Genki

Consumer Conditions

Genki World Explorer, an international health insurance

General contract information

With the following information, we want to provide you with a first overview of our product Genki World Explorer, which consists of one legally independent insurance contract developed by the LAC Living Abroad Community e. V. and concluded for its members. The following insurance conditions apply for this contract.

Please note, however, that this information is not exhaustive. The full binding content of the contract consists of

- the following Insurance Conditions:
    - Insurance Conditions Genki World Explorer International Health Insurance of Allianz Partners (hereinafter: AVB-PW/PWT);
- certificate of enrollment (considered as insurance certificate);
- other written agreements (where applicable);
- your membership application form.

1. Type of insurance contracts

Genki World Explorer consists of international health insurance for frequent travellers for up to two years.

Genki World Explorer is a group contract consisting of legally independent insurance contracts that provide insurance cover for members of the LAC Living Abroad Community e. V. (LAC) and participants of affiliated partner companies and organizations.

By participating in this contract, you will receive a certificate of enrollment with details on the Insured Person and the insured range of services.

The product Genki World Explorer is exclusively offered and managed by DR-WALTER GmbH (DR-WALTER) and Genki UG (haftungsbeschränkt).

2. Insurance cover

This document provides an overview on the most important benefits. For detailed conditions and exclusions of benefits, please refer to the insurance conditions.

Medical cover	**Limit**
Inpatient and outpatient treatments, including operations	no limit
Medicine, remedies and dressing material	no limit
Dental treatment for pain relief and simple fillings as well as repair of existing dentures and dental prostheses per case up to	€ 500
Medically necessary dental treatment as a result of an accident up to	€ 1,000
Outpatient initial treatment of mental illnesses up to	€ 1,500
Inpatient emergency treatment of first-time mental or emotional disorders up to	€ 20,000
Transport costs to the nearest hospital (e. g. with ambulance vehicles)	no limit
Return transport to the Insured Person's place of residence in their home country	no limit
Transport of the Insured Person's mortal remains	no limit
General deductible per insured event – optionally –	€ 0 / € 50
Deductible for trips to the US only: in case of treatment in an emergency room; not applicable if medically necessary or in case of a resulting inpatient stay	€ 250
90 days extension of insurance cover in case of extended stay abroad for medical reasons	no limit

3. Benefit exclusions

There is no liability to pay in health insurance for:

- Costs for the medical treatment of illness, ailments and physical malformation as well as the consequences thereof, which have been medically treated or for which the Insured Person has sought medical advice within the last six months prior to commencement of insurance coverage;
- withdrawal and weaning treatments;
- treatments or rehabilitation measures at a health resort or sanitarium;
- dentures including dental crowns (except for simple repair), inlays and onlays as well as orthodontics and prophylaxis

(for details see article 4 AVB-PW/PWT).

4. Obligations at the conclusion of the contract

You are not required to fulfill any pre-contractual duties of disclosure. Please fill out the application form correctly and in full so that we can properly assess and process your application. Incorrect information can result in full or partial loss of insurance cover.

For details, see the insurance conditions.

5. Obligations during the contract period

During the contract period, you have no specific obligations to meet (except for payment of the premium). For details, see the insurance conditions.

6. Obligations in the event of a claim

We depend on the cooperation of the Insured Person for quick and easy processing of any claims.

With regard to health insurance, it might be necessary in individual cases that the Insured Person:

- keeps the illness or the consequences of an accident as low as possible and avoids unnecessary costs,

- report the illness or the accident immediately, explain the extent of the damage and provide any relevant information;
- releases the treating doctor from their physician-patient privilege so that we can gather the necessary information,
- is diagnosed by a doctor of our choice,

7. Start of insurance cover

The membership is purchased for up to two years. Insurance cover starts – subject to statutory rights to revoke – at the date stipulated in the certificate of enrollment, but not until payment of the premium. All times stated on the documents are to be understood in German time.

Insured events that occurred prior to the start of the insurance cover are not covered. For details, see the insurance conditions.

The waiting period for medical claims will be 14 days from the issue date of the insurance confirmation. The waiting period does not apply in case of an accident or medical help aiming to prevent acute danger to the Insured Person's life. The waiting period can be waived if the insurance is purchased immediately subsequent to a prior insurance. In this case, please hand in a copy of your prior insurance.

The originally agreed duration of the contract can be extended up to two years.

8. Premium, premium payment, administration fee

The monthly premium consists of the membership fee of the LAC, the health insurance contribution Sections 37, 38 German insurance contract law (VVG) apply analogously to the payment of contributions (see excerpts from the law).

(1) The premium is indicated in the application and when the contract is concluded and is shown in the insurance confirmation and the premium invoice.

(2) The premium for the first month will be charged immediately upon conclusion of the contract. Subsequent monthly charges will start one month after the start of your insurance.

9. Contract cancellation

The membership can be ended in advance in case of early cancellation of the stay abroad by the Insured Person. For details, see the Insurance Conditions.

10. Particularities

(1) In addition to Title I, Article 2.1 Clause 2 of the Insurance Conditions AVB-PW/PWT there is insurance cover for up to 42 days outside the insured zone within an insured period of any 180 consecutive days.

(2) Notwithstanding Title I, Article 2.1 of the Insurance Conditions a stay in the home country of the Insured Person is considered to be included under the following conditions:

- The stay in your home country does not exceed 42 days within an insured period of any 180 consecutive days.

(3) In addition to Title I, Article 2.4 c of the Insurance Conditions AVB-PW/PWT, the Insured Person´s mortal remains are transported back to their Home Country.

(4) Notwithstanding Title I, Article 2.5 Clause 2 of the Insurance Conditions AVB-PW / PWT, we ask you to send the illness documents by email to leistung@dr-walter.com or by MY-SAFETY-APP 2 from DR-WALTER.

(5) Notwithstanding Title I, Article 7 of the Insurance Conditions (AVB-PW/PWT) the medical costs must have occurred in one of the following zones:

- Zone 1: worldwide excluding USA and Canada
- Zone 2: worldwide including USA and Canada

(6) In amendment to Title II – Medical emergency assistance coverage – Cover provided – of the Insurance Conditions (AVB-PW/PWT), the Medical Emergency Assistance can also be contacted during a stay in the home country in the event of a medical emergency.

Consumer information

The product Genki World Explorer is a travel health insurance offered and managed by DR-WALTER GmbH and Genki UG (haftungsbeschränkt). We, DR-WALTER GmbH, want to provide you as our

customer with the following comprehensive information about the involved insurance company and the underlying insurance policy:

1. Insurers

To offer you this insurance policy, DR-WALTER GmbH has teamed up with a carefully selected and renowned insurance company:

Health insurance is provided by:

Allianz Partners – AWP Health & Life SA
Eurosquare 2, 7 Rue Dora Maar
93400 Saint-Ouen, France
Court: Registre du Commerce et des Sociétés, Bobigny
Number: 401 154 679

The contract and service management is carried out by:

DR-WALTER GmbH
Eisenerzstr. 34
53819 Neunkirchen-Seelscheid, Germany
Head office: Neunkirchen-Seelscheid
Registration Court: District Court Siegburg, HRB 4701

DR-WALTER GmbH acts as an insurance agent for one or multiple clients in accordance with § 34d par. 1 Industrial Code.

The competent authority is IHK Bonn / Rhein-Sieg, Bonner Talweg 17, 53113 Bonn, P +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-L7N-VQ-57. You can verify this information at any time with the registration body: Deutscher Industrie- und Handelskammertag e. V. (DIHK), Breite Straße 29, 10178 Berlin
P +49 30 20308-0, https://www.vermittlerregister.info.

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.

2. Applicable law, Place of jurisdiction

Unless otherwise stipulated, the contract is governed by German law.

Both German law and place of jurisdiction apply for all contractual arrangements affecting Genki World Explorer in general, the LAC membership and contract management by DR-WALTER GmbH.

Whereas in the event of a dispute, French law and place of jurisdiction apply for the insurance cover provided within the international health insurance policy of Allianz France.

3. Languages

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

4. 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
E-mail: beschwerde@dr-walter.com

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

For complaints that affect international health insurance, please send a letter or e-mail to

Allianz Partners – AWP Health & Life SA – Relations Clients
Relations Clients
Eurosquare 2, 7 Rue Dora Maar, 93400 Saint-Ouen, France
E-mail: client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the mediation charter of the French Federation of Insurance Companies. Therefore, in the event of a persistent and definitive disagreement, the Policyholder and/or Covered Person have the option, after exhausting all other possible amicable remedies, to opt

for the Mediator of the French Federation of Insurance Companies, without prejudice to other possible legal action, who can be contacted at the following address:

La Médiation de l'Assurance
TSA 50 110, 75 441 Paris Cedex 09
https://www.mediation-assurance.org/

For complaints that do not affect health insurance, please contact

Versicherungsombudsmann e. V. (ombudsman for insurance matters)
Postfach 080632, 10006 Berlin, Germany
T 0800 3 696 000 (free telephone number from the German telephone network)
T +49 30 206058 99 (from abroad)
F 0800 3 699 000 (free telephone number from the German telephone network
F +49 30 206058 98 (from abroad)
E-mail: beschwerde@versicherungsombudsmann.de

For more information, go to: www.versicherungsombudsmann.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 contact the platform http://ec.europa.eu/consumers/odr/. Your complaint will then be sent to the ombudsman via this platform forwarded.

In addition, you can file a complaint with

Bundesanstalt für Finanzdienstleistungsaufsicht (Federal Financial Supervisory Authority)
Graurheindorfer Straße 108, 53117 Bonn, Germany
F +49 228 4108 1550
E-mail: poststelle@bafin.de

5. Information on the right of revocation according to Section 8 (2) number 2 Insurance Contract Act

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:

Allianz Partners – AWP Health & Life SA,
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.

End of information on the right of revocation

Definition of terms

The words and terms listed below and used in this product information have the following meanings:

Abroad, Foreign Country/-ies

Abroad and foreign country/-ies means all countries except the Home Country.

Acts of God

Acts of God are: explosions, storms, hail, lightning, floods, avalanches, volcanic eruptions, earthquakes, landslides.

Country of Stay

Country of stay is the foreign country where the Insured Person temporarily stays.

Home Country

Home country is the country where you have friends & family, a place to stay, no visa requirements and access to local healthcare.

Immediately

Without undue delay.

Insured Person/Covered Person

Insured person is the person mentioned by name in the insurance certificate who is covered by the insurance policy.

Insured Stay

Insurance cover is provided for the period mentioned in the insurance certificate. Insurance cover should always be purchased for the entire stay abroad and thereby include the entire outward and return journey to the country of stay or the home country.

LAC

LAC stands for LAC Living Abroad Community e. V. The LAC is an association that looks after the interests of people living abroad and provides them with information and services. Among these services is the framework agreement PW/PWT that LAC concluded as the policyholder, thereby providing insurance cover for its members during their stay abroad.

Medically necessary, medically necessary treatment

1. Treatments and diagnostic procedures are only covered if they are used for diagnostic, curative and/or palliative purposes, are medically necessary or appropriate. It is required that they are carried out by a legally accredited physician, dentist or other therapist. Claims/costs are only paid/reimbursed if the medical diagnosis and/or prescribed treatment is consistent with generally accepted medical practice. Treatments that the Insured Person undergoes against medical advice are not deemed to be medically necessary.
2. Medical services or healthcare are only deemed to be medically necessary and appropriate, if
    a) they are necessary in order to diagnose or treat the condition, illness or injury of a patient;
    b) ailments, diagnosis and treatment are consistent with the underlying illness;

c) they are the most appropriate kind and level of healthcare; and

d) if they are only carried out for an appropriate treatment duration.

Policyholder

Policyholder is the association LAC Living Abroad Community e. V. for its members as well as for companies and organizations that cover stays abroad of their members through LAC.

Insurance Conditions Genki World Explorer International Health Insurance (AVB-PW/PWT) of Allianz Partners

Introduction

The association known as „Living Abroad Community (LAC)“ has taken out with Allianz Partners a Health Plan on behalf of one of its members. The purpose of such a plan is to provide the members with the reimbursements complementary to the benefits in kind paid by the European Health Insurance Card.

Title I – Medical coverage

Article 1 – Coverage beneficiaries

The Covered Person alone.

Article 2 – Benefits

The guarantees granted to each Beneficiary including amounts and maximum limitations are provided in the Table of Benefit hereafter.

The benefits consist in covering the medical expenses incurred by the Covered Person.

Medical care to be covered must be recognised by the local medical authorities and provided by authorised practitioners (in compliance with the laws, regulations or other reasonable and customary relating to the practice of this profession in the country concerned).

2.1 Cover provided

1. In the event of illnesses, which occur in acute form, and accidents abroad, the insurer will pay the costs of

    a) medical treatment;

    b) medical transport;

    c) repatriation of the deceased person in the event of death.

2. Trips outside the rating area during the insured stay are covered up to a maximum of 42 days. Where travel is interrupted, home holidays are covered up to 6 weeks. Several home holidays are also possible as long as the overall duration does not exceed 6 weeks. Insurance is provided during home holidays only for the costs resulting from an accident or an emergency illness (as these terms are defined) if the treatment was practised by a general or specialized practitioner or the hospitalization was a necessity owing to the emergency and took place within twenty-four hours.

In all other cases, after express approval by the insurer.

2.2 Medical treatment

1. The insurer will pay the costs of medical treatment required, which is performed or ordered by doctors. This includes in particular

    a) in-patient treatment in hospital including operations;

    b) out-patient treatment;

    c) drugs, medicines and bandages;

    d) out-patient first-response medical care of psychological illnesses up to a total of € 1,500;

    e) in-patient emergency medical treatment for mental and psychological disorders occurring for the first time, up to a total of € 20,000.

    f) aids (e. g. aids for walking, rental of a wheelchair), if they are required for the first time on account of an accident or an illness during the insured stay.

2. Dental treatment

    a) The insurer will reimburse the costs for dental treatment for the relief of pain, including simple or temporary fillings and repairs to restore the function of dentures and replacement teeth up to a total sum of € 500 for each insured event.

b) If dental treatment is medically necessary as a result of an accident which the Insured Person has suffered during the insured stay, the insurer will pay the costs up to a total of € 1,000 for each insured event. An accident is deemed to have occurred if the Insured Person suffers involuntary damage to their health as a result of an event which suddenly impinges on their body from outside.

3. If the Insured Person is not medically transportable at the time of insurance expiry, the necessary medical costs will be covered until the Insured Person is medically transportable.

4. Telephone costs to make contact with the emergency call center of the insurer will be paid up to € 25 for each insured event.

2.3 Pregnancy / Labor

1. In the event of pregnancy occurring during the insured stay, the insurer will pay the costs for

   a) antenatal checkups up to and including the 12th week of pregnancy;

   b) two ultrasound examinations, unless further scans are medically necessary on account of special circumstances;

   c) treatment for complications during pregnancy;

   d) out-patient or in-patient labor. Additional costs for a Caesarean operation are also eligible for repayment, provided it is medically necessary;

   e) medically necessary termination of pregnancy;

   f) birth assistants and midwives;

   g) postnatal care of the mother and the newborn. The payments for newborns are limited to € 50,000.

2. If the pregnancy had already arisen before the commencement of the insured stay, the insurance cover is restricted to acute and unforeseeable deterioration in the health of the mother and / or child.

2.4 Medical transport / Repatriation

The insurer will pay the costs for

a) medically necessary transport abroad for hospitalization or initial outpatient treatment in a hospital; transport must be provided by a recognized emergency medical service;

b) medically effective and reasonable evacuation of the Insured Person to their place of residence in the home country or to a suitable hospital nearest to their place of residence. In the case of trips, the insurer will also pay the costs for medically effective and reasonable evacuation to the place of stay in the country of stay or to a suitable hospital nearest to their place of stay in the country of stay;

c) repatriation of mortal remains of the Insured Person to the place of residence prior to the trip or, optionally, burial abroad up to the amount of the repatriation costs.

2.5 Claims for medical costs

The medical costs claim form is provided by the insurer and must be submitted to it with the relevant supporting documents.

No copy, photocopy or duplicate of invoice is accepted.

The insurer may request, when relevant, any further document necessary for the application of the coverage.

The Covered Person shall be liable for any information provided by them which appear to be false, forged or exaggerated or any fraudulent or deceitful action by them; all undue payments paid by the insurer on the basis of these incorrect data shall be recovered.

2.6 Benefits amount

The reimbursements of medical costs are paid in Euro up to the maximum amounts stated below in the coverage table, per Covered Person, per civil year and up to the limit of the actual costs.

The benefits amount is calculated for each reasonable and customary cost item and according to the terms of this policy.

The reasonableness and customariness are assessed according to the medical practise which prevails in the country where the care is provided (treatment type, care and medical equipment quality, geographical area and country) and are subject to coding and rating standards of the medical procedures and treatments referenced or nomenclatured in each country.

The unreasonableness and uncustomariness may lead to a refusal of reimbursement for the medical costs or a limitation of the reimbursement amount.

2.7 Limitation to actual costs

Pursuant to Article 9 of the Act no. 89-1009 of August 30, 1990, and the Decree no. 90-769 of August 30, 1990, the reimbursements or compensations of the costs incurred by an illness, maternity or accident shall not exceed the amount of the costs remaining payable by the Covered Person after the payment of the benefits of any type they're entitled to.

Benefits of the same type taken out with several insuring bodies shall be enforceable up to the limit of each benefit, whatever the date it has been taken out. Within this limit, the policy beneficiary may obtain an additional compensation by submitting the breakdown of benefit(s) paid by the other insuring body(ies).

For the purpose of the aforementioned provisions, the limitation to the costs remaining payable by the Covered Person is determined by the insurer for each medical procedure or cost item.

Article 3 – Excluded risks related to medical coverage

Any costs incurred by the following events are not covered by the insurer:

- a claim arising directly or indirectly from the decay of an atomic nucleus,
- the consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or an act of terrorism, whatever the place these events take place and their protagonists, except if the Covered Person does not take an active part in such event or if they're called upon to perform a maintenance or monitoring mission in order to ensure the security of people and goods for the policyholder association.

The insurer reserves the possibility of modifying the coverage for one or several specific territories, subject to a 15-days prior notice to the Policyholder Association. This one may refuse this modification and terminate the policy by sending the insurer a registered letter with acknowledgement of receipt within 30 days from the date of receipt of the endorsement submitted by the insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder Association shall inform the member of the termination.

Article 4 – Excluded benefits related to medical coverage

The following benefits are not covered by the present contract, unless otherwise stipulated or to the exclusion of the benefits specified as being covered in the Table of Benefits hereunder:

- costs for the medical treatment of illness, ailments and physical malformation as well as the consequences thereof, which have been medically treated or for which the Insured Person has sought medical advice within the last six months prior to commencement of insurance coverage;
- medical treatment and other measures ordered by a doctor where the Insured Person was aware when starting the insured stay that, if the insured stay took place as planned, the treatment would have to be given for medical reasons (e. g. dialysis);
- costs for the medical treatment and other medically prescribed measures as well as medical transport, rescue and recovery measures relating to the exercise of the following sports: Motorcycle and car racing, including the training related hereto, parachuting, paragliding, bungee jumping, base-jumping, mountaineering (as long as special climbing equipment is required), free climbing, sport diving and scuba diving;
- any preventive treatment, vaccination, health check-up, as well as screenings;
- procurement and repair of heart pacemakers, prostheses, aids to sight and hearing aids;
- costs of accident or illness caused by mental illness or impaired consciousness, if this is a result of the consumption of alcohol, drugs, intoxicants or sedatives, sleeping tablets or other narcotic substances;
- acupuncture, fango and massages;
- need for care or safe-keeping;
- outpatient consultations of psychotherapy, psychoanalysis, hypnosis and the relevant treatments, if not covered under aforementioned details of benefits;
- payments for pregnancy and labor, if the pregnancy had already arisen before the commencement of the insured stay, unless there is an acute and unforeseeable deterioration in the health of the mother and / or child;
- medical checks, studies, treatments, consultations and complications relating to sterility, sterilization, sexual dysfunctions, contraception including insertion or removal of contraceptive devices, induced termination of pregnancy, except in the case of an interruption of pregnancy medically necessary and performed in compliance with local legislation;
- treatments provided outside the geographical area of the coverage as set out in the special conditions, except as provided for in Article 7;

- any form of experimental or uncontrolled treatment which does not follow customary or traditional, commonly accepted medical practices, unless the insurer has given its specific consent, and any form of treatment non recognized by the medical authorities where the treatment took place, or in the country of origin of the Covered Person;
- ancillary or „comfort“ costs in case of hospitalisation (telephone, television, hotel, Internet);
- medical care or treatments for drug addiction or alcoholism;
- disintoxication treatments;
- any surgery or treatment relating to a gender reassignment;
- the sterility, the diagnostics, treatments or complications arising from the sterilisation, the sexual dysfunction and the contraception, including the introduction or extraction of contraceptive device and any other contraceptive's methods, even if prescribed;
- any elective/voluntary surgery and/or plastic/aesthetic surgery;
- aesthetic treatments and consultations, rejuvenation cures, slimming cures;
- thermal cures;
- transportation and accommodation costs relating to thermal cures;
- medical costs relating to health or wellness treatments, e.g. thalassotherapy or ayurveda, and stays and health courses in therapy or fitness centres, even if this is medically prescribed;
- medical costs relating to a stay in a rest home or a convalescent home, except if this stay results from an hospitalisation or a severe surgery assessed by the insurer;
- consultations, treatments and complications relating to hair loss or hair transplantation, unless this treatment results from a hair loss caused by a serious illness;
- treatments to modify the refraction of an eye or both eyes (laser eye correction), including refractive keratotomy (RK) and photorefractive keratectomy (PRK),
- non-prescription medicines and non-prescribed para-pharmacy.

Article 5 – Forfeiture of the right to a benefit

The Covered Person is deprived of all rights to the benefits of a claim in the event the Covered Person voluntarily makes a false declaration about that claim including the date, nature, causes, circumstances and/or consequences and/or amount of the loss.

The forfeiture of this right also applies in the event the Covered Person knowingly uses inaccurate documents as supporting documents for that claim.

Title II – Medical emergency assistance coverage

It is agreed that the insurer delegates the execution of the following assistance services to DR-WALTER GmbH as specified in the administrative agreement.

Cover provided

The insurer will provide 24-hour assistance services through its Emergency Call Center in the event of the Insured Person suffering any of the following medical emergencies during the insured stay.

The medical emergency assistance is also applicable for trips during the insured stay up to a maximum of 42 days, but not during home holidays.

Illness / Accident

1. Information about medical care

The insurer will, on request, provide information before and after the start of the insured stay on the options for care of the Insured Person by a doctor. Where possible, it will appoint a German-speaking or English-speaking doctor.

2. Hospitalization

Where the Insured Person is treated as an in-patient in a hospital, the insurer will provide the following services:

a) Care

   Through a doctor appointed by the insurer, contact will be established with the hospital doctors giving treatment and, where required, with the Insured Person's doctor at home and will ensure information is passed between the doctors involved. The insurer will, on request, ensure that relatives of the Insured Person are informed.

b) Hospital visit

   If hospitalization looks likely to last for more than five days, the insurer will organize the outward journey for a person close to the Insured Person to the place of hospitalization and from there the return journey back to their place of residence. The insurer will pay the costs of the means of

transport. Should the Insured Person require accommodation in the vicinity of the hospital or the place of the funeral, the insurer will arrange the same and bear accommodation costs of up to € 70 per day for a maximum of seven days.

c) Cost payment guarantee / settlement

The insurer will give the hospital a guarantee to pay costs up to € 15,000. In the name of and at the request of the Insured Person, it will settle with the bodies responsible for bearing the costs of treatment. Any sums paid by the insurer that are not borne by the responsible insurance companies must be paid back to the insurer by the Insured Person within one month of the account being rendered.

3. Medical evacuation

The insurer will organize the medically effective and reasonable evacuation of the Insured Person to their place of residence in the home country or to a suitable hospital closest to the place of residence of the Insured Person by a medically appropriate means of transport (including air ambulance), if it is likely that the insured stay will have to be definitively terminated as a result of the illness / injury.

In the case of trips, the insurer will also pay the costs for medically effective and reasonable evacuation to the place of stay in the country of stay or to a suitable hospital nearest to the Insured Person's place of stay in the country of stay.

Dispatch of medicines

1. Where the Insured Person requires medicines which have been lost during the insured stay the insurer will organize procurement or replacement medicines and send them to the Insured Person and pay for their dispatch.
2. The Insured Person must refund the cost of replacement medicines to the insurer within one month of the account being rendered.

Death

If the Insured Person dies during the insured stay, the insurer will, at the request of the relatives, organize burial abroad or repatriation of the deceased person to the place of burial.

Psychological counseling

If the Insured Person suffers acute mental trauma during the insured stay requiring psychological assistance, the insurer will provide an initial counseling by telephone.

Obligation following occurrence of an insured event

1. The Insured Person will be under an obligation to make contact with the Emergency Call Center of the insurer immediately.
2. If this obligation is intentionally not met, the insurer will be released from its liability to make payment. The obligation to make payment remains to the extent that the failure to meet obligations is due neither to willful intent nor to gross negligence.

If an obligation is not met by virtue of gross negligence, the insurer will be entitled to reduce the level of payment to be made pro rata with the seriousness of the negligence of the Insured Person. The insurer will still be liable to make payment to the extent that the failure to meet the obligation does not affect the process of establishing whether the insurer has an obligation to pay the claim and if so, the level of payment to be made, unless the Insured Person has acted fraudulently.

Title III – Table of Benefits – Area of coverage

Article 6 – Table of Benefits

The purpose of the medical cover is to provide reimbursements complementary to the benefits paid by the European Health Insurance Card.

Medical cover	**Limit**
In-patient and out-patient treatment including operations	no limit
Drugs, medicines and bandages	no limit
Dental treatment for the relief of pain including simple fillings as well as repairs to restore the function of dentures and replacement teeth per insured event up to	€ 500
Medically necessary dental treatment as a result of an accident per insured event up to	€ 1,000
Out-patient first-response medical care of psychological illnesses up to a total of	€ 1,500
In-patient emergency medical treatment for mental and psychological disorders occurring for the first time, up to a total of	€ 20,000
Transportation costs to the next hospital with recognized emergency medical services	no limit

Medically effective and reasonable evacuation of the Insured Person to their place of residence	no limit
Repatriation of the Insured Person in case of death	no limit
General deductible per case – optionally –	€ 0 / € 50
Excess only for stays in the USA: for treatment in the emergency room; the excess is waived in case of medical necessity or subsequent in-patient treatment	€ 250

Medical emergency assistance and full assistance	**Coverage**
Information about medical care	service
Dispatch of medicines	costs of dispatch
Hospital visit of a person close to the Insured Person if hospitalization looks likely to last more than 5 days	transportation costs; hotel costs up to € 70 per day, up to a maximum of 7 days
Interruption of insured stay due to severe illness or accident of family members in case of in-patient treatment of more than 5 days	transportation costs

Article 7 – Area of coverage

The medical costs must have been incurred within the insurance period:

- in one of the regions or countries of the following rating area:
    - Zone 1: Europe – Europe defined as EU, Norway, Iceland, Liechtenstein, Switzerland, Andorra, Monaco, San Marino and Vatican City
    - Zone 2: Worldwide – Worldwide without USA and Canada
    - Zone 3: Worldwide – USA and Canada
- in another country:

during a trip of less than six weeks, only for the costs resulting from an accident or an emergency illness, as these terms are defined, provided the treatment was practised by a general or specialized practitioner or the hospitalization was a necessity owing to the emergency and took place within twenty-four hours,

- in all other cases, after express approval by the insurer.

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.

§ 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.

§ 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 Civil Code (BGB)

§ 195 Regular limitation period

The regular limitation period is three years.

Data protection notice

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

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

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

For further information, please go to www.dr-walter.com/datenschutz.

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

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

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

DR-WALTER GmbH
Eisenerzstr. 34
53819 Neunkirchen-Seelscheid, Germany
P +49 22 47 91 94 -0
F +49 22 47 91 94 -40

c) Responsible body

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

d) Your rights

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

You can assert these rights to the above address directly against DR-WALTER. For further questions with regard to data protection, please contact our data protection officer at DR-WALTER, Eisenerzstr. 34, 53819 Neunkirchen-Seelscheid, Germany, P +49 22 47 91 94 -0.

List of service providers

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,
- Techniker Krankenkasse,
- BDAE Holding GmbH,
- Foyer Santé S.A.,
- Globality S.A.,
- BD24 Berlin Direkt Versicherung AG

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:	Involved bodies / organizations:
Information on treatment and diseases, expert opinions on medical issues	Individual assignments
Banks	
Assigned functions:	**Involved bodies / organizations:**
Premium payments, payments in the event of a claim	• Postbank Köln – eine Niederlassung der DB Privat- und Firmenkundenbank AG, • Kreissparkasse Köln, Mündelsichere Anstalt des öffentlichen Rechts
Lawyers	
Assigned functions:	**Involved bodies / organizations:**
Legal advice, collections management, legal representation at court.	Individual assignments
Market and opinion researchers	
Assigned functions:	**Involved bodies / organizations:**
Customer satisfaction surveys, market and opinion research	• TÜV NORD CERT GmbH, • Shopauskunft.de GmbH & Co. KG
Consulting companies	
Assigned functions:	**Involved bodies / organizations:**
Support and advice e.g. in claims and billing matters (Germany and abroad), fraud detection, health programs; IT services	Individual assignments
IT and telecommunication companies	
Assigned functions:	**Involved bodies / organizations:**
Service providers for IT, network and telephone services	• AssFINET AG, • ikt Gromnitza GmbH & Co. KG,

	• Trevedi IT-Consulting GmbH, • IBExpert GmbH, • NETGO GmbH, • DATEV eG
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 AG, • bplusd Agenturgruppe GmbH, • Adspert Bidmanagement GmbH, • Sistrix GmbH, • KCS Internetlösungen Kröger GmbH, • Userlike UG • aveta | David Cürten • consentmanager 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:	**Involved bodies / organizations:** Individual assignments

Disposal of files and data media, document destruction

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