EXPAT FLEXIBLE

Insurance coverage for individuals in foreign countries (world travellers, professionals, freelancers, digital nomads, emigrants)

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100% outpatient treatment

valid worldwide

Return transport

Tooth replacement*

Aids and appliances*

Cancer prevention*

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INSURANCE TERMS AND CONDITIONS

for Fixed-Term Health Insurance Policies of the Expat Series for Long-Term Travels (Terms and Conditions Part II - Swiss Life Prévoyance et Santé)

Description of Insurance Benefits

	Benefits	EXPAT FLEXIBLE BASIS	EXPAT FLEXIBLE PLUS (in addition to EXPAT FLEXIBLE BASIS)
A1	**Outpatient Medical Treatment**	**100%** of the invoice amount charged for a medically necessary outpatient treatment as private patient, medically prescribed radiotherapy, light therapy and other physical treatments within the framework of the applicable official fee schedule for the respective professional group.	No supplementary coverage
A2	**Inpatient Medical Treatment**	**100%** of a medically necessary treatment in a hospital and a treatment-related accommodation in accordance with Art. 5 paragraph 8 of the Insurance Terms and Conditions Part I. In Germany, treatments will be covered within the framework of the general care class; outside Germany in derogation from the Insurance Terms and Conditions Part I, Art. 5 paragraph 8 as private patient in a double bedroom, if possible, and for medically necessary surgical interventions, radiotherapy, light therapies and diagnostics. In derogation from the Insurance Terms and Conditions Part I, Art. 6 paragraph 2b, medically necessary follow-up treatments shall be covered.	No supplementary coverage
A3	**Pharmaceutical Products, Bandages and Remedies**	**100%** if medically prescribed and necessary.	No supplementary coverage
A4	**Dental Treatment**	**100%** of the invoice amount charged for a medically necessary outpatient dental treatment. Inlays and onlays shall be excluded from coverage. Per year of the contractual term, a non-recurring preventive medical check-up and treatment shall be covered (inclusive of polishing and teeth cleaning).	No supplementary coverage
A5	**Tooth Replacement/ Orthodontic Treatment**	No coverage	In derogation from the Insurance Terms and Conditions Part I, Art. 6 paragraph 2q, insurance claims occurring after expiry of the qualifying period of 8 months shall be covered as follows: • **60%** of the invoice amount charged for a medically necessary denture; and • orthodontic treatments up to the age of 18 years within the framework of the official fee schedule valid at the time being; • but in no event more than a maximum amount of 500 Euro in the first insurance year; • up to a maximum amount of 800 Euro in the second insurance year; • up to a maximum amount of 1,200 Euro in each insurance year following thereafter. Dentures becoming necessary due to accidents shall be covered during the contract term within the maximum limits without qualifying period. In the event of registrations/deregistrations during the year, the indicated amounts shall be calculated on a pro rata basis. Claims arisen in a specific insurance year cannot be transferred to other insurance years.
A6	**Preventive Medical Checkups**	No coverage	Outpatient preventive medical examinations for early detection of cancer according to statutory programmes introduced in Germany.
A7	**Benefits in Connection with Pregnancies and Deliveries**	No coverage	No coverage
A8	**Aids and Appliances**	No coverage	In derogation from the Insurance Terms and Conditions Part I, Art. 6 paragraph 2g, coverage shall include medically necessary and prescribed aids and appliances in a simple form and their repair costs up to **80%** of the invoice amount, but in no case more than an aggregate amount of 1,000 Euro per insurance year. Costs for visual aids shall be reimbursed within the maximum limits up to **100 %**, but in no case more than up to 50 Euro per Insured Person and per insurance year. In the event of registrations/de-registrations during the year, the indicated amounts shall be calculated on a pro rata basis.

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	Benefits	**EXPAT FLEXIBLE BASIS**	**EXPAT FLEXIBLE PLUS** (in addition to EXPAT FLEXIBLE BASIS)
A9	**Psychotherapy**	No coverage	No coverage
A10	**Other Benefits**	a) **100%** for patient transports to the nearest reachable suitable hospital for inpatient treatments and, in the event of primary care after an accident, to the nearest reachable physician and back. b) In case of a medically necessary return transport or transfer to the country where the Insured Person has his or her usual abode or place of residence, the Insurer shall reimburse • up to 5,000 Euro in case of transports on one continent; • up to 10,000 Euro in case of transcontinental transports. In the event that a licensed air ambulance must be used for a return transport, said maximum limits shall not apply. To the extent that it is possible from a medical point of view, the most cost-effective means of transportation must be selected. A return transport is deemed to be required from a medical point of view if a sufficient medical care in the host country cannot be guaranteed. A certificate of the treating physician in the foreign country according to which the return transport is necessary from a medical point of view must be submitted.	No supplementary coverage
A11	**Follow-Up Liability**	In the event that a person cannot be returned to his or her home country until the end of the insured long-term travel because the person is unfit for transportation and the disease is due to a necessary and unplannable medical treatment, the Insurer shall reimburse the costs for the medical treatment until the day when the person becomes fit for transportation, but in no event for more than 30 days after termination of the insurance coverage.	No supplementary coverage

Monthly Premium

The insurance premium shall be an annual contribution indicated in equal monthly instalments. It shall in each case be due and payable in advance until the end of the insurance year.

	Scope of Application	**EXPAT FLEXIBLE BASIS**	**EXPAT FLEXIBLE PLUS** (in addition to the premium of **EXPAT FLEXIBLE** BASIS)
B1	**Worldwide, except for USA, Canada, Switzerland** (inclusive of insurance coverage for up to 42 days in case of stays in the USA, Canada and in Switzerland)	97 Euro	47 Euro
	Worldwide, except for USA, Switzerland (inclusive of insurance coverage for up to 42 days in case of stays in the USA and in Switzerland and up to 365 days in case of stays in Canada)	425 Euro	143 Euro

Annual Deductible

The deductible shall be applicable per insurance year and Insured Person. In this context, the insurer shall pay to the Insured Persons the amounts covered by the insurance, less the respective deductible, up to the amount agreed upon.

The EXPAT FLEXIBLE product does not include a deductible.

	Scope of Application	**EXPAT FLEXIBLE BASIS**	**EXPAT FLEXIBLE PLUS** (in addition to the premium of **EXPAT FLEXIBLE** BASIS)
B2	**Worldwide, except for USA, Canada, Switzerland** (inclusive of insurance coverage for up to 42 days in case of stays in the USA, Canada and in Switzerland)	0 Euro	0 Euro
	Worldwide, except for USA, Switzerland (inclusive of insurance coverage for up to 42 days in case of stays in the USA and in Switzerland and up to 365 days in case of stays in Canada)	0 Euro	0 Euro

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Contractual Fundamentals

C1	**Insurer**	Swiss Life Prévoyance et Santé, 7 rue Belgrand, F-92300 Levallois-Perret, Frankreich
C2	**Policyholder**	BDAE Expat GmbH
C3	**Parties Entitled to be Insured**	Natural persons and legal entities
C4	**Insurable Persons**	Natural persons entitled to be insured or natural persons and their family members, as reported by legal entities who are entitled to be insured, always provided that they are eligible for insurance according to the Insurance Terms and Conditions Part I, Art. 1. The maximum age for being eligible for insurance shall be 66 years. Insurance coverage shall automatically terminate no later than upon expiry of the month during which the Insured Person completes his or her 67th year of age. Life-partners and children living in a common household shall be regarded as family members.
C5	**Contractual Fundamentals**	Insurance Terms and Conditions for Fixed-Term Health Insurance Policies of the EXPAT Series for Long-Term Travels, Insurance Part I and Part II (EXPAT FLEXIBLE).
C6	**Scope of Application**	1. In compliance with the Insurance Terms and Conditions Part I, Art. 1 paragraphs 1 and 5 as well as the Insurance Terms and Conditions Part II, number 14, the Insured Person shall benefit from a worldwide insurance coverage during temporary stays outside of those countries where he or she has a usual place of abode or place of residence. Restricted coverage shall exist for stays in the USA and in Switzerland. a) If the area of applicability „worldwide, except for the USA, Canada, Switzerland" is selected, insurance coverage shall exist for holiday- and work-related stays in the USA, Canada and in Switzerland for an aggregate term of not more than 42 days during the insurance year. Insurance coverage shall, however, in no case exist earlier than after 60 days as from the start of the insurance coverage indicated in the confirmation of cover. Insurance coverage shall, however, be limited to an acutely occurring need for treatment. If the need for treatment of a disease was already known prior to the entry, coverage shall be excluded. Treatments becoming necessary for periods exceeding 42 days shall not be covered. The Insurer shall be given notice of the stay prior to entry. Upon request, evidence of the start and end of a stay must be submitted. b) If the area of applicability „worldwide, except for the USA, Switzerland" is selected, insurance coverage shall exist for holiday- and work-related stays in the USA and in Switzerland for an aggregate term of not more than 42 days during the insurance year. Insurance coverage shall, however, in no case exist earlier than after 60 days as from the start of the insurance coverage indicated in the confirmation of cover. Insurance coverage shall, however, be limited to an acutely occurring need for treatment. If the need for treatment of a disease was already known prior to the entry, coverage shall be excluded. Treatments becoming necessary for periods exceeding 42 days shall not be covered. The Insurer shall be given notice of the stay prior to entry. Upon request, evidence of the start and end of a stay must be submitted. c) With respect to holiday- or work-related stays of German citizens in Germany, insurance coverage shall exist for not more than an uninterrupted period of 60 day. As a whole, insurance coverage shall exist for a term of not more than 90 days per insurance year. Insurance coverage shall, however, in no case exist earlier than after 60 days as from the start of the insurance coverage indicated in the confirmation of cover. Upon request, evidence of the start and end of a stay must be submitted. 2. In the countries where the Insured Person has a usual abode or place of residence, insurance coverage shall exist according to the Insurance Terms and Conditions Part I, Art. 1 and to the extent that such countries are included due to a selection of the corresponding scope of application (Insurance Terms and Conditions Part II, number B1). Restricted coverage shall exist for stays in the USA and in Switzerland subject to 1.a) and b). 3. It shall be the responsibility of the Insured Persons to check whether the insurance fulfils the legal or local requirements applicable in the country of the usual abode or place of residence.
C7	**Start of Insurance Coverage**	At the time indicated in the confirmation of cover by taking due account of the Insurance Terms and Conditions Part I, Art. 4.
C8	**Insurance Year**	From 01 January to 31 December of a year.
C9	**Term of the Insurance Relationship**	**EXPAT FLEXIBLE BASIS**: Not more than 60 months **EXPAT FLEXIBLE PLUS**: In accordance with the term of the Basis module; conclusion only possible in connection with the Basis module.
C10	**Termination of the Insurance Relationship**	The insurance relationship for individual Insured Persons may be terminated towards the Policyholder at any time by the Person Entitled to be Insured or the Insured Person. If it is terminated it shall end upon expiry of the month following the month of termination.
C11	**Information on the State of Health**	For assessing the state of health at the time of contract execution, a health questionnaire shall be filled in completely and accurately for each Person to be Insured from who is 50 years of age or older. The Insurer or its authorised representative reserves the right to perform a risk analysis and shall decide upon the acceptance of the application. Depending on the outcome of the health check-up, the Insurer or its authorised representative reserves the right to incorporate additional provisions in the insurance terms. Please note the exclusions of benefits in the Insurance Terms and Conditions Parts I and II.
C12	**Qualifying Period**	**EXPAT FLEXIBLE BASIS**: No qualifying period **EXPAT LEXIBLE PLUS**: 8 months for dentures and orthodontic measures.
C13	**Miscellaneous**	A subsequent change between the modules or a subsequent addition of a module shall not be possible. Ageing reserves shall not be made. The conclusion of an insurance for reinstatement of health care coverage after suspension is recommended.

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INSURANCE TERMS AND CONDITIONS

for Fixed-Term Health Insurance Policies of the Expat Series for Long-Term Travels (Insurance Terms and Conditions Part I - Swiss Life Prévoyance et Santé)

Art.1 Insurable Persons and Eligibility for Insurance

Unless otherwise provided for, the following shall apply:

1. The application for inclusion of Insured Persons in the group insurance contract may be filed by Parties Entitled to be Insured only. Parties Entitled to be Insured shall be legal and natural persons, as defined in the respective underlying insurance terms.
2. Persons eligible for insurance shall be natural persons.
3. Not eligible for insurance and despite of insurance premium payments not insured shall be
   a) persons in need of permanent care. A person in need of permanent care shall be a person who needs the assistance of others for the majority of activities of daily life;
   b) persons whose participation in community life is permanently excluded. For classification purposes, the mental condition and the objective circumstances of life of the respective person are to be taken into account.
4. Coverage in Germany shall not exist for Insured persons whose centre of life is not only temporarily in the Federal Republic of Germany.
5. For Insured Persons holding a fixed-term residence document for the Federal Republic of Germany as well as for persons who are not in need of a residence document, the total period of all health insurance contracts which have been concluded during their stay at the time of applying for inclusion in the group insurance contract must not exceed a period of five years. Thus, the maximum insurance term for stays in Germany shall amount to a total of five years. In the event that a shorter term is agreed upon, a new contract of the same kind shall be subject to a maximum term that does not exceed a period of five years inclusive of the term of the expired contract. This shall also apply if the contract is concluded with another Insurer.

Art.2 Conclusion and Termination of the Insurance Contract

1. The group insurance contract shall be concluded between the Policyholder and the Insurer for a term of one year. The group insurance contract shall be extended by one year unless terminated at least three months prior to the end of the respective term.
2. The Policyholder shall be obliged to give the Persons Entitled to be Insured and the Insured Persons a notice in textual form of the termination of the group insurance contract two months prior to the date of effectiveness of the termination.
3. The statutory provisions on the extraordinary right to terminate shall remain unaffected.
4. Upon termination of the group insurance contract, the Insured Persons shall receive an offer about a continuation of the insurance coverage from the Insurer.
5. In the event that the Party Entitled to be Insured and the insured person are not identical, a termination will become effective only if the insured person affected by the termination has acquired knowledge of the termination letter and the Policyholder submits a corresponding evidence in this respect with the Insurer when causing the deregistration from the group insurance contract. In that case, the insured person concerned shall have the right to continue the insurance contract by indicating a future Party Entitled to be Insured. The declaration to this effect must be made within two months after receipt of the letter of termination.

Art.3 Insurance Premiums, Adjustment of Benefits, Insurance Year

1. The insurance premium shall be an annual contribution indicated in equal monthly instalments. It shall in each case be due and payable in advance until the end of the insurance year.
2. The Policyholder shall be entitled to de-register individual Insured Persons from the group insurance contract if they fail to pay the insurance premium.
3. The Insurer shall be entitled to adjust the premium or the volume of insurance benefits at the commencement of a new insurance year, always provided that the Policyholder is given notice of this intention three months prior to the end of the respective insurance year.
4. The insurance year is defined in the Insurance Terms and Conditions Part II for Fixed-Term Health Insurance Policies of the Expat Series for Long-Term Travels.
5. The Policyholder shall be obliged to inform the Persons Entitled to be Insured and the Insured Persons about an adjustment of the premium or the volume of insurance benefits in textual form two months prior to the end of the respective insurance year.

Art.4 Area of Application, Commencement, Term and Termination of Insurance Coverage

The Insurer offers Insured Persons staying in the area of applicability agreed upon within the framework of a fixed-term stay insurance coverage within the framework of these Insurance Terms and Conditions. Unless otherwise provided for, the following shall apply:

1. Insurance coverage for the Insured Person shall start after his or her binding inclusion in the group insurance contract and on the date indicated in the confirmation of cover (commencement of insurance coverage),
   a) but not prior to the start of the Insured Person's stay in the area of applicability agreed upon;
   b) not prior to the commencement of the Insured Person's eligibility for insurance;
   c) not prior to the payment of the insurance premium;
   d) not prior to the expiry of qualifying periods agreed upon.
2. Insurance claims occurred or existing prior to the start of the insurance coverage shall not be covered.
3. Insurance claims occurred during the qualifying period agreed upon in connection with the respective product shall not be covered.
4. The maximum insurance term for the Insured Persons is defined in the Insurance Terms and Conditions Part II of the respective product.
5. Insurance coverage for individual Insured Persons shall terminate, also with respect to insurance claims not yet settled:
   a) upon termination of the insurance relationship of the insured person but in no case later than upon expiry of the maximum insurance term of the selected product;
   b) upon de-registration from the group insurance contract by the Policyholder by taking due account of the product-specific terms and prerequisites;
   c) upon the death of the insured person;
   d) upon expiry of the month following the end of the temporary stay of the Insured Person in the area of applicability agreed upon or the definite return of the insured person to his or her home country;
   e) as soon as an Insured Person ceases to meet the requirements for his or her eligibility for insurance according to the Insurance Terms and Conditions Part I, Art 1;
   f) as soon as the product-specific requirements to be fulfilled for an eligibility for insurance of the Insured Person cease to exist;
   g) upon termination of the group insurance contract between the Insurer and the Policyholder.

Art.5 Subject Matter of Insurance Coverage and Volume of Insurance Benefits

Unless otherwise provided for, the following shall apply:

1. Insurance coverage can be derived from the confirmation of cover, these Insurance Terms and Conditions, the selected product and the statutory provisions applicable in the Federal Republic of Germany.
2. An insured event shall consist in the medically necessary treatment of an insured person due to illness or consequences of an accident. The insured event shall come into being upon the start of the medical treatment and end as soon as the need for treatment ceases to exist according to medical assessments. In the event that the medical treatment must be extended to a disease or to consequences of an accident having no causal connection to

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the initially treated illness, a new insured event shall be deemed to have come into being.

3. To the extent that the respective product provides for corresponding benefits, insured events shall also include:
   a) medical treatments inclusive of pregnancy examinations and treatments, always provided that the pregnancy did not yet exist at the start of the insurance relationship of the insured person, as well as treatments due to miscarriage;
   b) medically necessary pregnancy treatments due to acute symptoms and treatments due to miscarriage as well as medically necessary abortions and childbirths until the end of the 36th week of pregnancy (preterm delivery), even if the pregnancy already existed at the start of the insurance relationship of the insured person, always provided that a need for treatment did not exist at that time;
   c) childbirths after expiry of the product-specific qualifying period;
   d) outpatient examinations for early detection of diseases according to statutory programmes in Germany (targeted preventive checkups);
   e) death.
4. Depending on the insured product, the Insurer shall pay compensation for acutely and unforeseeably occurred insured events during the stay in the area of applicability agreed upon.
5. Kind and amount of the insurance benefits can be derived from these Insurance Terms and Conditions and the product selected in each case.
6. In the area of applicability agreed upon, the insured person may choose between legally recognized and licensed physicians, dentists, alternative practitioners and midwives who are registered in the visited country, always provided that they charge their fees according to the official fee schedule, if any, valid at the time being for their professional group or charge the locally customary fee.
7. Pharmaceutical products, bandages and remedies as well as aids and appliances must have been prescribed by the treating persons indicated in the Insurance Terms and Conditions Part I, Art. 5 paragraph 6, and pharmaceutical products must furthermore be purchased in pharmacies. Pharmaceuticals shall not, even not if medically prescribed, include nutriments, tonics, mineral water, disinfectants, cosmetic products, diet food and baby food and the like.
8. In the event of a medically necessary inpatient hospital treatment, the insured person may choose among public and private hospitals which are permanently managed by physicians, have sufficient diagnostic and therapeutic possibilities, record and keep medical histories and do not offer spa or sanatorium treatments and do not accept reconvalescents. Insurance coverage shall exist for the general care class (multi-bed room) without optional services (private medical treatment), unless otherwise agreed upon with respect to the specific product.
9. In the event of medically necessary treatments in hospitals which also provide spa or sanatorium treatments or accept reconvalescents, but otherwise comply with the requirements set forth in the Insurance Terms and Conditions Part I, Art. 5 paragraph 8, product-specific insurance benefits shall be provided only if the Insurer has given its written consent in this respect prior to the start of the treatment. In case of tuberculosis diseases, coverage shall exist within the scope of the insurance contract also if an inpatient treatment is carried out in tuberculosis clinics and sanatoriums.
10. Within the scope of the insurance contract, coverage shall exist for examination or treatment methods and medicines which are largely recognized in traditional medicine. In addition, methods and medicines which proved to be successful in practice or which are used for lack of traditional medical methods or pharmaceuticals shall be covered; the Insurer may, however, reduce its payments to the amount which would have been charged if traditional medical methods or pharmaceuticals had been applied.
11. Within the agreed volume, the Insurer shall pay for transfer and funeral expenses if the death of an insured person is due to an insured event.
12. Coverage shall, within the agreed volume, exist for additional costs arising for medically necessary and prescribed return transports to the nearest suitable hospital in the home country or at the place of the permanent residence of the insured person. A return transport shall be deemed to be necessary from a medical point of view if it can be shown that a sufficient medical treatment and care in the area of applicability agreed upon cannot be guaranteed and the physician appointed by the Insurer endorses the return transport. Costs for a co-insured accompanying person shall be reimbursed by the Insurer to the extent that such company is medically necessary, has been ordered by public authorities or is required by the acting transport company.

Art.6 General Restrictions of Insurance Benefits

Unless otherwise provided for, the following shall apply:

1. Damage or injuries caused by an active participation in strikes, war, warlike events, civil commotion, damage or injuries due to nuclear energy as well as damage or injuries caused by intentional acts of the Policyholder, the Party Entitled to be Insured or the insured person shall be excluded from coverage.
2. A duty to pay insurance benefits shall not exist with respect to:
   a) diseases and ailments inclusive of their consequences already existing and known at the time of the commencement of the insurance coverage. Apart from that, the consequences of those diseases and accidents which were treated during the last six months prior to the commencement of the insurance coverage shall not be covered;
   b) spa treatments and treatments in sanatoriums as well as rehabilitation measures of the statutory rehabilitation providers;
   c) treatments during a stay in a health resort or spa, also if the insured person stays in a hospital there. The restriction shall not apply if the insured person has his or her permanent residence at that place or becomes unable to work during a temporary stay due to an acute disease incurred independently from the purpose of the stay or due to an accident occurring at that place as long as said acute disease or accident makes a departure impossible from a medical point of view. Furthermore, the restriction shall not apply if and to the extent that the Insurer has given its written consent to benefits prior to the start of the stay;
   d) a treatment or accommodation based on infirmity, a need for care or custody;
   e) a treatment of mental or psychological disorder as well as hypnosis, psychoanalysis and psychotherapy;
   f) immunisation measures;
   g) aids and appliances;
   h) a treatment due to sterility, inclusive of artificial insemination as well as preliminary examinations and follow-up treatments related thereto;
   i) preventive medical checkups;
   j) treatments by spouses, parents, children, persons living in a common household or persons with whom the insured person lives together within an own family or the host family. Depending on the product agreed upon, documented material costs shall be reimbursed;
   k) treatments due to diseases inclusive of their consequences as well as due to the consequences of accidents caused by a profession-related participation in sporting competitions or competitions organised by associations and clubs, inclusive of their preparations, or recognized as damage or injury due to military services and not explicitly included in the insurance coverage;
   l) withdrawal treatments inclusive of withdrawal cures;
   m) treatments due to those diseases inclusive of their consequences, which occur because protective vaccinations recommended by the World Health Organisation or prescribed by law were omitted, unless such vaccinations were precluded for medical reasons. In this case, the medical reasons must be supported by a medical certificate to be submitted to the Insurer.
   n) treatments of a dependency syndrome and its consequences;
   o) suicide attempts and their consequences;
   p) organ donations and their consequences;
   q) dentures (like, e.g. pivot teeth, inlays, crowning, implants) and orthodontic treatments, occlusal splints and gnathological measures.
3. Unless otherwise agreed upon, the Insurer shall not be obliged to pay for treatments by physicians, dentists, alternative practitioners and clinics or midwives if a reimbursement of their invoice amounts has been excluded by the Insurer for good reason. As a precondition, the Insurer must have informed the Party Entitled to be Insured and the insured person prior to the occurrence of the insured event about those treating persons whose invoices will not be reimbursed. If an insured event has occurred prior to said notice, the costs incurred for treatments by the respective treating person must be reimbursed according to insurance benefits provided for in the respective product for a period of not more than three months as from the date of such notice.
4. If medical treatments or other measures for which benefits were agreed upon exceed the medically necessary extent or in the event that the claimed remuneration is not adequate when compared with local customary practices, the Insurer shall be entitled to reduce its payments to a reasonable amount.

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Art.7 Obligations and Consequences of their Infringement

1. After an insured event has occurred, the Policyholder, the Party Entitled to be Insured and the insured person shall be obliged
   a) to refrain from anything which could result in an unnecessary increase of costs;
   b) to give the Insurer or its authorised representative immediate notice of any damage or injury expected to exceed a sum of EUR 1,000;
   c) to permit the Insurer or its authorised representative to carry out any reasonable examination with respect to the cause and amount of its payment duty, to give any pertinent information in this context, to file original supporting documents and, in case of death, to submit the death certificate.
2. The Insurer must be given notice of every hospital treatment within a term of 10 days after its commencement.
3. The corresponding supporting documents shall be submitted to the Insurer by the Insured Person within a term of three months after each individual treatment.
4. In the event that insurance coverage of medical costs incurred by the insured person has also been concluded with another Insurer or such insurance coverage exists or the insured person makes use of his or her right to be insured within the framework of the statutory health insurance scheme, the Party Entitled to be Insured and the insured person shall be obliged to give the Insurer immediate notice of such other insurance.
5. Unless otherwise provided for in the product, pregnancies shall be reported to the Insurer within 4 weeks after having become aware of them.
6. Medically necessary return transports must be reported to the Insurer prior to carrying them out.
7. Upon request of the Insurer, the insured person shall be obliged to have himself or herself examined by a physician appointed by the Insurer.
8. If insurance benefits are paid, start and end and interruptions of a stay in the area of applicability as well as the fulfilment of the product-specific prerequisites for an eligibility for insurance have to be proved by the Insured Person upon the Insurer's request.
9. Stays in the USA/Canada/Switzerland and in Germany for holiday- or profession-related reasons shall be reported to the Insurer or its authorised representative prior to the start of the travel.
10. The Party Entitled to be Insured and the insured person shall be obliged to give the Policyholder immediate notice of any changes of their addresses.
11. If the Policyholder, the Party Entitled to be Insured or the insured person intentionally fails to comply with one of the obligations contractually agreed upon, the Insurer shall not be obliged to make payments. In the event of a grossly negligent violation of obligations, the Insurer shall be entitled to reduce insurance payments in proportion to the severity of the negligence of the Policyholder, the Party Entitled to be Insured or the insured person. The burden of proving that gross negligence has not occurred shall lie with the Policyholder, the Persons Entitled to be Insured or the insured person.

Art.8 Payment of Insurance Benefits

Unless otherwise provided for, the following shall apply:

1. The Insurer shall only be obliged to pay if the following supporting documents which will become the property of the Insurer - have been submitted:
   a) original supporting documents for payments actually made which show the surname, Christian name and date of birth of the treated person, the name and address of the treating person, the name of the disease, the description of the services rendered by the treating person as to kind, place and period of the treatment. In the event that medical treatment expenses are covered by another insurance and said other Insurer is claimed on first, copies of the invoices with refund endorsements shall be sufficient to give evidence in this respect. Supporting documents which were prepared in a foreign language and are important for the insurance benefits must, upon the Insurer's request, be accompanied by German or English translations;
   b) recipes shall be submitted together with the physician's invoice, the invoice for remedies, aids and appliances together with the prescription;
   c) if claims for reimbursement of costs for a medically necessary return transport are asserted, documents supporting the amount of expenses which would have incurred in the event of a scheduled return journey shall be submitted. In addition, a medical certificate about the medical necessity of the return transport must be submitted;
   d) in addition, the official certificate of death and a medical certificate about the cause of the death must be submitted if reimbursement of transfer or funeral expenses is claimed.
2. Expenses incurred in a foreign currency shall be converted to the currency valid at that time in the Federal Republic of Germany by applying the rate applicable on the day of the receipt of the supporting documents with the Insurer, unless it can be shown that the foreign currencies required for paying the invoices were bought at a less favourable exchange rate and that this was due to a change of currency parities.
3. Additional costs arisen because the Insurer remits amounts to a foreign country or because special transfer methods were agreed upon may be deducted from the insurance payments.
4. Claims for insurance benefits must not be assigned or pledged.
5. Within the framework of the examination of insurance benefits payable for an insured event it may become necessary that the Insurer collects personal health data to the extent permitted by law. In the event that the Party Entitled to be Insured or the insured person culpably fails to permit such data collection and no other opportunity to examine the claimed payments is made possible and, as a result, the Insurer is not able to finally determine the amount and volume of its payment obligation, payments shall not become due.
6. One month after having given notice of the insured event, the minimum amount to be paid on the merits of the case may be claimed as down payment. Passage of time shall be suspended as long as the Insurer is prevented from examining the claims due to a fault of the Policyholder, the Party Entitled to be Insured or the insured person.
7. Claims arising from this group insurance contract shall be subject to a limitation period of three years. The limitation period shall commence upon expiry of the year during which the respective payment can be requested.

Art.9 Compensation from Other Insurance Contracts and Claims against Third Parties

1. If compensation from another insurance contract can be claimed in case of an insured event, said other contract shall have priority over this contract. This shall also apply if a subordinated liability has been agreed upon in one of those insurance contracts, irrespective of the time when the other insurance contract was concluded. In the event that the insured event is, within the framework of this group insurance contract, at first reported to the Insurer, the latter shall make an advance payment and contact the other Insurer for cost-sharing purposes directly.
2. The claims of the Policyholder, the Party Entitled to be Insured or the insured person against third parties shall - to the extent permitted by law - be assigned to the Insurer if the latter has paid compensation for the damage or injury. To the extent necessary, the Policyholder, the Party Entitled to be Insured or the insured person shall be obliged to provide the Insurer with a declaration of subrogation. The Insurer's obligation to pay insurance benefits shall be suspended until said declaration of subrogation has been submitted.
3. The claims of the Policyholder, the Party Entitled to be Insured or the insured person against treating persons due to excessive fees shall - to the extent permitted by law - be assigned to the Insurer if the latter has reimbursed the respective invoice amounts. As far as necessary, the Policyholder, the Party Entitled to be Insured and the insured person shall be obliged to assist the Insurer when enforcing its claims. To the extent necessary, the Policyholder, the Party Entitled to be Insured or the insured person shall be obliged to provide the Insurer with a declaration of subrogation, if necessary. The Insurer's obligation to pay insurance benefits shall be suspended until said declaration of subrogation has been submitted.

Art.10 Setoff

The Policyholder, the Party Entitled to be Insured or the insured person shall only be entitled to offset own claims against claims of the Insurer if the counterclaims are undisputed and have been determined with legal effect.

Art.11 Declarations of Intent and Notices

Declarations of intent and notices forwarded to the Insurer shall be subject to text form (letter, fax message, e-mail, electronic data carrier etc.). The insured person shall have an own right to assert claims arising from the contract against the Insurer.

State: 14.09.2020

Art.12 Applicable Law/Contract Language

The applicable law shall be the German law, unless this is contrary to international law. Contract language shall be the German language.

Art.13 Profit Participation

This insurance shall not be eligible for a participation in profits.

Art.14 Supervisory Authority and Complaints Offices

In the event that you are not satisfied with a benefit paid or a decision made by the Insurer, please contact the respective Insurer directly.

The competent authorities for complaints relating to this insurance contract shall be the Federal Financial Supervisory Authority (BaFin / Bundesanstalt für Finanz- dienstleistungsaufsicht), Graurheindorfer Straße 108, 53117 Bonn, and the Autorité de Contrôle Prudentiel et de Résolution (ACPR - the French Insurance Supervisory Authority), 4 Place de Budapest CS 92459, 75436 Paris Cedex 09, France.

In the event of disputes arising from the application of this contract, the Policyholder and the Insured Persons shall explain the reasons for their complaint or refusal by means of a letter addressed to the Customer Service Department (Direction Services Clients), Assurances Collectives SwissLife Prévoyance et Santé - 7, rue Belgrand 92682 Levallois-Perret Cedex, France.

If the response is not satisfactory the Policyholder and the Insured Persons shall have the right to obtain the opinion of an independent mediator. Upon request, the conditions for an access to the ombudsman shall be made available to you at the head office of Swiss Life Prévoyance et Santé – 7, rue Belgrand 92300 Levallois-Perret France.

State: 14.09.2020

EXPLANATIONS

concerning the particularities of a group insurance policy and the duties according to the German Insurance Contract Act (VVG)

The particularities of a group insurance policy

Insurance coverage shall be granted within the framework of a group insurance contract (GIC). The policyholder shall be a company of the BDAE Group (BDAE) and the insurer shall be an insurance company permitted to conduct business operations in Germany pursuant to the German Insurance Contract Act (VAG). The insured person shall be granted insurance coverage by joining the group. Thus, the VVG shall not apply directly and immediately to the relationship between the policyholder and the insured person.

However, the rules from the VVG described in more detail below, in particular Art. 19 to 22, are applied in the legal relationship between the insured person and the policyholder (BDAE), which you confirm by your signature.

In compliance with the requirements of the supervisory authority, the GIC provides for some improvements of the legal situation of the insured person:

- In derogation from Art. 44, paragraph 2 VVG, the insured person may assert claims directly towards the insurer of the GIC.
- In derogation from Art. 35 VVG, the insurer shall not be entitled to set-off against claims not attributable to the insured person.
- The insured person shall be provided with any and all information usual pursuant to Art. 7 VVG and the VVG Decree on Information Duties.
- The insured person shall be given notice of any change, including a termination, of the GIC.
- The insured person shall hold a right of revocation similar to the one provided for in the VVG.
- Insured persons shall benefit from the principle of equality pursuant to Art. 138, paragraph 2 VAG.

According to the same requirements of the supervisory authority, certain obligations shall likewise apply to the insured persons; in this context, particularly the knowledge of the insured person and his or her behaviour shall be taken into account with respect to the insurance company's payment duties:

Art. 19, paragraph 5 VVG - consequences of an infringement of the statutory duty to disclose

For enabling BDAE to examine your application properly, you shall be obliged to give true and complete answers to the questions included in the application documents. This shall also relate to circumstances which might be of low importance from your point of view. If there is any information you do not want to disclose towards the intermediaries, please send it in text format directly to the BDAE without any delay. **Please note that you put your insurance coverage at risk when giving incorrect or incomplete information.** For more details about the consequences of an infringement of the duty of disclosure, reference is made to the information following hereinafter.

What are your pre-contractual duties of disclosure?

By the time when you make your contractual statement, you shall be obliged to give true and complete notice of any and all risk-relevant circumstances known to you and requested by us in text format. Risk-relevant circumstances are defined as circumstances relevant for the decision of BDAE to conclude the contract with the contents agreed upon. In the event that, after your contractual statement, but prior to the acceptance of the contract, BDAE asks you in text format to give information on risk-relevant circumstances, you shall also to this extent be obliged to report.

What are the potential consequences of an infringement of a pre-contractual duty to disclose?

1. **Rescission and loss of insurance coverage**

   If you and/or the person to be insured fail to comply with the pre-contractual duty of disclosure, BDAE may rescind the contract, unless you are able to show that you did not infringe the duty of disclosure either intentionally or with gross negligence. In the event of a grossly negligent infringement of the duty to disclose, BDAE shall not be permitted to rescind the contract if the contract would also have been concluded in case of knowledge of the undisclosed circumstances, even if such conclusion would have been made subject to other conditions. If the contract is rescinded, there will be no insurance coverage. If BDAE rescinds the contract after occurrence of an insured event, BDAE shall nevertheless be obliged to pay, always provided that you are able to show that the undisclosed or incorrectly disclosed circumstance was neither the cause of the occurrence or determination of the insured event nor the cause of the determination or extent of the payment obligation related thereto. If you fraudulently infringe the duty to disclose, there shall be no payment obligations at all. If BDAE rescinds the contract due to an infringement of the duty of disclosure, the insurance premium must nevertheless be paid until the date when the rescission becomes effective.

2. **Termination**

   If BDAE cannot rescind the contract because you did not infringe the pre-contractual duty of disclosure either intentionally or with gross negligence, the contract may be terminated with one month's notice. A right of termination shall be excluded if the contract would also have been concluded in case of knowledge of the undisclosed circumstances, even if it would have been made subject to other conditions.

3. **Contract amendment**

   If BDAE cannot rescind or terminate the contract because the contract would also have been concluded in case of knowledge of the undisclosed risks, even if under different conditions, such other conditions shall, upon request of BDAE, retroactively become part of the contract in the event that you have negligently infringed your duty to disclose. In the event that the premium increases by more than 10 % due to the contract amendment or if BDAE excludes coverage of the risk related to the undisclosed circumstance, you may terminate the contract without notice within a term of one month after receipt of the notice on the contract amendment. BDAE will draw your attention to such right.

4. **Exercise of the rights of the BDAE Group (Art. 21 VVG)**

   BDAE may assert its rights of rescission, termination or contract amendment in writing within a term of one month. Such term shall start at the time when BDAE gets knowledge of the infringement of the duty of disclosure underlying the right asserted by it. When exercising its rights, BDAE shall indicate the circumstances upon which it relies when asserting its rights. For substantiation purposes, BDAE may subsequently indicate additional circumstances if the term according to sentence 1 has not yet lapsed. BDAE shall not be able to rely on the rights of rescission, termination or contract amendment if BDAE was aware of the undisclosed risk or the incorrectness of the rendered information. The rights of rescission, termination and contract amendment shall become time-barred upon expiry of three years after contract conclusion. This shall not be applicable to insured events occurring prior to the expiry of said term. The term shall be extended to ten years if you infringed your duty to disclose intentionally or fraudulently.

5. **Wilful deception (Art. 22 VVG)**

   The right of BDAE to contest the contract due to wilful deception shall remain unaffected.

6. **Representation by another person (Art. 20 VVG)**

   If, at the time of contract conclusion, you have yourself represented by another person, both the knowledge and fraudulent behaviour of your representative and your own knowledge and fraudulent behaviour shall be taken into account with respect to the duty of disclosure, a rescission, termination, contract amendment or the limitation period for the exercise of the insurer's rights. You may rely on not having infringed the duty to disclose intentionally or with gross negligence only if the absence of intentional and grossly negligent behaviour relates both to your representative and to yourself.

☐ I have taken note of the explanations and agree to the applicability of the listed provisions of the VVG to the group insurance contract.

Place, date

Signatures
(Applicant, if appropriate as legal representative of persons to be co-insured and all persons of full legal age to be insured)

State: 01.12.2021

Supplementary Service:

PATIENT LEGAL EXPENSES INSURANCE FOR BDAE CLIENTS

In addition to your overseas health insurance, BDAE has concluded for you a patient legal expenses insurance for foreign countries without charge. Said insurance shall **provide protection against medical treatment and medical advice errors**. Thanks to the cooperation between BDAE and ARAG, said patient legal expenses coverage shall be available for you on a worldwide basis.

What is Insured?

The insurance policy shall become applicable whenever physicians or medical staff have committed treatment errors causing harm to you in any manner. True, the relationship between physicians and patients is based on confidence. Nevertheless, also medical professionals may make mistakes. In such events, it is often particularly difficult for patients to get justice when involved in a complicated conflict about treatment errors. This is all the more true because patients will in such events usually be forced to hold discussion with the professional liability insurance of the medical professional rather than with the treating physician himself or herself.

- **Legal disputes up to one million Euros** each shall be covered on a worldwide basis. Up to this amount, ARAG shall assume all lawyer's and legal costs.
- Upon request, the insurer shall also recommend a lawyer **specialised in medical law**.
- Access to the ARAG **online legal service** providing approx. 1,000 legally verified sample letters and documents from various fields of law.
- Within the framework of ARAG-JuraTel®, lawyers will be available for an **initial consultation by phone** in order to help you in case of claims for damages or in the event of an alleged criminal offence.
- Once per calendar year, you will be able to consult a lawyer accredited in Germany in order to prepare or amend an advance health care directive inclusive of an enduring power of attorney; in this context, an amount of up to EUR 250 shall be covered.

Which Errors are deemed to be Medical Treatment or Advice Errors?

It is not only the much-cited pair of scissors forgotten in the abdomen during a surgical intervention that must be regarded as treatment error. To give only one example, such errors also include a faulty advice on the dosage of a medicine. Hence, an inappropriate, particularly a careless, improper or delayed treatment of a patient by a physician shall be regarded as treatment error. If a physician has failed to inform a patient about the necessities and risks of a treatment, such failure shall be regarded as **medical advice error** – also covered by this insurance. All this shall not only apply to physicians, but also to hospital staff, psychotherapists, pharmacists or nursing services. With respect to the patient legal expenses insurance, all these persons have the same status as physicians.

About ARAG

ARAG is the largest family-owned company in the German insurance sector and considers itself as versatile quality insurer. Apart from its focus on legal expenses insurances, it also provides its customers in Germany with attractive need-based products and services under one roof in the fields of composite services, health and prevention. Operating in a total of 17 countries, inclusive of the USA and Canada, and offering a range of legal expenses insurances and legal services, ARAG furthermore holds a leading position in many international markets via its international branches, companies and shareholdings or interests. With its more than 4,000 employees, the group generates sales and premiums in a volume of more than EUR 1.6 billion.BDAE has been cooperating with the company since 2008. ARAG and BDAE have jointly developed the first legal expenses insurance for overseas stays that applies on a worldwide basis.

State: 30.09.2019

Supplementary Service:
MEDICAL ASSISTANCE FOR BDAE CLIENTS AND MEMBERS

Whoever is in need of medical care while staying abroad attaches importance to a rapid, qualified and seamless assistance. For this reason, the BDAE Group has integrated an Assistance Programme including the corresponding assistance, emergency and service offers in its insurance concept. The following assistance services shall be made available by BDAE to its insured persons and members in cooperation with the specialist Allianz Partners Deutschland GmbH:

- Multi-language, qualified **24 hour** emergency hotline
- **Worldwide network** of medical service providers
- Information on dental/**medical insurers** (e.g. names, addresses and phone numbers as well as consulting hours of physicians, dentists, hospitals and clinics within the actual region of stay)
- **Patient advice** in routine and emergency cases
- Assistance when fixing treatment dates with hospitals and physicians for outpatient treatments
- Organisation of the **admission to a hospital** in case of illness
- Help and **support of relatives** by providing country-specific data and information on health care services
- **Information transmission between primary physician and hospital** as well as message transfer service
- Assistance with respect to the procurement and **dispatch of prescription medicines** (to the legally permissible extent)
- Organisation of **interpreting** and translation services
- **Wordwide Access to medical information** in German and English
- Consulting and assistance in case of loss of important documents and means of payment

In addition to the assistance services mentioned on the left, BDAE shall upon request pay the costs for further services in connection of which the Allianz Partners Deutschland GmbH seeks authorisation directly from the BDAE and its risk carrier (insurer). These services include:

- Organisation of emergency evacuations as well as transfers to other suitable hospitals in medically necessary cases
- Organisation and implementation of repatriations up to EUR 250,000 per insured event
- Implementation and assumption of costs for transfers in case of death up to EUR 10,000

These services may be requested by person insured with the BDAE and BDAE members 24 hours a day and on 365 days a year. In order to guarantee a smooth operation, please ensure that you have your BDAE insurance number or your membership number ready when contacting Allianz Partners Deutschland GmbH.

24/7 Emergency Preparedness of the BDAE under

+49-40-30 68 74-74

State: 13.04.2021

Emma

Medical information always at hand with your personal Health Assistant

Thanks to the Digital Health Assistant *Emma*, you can access comprehensive health services straight from your smartphone. *Emma* is available to all BDAE customers – wherever they are!

Unique features

Instant information on your medical questions

Emma provides the most immediate medical guidance at any hour of the day:

- Text your questions to a medical professional
- Symptom checker provides instant medical guidance
- Explore reliable content about your symptoms from clinical partners

Healthcare provided at your convenience

Emma is conveniently managed through your preferred messenger service, and fits your schedule:

- All interactions centralised in your favorite chat app
- Inquire, respond and follow up at your convenience
- No download/installation required, simple initial registration

Human perspective on-demand

Emma connects you with healthcare professionals and provides medical information on demand:

- Medical hotline available in German and English
- DoctorChat to chat with medical professionals

Emma: it's that easy!

Start with a simple registration and use any of Emma's services at your convenience!

Visit the registration page via the link you have received and select your favorite messenger application. You can then start chatting with Emma by entering your personal activation code.

1

Your digital health assistant is available to you 24/7 via smartphone and PC

2

Ask about your symptoms

3

Read information on your symptoms, provided by Emma

4

Text a question to a medical professional and receive a personal response within minutes

5

Keep track of your medical chats and procedures on your messenger app

6

Call the BDAE medical hotline if your concern could not be clarified or you have questions relevant to the contract

Want to know more about Emma?

Who or what is Emma?

Emma is virtual health assistant – available 24/7 via WhatsApp, Telegram or our secure Webchat. Emma is a chatbot which gives you access to various helpful health services. You can, for example, assess your symptoms, ask a question to a medical professional or call him or her directly to get medical advices.

How much does Emma cost?

For you, as a customer of BDAE, Emma is free of charge. The service is fully included in your existing policy.

Who is behind Emma?

Emma is a virtual health assistant created and managed by Medi24, a trusted telehealth provider based in Switzerland, providing 24-hour telehealth services and medical assistance. Medi24 is a member of the Allianz Partners Group, the world's leading provider of assistance services.

Where can I find my activation code?

You will receive the link along with your personal activation code together with the confirmation of your BDAE insurance coverage. If you have any questions, please contact our Service team (contractinformation@bdae.com or +49-40-306874-23/43).