions asked in the application must be answered truthfully and to the best of the applicant’s knowledge.

3. Subject matter, scope, and area of validity of the insurance coverage

(1) The insurer provides coverage for illnesses, accidents, and other events specified in the contract. The insurer shall provide directly related additional services, if agreed. In the event of an insured event, the insurer shall reimburse expenses for medical treatment and other agreed benefits.

Notwithstanding any other contractual provisions, insurance coverage shall only apply insofar and as long as there are no economic, trade, or financial sanctions or embargoes of the European Union or the Federal Republic of Germany directly applicable to the contracting parties. This also applies to economic, trade, or financial sanctions or embargoes imposed by the United States of America on Iran, insofar as they are not opposed to any European or German legal provisions.

(2) An insured event is the medically necessary treatment of an insured person due to illness or as the result of an accident. The insured event begins with the medical treatment; it ends when, according to medical findings, the need for treatment no longer exists. If the treatment has to be extended to an illness or consequence of an accident that is not causally related to the illness or consequence previously treated, this constitutes a new insured event in this respect.

Insured events include:

- outpatient examinations for the early detection of diseases (targeted, preventive medical examinations);
- examination and treatment for pregnancy, premature birth, miscarriage, or an unforeseen medically necessary abortion;
- childbirth;
- return transport;
- transport of mortal remains or funeral at place of death.

(3) The worldwide insurance coverage includes the expenses incurred in the country of residence.

(4) The scope of insurance coverage is determined by the insurance policy, subsequent written agreements as well as statutory regulations. The insurance contract is subject to German law.

(5) The insurance coverage is valid in the following regions:

Region 1: Worldwide – Worldwide, except USA and Canada

Region 2: Worldwide – Worldwide, including USA and Canada

The target region is the region in which the insured person is staying, or will stay. If insurance coverage applies in region 1, it also applies in region 2 in the event of temporary travel (for a maximum of six weeks), but only for medical emergencies, consequences of an accident, and death.

The change to another region should be reported immediately to the insurer to have the best possible insurance coverage.

The policy covers stays in the home country for up to 180 days per calendar year.

4. Start of insurance coverage and waiting periods

(1) Insurance coverage begins (subject to acceptance of the application and statutory rights of revocation) at the time specified in the insurance certificate, but not before payment of the initial premium, and not before the start of the stay abroad.

(2) For newborns, insurance coverage begins immediately after birth if, on the day of birth, one parent has been insured under the group insurance contract for at least three months and the newborn accompanies the insured parent. Insurance coverage begins without risk premiums and without waiting periods if the application is made retroactively no later than two months after the date of birth. Coverage may not be higher or more comprehensive than that of a covered parent.

If insurance coverage is applied for at a later date, the parties may agree on a risk premium up to the simple premium amount.

In case of doubt, the presentation of the birth certificate is considered as registration of newborn children.

(3) The birth of a child is equivalent to adoption, provided that the child is still a minor at the time of adoption. In consideration of an increased risk, the parties may agree on a risk premium up to the simple premium amount.

(4) Waiting periods are calculated from the start of the insurance.

There is a 10-month waiting period for dentures, tooth and jaw adjustment (orthodontic treatment), childbirth, and psychotherapy.

In the event of an accident, the waiting periods for dentures as well as tooth and jaw adjustment (orthodontic treatment) do not apply.

There is a 2-year waiting period for surgical measures to correct refractive errors (e.g., LASIK), including the necessary pre- and postoperative examinations

In the event of amendments to the contract, the waiting period regulations shall apply to the added part of the insurance coverage.

5. Scope of the liability to pay benefits

(1) In the event of medically necessary outpatient or inpatient medical treatment, outpatient preventive examinations, examination and medically necessary treatment due to pregnancy as well as in the event of premature birth or miscarriage or in the event of an unforeseeable medically necessary termination of pregnancy, in the event of childbirth, the following costs are covered by the insurance

in the cover variant Plus to

a) 100% of the costs of medical consultations, visits, and procedures including operations and ancillary operating costs;

These services can also be provided by therapists who are licensed in the country of residence and practice recognized medical professions there (for example, non-medical practitioners, chiropractors, physiotherapists, osteopaths). This includes alternative treatment methods such as:

- acupuncture (needle technique)
- homeopathy
- Traditional Chinese Medicine (TCM) treatment methods

b) 100% of the costs of obstetrics and follow-up care by a midwife or male midwife. In addition to the costs of childbirth, we reimburse all medically necessary examinations and treatments as part of prenatal care, pregnancy complications, and a medically necessary Caesarean section;

Examinations by a midwife or male midwife and prenatal, obstetric, and postnatal care services are refundable.

c) 100% of the costs of prescribed medicines and dressings;

Lifestyle products (including potency, hair growth, or weight reduction products), contraceptives, nutrients and tonics, vitamin and vitamin mix products, cosmetics, and similar products are not considered medicines even if they have been prescribed by a doctor and are therefore not covered by the insurance.

d) 100% of the costs of medically prescribed remedies such as baths, physiotherapy, manual therapy, massages, inhalations and light, heat and other electrical and physical treatments;

- Osteopathic and/or chiropractic treatments, a total of max. 20 treatments per calendar year including medicines and dressings;
- Speech therapy: treatments provided as part of or in conjunction with speech therapy and provided by a qualified speech therapist are refundable;
- Occupational therapy: treatments provided as part of or in conjunction with occupational therapy and provided by a qualified occupational therapist are refundable.

e) 100% of the costs of medically prescribed aids (with the exception of visual aids and aids used in the context of the care of an insured person, as well as sanitary aids) up to a total invoice amount of EUR 1,000.00 per person and calendar year. Expenses for the functionality (except repairs within a maximum rate), use, and care of medical aids are not refundable;

f) 100% of the costs of life-supporting medical aids and devices;

A medical aid or device is life-supporting if without its use a life-threatening situation would immediately arise (e.g., ventilators for life-sustaining ventilation, monitoring devices for respiratory and heart rates, systems for home dialysis and for oxygen therapy).

g) 100% of the costs of diagnostic examinations;

This includes pathology, radiology, computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), as well as application of X-rays, radium and isotope therapy.

h) 100% of the costs of accommodation and meals during inpatient medical treatment in a double room;

Inpatient follow-up treatment is any treatment preceded by inpatient hospital treatment and any such follow-up treatment must begin no later than two weeks after completion of the mentioned inpatient hospital treatment. A right to benefits exists at most for the expenses incurred in the first 28 days of inpatient follow-up treatment.

i) 100% of the costs of the necessary transport to or from an inpatient medical treatment to the nearest hospital recognized in accordance

with par. 3 or the nearest hospital that is suitable from a medical point of view;

j) 100% of outpatient transport costs;

Necessary transportation to and from the doctor, dentist or hospital for primary care after an emergency or accident and transport to dialysis, radiation therapy, or chemotherapy, as well as travel to and from outpatient surgery (on the day of surgery) are refundable.

k) 100% of the costs of home nursing care;

Home nursing care following a continuous inpatient hospital stay of at least two weeks. A medical opinion must be submitted to prove the medical necessity of home nursing care. Coverage includes home nursing care services that are typically medical services (e.g., dressing changes, ostomy care, medication administration, etc.).

Reimbursement is EUR 200.00 per day, up to a maximum of EUR 2,800.00 per insured person per calendar year.

Other care services, such as washing, dressing, housekeeping, etc., are not covered.

l) 100% of the costs of outpatient psychological therapy, as part of primary care, for up to 3 sessions;

m) 100% inpatient psychotherapy;

If the emphasis of the inpatient treatment is on psychotherapeutic treatment, benefits are payable at most for the expenses incurred in the first six weeks per insured event.

n) 100% of the costs of dental treatment;

e.g., high-quality dental fillings (inlays), extractions, root canal treatments, diseases of the oral mucosa and periodontium, dental prophylactic measures, but not dental cleaning.

o) 50% of the costs of dentures and jaw adjustment (orthodontic treatment) as a result of an accident;

p) 100% of the costs of return transports;

If there is a medical indication for a return transport due to an illness or the consequence of an accident and if this is medically reasonable and justifiable, the necessary expenses for the medical transport of an insured person (including the costs, if any, for any medically trained personnel required to accompany the insured person) from abroad to his/her home country will be reimbursed in full.

This also includes rescue flights (patient transport with an ambulance aircraft specially equipped and approved for this purpose) if, according to a medical certificate, such a flight is the only way to save the life of insured persons who are seriously ill or injured, and if it is carried out by an air rescue company recognized in accordance with the guidelines for the performance of ambulance flights.

q) 100% of the necessary costs of a return transport of co-insured children under 18 years as well as an accompanying person will be reimbursed up to a total amount of EUR 5,000.00, provided that the main person insured and all co-insured adult persons have been returned home or have died;

r) 100% of the costs of transport of mortal remains/funeral costs;

If the insured person dies abroad, the costs of repatriation of his/her mortal remains – even after prior cremation at the place of death – to his/her place of residence in the original country of departure will be reimbursed. In lieu of the cost of transporting the mortal remains, the cost of burial at the place of death may be reimbursed. Coffins, caskets, and urns are reimbursable in simple designs.

Costs incurred in connection with funeral services or religious or ritual ceremonies, as well as, for example, costs of flower arrangements, advertisements, funeral cards, etc., are not refundable.

s) 100% of the costs of a blood bag transport;

If blood bags are medically necessary for an operation at a location where the operation is being performed and HIV infection is expected to be present in the blood bags available on-site or if the necessary blood bags are not available on-site, the necessary costs for transporting blood bags abroad will be reimbursed.

t) 100% of rooming-in costs;

If, in addition to an insured child up to the age of 18, a parent is admitted to hospital as an accompanying person, a daily hospital allowance of EUR 50.00 per day will be paid for the duration of the accompaniment, up to a maximum of EUR 500.00 per calendar year and insured child. Additional costs for accommodation and meals for a parental companion for children up to the age of 12 are reimbursed in the event of inpatient hospital treatment.

u) 100 % of search, rescue, and recovery costs;

If the insured person suffers an accident and has to be searched, rescued, or recovered as a result, the insurance covers the costs incurred up to EUR 10,000.00.

additionally in the cover variant Best to

v) 100% of all vaccination costs – including work-related vaccinations or vaccinations required to travel abroad – as well as vaccines and any medical expenses incurred as a result of vaccination. The policy does not cover vaccinations that take place prior to the start of coverage;

w) 100% of the costs of medically necessary preventive examinations for the early detection of diseases;

x) 100% of the costs of outpatient rehabilitation measures;

Expenses for outpatient rehabilitation measures are refundable if the other insured benefits listed above are not sufficient to achieve the medically necessary treatment objective. Entitlement to outpatient rehabilitation measures is limited to a maximum of 20 days of treatment, unless an extension is urgently required for medical reasons.

y) Surgical procedure to correct ametropia (e.g., LASIK);

The insurance policy covers the surgical procedure to correct ametropia (e.g., LASIK), including the necessary preliminary and follow-up examinations, after a period of 2 years – calculated from the start of the insurance or the reported start of the insured person’s trip. Expenses are refundable up to a total invoice amount of EUR 2,000.00 per eye during the entire contract period.

z) Visual aids;

Glasses, contact lenses, and sunglasses with prescription lenses (even with a refraction by the optician): expenses up to an invoice amount of EUR 300.00 within two calendar years are refundable. The period begins with the calendar year in which the first visual aid of an entitlement period is obtained.

aa) Extended prenatal care services;

100% of the costs of first trimester screening and amniocentesis.

The insurance coverage also includes the costs of birth preparation courses and postnatal exercises, in each case up to the maximum amount of EUR 500.00.

Provided that the inpatient stay for a childbirth has lasted less than three days or a home birth has taken place, a lump sum of EUR 130.00 is paid (lump sum for childbirth).

ab) 100 % of the costs of accommodation and meals for inpatient treatment in a single room, as well as treatment by the chief physician;

Rooms with luxury amenities such as deluxe and executive rooms and suites are non-refundable.

ac) From the 15th day of a medically necessary hospital stay, a daily hospital allowance of EUR 50.00 per day is paid without proof of costs. The maximum benefit period is 20 days per calendar year;

ad) 100% of the costs of 2 professional dental cleanings per insurance year;

ae) 50% of the costs of dentures as well as tooth and jaw adjustment (orthodontic treatment);

The insurance covers expenses for dentures (e.g., dental prostheses, pivot teeth, bridges, crowns, implants), repairs to dentures, as well as for dental and jaw adjustment, functional analysis and functional therapy services, including preliminary and follow-up treatments.

af) 100 % of the costs of outpatient psychotherapy;

If treatment requires more than 15 sessions (including probatory sessions), the insured person must obtain written authorization from Barmenia for reimbursement of therapy in excess of this amount.

Insurance coverage for these benefits begins in accordance with clause 4 of the contract.

The insurance policy covers pre-existing conditions. The prerequisite for this is the detailed and truthful answering of the health questions asked (see clause 2) and a medical examination of each insured person (exceptions see clause 4 subsection 2-3). In these cases, the insurer may, insofar as an increased risk exists, levy a premium surcharge and/or decree an exclusion of benefits.

(2) The insured person is free to choose among physicians and dentists who are licensed to provide medical treatment under the law applicable to the country of stay. The services of therapists who are licensed in the country of residence and practice recognized medical professions there (e.g., non-medical practitioners, chiropractors, physiotherapists, osteopaths) may also be used.

(3) In the case of medically necessary inpatient treatment, the insured person is free to choose from among the hospitals generally recognized in the country of stay, which are under permanent medical supervision, have adequate diagnostic and therapeutic facilities, work according to generally accepted scientific methods, and keep medical records.

(4) The insurer shall pay to the contractual extent for examination or treatment methods and medicines that are predominantly recognized by conventional medicine. The insurer will also pay for methods and medicines that have proven equally promising in practice or which are used because no conventional medical methods or medicines are available; however, the insurer may reduce his benefits to the amount that would have been incurred if available conventional medical methods or medicines had been used.

6. Limitation of the liability to pay benefits

(1) There is no liability to pay benefits for

a) such illnesses including their consequences as well as for consequences of accidents and for deaths caused by active participation in war events;

b) treatment abroad that was the sole reason or one of the reasons for starting the trip;

c) illnesses and accidents based on intent, including their consequences, or for withdrawal procedures, including withdrawal and weaning treatment;

d) treatments at a health resort or sanitarium as well as rehabilitation treatment, except for those benefits listed under clause 5.

e) treatment by spouses, life partners, parents or children. Proven material costs will be refunded in accordance with the tariff;

f) items with little therapeutic benefit, equipment that can be assigned to the fitness and/or wellness sector, furthermore radiotherapy equipment and TENS units, other sanitary or medical-technical supplies (e.g., clinical thermometers, heating pads, massage equipment, blood pressure monitors), as well as accessories that are not directly related to the purpose of acquisition, furthermore maintenance and operating costs;

g) occupational medical examinations, examinations for obtaining a residence permit or work permit, and kindergarten and school readiness certificates;

h) diagnosis and treatment of infertility, its cause and consequences, including artificial insemination and related preventive examinations and follow-up treatments;

i) treatment or placement due to need of care or custody;

j) vaccinations that were carried out prior to the start of the insurance coverage;

k) cosmetic treatments and operations that are not medically necessary (e.g., cosmetic surgery);

l) medical treatment and other medically prescribed measures as well as for transport of patients, rescue, and recovery measures in connection with the practice of professional sports.

(2) If a medical treatment or other measure for which benefits have been agreed exceeds what is medically necessary, the insurer may reduce his benefits to a reasonable amount. If the expenses for the medical treatment or other services are conspicuously

disproportionate to the services provided, the insurer is not obliged to pay benefits in this respect.

(3) If there is also an entitlement to benefits from statutory accident insurance or social security pension insurance, to statutory medical care or accident care, the insurer is only liable to pay for the expenses which remain necessary despite the statutory benefits.

(4) If the insured person has a claim against more than one party liable to refund costs due to the same insured event, the total reimbursement may not exceed the total expenses.

7. Payment of benefits

(1) The insurer is only liable to provide benefits if the evidence required by him is provided; such evidence becomes the property of the insurer.

(2) In each case, the expenses are counted in the calendar year in which the treatment occurred or the funds were received. The expenses must be proven by the originals of the invoices or by copies of the invoices confirming the benefits provided by other insurers or health insurers. Medical bills must include:

- name of the treated person,
- designation of all diseases,
- information about the individual medical services with clauses of the applied fee schedule,
- treatment data.

The evidence should be submitted no later than March 31 of the year following the medical treatment.

(3) In all other respects, the conditions for the due date of the insurer's benefits are derived from § 14 VVG (see annex).

(4) Costs incurred in a foreign currency are converted into euros at the current exchange rate on the day the receipts are received by the insurer. The rate of the day is the official euro exchange rate of the European Central Bank. For non-traded currencies for which no reference rates have been fixed, the rate according to "Exchange Rate Statistics", published by the Deutsche Bundesbank, Frankfurt/Main, shall apply according to the latest status, unless the insured person proves by bank receipt that he/she has acquired the foreign currencies required for payment of the invoices at a less favorable rate.

(5) Translation costs are not deducted from the benefits. Costs for transfer of insurance benefits will be deducted from the benefits only if they are incurred because the insurer makes bank transfers abroad at the policyholder's request or chooses special forms of bank transfer.

(6) Claims to insurance benefits may neither be assigned nor pledged. Non-assignment in accordance with sentence 1 shall not apply to contracts concluded on or after October 1, 2021; statutory non-assignment clauses shall remain unaffected.

(7) If an insurance card has been issued on the basis of which it is possible to bill a service provider directly, the non-assignment clause does not apply in this respect.

8. Set-off

The policyholder or the main insured person may only set off against claims of the insurer if the counterclaim is undisputed or has been legally established.

9. Informing the insured persons

(1) The policyholder shall adequately inform the main insured persons about their insurance cover and the essential provisions of this contract.

(2) The policyholder is obliged to notify all insured persons immediately if the contract is terminated – in whole or in part – by notice of cancellation. The policyholder shall notify the affected persons that the insurance coverage under this agreement has been terminated and that insurance benefits will no longer be paid.

10. Withdrawal from group insurance

(1) The insurance coverage of the individual insured person shall end – also for pending claims –

a) with the termination of the stay abroad or with the return to the home country;

b) when the prerequisites according to clause 1 cease to apply;

c) with the death of the insured person;

d) after a return transport to the home country;

e) with the transfer of the policyholder's registered office to a state that is not a member state of the European Union or a contracting state of the Agreement on the European Economic Area;

f) with the termination – in whole or in part – of the group insurance contract by the policyholder;

g) with the termination – in whole or in part – of the group insurance contract by the insurer.

The policyholder shall inform the insurer immediately about the reasons for termination specified in a) to e).

(2) Insured persons who had their residence in the Federal Republic of Germany prior to an uninterrupted stay abroad of at least three months and who subsequently return there may apply for continuation of their insurance as individual insurance under the insurer's General Insurance Conditions valid for this purpose within a period of two months after termination of the insurance under the group contract. If the insurer accepts the application, the insurance period completed without interruption in the group insurance contract will be counted towards the waiting periods, insofar as it concerns benefits which were also the content of this group insurance contract and the individual insurance begins at the latest on the first of the month following the submission of the application.

11. Declarations of intent and notifications

Declarations of intent and notifications to the insurer must be made in writing.

12. Contract language/Applicable law

(1) The policy provisions are written in German. Any communication during the term of the insurance will also be in German. If documents are provided in English, this is to be understood as a service of the insurer, which has no effect on the agreed contract language.

(2) The insurance contract is subject to German law.

(3) The insurer cannot guarantee that the contract is a substitutive health insurance policy in the sense of a possibly existing local health insurance obligation. It is not the insurer's responsibility to determine whether this group insurance is a suitable substitute. The insurer is not obliged to ensure compliance with all relevant rules and regulations related to the employee relocation for all insured persons covered by the insurance contract.

(4) With regard to the insurance obligation existing in Germany in accordance with § 193 (3) sentence 1 of the German Insurance Contract Act (VVG), the insurer expressly points out that the group insurance is not a substitutive health insurance within the meaning of § 146 of the Insurance Supervision Act (VAG) and is therefore not suitable for fulfilling the obligation to insure.

13. Amendment of the group insurance policy

(1) If a provision in this contract has been declared invalid by a supreme court decision or by a binding administrative decision, the insurer may replace it with a new provision if this is necessary for the continuation of the contract or if adherence to the contract without a new provision would represent an unreasonable hardship for one party to the contract, even taking into account the interests of the other party to the contract.

(2) The new regulation is only effective if it adequately takes into account the interests of the policyholder while preserving the objective of the contract. It shall become part of the contract two weeks after the policyholder has been informed of the new regulation and the relevant reasons for it.

14. Declaration on the insured person's authority to receive

The policyholder hereby irrevocably names all persons insured under this Group Insurance Contract as authorized recipients of the respective insurance benefits relating to their person. Barmenia Krankenversicherung AG is entitled to pay the said insurance benefits in each case directly to the individual insured person as the claimant or to a third party authorized by the latter to receive the benefit. (Note: Payments with a debt-discharging effect to third parties, e.g. hospitals, doctors, etc., who submit invoices for reimbursement and wish to collect the insurance benefit directly are only possible if a written direct debit authorization or declaration of assignment signed by the insured person is submitted to us by the third party along with the reimbursement request).

Reference to the consumer arbitration board Ombudsman Private Health and Nursing Care Insurance

Main persons insured who are not satisfied with decisions made by the insurer, or whose negotiations with the insurer have not led to the desired result, can turn to the Private Health and Nursing Care Insurance Ombudsman.

Ombudsman Private Health and Nursing Care Insurance
PO Box 06 02 22
10052 Berlin
Web: www.pkv-ombudsmann.de

The ombudsman for Private Health and Nursing Care Insurance is an independent arbitration board that works free of charge for consumers. The insurer has undertaken to participate in the arbitration proceedings.

Consumers who have concluded their contract online (e.g. via a website) can also submit their complaint online to the http://ec.europa.eu/consumers/odr/ platform. Your complaint will then be forwarded via this platform to the Private Health and Nursing Care Insurance Ombudsman.

Note: The Private Health and Nursing Care Insurance Ombudsman is not an arbitration board and cannot make binding decisions on individual disputes.

Reference to the insurance Supervision

If main persons insured or policy holder are not satisfied with the service provided by the insurer or if disagreements arise during the processing of the contract, they can also contact the supervisory authority responsible for the insurer. As an insurance company, the insurer is subject to supervision by the German Federal Financial Supervisory Authority.

Federal Financial Supervisory Authority (BaFin)
Sector Insurance Supervision
Graurheindorfer Straße 108
53117 Bonn
Mail: poststelle@bafin.de

Note: The BaFin is not an arbitration board and cannot make binding decisions on individual disputes.

Reference to the legal process

Regardless of the possibility of turning to the consumer arbitration board or the insurance supervisory authority, taking legal action is open to the mainperson insuredor policy holder.

Health insurance guarantee fund

Medicator AG, Gustav-Heinemann-Ufer 74 c, 50968 Cologne, in agreement with the Federal Financial Supervisory Authority (Bundesanstalt für Finanzdienstleistungsaufsicht), protects policyholders against the consequences of the insolvency of a health insurance company.

Law excerpts

GERMAN INSURANCE CONTRACT ACT (VVG)

§ 8 Policyholder's right of revocation

(1) The policyholder may revoke his contractual agreement within 14 days. The policyholder shall declare his revocation to the insurer in writing, but need not state any reason; timely dispatch shall suffice for compliance with the time limit.

(2) The revocation period shall begin at such time as the policyholder receives the following documents in writing:

1. the insurance policy and the terms of contract, including the general terms and conditions of insurance, as well as the other information in accordance with section 7 (1) and (2), and

2. a clearly worded instruction regarding the right of revocation and the legal consequences of the revocation which makes clear to the policyholder his rights commensurate with the requirements of the means of communication employed, and the names of the person to whom the revocation is to be declared, with an address at which documents may be served, as well as a note making reference to the commencement of the revocation period and to the rules set out in subsection (1), second sentence.

(3) The right of revocation shall not apply

1. to contracts of insurance with a term of less than one month,

2. to contracts of insurance for provisional cover, unless they are distance contracts within the meaning of section 312b (1) and (2) of the German Civil Code,

[…]

§ 14 Due date of the payment

(1) Payments of the insurer are due after the end of the assessment required to determine the occurrence of an insured event and the amount of compensation payable by the insurer.

(2) If such assessment is not finished after expiry of one month since the notification of the insured event, the policyholder can request payment by installments amounting to the minimum that the insurer can be expected to be required to pay. The period shall be suspended as long as the assessment cannot be finished due to a fault of the policyholder.

(3) Any agreement under which the insurer is exempt from his obligation to pay default interest shall be invalid.

§ 19 Duty of disclosure

(1) The policyholder shall disclose to the insurer before making his contractual acceptance the risk factors known to him which are relevant to the insurer's decision to conclude the contract with the agreed content and which the insurer has requested in writing. If, after receiving the policyholder's contractual acceptance and before accepting the contract, the insurer asks such questions as are referred to in the first sentence, the policyholder shall also be under the duty of disclosure as regards these questions.

(2) If the policyholder breaches his duty of disclosure under subsection (1), the insurer may withdraw from the contract.

[…]

§ 28 Breach of a contractual obligation

(1) In case of a breach of a contractual obligation towards the insurer that the policyholder needs to fulfill prior to the occurrence of the insured event, the insurer may cancel the contract without notice within one month from the time he becomes aware of the breach, unless the breach is not the result of intention or gross negligence.

(2) Where the contract stipulates that the insurer is exempt from its liability to pay in case of a breach of a contractual obligation that the policyholder needs to fulfill, the insurer is only exempt from its liability to pay if the policyholder has deliberately breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce his benefits according to the severity of the fault of the policyholder; the burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) By way of derogation from paragraph 2, the insurer is obliged to pay if the breach of the obligation was neither the cause for the occurrence or determination of the insured event nor for the determination or scope of the insurer's liability to pay. Sentence 1 shall not apply if the policyholder has fraudulently breached the obligation.

(4) Where an obligation to provide information is breached after the occurrence of the insured event, the insurer's full or partial exemption from performance according to paragraph 2 requires that the insurer has informed the policyholder in writing by separate notification about this legal consequence.

(5) An agreement based on which the insurer is entitled to withdraw from the contract in the event of the non-observance of an incidental obligation shall be void.

§ 37 Delayed payment of first insurance premium

(1) If the single premium or the first premium is not paid in good time, the insurer shall be entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.

(2) If the single premium or first premium has not been paid when the insured event occurs, the insurer shall not be obligated to effect payment, unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if he had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

§ 38 Delayed payment of subsequent premium

(1) If a subsequent premium is not paid in good time, the insurer may set the policyholder a payment deadline of no less than two weeks

at his expense and in writing. The setting of the deadline shall only be effective if it details the individual amounts of the premium which are in arrears, the interest and costs, as well as quoting the legal consequences associated in accordance with subsections (2) and (3)with expiry of the time limit; in the case of consolidated contracts, the amounts must be quoted separately.

(2) If the insured event occurs after the deadline expires, and if the policyholder is in arrears as regards the payment of the premium or of the interest or costs, the insurer shall not be obligated to effect payment.

(3) The insurer may, after the deadline expires, terminate the contract without prior notice insofar as the policyholder is in arrears as regards the payment of the due amounts. The termination can be linked to the setting of the payment deadline in such a way that it becomes effective once the deadline expires if the policyholder is in arrears as regards the payment at that point in time; the policyholder must be explicitly informed of this in the termination. The termination shall become void if the policyholder makes the payment within one month after the contract has been terminated or, if it has been linked to the setting of a deadline, within one month after the deadline expires; subsection (2) shall remain unaffected.

§ 86 Subrogation of claims for compensation

(1) Where the policyholder has a claim for compensation against a third party, the insurer is subrogated to this claim if he compensates the damage. This subrogation cannot be asserted to the policyholder's disadvantage.

(2) The policyholder has to assert his / her claim for compensation or any right to secure this claim properly and in due time and assist the insurer, as far as necessary, in enforcing such claim for compensation. Where the policyholder breaches this obligation intentionally, the insurer is exempt from his liability to pay insofar as he can consequently not claim compensation from the third party. In case of a grossly negligent breach of obligations, the insurer is entitled to reduce his benefits according to the severity of the policyholder's fault. The burden of proof for the non-existence of a grossly negligent behavior lies with the policyholder.

(3) If the policyholder's claim for compensation is against a person with whom he / she lived in cohabitation when the damage occurred, the subrogation in accordance with paragraph 1 cannot be asserted unless this person has intentionally caused the damage.

§ 193 Insured person; obligatory insurance

(1) The health insurance may be taken out for the policyholder or for another person. The insured person shall be that person for whom the insurance is taken out.

(2) Where the knowledge and the conduct of the policyholder are of legal significance under this Act, in the case of insurance for another person, account shall also be taken of the knowledge and conduct of that person.

(3) Each person with a place of residence in Germany shall be obligated to conclude and maintain with an insurance company licensed to operate in Germany for himself and for the persons legally represented by him, insofar as they are not themselves able to conclude contracts, a cost-of-illness insurance which comprises at least a cost refund for outpatient and inpatient treatment and in which the absolute and percentage excesses for outpatient and inpatient treatment which have been agreed for services covered by the respective tariff for each person to be insured are limited to an amount of Euro 5,000 per calendar year; for persons entitled to medical expenses assistance, the possible excesses emerge through the analogous application of the percentage not covered by the rate of medical expenses assistance to the maximum amount of Euro 5,000. The obligation in accordance with the first sentence shall not apply to persons who

1. are insured or subject to obligatory insurance in statutory health insurance, or

2. have a right to free treatment, to medical expenses assistance or to comparable rights to the extent of the respective entitlement, or

3. have a right to benefits in accordance with the Asylum-Seekers Benefits Act, or

4. are recipients of recurrent benefits in accordance with the Third, Fourth and Seventh Chapters of Social Code Book XII, and recipients of benefits in accordance with Part 2 of Social Code Book IX, for the duration of the receipt of such benefits and during periods of an interruption of the receipt of benefits of less than one month if the receipt of benefits commenced prior to 1 January 2009.

A cost-of-illness insurance contract agreed prior to 1 April 2007 shall be deemed to meet the requirements of the first sentence.

§ 194 Applicable provisions

(1) Insofar as the insurance cover is granted in accordance with the principles of indemnity insurance, sections 74 to 80 and sections 82 to 87 shall apply. Sections 23 to 27 and section 29 shall not apply to health insurance. Section 19 (4) shall not apply to health insurance if the policyholder is not responsible for the breach of the duty of disclosure. Notwithstanding section 21 (3), first sentence, the time limit for asserting the insurer's rights shall be three years.

(2) If the policyholder or an insured person is entitled to the repayment of remuneration paid without legal basis to the provider of services for which the insurer has paid compensation on the basis of the contract of insurance, section 86 (1) and (2) shall apply mutatis mutandis.

(3) Sections 43 to 48 shall apply to health insurance with the proviso that only the insured person may demand payment of the insurance benefit if the policyholder has designated him in writing to the insurer as the beneficiary of the insurance benefit; such designation may be revocable or irrevocable. Where this condition is not met, only the policyholder may demand payment of the insurance benefit. The insurance policy need not be presented.

§ 195 Period of insurance

(1) Health insurance which may wholly or partially substitute for health and long-term nursing care insurance cover provided for in the statutory social insurance system (substitutive health insurance) shall be for an indefinite period, unless subsections (2) and (3) and sections 196 to 199 provide otherwise. Where the non-substitutive health insurance cover is provided in the manner of life insurance, the first sentence shall apply mutatis mutandis.

(2) In the case of vocational training, overseas, travel and residual debt health insurance, a period of contract may be agreed.

(3) In the case of health insurance for a person with a temporary residence permit for Germany, agreement may be reached to the effect that the insurance will expire after five years at the latest. If a shorter term has been agreed, a similar new contract may only be concluded with a maximum term that does not exceed five years when added to the term of the expired contract; this shall also apply if

the new contract is concluded with another insurer.

§ 205 Termination of the contract by the policyholder

(3) If the contract of insurance provides that when the policyholder reaches a certain age or when other preconditions referred to therein are met the premium for another age or another age group applies or the premium is calculated taking old age reserves into account, the policyholder may terminate the insurance agreement with regard to the affected insured person within two months after the change with effect from the time it became effective if the premium increases as a result.

(4) If the insurer increases the insurance premium or reduces a benefit on account of an adjustment clause, the policyholder may terminate the insurance policy with regard to the affected insured person within two months after receipt of the communication of the change with effect from such time as the increase in the premium or the reduction of the benefits is to take effect.

§ 213 Collection of personal health data from third parties

(1) The insurer is only allowed to collect personal health data from the following third parties: physicians, any kind of hospitals, nursing homes and staff, other personal insurance providers and providers of compulsory health insurance as well as employers' liability insurance associations and authorities; such collection of data is only allowed if knowledge of said data is necessary to assess the insured risk or the liability to pay and if the affected party has given his / her declaration of consent.

(2) The declaration of consent in accordance with paragraph 1 can be given prior to issuing the contract statement. The affected person must be informed about data collection as stipulated in paragraph 1 and may object to the collection.

(3) The affected person can request at any time that a collection of data is only carried out if he / she gave his / her consent for each individual data collection.

(4) The affected person must be informed about his / her rights, in particular about the right of objection in accordance with paragraph 2 when being informed about data collection.

GERMAN INSURANCE SUPERVISION ACT (VAG)

§ 153 Hardship tariff

(1) Non-payers within the meaning of section 193 (7) of the German Insurance Contract Act form a tariff within the meaning of section 155 (3) sentence 1. The hardship tariff provides for the reimbursement of expenses solely in connection with benefits necessary for the treatment of serious illness and pain and those associated with pregnancy and maternity. By way of derogation from the above provision, expenses for insured children and young persons, in particular expenses for preventive medical examinations aimed at the early discovery of illnesses under statutory programmes and for immunisation recommended by the German Standing Committee on Vaccination (Ständige Impfkommission – STIKO) at the Robert Koch Institute under section 20 (2) of the German Protection against Infection Act (Infektionsschutzgesetz – IfSG) must be reimbursed.

(2) A standard premium must be calculated for all insured persons under the hardship tariff; section 146 (1) nos. 1 and 2 applies in all other respects. In the case of insured persons whose insurance contract only provides for the reimbursement of a percentage of the expenses incurred, the hardship tariff provides benefits equivalent to 20, 30 or 50 per cent of the insured treatment costs. Section 152 (3) applies, with the necessary modifications. The calculated premiums under the hardship tariff must not exceed the amount required to cover the claims expenditures under the tariff. Additional expenses that arise in connection with guaranteeing the limitations specified in sentence 3 must be allocated equally to all the insurer's policyholders with an insurance contract that satisfies an obligation under section 193 (3) sentence 1 of the German Insurance Contract Act. The provision for increasing age must be offset against the premium to be paid under the hardship tariff such that up to 25 per cent of the monthly premium is covered by a withdrawal from the provision for increasing age.

GERMAN CRIMINAL CODE (STGB)

§ 218a Exemption from punishment for abortion

(2) A termination which is performed by a physician with the consent of the pregnant woman is not unlawful if, considering the pregnant woman's present and future circumstances, the termination is medically necessary to avert a danger to the life of or the danger of grave impairment to the pregnant woman's physical or mental health and if the danger cannot be averted in another manner which is reasonable for her to accept.

(3) The conditions of subsection (2) are also deemed fulfilled with regard to a termination performed by a physician with the consent of the pregnant woman if, according to medical opinion, an unlawful act under sections 176 to 178 has been committed against the pregnant woman, there are cogent reasons to support the assumption that the pregnancy was caused by the act and no more than 12 weeks have elapsed since conception.

GERMAN CIVIL CODE (BGB)

§ 195 Regular limitation period

The regular limitation period is three years.

Data protection notice

a) Data protection principles of DR-WALTER GmbH (hereinafter referred to as DR-WALTER)

The protection of your privacy and of your personal data is paramount to us. We guarantee that we will always treat your data with the utmost confidentiality. Nowadays, insurance companies can only carry out their tasks with the aid of electronic data processing (EDP). Our state-of-the-art EDP enables us to handle contractual relationships correctly, quickly and in a cost-effective manner.

Both our behavior and our tools are in accordance with the General Data Protection Regulation (GDPR), the Federal Data Protection Act (BDSG) as well as with other specific regulations for online data protection. Our data protection officer ensures that our data protection principles and any relating regulations are fully met.

For further information, please go to https://www.dr-walter.com/en/data-protection.html.

b) Information about the use of your data by DR-WALTER

We need your personal data to process your applications and contracts, for claims handling and for individual supervision and consultancy. Collection, processing and use of your data are regulated by law. We have adopted a code of conduct for the handling of personal data that complies with the code of conduct of the German Insurance Association (GDV). Our code of conduct is based on data protection regulations of the German Insurance Contract Act (VVG), the General Data Protection Regulation (GDPR), the Federal Data Protection Act as well as other significant laws but also on further measures to strengthen data protection. For more information, go to https://www.dr-walter.com/en/data-protection/personal-data.html to learn about our code of conduct with regard to handling your personal data.

DR-WALTER cooperates with several service providers in the use of health data and other data protected under § 203 German Criminal Code (StGB). At https://www.dr-walter.com/en/data-protection/list-of-service-providers.html, we provide you with an overview of the service providers we work with. At your request, we can send you a printed list of the service providers as well as our code of conduct. Please contact:

DR-WALTER GmbH
Eisenerzstr. 34
53819 Neunkirchen-Seelscheid, Germany
P +49 2247 9194 -0
F +49 2247 9194 -40

c) Responsible body

Collection of your personal data is carried out by DR-WALTER GmbH, Eisenerzstr. 34, Germany, 53819 Neunkirchen-Seelscheid (responsible body).

d) Your rights

You have the right to obtain information free of charge about your data stored by us. You also have the right to withdraw any granted consent to the collection, processing and use of your personal data at any time and with future effect as well as the right to correct any incorrect data or to delete or block any impermissible or no longer needed data.

You can assert these rights to the above address directly against DR-WALTER. For further questions with regard to data protection, please contact our data protection officer at DR-WALTER, Eisenerzstr. 34, Germany, 53819 Neunkirchen-Seelscheid, P +49 2247 9194 -0.

Privacy Policy of Barmenia Krankenversicherung AG

Data protection information for interested parties and customers

With this notice, we inform you about the processing of your personal data by the Barmenia company responsible for data collection and your rights under data protection law.

Controller responsible for data processing

Depending on whether the insurance coverage and/or credit you seek or have is provided by Barmenia Versicherungen a. G., Barmenia Krankenversicherung AG, Barmenia Lebensversicherung a. G. or Barmenia Allgemeine Versicherungs-AG, the respective insurance company providing the specific insurance coverage is the entity responsible for processing your personal data. Names and contact details of the above mentioned Barmenia companies:

Barmenia Versicherungen a. G.
Barmenia Krankenversicherung AG
Barmenia Lebensversicherung a. G.
Barmenia Allgemeine Versicherungs-AG
Barmenia-Allee 1
42119 Wuppertal
Phone: 0049 202 438 -00
Email: info@barmenia.de

You can contact the joint data protection officer of the aforementioned companies by mail at the above address with the addition ‘Data Protection Officer’ or by email at: datenschutz@barmenia.de

Purpose and legal basis of data processing

We process your personal data in compliance with the EU General Data Protection Regulation (GDPR), the German Federal Data Protection Act (BDSG), the provisions of the German Insurance Contract Act (VVG) relevant to data protection and all other applicable laws. In addition, our company has committed itself to the „Code of Conduct for the Handling of Personal Data by the German Insurance Industry“, which specifies the above-mentioned laws for the insurance industry. You can find them online at datenschutz.barmenia.de.

If you submit an application for the conclusion of an insurance contract in person or via an insurance broker commissioned by you or via one of our self-employed insurance agents, or if you obtain an offer for the conclusion of an insurance contract from us via one of the aforementioned agents, we require your personal data requested in the application form or in the offer screen (including health data for some products) in order to assess the risk to be assumed by us and, if necessary, for the establishment of the insurance contract.

In the event that an application is received/an offer is solicited by an insurance agent, the agent shall initially collect the aforementioned data in order to carry out its brokerage activities. With the official forwarding of your application to us or with the input of your data into the electronic offer screen of our company in case of electronic offer request, the agent transmits said data to us. If we accept your application or if you accept our offer, the requested insurance contract will come into effect and we will process this data and the personal data collected by us during the term of the contract at the same time for the purpose of implementing the contractual relationship, e.g., for invoicing or amending the contract. In the event of a claim, we require further information from you to be able, for example, to check whether an insured event has occurred and to estimate the amount of the loss.

The conclusion or performance of the insurance contract is not possible without the processing of your personal data.

In addition, we need your personal data to compile insurance-specific statistics, e.g., for the development of new tariffs or to meet regulatory requirements. We use the data of all contracts existing with a Barmenia company for a consideration of the entire customer relationship, for example, for advice regarding a contract adjustment, amendment, for decisions out of goodwill, or for comprehensive information provision.

The legal basis for the collection and processing of personal data for pre-contractual purposes and for the performance of the contract to be concluded or already concluded with you is Article 6 par. 1 b GDPR.

If specific categories of personal data (e.g., health data) are required for the conclusion and performance of the contract, we require your consent. If we create statistics with this kind of data, this is done on the basis of Article 9 (2) j GDPR together with Section 27 BDSG.

We also process your data to protect legitimate interests of us or of third parties (Article 6 par. 1 f GDPR). This may be necessary in particular:

- to ensure IT security and IT operations and to carry out IT tests
- to advertise our own insurance products and other products of the companies of the Barmenia Group and their cooperation partners as well as for market and opinion surveys
- to check your ability and willingness to pay
- to prevent, investigate and record criminal offenses; in particular, we use data analysis to identify clues that may point to insurance fraud.

In addition, we process your personal data to fulfill legal obligations, such as regulatory requirements, commercial and tax retention obligations, or our obligation to provide advice. The legal basis for the processing in this case is the respective legal regulations together with Article 6 par. 1 c GDPR.

Should we wish to process your personal data for a purpose not mentioned above, we will inform you of this in advance within the framework of the legal provisions.

Categories of recipients of the personal data

Reinsurers:
If necessary, we insure risks assumed by us with special insurance companies (reinsurers). For this purpose, it may be necessary to transmit your contract and, if applicable, claims data to a reinsurer so that he can form its own opinion of the risk or the insured event. In addition, it is possible that the reinsurer supports our company due to its special expertise in risk or benefit assessment as well as in the evaluation of procedures. We transmit your data to the reinsurer only to the extent that this is necessary for the performance of our insurance contract with you or to the extent necessary to protect our legitimate interests. For more information on the reinsurer commissioned, please go datenschutz.barmenia.de. You can also request the information using the contact information above.

Distributor/intermediary:
Insofar as you are serviced by a distributor/intermediary with regard to your insurance contracts, your distributor/intermediary processes the application, contract and benefit data required for the conclusion and performance of the contract. Our company also transmits this data, insofar as it has been communicated to it directly by you or a third party, to the distributor/intermediary who manages your contract, insofar as the distributor/intermediary requires the information for your support and advice in insurance and financial services matters.

Data processing in the group of companies:
The insurance companies in the Barmenia group perform certain data processing tasks for the companies affiliated in the group. For example, your data may be processed for the central administration of address data, for telephone service, for billing purposes or for joint mail processing in a common program for all companies in the group. In our list of service providers, you will find the companies that participate in centralized data processing.

External service providers:
In some cases, we use external service providers to fulfill our contractual and legal obligations.

A list of the contractors and service providers we use and with whom we have more than a temporary business relationship can be found in the overview in the application/attachment and in the current version on our website at datenschutz.barmenia.de.

Further recipients:
In addition, we may transfer your personal data to other recipients, such as authorities for the fulfillment of legal notification obligations (e.g., law enforcement agencies, tax authorities or social insurance agencies).

Duration of data storage

We will delete your personal data as soon as they are no longer required for the above-mentioned purposes. In this context, personal data may be retained for the period during which claims can be asserted by us or against our company (statutory limitation period of three or up to thirty years). In addition, we store your personal data insofar as we are legally obligated to do so. Corresponding obligations to provide evidence and to retain records result, among other things, from the German Commercial Code (HGB) and the German Fiscal Code (AO). The storage periods are then up to ten years.

Right of access

You can request access to the data stored about you at the above address. In addition, under certain conditions, you can request the correction or deletion of your data. You may also have a right to restrict the processing of your data and a right to receive the data you have provided in a structured, common and machine-readable format.

Right to object

You have the right to object to the processing of your personal data for direct marketing purposes.

If we process your data to protect legitimate interests, you can object to this processing if reasons arise from your particular situation that conflict with the data processing.

Right to lodge a complaint

You have the option of contacting the above-mentioned data protection officer or a data protection supervisory authority with a complaint. The data protection supervisory authority responsible for us is:

Landesbeauftragte für Datenschutz und Informationsfreiheit
Nordrhein-Westfalen Postfach 20 04 44
40102 Düsseldorf

Credit reports

Insofar as it is necessary to protect our legitimate interests, we request information from credit agencies to assess your general payment behavior. For this purpose, we transmit your data (name, address and, if necessary, date of birth) to the credit agency. For more information on credit agencies, go to datenschutz.barmenia.de.

Information system of the insurance industry

If necessary, Barmenia Allgemeine Versicherungs-AG uses the information system (HIS) of informa HIS GmbH in vehicle insurance claims settlement to support risk assessment in the event of a claim, to clarify the facts in the examination of benefits and to combat insurance fraud. This requires an exchange of certain personal data with HIS. For more information on HIS, go to datenschutz.barmenia.de.

Data exchange with your former insurer and other agencies

In order to be able to check the information you provided when concluding the insurance contract (e.g., to carry over a no-claims bonus in motor vehicle liability insurance) or your information when an insured event occurs, personal data may be exchanged to the extent necessary for this purpose, e.g., with the former insurer named by you in the application or the treating physicians notified, as well as with hospitals, nursing homes, etc. If we transfer special categories of personal data (e.g., health data) in our inquiries, e.g., to the previous insurer, and if we collect such special data, we will obtain your consent in advance in each individual case.

Automated individual case decisions

In the context of health insurance benefit settlement, we make fully automated decisions about our obligation to pay benefits based on the information you provide about the insured event and the data stored about your contract. The fully automated decisions are based on rules defined in advance by the company. In doing so, we take into account, for example, the respective classification of the medications or medical treatments to be billed.

List of service providers

Service providers commissioned by DR-WALTER GmbH

In accordance with „Verhaltensregeln für den Umgang mit personenbezogenen Daten durch die deutsche Versicherungswirtschaft“ (Code of Conduct Data Protection)

German insurers have issued a Code of Conduct for the protection of your personal data and your privacy. We, DR-WALTER, comply with this Code of Conduct and would like to provide you with a list of service providers (companies and private individuals) with whom we work together during order processing when it comes to data processing and assignment of functions. The list also includes service providers with whom we cooperate in the use of health data and other data protected under § 203 German Criminal Code (StGB). We also work together with service providers who collect, process and use health data and other data protected under § 203 StGB.

INSURERS AND REINSURERS

Assigned functions:	**Involved bodies / organizations:**
Collection, processing or use of personal data to establish, carry out or end an insurance contract (e. g. application processing, risk assessment, policy management, determination of the liability to pay)	insurers mentioned in the insurance certificate • Generali Deutschland Krankenversicherung AG, • Dialog Versicherung AG, • Würzburger Versicherungs-AG, • HanseMerkur Reiseversicherung AG, • ERGO Reiseversicherung AG, • ERGO Versicherung AG, • Allianz Partners – AWP Health & Life SA, • Inter Krankenversicherung AG, • Hiscox SA, • Barmenia Krankenversicherung AG, • Barmenia Allgemeine Versicherungs-AG, • Techniker Krankenkasse, • BDAE Holding GmbH, • Foyer Santé S.A., • Globality S.A., • BD24 Berlin Direkt Versicherung AG, • Hallesche Krankenversicherung a. G.

ASSISTANCE COMPANIES

Assigned functions:	**Involved bodies / organizations:**
Assistance services	• MD Medicus Assistance Service GmbH, • GMMI, Inc., • Europ Assistance SA, Niederlassung für Deutschland, • International SOS B.V., • International SOS GmbH, • Global Excel Management Inc.

DOCTORS, DENTISTS, PSYCHOLOGISTS, PSYCHIATRISTS, EXPERTS, OTHER HEALTHCARE PROFESSIONALS, INSTITUTIONS FOR MEDICAL EXAMINATIONS, HOSPITALS

Assigned functions:	**Involved bodies / organizations:**
Information on treatment and diseases, expert opinions on medical issues	Individual assignments

BANKS

Assigned functions:	**Involved bodies / organizations:**
Premium payments, payments in the event of a claim	• Postbank Köln – eine Niederlassung der DB Privat- und Firmenkundenbank AG, • Kreissparkasse Köln, Mündelsichere Anstalt des öffentlichen Rechts

LAWYERS

Assigned functions:	**Involved bodies / organizations:**
Legal advice, collections management, legal representation at court.	Individual assignments

MARKET AND OPINION RESEARCHERS

Assigned functions:	**Involved bodies / organizations:**
Customer satisfaction surveys, market and opinion research	• TÜV NORD CERT GmbH, • eKomi Holding GmbH

CONSULTING COMPANIES

Assigned functions:
Support and advice e.g. in claims and billing matters (Germany and abroad), fraud detection, health programs; IT services

Involved bodies / organizations:
Individual assignments

IT AND TELECOMMUNICATION COMPANIES

Assigned functions:
Service providers for IT, network and telephone services

Involved bodies / organizations:
- AssFINET AG,
- ikt Gromnitza GmbH & Co. KG,
- Trevedi IT-Consulting GmbH,
- IBExpert GmbH,
- NETGO GmbH,
- DATEV eG,
- i42 Informationsmanagement GmbH
- ebuero AG
- Air Doctor Ltd.

ONLINE SUPPORT

Assigned functions:
Service providers for web hosting, internet portals, online policy procurement, email marketing and live chat

Involved bodies / organizations:
- Host Europe GmbH,
- 1&1 Internet AG,
- JMC Technologieberatung GmbH,
- united-domains AG,
- STRATO AG,
- ALL-INKL.COM,
- COREER GmbH,
- Einmahl WebSolution GmbH,
- emarsys eMarketing Systems GmbH,
- bplusd Agenturgruppe GmbH,
- Adspert Bidmanagement GmbH,
- Sistrix GmbH,
- KCS Internetlösungen Kröger GmbH,
- Userlike UG,
- aveta | David Cürten,
- consentmanager GmbH,
- SIX Payment Services (Europe) S.A.,
- OMQ GmbH,
- Macaw Germany Cologne GmbH

CREDIT BUREAUS, ADDRESS BROKERS

Assigned functions:
Collection of information during the application stage, claims management

Involved bodies / organizations:
Individual assignments

DISPOSAL COMPANIES

Assigned functions:
Disposal of files and data media, document destruction

Involved bodies / organizations:
Individual assignments

If required we will send you all contact details of our service providers.