Consumer Information Grant-Health-Insurance

General Customer Information

With the following information, we, DR-WALTER GmbH, would like to provide you, the customer, with comprehensive information about the insurance company involved and the underlying insurance policies. These insurances are offered by DR-WALTER GmbH and its sales partners.

Grant-Health-Insurance consists of a substitutive group health insurance for temporary (tariff BD) or unlimited (tariff DOGP) stays in Germany, as well as optional compulsory nursing care insurance and daily sickness allowance insurance.

These insurance policies were developed and concluded by DEGIS gGmbH, with the participation of DR-WALTER GmbH, for its members. The risk carrier is Hallesche Krankenversicherung a. G.

1. Type of insurance contracts

The BD and DOGP tariffs are substitutive group health insurance in accordance with § 146 of the Insurance Supervision Act (VAG).

The EKT tariff is a group daily allowance insurance for foreigners that provides a wage replacement benefit in the event of incapacity for work.

The long-term care insurance is a private compulsory long-term care insurance in accordance with Section 110 of the German Social Code XI (SGB XI).

2. Identity of the companies involved

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

Insurance cover, as well as contract and benefit processing, is provided by:

Hallesche Krankenversicherung a. G.

Reinsburgstr. 10

70178 Stuttgart, Germany

Headquarters: Stuttgart

District Court Stuttgart HRB 2686

The contract brokerage 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 Hallesche Krankenversicherung a. G. is the Management Board: Christoph Bohn (Chariman), Dr. Jürgen Bierbaum (vice Chairman), Frank Kettnaker, Wiltrud Pekarek, Martin Rohm, Udo Wilcsek

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

4. Main business activity of the insurers

Hallesche Krankenversicherung a. G. 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 and Special Conditions of Insurance (AVB) describe type and scope of the insurance benefits and contain all other regulations.

The entire content is derived from the following documents:

- General Insurance Conditions of the Group Insurance for Temporary Stays in Germany (U), of Hallesche Krankenversicherung a. G.,
- Tariff conditions BD/Group, of Hallesche Krankenversicherung a. G.,
- Tariff conditions DOGP/Group, of Hallesche Krankenversicherung a. G.,
- General Insurance conditions of Daily Sickness Benefits Group Insurance (U), of Hallesche Krankenversicherung a. G.,
- Tariff conditions EKT/Group, of Hallesche Krankenversicherung a. G.,
- General Insurance Conditions for Private Nursing Care Insurance MB/PPV 2022, of Hallesche Krankenversicherung a. G.,
- Tariff conditions PV with tariff levels PVN and PVB, of Hallesche Krankenversicherung a. G.,
- For further information, please refer to the general and additional customer information and the respective fact sheet,
- 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 premiums are monthly premiums. These are due in advance at the beginning of each insured calendar month. The total premium consists of the individual premiums of the selected insurance policies. Based on your selection, the total premium will be shown on our website, as well as in the consultation protocol and your insurance certificate.

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 the insurance conditions as well as late payment fines, may be incurred. There are no other taxes, fees or charges.

9. Details of payment of premiums

The premium is a monthly premium and is due in advance at the beginning of each insured calendar month.

10. Validity of the information provided

The information provided is generally not limited in time.

11. Conclusion of the contract

After submitting your necessary data, we can accept your application within six weeks. This period begins on the day

of the declaration of accession. If the insured person receives the confirmation of insurance within the acceptance period, the insurance contract is concluded without any further declaration of intent. The earliest possible start of insurance is the date of entry into Germany by the person to be insured.

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.

12. 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.

13. Contract period

Health insurance under the DOGP domestic tariff is not limited in time.

Health insurance according to tariff BD ends on the end date specified by the insured person, but after five years at the latest.

The terms of the daily sickness allowance and long-term care insurance are adjusted to the term of the health insurance.

The minimum contract period is two years.

14. Information on the termination of the contract

The insured person may terminate the insurance relationship, after expiry of the minimum contract period, at the end of each insurance year with three months notice.

The contract can also be terminated before the end of the minimum contract period and with one month's prior notice by cancelling the DEGIS membership.

If the insurance relationship serves the fulfilment of the obligation to insure, the termination requires that a new contract is concluded for the insured person with another insurer which meets the requirements for the obligation to insure.

Further reasons for termination result from § 14 of the General Insurance Conditions of the group insurance for temporary stays in Germany (U).

Upon termination of the health insurance, the daily sickness allowance and long-term care insurance shall also be terminated.

15. 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 abode,
- Stuttgart as the registered office of Hallesche Krankenversicherung a. G. for legal actions against Hallesche Krankenversicherung a. G,
- for any legal actions against you, the court of the place where you have your residence or habitual abode shall have jurisdiction,
- if you move abroad outside the European Union / the European Economic Area, the place of jurisdiction for actions against Hallesche Krankenversicherung a. G. shall be Stuttgart, the same shall apply if your place of residence or habitual abode is unknown.

16. Languages

Our correspondence with you will be both in English and German.

17. 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:

Hallesche Krankenversicherung a. G., 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.

Subsection 2

Additional information requirements for this health insurance policy

For this health insurance policy, the insurer must provide you with the following information in addition to the above:

1. information in euros on the amount of the costs included in the premium; the included acquisition costs must be shown as a uniform total amount and the other included costs as a proportion of the annual premium, stating the respective policy period; in the case of the other included costs, the included administrative costs must also be shown separately as a proportion of the annual premium, stating the respective policy period;

2. information in euros on possible other costs, in particular costs that may arise on a one-off basis or for a special reason;

3. information about the effects of rising health care costs on future premium development;

4. information on the options for limiting premiums later in life, in particular the options for switching to the basic

tariff or to other tariffs in accordance with section 204 of the German Insurance Contract Act (VVG) and agreeing on benefit exclusions, as well as the option of reducing premiums in accordance with section 152 (3) and (4) of the Insurance Supervision Act (VAG);

5. a note that a change from private to statutory health insurance at an advanced age is usually ruled out;

6. a note that a change within private health insurance at an advanced age may be associated with higher premiums and may be limited to a change to the basic tariff;

7. an overview in euros of the development of premiums over the period of the ten years preceding the offer; please state what monthly premium would have been payable in each of the ten years preceding the offer if the insurance contract had been concluded at that time by a person of the same sex as you with an entry age of 35; if the tariff offered has not yet existed for ten years, the time of introduction of the tariff shall be taken into account and it shall be pointed out that the informative value of the overview is limited due to the short time that has passed since the introduction of the tariff; in addition, the development of a comparable tariff that has already existed for ten years shall be presented.

End of information on the right of revocation

Health Insurance Fact Sheet of the Federal Financial Supervisory Authority

In the press and in public, terms are used in connection with private and compulsory health insurance that require explanation. This fact sheet aims to briefly explain the principles of compulsory and private health insurance.

1. Principles of compulsory health insurance

The German compulsory health insurance system is based on the principle of solidarity. This means that the amount of the premium does not depend primarily on the scope of benefits, which is essentially defined by law, but on the individual fitness of the insured member determined according to certain flat-rate rules. Premiums are regularly assessed as a percentage of income. Furthermore, the insurance premium is charged on a pay-as-you-go basis. This means that all expenses in the calendar year are covered by the premiums received in that year. Apart from a statutory reserve, no other accruals are created. Under certain conditions, spouses and children are also insured free of charge.

2. Principles of private health insurance

In private health insurance, a separate premium needs to be paid for each insured person. The amount of the premium depends on the age and the state of health of the insured person at the time of conclusion of the contract and on the tariff concluded. Risk-adjusted premiums are charged, which are calculated in accordance with actuarial principles.

The higher utilization of health care services with increasing age is taken into account by old age provisions. The calculation assumes that health care costs do not increase and that premiums do not rise solely because the insured person is getting older. This calculation method is referred to as Anwartschaftsdeckungsverfahren (funding procedure for future pension payments) or Kapitaldeckungsverfahren (funding principle). A change of the private health insurance company is usually possible at the end of the insurance year. It should be noted that for the health insurers – with the exception of insurance in the basic tariff – there is no obligation to accept the insured person; in addition, the new insurer will demand another medical examination and the premiums are charged with regard to the age the insured person will then have reached. Part of the calculated old-age provision can be transferred to the new insurer (If you already had private health insurance before 01.01.2009, special regulations apply to you. Please obtain separate information on these regulations, if applicable). The remaining part may be taken into account when calculating the premium of a supplementary insurance policy if such a policy is taken out; otherwise it will remain with the previous group of insured persons. A return to compulsory health insurance is generally ruled out, especially in old age.

Additional customer information on health insurance

Note: This customer information relates to the comprehensive health insurance policies BD/Group and DOGP/Group.

1. Effects of rising health care costs on future premium development

The development of health care costs depends on an extraordinarily large number of factors – making a forecast very difficult. Based on the experience of the past decades, medicine will continue to advance and patients' demands for medical care will continue to increase.

In diagnostics, for example, computed tomography (CT) and magnetic resonance imaging (MRI) are being used more and more frequently so that targeted therapy can be initiated quickly. The use of expensive high-tech medicine and its further development is just one example of medical progress and the many possibilities that now exist for treating illnesses and thus improving the patients' quality of life. This, too, means that health care costs will continue to rise – for those with private insurance as well as for those with compulsory insurance, for both the younger and the older generation. The illustration on the back of this customer information gives you an impression of the influence of rising medical costs on the development of health insurance premiums.

2. Options to slow the increase of premiums later in life

The BD/Group and DOGP/Group tariffs can be taken out by persons who enter Germany from abroad and become subject to compulsory insurance in the German statutory health insurance or full health insurance.

The insurance period in the BD/Group tariff is limited to a maximum of five years in accordance with § 195(3). Premium-limiting measures for age are not included in this tariff for this reason. For persons taking out the BD/Group tariff, the planned period of stay in Germany should not exceed five years.

The insurance period in the DOGP/Group tariff is unlimited.

If the DOGP/Group tariff has been taken out, or if the option is taken up, e.g. due to a deferral of the residence title, to change to another, unlimited tariff of the comprehensive health insurance, the following applies:

In addition to the surcharge in compulsory health insurance, which is accumulated and used from the age of 65 to slow any increases of premiums that then become necessary, provision can be made, for example, by agreeing to a reduction in premiums in the future. From the age of 65, the health insurance premium is reduced by the agreed reduction amount. Furthermore, there are also other ways to make provisions, e.g., with a Finanzierungsrente (particular type of pension).

In accordance with section 204 of the German Insurance Contract Act (VVG), it is possible to switch to other tariffs of the insurer with similar insurance coverage.

Older insured persons who live in Germany also have the option of agreeing to the industry-wide standard tariff or basic tariff. In both cases, access is subject to certain legal requirements, with the premium being limited to the maximum premium within compulsory health insurance. If payment of the premium for the basic tariff results in financial need for assistance within the meaning of the German Social Code (SGB), in particular Book 2 SGB or Book 12 SGB, the respective maximum premium is reduced to half for the duration of the need for assistance. The same applies if there is a need for assistance regardless of the amount of the premium. In these cases, the Federal Employment Agency or cities and municipalities, as the respective responsible institution, may grant a subsidy upon application under the conditions specified in section 152 (4) of the Insurance Supervision Act (VAG).

3. Possibility of changing to compulsory health insurance at an advanced age

A change to compulsory health insurance is usually not possible at an advanced age. It is possible, however, in case the affected person becomes subject to compulsory insurance or entitled to family insurance. However, changing to compulsory health insurance is not possible for persons who have reached the age of 55 and have not been insured in the compulsory health insurance system in the last five years (except for recipients of unemployment benefits (Arbeitslosengeld II) and persons entitled to family insurance).

4. Possibility of changing within private health insurance at an advanced age

A change within private health insurance at an advanced age may result in higher premiums and may be limited to the standard or basic tariff of private health insurance.

5. Development of premiums over the preceding ten years

First-class benefits and affordable premiums are what make Hallesche health insurance cover so high quality. With medical progress and corresponding innovations, private health insurance cover is constantly expanding – and thus

gaining in value. With great commitment, we ensure a favourable premium development compared to the market. The independent rating agency Assekurata has rated Hallesche's premium stability as „very good" for years.

The overview shows an example of the premium development in euros for an insured person who opted for Hallesche at the age of 35 and has been insured with us for 10 years or since the introduction of the tariff.

Please note: No conclusions can be drawn from this illustration regarding future premium development.

Max Mustermann										
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
BD.2	322,89€	322,89€	322,89€	322,89€	265,23€	265,23€	265,23€	265,23€	265,23€	265,23€

Max Mustermann										
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
DOGP.2	293,78€	293,78€	293,78€	276,16€	308,03€	350,04€	350,04€	350,04€	350,04€	350,04€

Additional information on the conditions and premiums of health insurance

The following information provides you with an overview of the underlying insurance conditions for the desired tariffs. The complete contents of the contract are set out in the insurance policy, the customer information and the insurance conditions. Please read the entire terms of the contract carefully.

1. Type of insurance contract offered

Comprehensive health insurance policy

2. Description of the insurance coverage and any excluded risks

Scope of the agreed insurance coverage in the tariffs BD/Group and DOGP/Group:

Group medical expenses insurance for outpatient medical treatment, dental treatment and dentures, inpatient medical treatment and childbirth without deductible.

The insurance cover is based on the following insurance conditions:

- General insurance conditions of group insurance for temporary stays in Germany (U), of Hallesche Krankenversicherung a. G.,
- Tariff conditions BD/Group, of Hallesche Krankenversicherung a. G.,
- Tariff conditions DOGP/Group, of Hallesche Krankenversicherung a. G.

For details of the insurance coverage, please refer to sections 4 et seqq. “Scope of the liability to pay benefits” of the general insurance conditions and the tariff conditions.

3. Amount of premiums to be paid, their due date, as well as the period for which the premiums are to be paid and the consequences of non-payment or late payment

The total monthly premium results from the selected tariff as well as from the individual access requirements of the insured person. The following table illustrates the possible monthly premiums:

Tariff BD.2		**Tariff DOGP.2**	
Eintrittsalter	Monatsbeitrag	Eintrittsalter	Monatsbeitrag
0-16	201,94	0-16	252,43
17-20	256,92	17-20	321,35
21	156,41	21	„
22	162,43	22	„
23	170,45	23	313,29
24	180,48	24	„
25	190,50	25	„
26	200,53	26	„
27	210,55	27	„
28	220,58	28	353,09
29	230,61	29	„
30	239,03	30	„
31	245,85	31	„
32	251,46	32	„
33	255,47	33	385,48
34	257,88	34	„
35	260,28	35	„

36	262,69	36	„
37	265,10	37	„
38	267,50	38	414,92
39	269,91	39	„
40	272,31	40	„
41	275,12	41	„
42	278,33	42	„
43	282,74	43	458,41
44	288,76	44	„
45	296,78	45	„
46	306,40	46	„
47	317,63	47	„
48	330,47	48	521,29
49	344,90	49	„
50	360,55	50	„
51	377,39	51	„
52	395,44	52	„
53	413,88	53	594,68
54	432,33	54	„
55	450,78	55	„
56	469,23	56	„
57	487,68	57	„
58	506,12	58	665,47
59	524,57	59	„
60	543,02	60	„
61	561,47	61	„
62	579,92	62	„
63	598,36	63	730,86
64	616,81	64	„

Tariff BD.2

The contributions are stated in € and apply for each full calendar month of the stay abroad. The entry age is the difference between the year of birth and the calendar year in which the insurance relationship begins. Children pay the contribution for age 0-16 until the end of the year in which they turn 16, after which the contribution for age 17 is payable.

Status May 2020

Tariff DOGP.2

The contributions are stated in € and apply for each full calendar month of the stay abroad. The entry age is the difference between the year of birth and the calendar year in which the insurance relationship begins. Children pay the contribution for the age group 0-16 until the end of the year in which they turn 16. From the beginning of the

next year until the end of the year in which they turn 20, the contribution for the age group 17-20 is payable. Thereafter, the contribution for age 21 is payable.

Status May 2019

Unless another payment method is agreed, the insurance premium is due monthly – on the first of the month. If a direct debit authorization has been given, the premium will be debited from the specified account on the due date in each case. In case the parties agreed to a different payment method (e.g., bank transfer, standing order), the payment must take place in due time before the due date. Failure to pay or late payment of premiums jeopardizes the agreed insurance coverage and, under certain circumstances, the continuation of the contract. For details, please refer to section 8 “Payment of premiums” of the respective general insurance conditions.

There are costs involved in arranging and taking out health insurance. Acquisition costs include all costs directly attributable to the establishment of a contract, i.e., advertising, consulting and brokerage expenses, risk assessment, issuance of the contract, etc. There are also other costs associated with managing the contract. This includes, for example, the costs of implementing changes to contracts or maintaining your personal data (e.g., change of address or change of bank details), as well as for the management and maintenance of contracts, debt collection and compliance with statutory regulations as part of proper accounting practice. Therefore, acquisition and distribution costs and other costs must be covered for the insurance coverage, whereby the following information only refers to the substitutive comprehensive health insurance. Any risk surcharges are not taken into account. The same applies to any group discount or a discount for Sammelinkasso insurance (particular form of group insurance) that would reduce the reported costs.

In the BD.2 tariff, costs amounting to 25.1% of the monthly premium are incurred. In the DOGP.2 tariff, costs amounting to € 72.28 of the monthly premium are incurred for persons from the entry age of 21.The costs are already included in the total monthly premium. The costs are always to be paid during the entire term of the contract. In the event of a premium adjustment, the percentage of costs to be paid usually remains the same. Should the payment of premiums not be made as agreed, further expenses will be incurred in addition to those already included in the premiums, which may be invoiced. This relates to costs incurred by the return of direct debits, a reminder fee for expenses incurred in processing reminders and, where applicable, default interest or surcharges for late payment.

Tax deductibility

The premiums for long-term care insurance and large parts of the premium for comprehensive health insurance are tax deductible. Depending on the individual tax situation, this may result in savings on premiums.

The following percentages of the paid annual premium are tax deductible:

1. In tariffs BD.2 and DOGP.2 (comprehensive health insurance policy)

    - 82,60 % of the paid annual premium.

2. In tariff In the long-term care insurance (private compulsory long-term care insurance)

    - 100 % of the paid annual premium.

General Conditions of the Group Insurance for temporary stays in Germany (U)

Germany (U) As per January 2022

§ 1 Object insured, Extent and Scope of Insurance Coverage

(1) The insurer grants insurance coverage for diseases, accidents and further occurrences mentioned in the contract. The insurer performs, if agreed upon, additional services in direct connection with the events insured against occurring. In case of the event insured against (§ 1 para. 2) the insurer reimburses costs for medical treatment andother services agreed upon.

(2) The event insured against occurs if a medical treatment of the person insured is necessary due to an illness or accident sequelae. The event insured against starts with the medical treatment and ends when the necessity for medical treatment according to the medical results is no longer given. If the medical treatment has to be extended due to a disease or accident sequelae originally not connected with the former treatment, this will be considered a new event insured against. The following will be considered anevent insured against as well:

a) examination and medically necessary treatment due to pregnancy and delivery,

b) examinations for the purpose of early recognition of diseases (medical check-ups), if the person insured has taken out hospital coverage only, these examinations are onlycovered, if they have to be carried through in a hospital due to medical reasons,

c) miscarriages and not illegal abortions,

d) death,

e) specialised outpatient palliative care and stationary care at a hospice, provided the tariff provides conditions for it.

(3) The extent of the insurance coverage ensues from the insurance policy, further written agreements, the General Conditions of Insurance, the tariff, the group insurance contract as well as the legal regulations of the Federal Republic of Germany.

(4) The insurance coverage extents to medical treatment in Europe aswell as outside Europe.

(5) The policy holder may demand the modification of the coverage in a similar coverage, if the person insured fulfils the conditions of the eligibility and if the group insurance contract provides for this coverage. The insurer accepts the application of modification within a reasonable time. The rights acquired remain the same; a possible old age reserve as per the technical bases of calculation for the higher risk in old age will be credited as per the calculation bases. If the new insurance coverage is higher or more extensive, a risk surcharge (§ 8 para 3 and 5) may be requested or an exclusion of coverage may be agreed upon for this higher part of coverage. This right of modification does not exist for qualifying period insurances and for suspension insurances, if the reason for the qualifying period or suspension is still given, this right does also not exist for limited insurance contracts. The change of the insurance coverage out of a tariff in which the premiums have been calculated without considering the sex into a tariff in which this is not the case is not possible. A modification of the insurance coverage into the tariff in case of predicament as per § 153 of the German Trustee Investment Act (VAG – see appendix) is also not possible.

§ 2 Commencement of Insurance Coverage

(1) The insurance coverage will commence on the day mentioned on the application (commencement of insurance coverage). This time may not be before the day of first receipt with the insurer. If the insurer receives the application only in the month after next (or later) following the first receipt of the application form, the soonest possible commencement of insurance coverage will be the date of receipt of the application different from sentence 1 and 2.

Events insured against occurring before the inception date are only covered from the inception date on if the insurer has duely been informed and if these have not been excluded from the insurance coverage by special agreements. After the issue of the confirmation of insurance events insured against occurring are only excluded from the coverage if they occur before the inception date. A written declaration is equal to an insurance policy.

(2) New-born babies are under insurance coverage without any risk surcharges and without waiting periods from the completion of birth on, if on the day of birth one parent is insured with the insurer and if the application to the insurance is made within two months after the date of birth backdated to the day of birth. The monthly premium rates are only to be paid from the month on which follows the monthof birth. From birth onwards, insurance coverage also exists in this context for all health issues, birth defects, as well as hereditary diseases and anomalies arising before completion of the birth. The extent of the insurance coverage must not be higher than that of one parent insured.

(3) The changement of the insurance coverage within the period of the insurance contract does not alter the insurance year as agreed on the conclusion of the contract.

§ 3 Confirmation of Eligibility, Insurance Policy

(1) The main persons insured have to declare their eligibility as well as that of the persons to be co-insured on the form issued by the insurer; the questions are to be answered completely for all persons to be insured.

(2) The insurer issues an insurance policy for each main person insured.

(3) Main persons insured are the persons eligible according to § 1 para. 1 of the group insurance contract. The main person's spouse, homosexual partners as per § 1 of the German Lebenspartnerschaftsgesetz (Law of Homosexual Partnerships -see appendix) and children are co-insured persons, if insurance coverage hasbeen applied for them.

§ 4 Scope of Obligation to Pay Benefits

(1) The type and amount of insurance benefits ensue from the General Conditions of Insurance and the tariff.

(2) The person insured may consult a physician or dentist of his own choice, who however has to be registered and may choose hospital ambulances and medical care centres for outpatient treatment as well as service providers listed in the tariff. He or she may also consult non-medical practitioners as per the German Non-Medical Practitioner Act (Deutsches Heilpraktikergesetz).

(3) If the tariff provides benefits for remedies, these must be provided by physicians, non-medical practitioners or members of medical staff or healthcare professionals (such as massage therapists, physical therapists, physiotherapists, occupational therapists, speech therapists, podiatrists, dietry assistants, oecotrophologists, nutrition scientists), provided they are licensed for the medical treatment according to the respective country of stay.

(3a) If a tariff provides benefits for digital health applications, such an application must be a low-risk medical device (I or IIa) whose main function is essentially based on digital technologies and must be intended to support the detection, monitoring, treatment or alleviation of illnesses or the detection, treatment, alleviation or compensation of injuries or disabilities in the persons insured or in the care provided by the service providers namedin Article 4 (3) of the tariff conditions.

(4) Medicaments, dressings, remedies and aids must be prescribed by a person approved in (2) Certain medicine-like nutriments that are imperative in order to avoid serious health damage (e. g. in case of enzyme deficiency diseases, Crohn's disease and cystic fibrosis), are also considered as medicine and which are administered enterallyor parenterally in particular.

(5) If a hospital treatment is medically necessary, the person insured may choose among public and private hospitals which are under permanent direction of a physician, have sufficient diagnostic and therapeutical facilities and maintain medical records. This also includes hospitals of the Federal Armed Forces.

(6) The benefits of the tariff for a medically necessary hospital treatment in clinics which also carry through cures and sanatorium treatments, but which meet the conditions stated in (4) are only granted if the insurer has given his consent in writing before the commencement of thetreatment. In case of TB-diseases hospital treatment in a TB-sanatorium or clinics are covered up to the extent agreed upon in the contract. Sanatoria are institutions which are under the responsible direction and control of a permanently present doctor and in which cure treatments are carried through on an in-patient basis. The condition for a reimbursement of the costs for a stay in a sanatorium is, if the tariff provides benefits for that, the confirmation of the medical necessity by a doctor and that the insurer accepts it.

A written consent of the insureris not required,

a) in the event of an emergency admission resp. if the hospital is the only providing hospital in the vicinity of the insured and only medically necessary medical treatments are to be performed which require a hospitalisationand therapy, or

b) if an accident or an acute disease occurs during a stay in a hospital, if this occurrence is independent from the original purpose of treatment, and if this occurrence requires a medically necessary hospital treatment, or

c) if it is about a medically necessary hospital treatment for a surgical intervention, or

d) for the first 3 weeks of a medically necessary post-hospital curative treatment (Anschlussheilbehandlung) which begins within 28 days after an acute hospital treatment and must occur in a facility which is approved by a legal rehabilitation authority for the respective post-hospital curative treatment. A further requirement is that a written claim for benefits is made and granted (before the start of the post-hospital curative treatment) at a legal rehabilitation authority, provided this is fundamentally obligated to provide benefits. Insofar as benefits are authorised in this context, these are to be madeuse of first.

(7) According to the contract the insurer reimburses costs for medicaments, for treatments and for examinations mainly carried out according to orthodox medicine. Furthermore the insurer reimburses the costs for methods applied and medicaments which have been tried and tested with good results or which have been used due to the fact that no orthodox methods or medicaments are available. However, the insurer may reduce his reimbursement to the amount of orthodox methods or medicaments.

(8) Before a medical treatment starts which possibly surpases the amount of € 2,000, the person insured may ask in writing for more information about the extent of the insurance coverage for the envisaged medical treatment. The insurer will give the information within four weeks at the latest; if the carrying through of the medical treatment is urgent, the information is given immediately, at the latest within two weeks. The insurer considers the tentative treatment plan and the possible costs together with other documents. The delay starts with the receiving of the demand with the insurer. If the information is not given within the stated time, it is assumed that the envisaged medical treatment is necessary until the proof of the opposite.

(9) The insurer informs the main person insured or the person insured on demand about medical reports or opinions or gives access to these documents which the insurer has asked for for the verification of the obligation to pay, if the medical treatment is necessary or not. If severe therapeutic reasons or other severe reasons are against that, the information or the access to the main person insured or the person insured may only be asked for that a named doctor or solicitor may be given the information or access. The claim may only be laid by the person concerned or his or her statutory representative. If the main person has received the report or the opinion on demand of the insurer, the insurer will reimburse the costs occurred.

§ 5 Limitations of Obligation to Pay

(1) The insureris not obliged to pay for

a) disease, their consequences included, accident sequelae and death which result from active participation in war or riots or which are recognized as an accident during the military service and which are not expressively included in the insurance coverage;

b) intentionally caused diseases and accidents, their consequences included, as well as for withdrawal, detoxification treatments included.

If the person insured has no further claims of reimbursement or benefits in kind, the insurer may grant – differing in the tariffs – payment according to tariffs with benefits for general hospital treatment for the first three hospital addiction treatments (outpa-tient or inpatient withdrawal treatments resp. detoxification treatments) for substance addictions if

- the inpatient rehabilitation occurs in a facility approved by a legal rehabilitation authority for the respective rehabilitation measures,
- the outpatient rehabilitation occurs through professional services and facilities and the insurer has given his consent to pay in writingbefore the treatment commences.

There is no obligation to provide benefits for rehabilitation due to nicotine addition.

This consent may be made dependent on the assessment of success by a doctor chosen by the insurer. For inpatient rehabilitation measures, the insurer is only chargeable for general hospital services independently of the inpatient tariff.

For the first addiction treatment, 100% of the negotiated benefit is refundable. For the second and third addiction treatment, 80% of the negotiated benefit is refundable. The remaining 20% is refundable after completion of the rehabilitation, provided the completion was neither ended due to disciplinarian reasons nor ended prematurely without a doctor‘s approval.

c) treatment by doctors, dentists, non-medical practitioners and in hospitals or clinics whose invoices have been excluded from reimbursement by the insurer with good reason, if the event insured against occurs after the notification of the policy holder about the exclusion of benefits. If there is the occurrence of an event insured against while the policy holder is informed about the exclusion, the insurer is not obliged to pay for costs occurred after the period of three months after the notification; this correspondingly applies for all other service providers named in these conditions and in the tariff.

d) spa and sanatorium treatment as well as for rehabilitation measures provided by the public rehabilitationcentres;

e) the accommodation due to the necessity of nursing care or keeping in such a resort.

f) treatments by spouses, homosexual partners as per § 1 of the German Lebenspartnerschaftsgesetz (Law of Homosexual Partnerships) (see appendix), parents or children; costs occurred for objects needed for the treatment are reimbursed according to the chosen tariff, if proof thereof is given;

(2) If the medical treatment or any other medical measure for which benefits have been agreed upon exceed the medically necessary extent, the insurer may reduce the benefits to a reasonable amount. If the expenses for medical treatment or other services are in a conspicuous disproportion to the services rendered, the insurer is not obliged to pay.

(3) If the person insured is entitled to benefits paid by the legal casualty insurance or the legal old-age pension scheme or to legal medical care or accident welfare work, the insurer is only obliged to pay benefits for those expenses which will remain necessary after pre-payment by the German National Health System – regardless of the person insured's claim for daily hospital indemnity.

(4) If the policy holder or the person insured may lay claims with several institutions obliged to pay, the total of reimbursements may not exceed the total of expenses.

§ 6 Payment of Insurance Benefits

(1) The insurer will only be obliged to pay benefits, if the requested and necessary proof is given. These documents will become property of the insurer.

(2) The insurer is obliged to pay benefits to the person insured, if the policy holder has named this person in writing or electronically as being legitimated for these benefits. If this condition is not met, only the policy holder may claim thbenefits.

(3) The medical expenses occurred in foreign currency will be converted into Euro on the basis of the exchange rate of the day of receipt of the invoices with the insurer. The exchange rate is for traded currenciesthe official Euro exchange rate of the European Central Bank. For non-traded currencies, for which there are no reference rates, the latest exchange rate of the "Devisenkursstatistik" published by the Deutsche Bundesbank, Frankfurt am Main, is valid, unless the person insured proves that the exchange rate of the currency with which he or she has paid the invoice was more unfavourable due to a modification of the exchange modalities.

(4) Expenses for the remittance or for translations may be deducted from thebenefits.

(5) Claims for insurance benefits may neither be assigned nor pledged. The prohibition of assignment pursuant to sentence 1 shall not apply to insurance contracts concluded on or after October 1, 2021; statutory prohibitions of assignment shall remain unaffected.

(6) The original invoices are to be submitted to the insurer. The names of the persons treated, the designation of the disease, the dates of treatment and the details of the services rendered as well as the corresponding numbers of the scale of charges are to be stated on the invoice. For hospital invoices please state the optional services separately chargeable as well as the chosen accommodation separately chargeable. If the person insured has taken out another insurance, the insurer will accept duplicates of the invoices, on which the benefits paid by the other insurance company are confirmed.

(7) In addition to the original invoice the insurer requires the following documents for reimbursement:

a) in case of repatriation to Germany: a medical confirmation of the necessity ofthe repatriation;

b) in case of repatriation to Japan or burial in the Federal Republic of Germany: a medical certificate about the cause of death.

(8) If the person insured has taken out several insurance contracts, the insurer acknowledges invoice copies on which the other insurancecompany has marked its benefits.

(9) Reimbursement of expenses occurred for medicaments, dressings and remedies can only be effected if the invoices thereof are submitted togetherwith those of the treating person.

§ 7 Payment of Contributions

(1) The contribution is a monthly contribution. It is to be paid in advance and is due on the first of each month.

(2) If the person insured is applied for the health insurance coverage which is compulsory in Germany (§ 193 para. 3 of the German Insurance Contract Law (VVG – Versicherungsvertragsgesetz -see appendix) after one month of the obligation to have such insurance has occurred, a surcharge to the contribution of one monthly premium has to be paid for each month not insured after the time of obligation. One sixth has to be paid for each month not insured above the period of 6 months of non-insurance. If the period of non-insurance may not be calculated, it can be assumed that the person insured has not been insured for five years at least; times before 1 January 2009 are not considered. The surcharge has to be paid once in addition to the current premium. The policy holder may demand a deferment of the payment, if the interests of the insurer may be taken intoaccount by the agreement of a reasonable part-payment. Interests of the amount paidin parts are paid.

(3) The first contribution is to be paid immediately after 2 weeks after the issue of the insurance policy.

(4) If the policy holder is in arrears of two months of premium payment when fulfilling his or her obligation of health insurance coverage in Germany (§ 193 para. 3 VVG – German Insurance Contract Law – see appendix), the insurer reminds him or her. The policy holder has to pay an interest on arrears of 1 % of the premium arrears for each month of the premium arrears. If the arrears of premiums, including the interests on arrears, are higher than one monthly premium two months after the reception of the reminder, the insurer reminds for the second time mentioning the possible suspension of the insurance coverage. If the premium arrears together with the interests on arrears are higher than one monthly premium one month after receiving the second reminder, the insurance contract is suspended from the first day of the following month on. During the suspension of the insurance contract the person insured is regarded as being covered according to the tariff in case of predicament as per § 153 VAG (see appendix). So far, the General Conditions of Insurance of the Tariff in case of Predicament (German AVB/NLT) are valid in the current version. The suspension of the insurance coverage does not come into effect, if the person insured is or becomes needy in the sense of the Second or Twelfth Book of the Social Legislation Book. Without prejudice to that, the contract will be continued in the tariff in which the person insured has been covered before the coverage as per the tariff in case of predicament from the first day of the month after next, if all premium parts in arrears including the interests on arrears and the collection charges have been paid. In the cases of sentences 7 and 8 the person insured is to be treated as before the coverage in the tariff in case of predicament as per § 153 VAG (see appendix), apart from the used parts of old age reserve during the period of suspension. Possible modifications of premiums and changes of the General Conditions of Insurance Coverage of the tariff in which the person insured has been covered before the suspension are valid as of the day of continuation of the coverage in this tariff. The need of social assistance is to be proven by the respective carrier as per the Second or the Twelfth Book Social Legislation; the insurer may demand a new confirmationin reasonable intervals.

(5) In case of insurances not mentioned in para. 4 the fact that the first contribution or the following contributions are not paid in due time may lead to the insurance coverage be lost under the conditions of § 37 and § 38 VVG (German Insurance Contract Law – see appendix). If the contribution or the part contribution is not paid in due time and if the policy holder has been reminded in writing or electronically, the policy holder is obliged to pay the collection fees – the amount ensues from the tariff.

(6) If the insurance contract ends before the expiry of the term of the contract, the insurer only gets the premium amount or premium rate equivalent to the period in which the coverage has been granted. If the insurance contract is terminated by withdrawal on the basis of § 19 para. 2 VVG (German Insurance Contract Law – see appendix) or by avoidance of the insurer because of fraudulent misrepresentation, the insurer only gets the premium amount or premium rate equivalent to the period up to the coming into effect of the withdrawal or avoidance declaration. If the insurer resigns, because the first premium or the first premium rate has not been paid in time, he may charge a reasonable fee for the business.

(7) The contributions are to be paid to the institution mentioned by the insurer.

(8) If and to what extent the top of the group insurance contract as policy holder has transferred the obligation of premium payment to the main person insured and this obligation has been accepted by the main person insured, the policy holder and the main person insured are subject to the same regulations.

§ 8 Calculation of Premiums

(1) The calculation of the premiums is effected as per the rules of the German Trustee Investment Act – VAG and is fixed in the technical basisof calculation of the insurer.

(2) For a modification of the premiums of tariffs calculated similarly as the tariffs of the life assurance as well as for a change of the insurance coverage the sex and the person insured's age or age group of the point of time of the modification are considered; in consideration of the gender, this is deemed not to apply for tariffs whose premiums are increased independently of gender. The entry age of the person insured is taken into account by crediting accruals for increasing risks for higher age groups according to the technical basis of calculation. An increase of the premiums or the reduction of benefits by the insurer because of the ageing of the person insured, however, is not allowed during the insurance, as far as these accruals have to be calculated.

(3) In case of modification of the premiums the insurer may change specially agreed risk surcharges accordingly.

(4) The age of the person insured as per the tariff is the difference between the year of birth and the calendar year in which the modificationof premiums comes into effect.

(5) If in case of modifications of the agreement a higher risk exists, the insurer is entitled to an adequate surcharge for this new part of the insurance coverage in addition to the premium. This surcharge is calculated as per the principles of the insurer for the settlement of higher risks.

(6) To finance a qualifying period for reduction of the premiums in old age or to avoid or limit increases of premiums additional amounts are counted and spent to the accruals for higher risks in old-age as per the rules of the Versicherungsaufsichtsgesetz (German Trustee Investment Act – VAG) -see below § 150 VAG).

§ 9 Modification of Premiums

(1) Within the frame of the contractual commitments to pay benefits, the latter may be altered due to rising treatment costs, a higher demand of medical services or as a result of a higher life expectancy. The insurer compares at least once a year the required insurance benefits with the calculated insurance benefits and the probability of death according to the technical basis of calculation for each tariff. Should this difference for one group of insureds, which is observated, of a tariff be more than the percentage laid down in law or in the tariff, all contributions of this group will be checked by the insurer and – if necessary – be adjusted on the trustee's agreement. Under the same conditions a fixed deductible may be changed and a risk surcharge be altered accordingly.

Should this difference as per sentence 2 be more than 5% of the insurance benefits calculated in the technical basis of calculation, all tariff premiums of the group will be checked by the insurer and, if necessary, will be adjusted on the trustee's agreement. In the course of a change of the premiums the required increase for the guaranteed contribution in the standard tariff (§ 14 para. 13, sentence 2) as well as the required increase for the limitations of amounts in the basic tariff (§ 14 para. 15 sentence 2) are compared with the respective calculated increases and -if necessary – adjusted. In tariffs with adequate accruals for increasing risks for higher age-groups the amount of the contribution and the accruals to be fixed depend on the calculated probabilities of an early end of the insurance (§ 14 n° 1). These may change due to influences unforeseen. Therefore at least once a year the insurer compares in each age group of a tariff the required basis of calculation with the calculated probabilities of the technical calculation basis. Should this comparison result in a too highly calculated probability in one age group the insurer may check all contribution rates of this tariff and may adjust them on the trustee's agreement if need be.

(2) A change of the contribution may be refrained, if the insurer and the trustee came to the decision that the change of the granted insurance benefitsare only temporarily.

(3) Premium modifications as well as changes of deductibles and possible risk surcharges agreed upon will come into effect on the beginning of the second month following the notification of the policy holder.

§ 10 Obligations

(1) The insurer is to be notified about each hospital treatment within 10days after its beginning.

(2) The main person insured and the person insured legitimated for benefits (see § 6 n° 2) have to give every information which the insurer demands and which is required to establish the oc.currence of the event insured or the insurer's obligation to pay benefits as wellas the extent thereof.

(3) On the insurer's demand the person insured is obliged to see a doctor appointed by the insurerin order to be examined.

(4) If the person insured has a health insurance contract with another insurer or if the person insured makesuse of the right to be insured within the statutory health insurance, the main person insured is obliged to inform the insurer about the other insurance contract immediately.

(5) As far as possible the person insured is obliged to minimize the damage and to refrain from all actions which may harm the convalescence.

§ 11 Consequences of a Violation of the Obligations

(1) The insurer is completely or partly released from the obligation to pay with the limitations mentioned in § 28 para. 2 to 4 VVG (German Insurance Contract Law – see appendix), if one of the obligations mentioned in § 10 para. 1 to 4 is violated.

(2) The knowledge and the default of a co-insured person are equal to the knowledge and default of the mainperson insured.

§ 12 Obligations and Consequences in case of Neglect of Duties in case of Claims against Third Parties

(1) If the main person insured or a co-insured person has compensation claims against third parties, he or she is obliged to assign these claims to the insurer in writing up to the compensation to be paid according to the insurance contract (reimbursement as well as in-kind benefits or services) without prejudice to the statutory assignment of claims according to § 86 VVG (German Insurance Contract Law – see appendix).

(2) The main person insured or a co-insured person has to protect such a claim or any right guaranteeing the claim taking into consideration the rules of form and periods and has to be involved in the implementationby the insurer as far asnecessary.

(3) If the main person insured or a co-insured person neglects his or her duty mentioned in para. 1 and 2

intentionally, the insurer will not be obliged to pay in so far that he may not lay claims against third parties. In case of a grossly negligent violation of the obligation the insurer is entitled toreduce the benefits in relation to the severity of the negligence.

(4) If the main person insured or a co-insured person may lay a claim of repayment of already paid fees without a legal basis to the performer of services, which the insurer has reimbursed on the basis of the insurance contract, para. 1 to 3 are to be applied accordingly.

§ 13 Setoff

The policy holder or the main person insured can only set off the insurer's claims, if the cross claim is uncontested and is established of legal force.

§ 14 Termination of the Insurance Coverage

(1) The insurance coverage for the individual persons insured ends:

a) at the omission of the eligibility;

b) in case of death;

c) on withdrawal from the group insurance contract to the end of any insurance year within three months' notice;

d) if thegroup insurance contract isterminated;

e) on withdrawal from the group insurance contract in order to continue the insurance according to the standard insurance plan with the guarantee of a maximum contribution;

f) with the continuation of the insurance contract in the basic tariff due to no complete payment of outstanding parts of premiums, surcharges on overdue payment and collection costs of health insurances which serve to fulfil the obligation of healthinsurance coverage inGermany (§ 7 para. 4).

(2) If a person insured becomes a statutory health insurance contributor by law, the main person insured may retroactively cancel the health insurance or an existing qualifying period insurance for this coverage for the person insured within three months after the beginning of the compulsory insurance. The cancellation of the coverage becomes invalid, if the main person insured does not give proof of the beginning of the compulsory insurance within two months after the insurer has requested him to do so in writing or electronically, unless the main person insured is not responsible for missing the notice. If the main person insured makes use of this right, the insurer is only entitled to the contribution up to the date of the coming into effect of the compulsory insurance. After this period the main person insured may cancel the health insurance or an existing qualifying period insurance for this coverage to the end of the month in which the compulsory insurance comes into effect, if he or she gives proof. The insurer is entitled to receive the contribution up to the end of the insurance contract. The compulsory insurance is equal to the statutory claim of family insurance or the permanent claim of medical care of an employment as a civil servant or any similar employment. For a corresponding cancellation, the insurer is obliged to accept an application for additional insurance without a renewed risk assessment and without renewed waiting times, provided additional insurance and legal insurance cover together do not exceed the previous scope of benefit. The additional insurance must begin immediately following the cancelled tariff and the application must be placed together with the cancellation. In case of a cancellation in due course the health insurance coverage ends technically for the persons insured who become liable to the statutory health insurance and for the tariffs insured as per the end of the month in which the liability has become effective. The same applies for a co-insured person who is entitled to a family insurance due to the liability to the statutory health insurance. The contribution rates which fall due within the period of the commencement of the liability till the technical end of the insurance will be paid back or will be balanced with future health insurance contribution rates, if the insurance is continued. The insurance ends -even in case of pending events insured -on the date of the commencement of the liability; the insurer indicates that to the policy holder together with the confirmation of the cancellation.

(3) The main person insured may demand within two weeks after receipt of this declaration the termination of the remainning part of the insurance contract with effect of the end of the month in which he or she has received the declaration of the insurer, if the insurer contests, declares the withdrawal or the cancellation of the contract only for individual persons insured or tariffs, in case of cancellation to the time of validity.

(4) If the insurance contract serves to fulfil the obligation of health insurance coverage in Germany (§ 193 para. 3 VVG – German Insurance Contract Law – see appendix), the cancellation as per para. 1 c) and para. 3 requires that a new contract with another insurer is taken out for the person insured, which fulfils the requirements of the obligation of health insurance coverage. The cancellation only becomes effective, if the main person insured gives proof within two months after the concellation that the person insured is covered with a new insurer without any interruption; if the point of time at which the cancellation has been expressed is more than two months after the declaration of the cancellation, the proof has to be given at this point of time

(5) In case of a cancellation of a substitute comprehensive health insurance coverage and a conclusion of a new substitute contract at the same time (§ 195 para. 1 VVG – German Insurance Contract Law – see appendix) the main person insured may demand that the insurer transfers to the new insurer the calculated old age reserve of the person insured at the amount of the value of transfer at the time of commencement of insurance coverage later than 31 December 2008 in the respective tariff according to § 146 para. 1 n° 5 of the VAG – German Trustee Investment Act (see appendix). This does not apply for contracts concluded before 1 January 2009. The following applies for insurance contracts of the substitute health insurance which have been concluded before 1 January 2009: The main person insured may demand that the insurer transfers the calculated reserves for old age of the person insured at the amount of the part of coverage which corresponds to the benefits of the basic tariff to the new insurer, if the cancellation of the existing insurance contract is effected between 1 January 2009 and 30 June 2009, coming into force atthe next possible date.

(6) If there are arrears of premiums at the time of cancellation of the insurance contract, the insurer may retain the existing value of transfer up to the time of complete payment of outstanding premiums.

(7) The insurer is obliged to pay for current events insured against for further four weeks after the termination of the contract, however only within the frame of the benefits agreed upon.

(8) If the insurance contract ends for individual persons insured, they have the right – should the conditions of the tariffs allow this – to continue the insurance coverage according to the same tariffs of the insurer's individual insurance plan under the condition that the group insurance coverage has been granted more than three months and that the continuation of the insurance coverage has been applied for with the insurer within the two months following the withdrawal from the group insurance contract. In case of higher benefits under insurance coverage special conditions may be agreed upon for thesehigher benefits.

(9) If the insurance contract ends as per § 14 n° 1 f) due to the continuation in the basic tariff, the persons insured have no right of continuation of coverage as per n° 8.

(10) In case of the changement into an individual insurance contract the period during which the person has been permanently insured within the frame of the group insurance contract will be counted to possible waiting periods of the individual insurance.

(11) If a group insurance contract is terminated by the insurer or if the group insurance contract ends because the agreedminimum number of persons to be insured has not been reached, the persons insured have the right to continue the insurance coverage considering the rights out of the existing contract and the reserves for old age, if such have been acquired, under the conditions of the individual insurance. This is also valid if the policy holder cancels the contract, if no other policy holder is named. The persons insured are informed about this cancellation or termination and the right of continuation of coverage in writing or electronically. The right of continuation of coverage ends two months after the time when the person insured has taken note of it.

(12) If the health insurance is practised as per the life assurance, the main persons and the co-insured persons have the right to continue an insurance contract cancelled in the form of a qualifying period insurance. This continuation is to be applied for within 2 months after the termination of the insurance contract at the latest. The continuation is without any interruption to the previous coverage.

(13) The main person insured may demand that persons insured of the contract who fulfil the conditions of § 257 para. 2a n° 2, 2a and 2b SGB V (German Social Legislation, Book V -see appendix) in the version valid up to 31 December 2008 may change to the standard tariff with a guarantee of maximum premiums. To guarantee the maximum premiums a surcharge laid down in the technical calculation basis is added. As per the standard tariff the person insured may not take out another additional or comprehensive health insurance coverage -see n° 1 para. 5 and n° 9 of the conditions of the standard tariff. The change to the standard tariff is always possible when meeting the legal conditions; the insurance in the standard tariff commences on the first of the month following the application of the main person insured for a change into the standard tariff.

(14) Paragraph 13 does not apply for insurance contracts taken out as per 1 January 2009 and later.

(15) The main person insured may demand that persons insured of the contract may change to the basic tariff with the guarantee of a maximum contribution and reduction of premium in case of need of social assistance, if the first taking out of the contract of the existing substitute comprehensive health insurance has been effected 1 January 2009 and later or if the person insured has completed his or her 55th year or if he or she has not completed his or her 55th year, but fulfils the conditions for a claim of a pension of the statutory pension scheme and if he or she has laid a claim for such a pension or if he or she obtains a pension as per the government or similar regulations or if he or she is in need of social assistance as per the Second or Twelfth Book of the Social Legislation. To grant these limitations of contribution the surcharge laid down in the technical calculation basis is charged. § 14 para. 13 sentence 4 appliesaccordingly.

§ 15 Declarations of Intention and Information

Declarations of intention and notifications towards the insurer have to be done in writing or electronically.

§ 16 Jurisdiction

(1) The court of the place where the main person insured has his or her residence or if he or she has none the place of the usual stay has jurisdiction in legal actions of the insurance contract against themain person insured.

(2) Legal actions of the main person insured against the insurer may be entered to the court of the place of residence or usual stay of the main person insured or with the court of the legal domicile of the insurer.

(3) If the main person insured transfers his or her place of residence or usual stay in a country which is not part of the European Union or state of the European Economic Area or ifhis or her residence or usual stay is not known at the time of the filing of the action, the court at the place of the legal domicile of the insurer is responsible.

(4) § 17 para. 3 is not valid, if the residence or usual stay is transferred to Switzerland after the conclusion of the contract.

(5) Legal actions against the insurer may be brought to the court of the legal domicile of the insurer by the policyholder.

(6) Legal actions out of the insurance contract against the policy holder may be brought to the court of the residence or legal domicile or headquarters or branch of his business or commercial enterprise of the policyholder.

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 arbitrationproceedings.

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 FederalFinancial 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.

Tariff BD/Group

Essential Parts of Tariff BD/Group

Out-patient medical treatment

- 100% reimbursement of out-patient medical treatment
- 100% reimbursement of way-charges and transports
- 100% reimbursement of X-raydiagnosis and therapy
- 100% reimbursement of medicaments and dressings
- 100% reimbursement of remedies as perthe tariff
- 100% reimbursement of medical aids as per the tariff
- 100% reimbursement of visual aids up to € 325
- 100% reimbursement of medical check-ups as perthe tariff
- 100% reimbursement of vaccinations
- 100% reimbursement of psychotherapy
- reimbursement as per the tariff of out-patient deliveries and delivery at home plus and a lump-sum of € 750 as well as delivery
- 100% reimbursement of treatments by a non-medical practioner
- 100% reimbursement of specialised out-patient palliative care
- 100% reimbursement of domestic nursing

Hospital medical treatment

- 100% reimbursement of accommodationin a one, two or more bedded room (tariff rate BD.1) or in a two or more bedded room (tariff rate BD.2)
- 100% reimbursement of treatment by the senior consultant
- 100% reimbursement of transportation
- 100% reimbursement of a person accompanying
- costs for child care abroad
- 100% reimbursement of in-patient care in hospices

Dental benefits

- 100% reimbursement of dental treatment
- 80% reimbursement of dentures and orthodontic measures up to a maximum of € 1,025 per person and calendar year

Transports to and from abroad

- 100% reimbursement of repatriations from abroad
- 100% reimbursement of repatriations in case of death to the home country orburial in the Federal Republic of Germany up to a maximum of €15,000
- 100% reimbursement of return transports of children up to € 5,000 per child
- 100% reimbursement of transports of stored blood units abroad

Digital health applications

Health Group Insurance for out-patient medical treatment, dental treatment and dentures, in-patient medical treatment and delivery
As per January 2022

This tariff is only valid in connection with the General Conditions of Insurance of the Group insurance for temporary stays in Germany.

I. Eligibility

Every person who fulfils the conditions of the group insurance contract and who is travelling with a temporary residence permit to Germany may be insured according to this tariff (main person insured). Accompanying spouses, homosexual partners as per § 1 of the German Lebenspartnerschaftsgesetz (Law of homo-sexual partnerships) and children of the main person insured may also be insured (co-insured persons), if they also have a temporary residence permit for Germany.

The period of insurance is limited to five years (§ 195 para. 3 Versicherungsvertragsgesetz -German Insurance Contract Law). Similar previous, temporary coverage, as well with another insurer will be deducted from the maximum insurance period, which is being abbreviated accordingly (§ 195 para. 3 sentence 2 Versicherungsvertragsgesetz -German Insurance Contract Law).

The coverage ends at the latest after the expiry of the maximum insurance period and ends as well in case the temporary residence permit for Germany has been omitted. The insured persons have the right to continue the insurance in an unlimited similar tariff within the group insurance contract, if the eligibility in the group insurance is still given. The reached entry age at the time of the tariff change is to consider. Continued insurance rights as per the valid General Conditions of Insurance remain unaffected.

II. Insurance Benefits

1. Out-patient or hospital medical treatment

In case of a medically necessary out-patient or hospital treatment the reimbursable costs are paid 100%, that is for

1.1 Medical treatment

Such as consultations, visits, examinations, special services as well as operations (however see point 3).

1.2 Services of a midwife

1.3 Way charges of the nearest physician

1.4 Transportation

Transports to and from the nearest suitable physician in case of

- Inability to walk;
- dialysis
- deep X-ray therapy
- chemotherapy.

In case of emergency transports to the nearest suitable doctor or to the hospital treatment in the nearest suitable hospital and back.

1.5 X-ray diagnosis and therapy

1.6 Medicaments and dressings

1.7 Remedies

The following remedies are covered:
physiotherapy/kinesitherapy, remedial exercises, massages, physiotherapy in palliative care, packs/hydrotherapy/baths, inhalations, crymotherapy and thermotherapy, electrical and physical medical treatment, electrotherapy, phototherapy, exposure, speech therapy, ergotherapy, chiropody, nutrition therapy. A lump-sum of € 50 will be paid for any prenatal classes as well as for regression therapy after pregnancy.

1.8 Visual aids

100% of the costs will be reimbursed up to a total of € 325. Only after 2 years of the last purchase of visual aids may the person insured make another claim. New visual aids can be claimed before the end of the 2 years period in case the visual acuity has changed by at least 0,5 dioptres.

1.9 Medical aids (with the exception of visual aids)

The costs for aids (objective and technical devices as well as body replacements),

- which directly palliate or balance handicaps, sequelae of diseases or accidents (e. g. wheelchairs, prostheses)
- which are necessary for a therapy and diagnostics (e.g. blood pressure monitor),
- which are decisive for the life support (life-preserving aids such as oxygen resuscitation apparatus).

Furthermore we reimburse the costs for the purchase and the training of a guide dog.

Furthermore the costs for the repair and reparation of aids, except the repair of soles and heels of orthopaedic made-tomeasure shoes are reimbursed.

Aids are not reimbursable

- if the German Compulsory Nursing Care Insurance covers these,
- if they are within the range of fitness, wellness and / or relaxing,
- if they are articles of daily use and hygiene articles of daily
- use (such as clinical thermometer, anti allergy bed linen).

Aids which are required for a limited period of time should be leased.

Generally, the insurer offers support for the choice and purchase or lease of suitable aids with an aids service provider. Therefore it is recommended to join the medical prescription of aids if the invoice amounts € 350 and more.

1.10 Medical check-ups

Among these are the medical check-ups for early screening of diseases as per the statutory programmes introduced in the Federal Republic of Germany.

1.11 Vaccinations

The costs for vaccinations against influenza, tetanus, diphtheria, rabies, poliomyelitis as wellas tick bites are reimbursable.

The costs for single or multiple vaccinations recommended by the German Permanent Committee (STIKO – Ständige Impfkommission) with the Robert Koch-Institut are reimbursable; not reimbursable are vaccinations which are recommended before a stay abroad and vaccinations as a result of professional activity which the employer has to offer on the basis of legal prescriptions.

1.12 Psychotherapy

1.13 Out-patient delivery, delivery at home as well as delivery

In case of an out-patient delivery or delivery at home a lumpsum for deliveries of € 750 is paid on top the reimbursement as per II.1.1 to 1.11 to pay other costs.

In case of a delivery in an institution which is lead by midwifes (such as a house for deliveries, a midwifes‘ house) 100% of the costs will be reimbursed instead of the delivery lump-sum of € 750, however only the costs which would have occurred for a delivery in a hospital. These costs are also reimbursable if while giving birth (start of labours or rupture of the membranes) the mother has to be admitted to a hospital.

1.14 Out-patient medical treatment by a non-medical practitioner in the sense of the German Law for Non-Medical Practitioners

Such as:
Every method of examination and treatment mentioned in the respective valid scale of charges for non-medical practitioners, remedies and way charges included up to the respective maximum amount as well as medicaments and dressings.

1.15 Specialised out-patient palliative care

The costs for a medically prescribed specialised out-patient palliative care are reimbursable, if this care aims to enable a care of the person insured in the familiar domestic surroundings or within the family, if

- the person insured suffers from a disease which is not curable, which hasadvanced a little or a lot,
- if only a limited life span of weeks or few months – for children some years – is tobe expected and
- an extremely expensive care willbe necessary

Homes for the elderly, hospital nursing care institutions and hospices.

100% of the reimbursable costs for doctors and specialists of the out-patient palliative care will be reimbursed up to the amount which would be invoiced for a person insured in the statutory health insurance.

1.16 Domestic nursing

The costs for a medically prescribed domestic nursing (consisting of all possible features of care, that is: medical treatment – to mention examples: change of dressing, giving medicaments, to measure blood pressure etc. -, the basic daily care and the care of the household) outside of in-patient institutions such as nursing homes, hospices and homes for rehabilitation by suitable experts, if a person living in the same household of the ill is not able to nurse and to care for him or her properly and if

- the domestic care is necessary to guarantee the aim of the medical treatment or (caseA)
- a hospital treatment is recommended, but cannot be carried through or if a hospital treatment can be avoided or shortened with domestic nursing (case B),

will be reimbursed as follows:

a) In case A and B the costs for medical treatment (change of dressings, giving medicaments etc.) are reimbursed.

In case that a hospital stay can be avoided also the costs for the daily care (such as hygiene, dressing) and for the organisation of the household (such as shopping, cooking) will be paid for upto four weeksper event insured against occurring, if no need of care in the sense of the German Nursing Care exists. Above the period of four weeks the costs will only be reimbursed, if the insurer has given a written consent.

b) 100% of the costs mentioned in a) are reimbursed, if they are reasonable. The costs are reasonable up to the amount of the general customary rates

If for a period of 6 months at least an especially high need of medical care is given, which requires the permanent presence of a suitable nurse for the individual control and commitment, especially because the nursing measures are unexpectedly required during day time and the night, no matter which intensity and frequency or if a life-sustaining aid (such as an oxygen resuscitation apparatus) is required day and night (intensive medical nursing care) and If this intensive medical nursing care is possible in the domestic surroundings or in a suitable institution (nursing home) within a radius of 50 km, the respective least costs for this nursing care are regarded as reasonable.

The reasonable costs for intensive nursing care are also reimbursed for stays in in-patient institutions (such as nursing homes).

It is recommended to ask the insurer for a take over of charges to be in a position to judge the reasonableness of the costs.

1.17 Accommodation, boarding and care in hospital General hospital benefits

a) In hospitals which liquidate according to the Krankenhausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German regulation of hospital charges -costs for general hospital benefits are: the hospital and nursing charges, special costs, lump-sums, the separately charged services of a doctor who has extra beds in a hospital, the costs for a mid-wife as well as for a delivery nurse who both work for several hospitals.

b) In hospitals which do not liquidate according to the Krankenhausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German regulation of hospital charges – costs for general hospital benefits are: accommodation in a three or more bedded room (General Nursing Class) included the separately charged fees for a midwife and a delivery nurse without individual optional or additional benefits.

Services of choice

a) In hospitals which liquidate according to the Krankenhausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German regulation of hospital charges -costs for services of choice according to those regulations are the costs for separately calculable accommodation in a one or two bedded room (surcharge to the nursing costs) and the treatment by the senior consultant which has been separately agreed upon.

b) In hospitals which do not liquidate according to the Krankenhausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German regulation of hospital charges – costs for services of choice are the additional costs for a one or two bedded room and the treatment by the senior consultant which has been separately agreed upon.

If a hospital distinguishes classes of nursing, the following is agreed: the first class of nursing is a one bedded room, the second nursing class is a two bedded room and the third nursing class is a three or more bedded room.

Reimbursed are 100% of the reimbursable costs, in

tariff rate BD.1

- a stay in a one, two or more bedded room

tariff rate BD.2

- a stay in a two or more bedded room
- a stay in a one bedded room limited to the treatment by the senior consultant as well as further reimbursable costs which would have occurred during a stay in a two bedded room. If these cannot be proved the respective costs in a comparable neighbouring hospital are billed.

(however see artificial insemination)

The main person insured gets a daily hospital indemnity for all claims not laid, which amounts to:

Tariff insured	accommodation	with treatment by the senior consultant	without treatment by the senior consultant

BD.1	one bedded room		€ 15
	two bedded room	€ 20	€ 35
	more bedded room	€ 30	€ 45
BD.2	one bedded room		€ 15
	two bedded room		€ 15
	more bedded room	€ 15	€ 30

In case of a semi in-patient medical treatment no daily hospital indemnity is paid.

1.18 In-patient care in hospices

The costsfor a medically prescribed necessary in-patient or semi in-patient care in a hospice in which the palliative medical treatment isgiven are reimbursable,

- if the person insured suffers from a disease which is not curable, which has advanced a little or a lot,
- if only a limited life span of weeks or few months – for children some years – is to be expected and
- if out-patient care in the household or family of the person insured or if care in a nursing institution cannot be given reasonably.

The reimbursable costs will be paid up to the amount which is paid for the care of a person insured in the statutory health insurance less any other reimbursement claims, such as of the private nursing care insurance.

2. Cure treatment

In case of a cure in a spa or health resort, also in case of a stay in a sanatorium the reimbursable costs mentioned in II.1.1 to 1.16 (out-patient medical treatment) are reimbursed as per the percentages mentioned there.

3. Artificial insemination

50% of the reimbursable costs agreed upon in the treatment plan are reimbursed.

The costs for an artificial insemination (measures of the assisted reproduction medicine to support the wish for a child) are reimbursable after a prior written consent, if besides the medical necessity the following conditions are met:

- The person insured suffers from an organic sterility which can only be treated with reproduction medicine.
- At the time of the treatment the woman is younger than 40 years of age.
- The treatment is carried through with spouses or couples living together similar as spouses and only the eggs and sperma of the couple is used (homologue insemination).
- The treatment is taken out according to German law.
- Before starting the treatment the insurer has to be handed out a tentative therapy and cost plan.

Reimbursed under the above-stated conditions up to

- 8 insemination cycles in the spontaneous cycle and
- 3 insemination cycles according to hormonal stimulation

as well as a maximum total of up to 3 attempts from the following measures:

- in vitro fertilisation (IVF)
- intracytoplasmic sperm injection (ICSI) (including the necessary IVF)
- intra-tubal gamete transfer (GIFT), a max of 2 attempts hereof.

The number of reimbursable attempts increases by the number of attempts in which a clinically proven pregnancy occurs, however, this is unsuccessful due to complications (e.g. due to abortion)

If the insured person or their partner has claim for benefits at a different service provider (e.g. statutory or private health insurance) for reproductive medical procedures, this claim for benefits shall override the obligation of the insurer to provide benefits. The insurer is only obligated to provide benefits for such expenses that remain after advance payment of the other service provider.

4. Cryopreservation

Expenses for a one-time cryopreservation of egg cells and/or sperm cells or germ cell tissue are reimbursable after prior written consent. We will therefore reimburse the costs for

- the preparationand collection,
- the processing,
- the transport,
- the freezing,
- the storage and
- the subsequent thawing of egg and/or sperm cells or germ cell tissue.

We will grant cover whenthe insured person

- receives a medically necessary therapy which is likely to damage germ cells and
- can claim benefits for artificial insemination according to II.3.

We will only reimburse the costs for storage as long as the insured person could claim benefits for artificial insemination in accordance with II.3.

100% of the eligible expenses will be reimbursed.

5. Reimbursement of costs for a person accompanying

If a person insured is in hospital treatment and is accompanied by a person who is in-patient as well, the costs for accommodation and boarding which are separately charged are reimbursed for that person as well if the accompanying person is medically necessary.

The period of accompanying and the expenses for boarding and accommodationof that person are to beproved by the hospital.

6. Reimbursement of costs for child care abroad

In case of a medically necessary in-patient stay of the parent insured caring for the child or any in-patient stay of the parent as an accompanying person (see II.5) a daily benefit of € 25 is paid, if at least one child up to the age of 12 is living in the same household abroad and does not accompany the hospital stay.

7. Dentaltreatment

Such as general, preventive, preservative and surgical benefits, X-rays, treatment of a stomatopathy and diseases of the jaw as well as periodontosis treatment.

100% of the reimbursable costs without maximum limitation are reimbursed.

8. Dentures and orthodontic measures

such as prosthetic dentures, crowns of all kind, bridges and pivot teeth, reparation of dentures, dental splints, occlusal overlays, orthodontic measures, analytic and therapeutic measures as well as inlays (necessary preparatory surgical measures to build up the jawbone included).

Orthodontic treatments which start after the age of 18 are not reimbursable. This does not apply to expenses which are occurring as a result of an accident.

80% of the reimbursable costs are reimbursed. The benefits are limitedto € 1,025 per person and calendar year.

9. Repatriation

100% of the necessary costs for a repatriation to the Federal Republic of Germany or to the country out of which he or she originally has left, if the ill or injured person who is not able to travel as a regular passenger in the own or public means of transport) and

- no reasonable treatment is possible in the country of residence or
- if according to the type and severity of the disease or accident sequelae a medically necessary hospital treatment would last more than two weeks.

The claim for a reimbursement is reduced by the costs which would have occurred for a normal return, if he or she has a claim for reimbursement of the costs for this normal return.

10. Repatriation in case of death to the home country or burial in the Federal Republic of Germany

100% of the necessary costs will be reimbursed up to the total of € 15,000.00.

11. Return transport of children

The necessary costs of a return transport of co-insured children under 16 years of age are reimbursable, if the main person insured and all co-insured adults are transported back or have deceased. The travel costs include the costs for a transport to and from the travel destination of an accompanying person as well as the costs for the travel back of children.

100% of the travel costs of the general class of transportation will be reimbursed for each child insured as well as the necessary costs for an overnight stay; however not more than the total of € 5,000.

12. Transport of stored blood units abroad

The costs for a transport of storedblood units abroad are reimbursable, if stored blood units are required for an operation outside Europe and if foreign available blood units may be infected.

100% of the costs are reimbursed.

13. Digital health applications

13.1 In the event of an insured case, expenses for digital health applications included in the list of digital health applications of the Federal Institute for Drugs and Medical Devices (compare with § 139e (1) SGB V, see Annex 2) are reimbursable at 100% up to the prices specified therein, if these applications

a) are according to the prescription of the attending physician or the attending psychotherapist, or

b) are claimed for after prior written consent of the insurer.

13.2 Other digital health applications are also reimbursable at 80% up to an invoice amount of € 2,000 per year in the event of an insured case, provided that the insurer has agreed to reimburse them in writing prior to their use.

13.3 The benefits are initially provided for a maximum of 12 months. Thereafter, a new prescription or prior written consent is required in each case.

13.4 Instead of providing reimbursement of expenses, the insurer can also provide the digital health applications itself. The limitation according to II.13.3 applies accordingly in thiscase.

13.5 The reimbursable expenses will exclusively include the costs for the acquisition of the rights of use to the digital health application. We will not reimburse any costs in connection with the use of the digital health applications, in particular for the acquisition and operation of mobile end devices or computers, including internet, electricity and battery costs.

III. Further Insurance Coverage

In the event of a claim, if benefits can be claimed from other insurance contracts, these benefit commitments take precedence. This also applies if subordinate liability is stipulated in one of these insurance contracts, irrespective of when the other insurance contracts were concluded. The reimbursable costs are reduced by the amount reimbursed by the other insurer. If the other insurer does not reimburse within the contractual or statutorily extent, a maximum of 50% out of this tariff will be reimbursed. If the insurance benefits as per II. are not covered with the other insurer, these will be fully reimbursed.

If a claim for benefits exists towards service providers other than those specified in § 5 para. 3 of the General Conditions of the group insurance for temporary stays in Germany, the main person insured is at liberty to decide which party to report the claim to. If the claim is reported by the main person insured to Hallesche Krankenversicherung AG first, it will make an advance payment within the framework of its obligations. Additionally, § 12 of these Terms of Insurance applies.

Tariff DOGP/Group

Essential Parts of Tariff DOGP/Group

Out-patient medical treatment

- 100% reimbursement of out-patient medical treatment
- 100% reimbursement of way-charges andtransports
- 100% reimbursement of X-raydiagnosis and therapy
- 100% reimbursement of medicaments and dressings
- 100% reimbursement of remedies as perthe tariff
- 100% reimbursement of aids as per the tariff
- 100% reimbursement of visual aids up to € 260.00
- 100% reimbursement of psychotherapy
- 100% reimbursement of medical check-ups as perthe tariff
- 100% reimbursement of vaccinations as per the recommendations in the FRG

Hospital medical treatment

- 100% reimbursement of accommodationin a one, two or more bedded room (tariff rate DOGP 1) or in a two or more bedded room (tariff rate DOGP 2)
- 100% reimbursement of treatment by the senior consultant
- 100% reimbursement of transportation
- 100% reimbursement of a person accompanying a child

Dental benefits

- 100% reimbursement of dental treatment
- 80% reimbursement of dentures and orthodontic measures of up to a maximum of€ 1,025 per person and calendar year

Repatriations from abroad

- 100% reimbursement of repatriations
- 100% reimbursement of repatriations in case of deathup to a maximum of € 10,230
- 100% reimbursement of burial in the FRG up to a maximum of € 2,560

Digital health applications

Health Group Insurance for out-patient medical treatment, dental treatment and dentures, in-patient medical treatment and delivery

As per January 2022

This tariff is only valid in connection with the General Conditions of Insurance of the Group insurance for temporary stays in Germany.

I. Eligibility

Every person who fulfils the conditions of the group insurance contract and who is temporarily delegated from a foreign com.pany (parent company) to the affiliated company in Germany (policy holder) may be insured according to this tariff (main per.son insured). Dependants may also be insured (co-insured perso.ns). Current conditions are included in the insurance coverage.

II. Insurance Benefits

1. Out-patient medical or hospital treatment

In case of a medically necessary out-patient or hospital treatment, the insurer reimburses 100% of the reimbursable costs for:

1.1 Medical treatment

such as counseling, consultations (visits), examinations, extra services as well as operations (however, see point 2).

1.2 Services of a mid-wife

1.3 Way charges of the nearest physician

1.4 Transportation

to and from the nearest responsible physician in case of disability to walk; necessary ambulance transportation to the nearest physician or to the nearest responsible hospital in case of an in-patient treatment

1.5 X-ray diagnosis and therapy

1.6 Medicaments and dressings

1.7 Remedies

such as baths, massages, radiotherapy, inhalations, electricaland physical medical treatment and physiotherapy

1.8 Aids

such as spectacles -no luxury types -, contact lenses, bandages, inlays, trusses, hearing aids, artificial prostheses etc. Costs for sanitary kit and healing apparatus of all kind are not reimbursable.

100% of the reimbursable costs occurred are reimbursed where-as the maximum reimbursement for visual aids amounts to € 260.00. Only after 2 years of the last purchase of visual aids may the person insured make another claim. Within the period of those 2 years a new claim can only be laid if the visual acuity has changed at least 0.5 dioptres.

1.9 Psychotherapy

1.10. Medical check-ups

within the frame of programmes introduced by law in the Federal Republic of Germany.

1.11. Vaccinations

Such as single and multiple vaccinations according to the recommendation of the Committee of Vaccinations in the Robert-Koch-Institut (STIKO). Vaccinations due to a journey abroad and work related vaccinations to which the employer is obligated as perlegal regulations are not covered.

1.12 Accommodation, boarding and care in hospital General hospital benefits

a) In hospitals which liquidate according to the Krankenhausent.geltgesetz -German Law of Costs for Hospital Benefits or ac.cording to the Bundespflegesatzverordnung – German regulati.on of hospital charges -costs for general hospital benefits are: the hospital and nursing charges, special costs, lump-sums, the separately charged services of a doctor who has extra beds in a hospital, the costs for a mid-wife as well as for a delivery nurse who both work for several hospitals.

b) In hospitals which do not liquidate according to the Kranken.hausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German re.gulation of hospital charges – costs for general hospital benefits are: accommodation in a three or more bedded room (General Nursing Class), medical services included as well as additional costsand theservices for a mid-wife and a delivery nurse.

Services of choice

a) In hospitals which liquidate according to the Krankenhausent.geltgesetz -German Law of Costs for Hospital Benefits or ac.cording to the Bundespflegesatzverordnung – German regulati.on of hospital charges -costs for services of choice according to those regulations are the costs for separately calculable accom.modation in a one or two bedded room (surcharge to the nursing costs) and the treatment by the senior consultant which has been separately agreed upon.

b) In hospitals which do not liquidate according to the Kranken.hausentgeltgesetz -German Law of Costs for Hospital Benefits or according to the Bundespflegesatzverordnung – German re.gulation of hospital charges – costs for services of choice are the additional costs for a one or two bedded room and the treatment by the senior consultant which has been separately agreed upon.

If a hospital distinguishes classes of nursing, the following is agreed: the first class of nursing is a one bedded room, the se.cond nursing class is a two bedded room and the third nursing class is a three or more bedded room.

Reimbursable are in

Rate DOGP 1

100% of the reimbursable costs without maximum limitation in case of stayin aone, two or more bedded room.

Rate DOGP 2

100% of the reimbursable costs without maximum limitation in case of stay in a two or more bedded room, in case of stay in a one bedded room the benefit is limited to private treatment by a doctor, to the transport as well as to the other reimbursable costs which would have occurred for a stay in a two bedded room. If these costs cannot be proven the costs occurring in the nearest comparable hospital are decisive.

2. Artifical insemination

The costs for an artificial insemination (even in case of a hospital stay) are reimbursable, if the following conditions are met:

- The measure is necessary as a result of a medical diagnosis.
- The medical findings have good prospects for a pregnancy; these prospects do not exist any more, if three trials are unsuccessful.
- The persons who take advantage of this measure are married.
- Only the spermia and ovocytes of the spouses are used.
- The measure is taken out according to the German Embry.onen-Schutzgesetz (EschG) – German law to protect embryoes.

Furthermore is decisive:
Only the following treatments are reimbursable: Persons insured have to be 25 years or older, no reimbursement is made for female persons insured having reached the age of 40 and male persons insured having reached the age of 50. Before starting the treatment the insurer has to be handed out a tentative treatment plan for agreement. The reimbursable costs are 100% of the costs agreed upon as per the treatment plan. We reimburse 100% of the reimbursable costs. If no treatment plan is handed out, no reimbursementwill be made.

3. Reimbursement of costs for a person accompanying a child

If a child insured up to the age of 8 years is in hospital treatment and is accompanied by a parent who is in-patient as an accompanying person as well, the costs for accommodation and boarding which are separately charged are reimbursed for that person as well. The period of accompanying and the expenses for boarding and accommodation of that person are to be proved by the hospital.

4. Dental treatment

Such as general, preservative and surgical benefits, X-rays, treatment of a stomatopathy and of diseases of the jaw as wellas treatment of periodontosis.

100% of the reimbursable costs without maximum limitation are reimbursed.

5. Dentures and orthodontic measures

Such as dentures, reparation of the function of dentures, crowns, bridges, pivot teeth and orthodontic measures.

80% of the reimbursable costs are reimbursed. The benefits are limited to € 1,025.00 per person and calendar year.

6. Medically necessary repatriation

100% of the necessary costs – as far as they are additional travel costs -for a repatriation (transport of ill or injured persons who are not able to travel as a regular passenger in the own or public means of transport)

- to the Federal Republic of Germany, if the repatriation is required for medical reasons
- from the Federal Republic of Germany to the country out of which he or she originally has left, if according to the type and severity of the disease or accident sequelae a medically necessary hospital treatment would last more than two weeks and if the employment of the main person insured in the Federal Republic of Germany will end for the policy holder with the repatriation.

7. Repatriation in case of death to the home country

100% of the necessary costs will be reimbursed up to the total of € 10,230.00.

8. Burial in the Federal Republic ofGermany

100% of the reimbursable costs up to € 2,560.00.

9. Benefits for in-patient medical treatment not claimed are reimbursed as daily benefits to the main person insured as follows.

coverage insured	accommodation	with private treatment	without private treatment

rate DOGP 1	One bedded rom		€ 13.00
	Two bedded rom	€ 16.00	€ 29.00
	three or more bedded rom	€ 26.00	€ 39.00
rate DOGP 2	One bedded rom		€ 13.00
	Two bedded rom		€ 13.00
	three or more bedded rom	€ 11.00	€ 24.00

10. Digital health applications

10.1 In the event of an insured case, expenses for digital health applications included in the list of digital health applications of the Federal Institute for Drugs and Medical Devices (compare with § 139e (1) SGB V, see Annex 2) are reimbursable at 100% up to the prices specified therein, if these applications

a) are according to the prescription of the attending physician or the attending psychotherapist, or

b) are claimed for after prior writtenconsent of the insurer.

10.2 Other digital health applications are also reimbursable at 80% up to an invoice amount of € 2,000 per year in the event of an insured case, provided that the insurer has agreed to reimburse them in writingprior to their use.

10.3 The benefits are initially provided for a maximum of 12 months. Thereafter, a new prescription or prior written consent is required in each case.

10.4 Instead of providing reimbursement of expenses, the insurer can also provide the digital health applications itself. The limitation according to II.10.3 applies accordingly in this case.

10.5 The reimbursable expenses will exclusively include the costs for the acquisition of the rights of use to the digital health application. We will not reimburse any costs in connection with the use of the digital health applications, in particular for the acquisition and operation of mobile end devices or computers, including internet, electricity and battery costs.

General Insurance conditions of Daily Sickness Benefits Group Insurance (U)

The General Insurance conditions of Daily Sickness Benefits Group Insurance (U) are only available in the German version.

Essential Parts of the Tariff EKT/Group

- Daily sickness allowance from the date of inability to work, which is mentioned in the tariff rate

Tariff EKT/Group

Group-insurance of daily benefits for long-term stays abroad of more than 91 days
As per December 2012

This tariff is only valid in connection with the General Conditions of insurance for the daily indemnity group insurance abroad.

I. Eligibility

Every person who fulfils the conditions of the group insurance contract and who temporarily travels abroad or persons who temporarily stay in Germany may be insured according to this tariff (main person insured). Eligible are persons who have a permanent position or who receive income out of independent professional activities. This tariff may only be taken out together with tariff ELW or ELW./Group, ELA/Group, D/Group, DOGP/Group, DSB/Group, BD/Group or BDSB/Group. If one of these plans are cancelled the coverage of EKT/Group ends as well.

II. Amount of daily sickness allowance; Waiting Period

1. Only a daily benefit of the maximum amount of the daily professional net income may be insured. Other daily sick bene-fits are to be considered.

2. Employees taking out this coverage have to choose the tariff rate (waiting period) according to the period of claim for cont-inued payment of wages in case of disability to work (wage, salary, health welfare benefit or sickness allowance etc.). The waiting period is the time from the beginning of the disability to work to the day from which on this daily benefit is paid. The waiting period of the chosen tariff rate must not be shorter than the period of claim for continued payment of wages.

3. The waiting period must be renewed for each case of disabi-lity to work. Periods of repeated disability to work due to the same disease may be added if the employer may add them for employees with claim to continued payment of wages.

III. Insurance Benefits

The daily benefits insured will be paid from the day of disability to work on for a maximum of 26 weeks, Sundays and (bank) holidays included, from the day on mentioned in the tariff rate as for example

tariff rate EKT. 43	from the 43rd day on
tariff rate EKT. 92	from the 92nd day on
tariff rate EKT. 183	form the 183rd day on.

If the disease or accident sequelae makes a longer stay abroad necessary due to a disability to travel or to be transported, insur-ance coverage is given for the period up to the restoration of the ability to travel or to be transported.

Tariff PVN Compulsory Nursing Care Insurance

Version of January 2022

This English translation describes the Essential Parts of the tariff PVN. If you have any further questions please contact our English customer service: +49 (0)711/66 03-27 00

Essential Parts of the tariff PVN

The tariff provides benefits in line with the appli-cable care rates as follows:

The Care degree to which a person is in need of care is classified depends on the degree of impairments of independence or abilities and the need to seek help from others. This is determined during an as-sessment by independent experts.

- Care degree 1: Low impairment of independ-ence
- Care degree 2: Considerable impairment of in-dependence
- Care degree 3: Sever impairments of independ-ence
- Care degree 4: Most severe impairment of inde-pendence
- Care degree 5: Most sever impairment of inde-pendence with special requirements for nursing care

Care services provided in the person‘s home

- for care degree 2 up to € 724 a month
- for care degree 3 up to € 1,363 a month
- for care degree 4 up to € 1,693 a month
- for care degree 5 up to € 2,095 a month

As an alternative, a care allowance can be claimed

- for care degree 2 up to € 316 a month
- for care degree 3 up to € 545 a month
- for care degree 4 up to € 728 a month
- for care degree 5 up to € 901 a month

Persons in need of care can receive a care allowance if the long-term care is organised by themselves, e.g. by relatives.

Substitute care if a carer is unable to work

The maximum rate for substitute care is € 1,612 per calendar year for a maximum of 42 days, and it does not vary according to the care degree. However, care degree 2 must be provided as a minimum. If the maximum amount of substitute care has been used up, costs are paid for a maximum of a further 56 days and up to € 806 in the form of respite care (subject to availability).

Respite care

Expenses up to a total amount of € 1,774 per calen-dar year. The entitlement is limited to eight weeks per calendar year. The minimum care degree in re-spect of which payment is made is care degree 2. If the maximum amount of care has been used up, the costs of substitute care are paid for at most 42 days and up to € 1,612 (subject to availability)

Partial in-patient care

- for care degree 2 up to € 689 a month
- for care degree 3 up to € 1,298 a month
- for care degree 4 up to € 1,612 a month
- for care degree 5 up to € 1,995 a month

In-patient care

- for care degree 1 up to € 125 a month
- for care degree 2 up to € 770 a month
- for care degree 3 up to € 1,262 a month
- for care degree 4 up to € 1,775 a month
- for care degree 5 up to € 2,005 a month

In-patient care in an institution which provides care for disabled people (§ 43a SGB XI) [Social Security Code, book 11]

For care degrees 2 to 5: 15% of the monthly care allowance, subject to a maximum of € 266 per month.

Care aids

Reimbursement is provided for all the care aids that are listed in the catalogue of aids which is used for private compulsory nursing care insurance. The in-surer organises the procurement of care appliances. Technical equipment is primarily hired out / rented. If renting is not possible, the costs of such aids are fully reimbursed (10% deductible applies for insured persons over the age of 18 when they inde-pendently procure a care aid from a third party medical supplies store, subject to a maximum of € 25 per aid). Expenses of € 40 per calendar month are reimbursed for aids intended for consumption.

Measures for improving the individual‘s home environment

Grant of up to € 4,000 for each measure. If there is more than one person in need of care in the same household: the grant is limited to the amount which is produced by dividing the costs of the measure by the number of people living there who are entitled to a grant; measures costing up to € 16,000 are eli-gible.

Additional support payments

Care degrees 1 to 5 up to € 125 a month for expendi-ture which is specifically for providing quality-ap-proved services which provide respite for carers who are related to the recipient of care, and for pro-moting the independence and autonomy of the per-sons who are in need of care in relation to the struc-turing of their day-to-day lives. The support amount is used for the reimbursement of expenses which are associated with the use of semi-in-patient care services, respite care, and out-patient care services within the meaning of § 36 (for care degrees 2 to 5, but not the use of services for promoting the ability of persons who are in need of care to care for them-selves), or of expenses which are associated with the use of services which are recognised under regional legislation for the provision of support with day-to-day living within the meaning of § 45a.

Insured persons in residential groups for whom care is provided on an out-patient basis

- € 214 a month

The setting up of residential groups for whom care is provided on an out-patient basis

The claim of the insured person entails to the amount resulting from dividing the maximum sub-sidy amount per residential group of € 10,000 by the number of residents entitled to subsidy, but not more than € 2,500.

Care period

If a family member becomes a care case, it takes a lot of time for relatives to adjust to the new situa-tion and organise the care situation. Employees can take up to ten days off at short notice. If the rela-tives are cared for at home, employees are also en-titled to an unpaid, but socially insured, leave of up to six months form the employer. The company must have more then 15 employees for this.

Foreign care

Even if care is not provided in Germany, benefits form the compulsory nursing care insurance are pos-sible. In principle, the payment of care allowance for a period of six weeks is provide for nursing care abroad. In the territory of the European Economic Area (EEA) and in Switzerland, the care allowance is paid beyond the six weeks, i.e. on a permanent basis.

Digital care applications

In the case of home care, insured persons are covered for reimbursement of costs for digital care applications and necessary supplementary support services provided by outpatient care. At the request of the insured person, the insurer shall decide on the necessity of providing the person in need of care with a digital care application. The insured person‘s entitlement is up to a total of € 50 per month.

Annex

SOCIAL SECURITY ACT, FIFTH BOOK [SOZIALGESETZBUCH, SGB]

§ 139e Directory for digital health applications; authorisation to prescribe

(1) The Federal Institute for Medication and Medical Devices will maintain a list of reimbursable digital health applications in accordance with § 33a. The directory will be structured according to groups of digital health

applications which are comparable in their functions and areas of application. The Federal Institute for Medication and Medical Devices will publish the list and any amendments thereto in the Federal Gazette and on the Internet.

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 and list of service providers Hallesche

The data protection information and the list of service providers of Hallesche Krankenversicherung AG are only available in the German version.

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: 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)	Involved bodies / organizations: 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: Assistance services	Involved bodies / organizations: • 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: Information on treatment and diseases, expert opinions on medical issues	Involved bodies / organizations: Individual assignments
Banks	
Assigned functions: Premium payments, payments in the event of a claim	Involved bodies / organizations: • Postbank Köln – eine Niederlassung der DB Privat- und Firmenkundenbank AG, • Kreissparkasse Köln, Mündelsichere Anstalt des öffentlichen Rechts
Lawyers	

Assigned functions: Legal advice, collections management, legal representation at court.	Involved bodies / organizations: Individual assignments
Market and opinion researchers	
Assigned functions: Customer satisfaction surveys, market and opinion research	Involved bodies / organizations: • 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.

Data protection notice and list of service providers Hallesche

The data protection information and the list of service providers of Hallesche Krankenversicherung AG are only available in the German version.