Terms and Conditions

of the group iPMI policy
coverage for individuals

VYV International Benefits
acting in the name and on behalf of
MGEN International Benefits and MFPrévoyance

April 2023

Content

1. Terms and Conditions

The purpose of this document is to define the terms and conditions of the insurance cover for Primary Members and other Covered Persons available through the **Association for Insurance Coverage** (the "Association"), with reimbursement of medical and related expenses, in accordance with the terms and conditions set out below (the "Policy").

Coverage is defined by:

- The present Policy and its appendices including the Membership Certificate ("Membership Certificate");
- A policy booklet, if applicable; and
- A data privacy notice

all of which form an integral part of the Policy.

All definitions in this Policy are defined in section 2 "Definitions," hereto, or in the document text itself.

EFFECTIVE DATE, DURATION, AND ANNIVERSARY DATE

Coverage under this Policy comes into effect on the date specified on the Membership Certificate ("Policy Effective Date"). The policy anniversary date ("Policy Anniversary Date") will fall on each anniversary of the Policy Effective Date.

Coverage under this Policy will continue unless the coverage has otherwise been terminated, and contingent upon the Primary Member and other Covered Persons continuing to be eligible for coverage, (ii) the Masterpolicy between the Insurer and the Association not having been terminated, (iii) the Primary Member having agreed to the changes of rates or terms set out in a request delivered by the Association (also acting on behalf of the Insurer) to the Primary Member no later than three (3) months before the Anniversary Date to apply from the Anniversary Date, unless the Policy has otherwise been terminated by either the Association (acting also on behalf of the Insurer) or the Primary Member.

Coverage for those persons included in the coverage of the Primary Member under the Policy shall become effective at the time those persons are enrolled in the coverage of the Primary Member or, subsequently, once the persons concerned meet the required conditions.

The period of insurance will be from the date on which the Primary Member and other Covered Member join the Insurance unless otherwise as indicated herein and as indicated herein.

PREMIUM RATES

Premium rates for the Policy will be determined according to the age, benefits, and zone of coverage/ country of destination of each Primary Member and other Covered Person. In addition, an underwriting premium may, prior to the acceptance of the application and issuance of a Membership Certificate, be added to the premium based on the health declaration included with the Application Form.

Premium rates may change according to the age of the Primary Member and other Covered Persons at each Policy Anniversary Date based on the rate table by age established at the time of application.

In addition, the Insurer reserves the right to modify the premium and/or the policy terms from time to time in case of changing regulations, technical results, or increases of external costs relating to the benefits provided under this Policy, among other causes, as required. Any such changes in the premium and/or the policy terms will come into effect no earlier than the next Policy Anniversary Date, at which point the Primary Member will have the right to choose whether or not to continue coverage under the new terms.

The Plan Administrator, on behalf of the Insurer, will notify the Primary Member of any change to the premium and/or Policy terms at least two (2) months prior to such change coming into effect. The change in premium and/ or Policy terms will take effect from the next Anniversary Date following the notification to the Primary Member.

Nevertheless, the Primary Member retains the right to request the termination of membership in the Association within thirty (30) days following notification of a change in premiums and/or policy terms.

The premium is stated in EURO or USD.

This Policy covers the Primary Member and other Covered Persons as listed on the Membership Certificate, in accordance with the definitions contained in this Policy.

ELIGIBILITY FOR COVERAGE

Coverage under the Policy includes the Primary Member and other Covered Persons as defined in this Policy and as listed on the Membership Certificate. This Policy is intended to provide coverage for Primary Members and their eligible Dependents residing outside of his/her Home Country. This Policy is not intended to be supplemental health insurance in Germany. The Primary Member must be aged eighteen (18) or older at the time of completing the Application Form. Coverage is contingent on the Application Form being accepted by the Insurer. The Insurer will not accept any Application Form where such activity would violate any applicable law, sanction, or regulation.

The Primary Member and other Covered Persons must be under the age of sixty-five (65) upon joining coverage under the Policy.

Personal data and/or other sensitive data are required for the underwriting, administration, and management of the present Policy. Primary Members and other Covered Persons shall be considered "Data Subjects" for the purpose of applying the provisions described in Appendix 3 - Data Privacy Notice, and any other Data Privacy Notice provided by the Plan Administrator.

ZONES OF COVERAGE

This Policy provides insurance cover for each Primary Member and other Covered Person in the zones of coverage identified on the Primary Member's Membership Certificate.

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

- in one of the countries of the zones of coverage defined herein; or
- in another country: the Policy shall provide coverage for emergency treatment outside the zone of coverage stated on the Membership Certificate for a period of sixty (60) days per trip. The coverage shall begin from the time the Covered Person leaves his/her residence or working place to conduct the travel.

Emergency treatment outside zone of coverage is treatment for medical emergencies that occur during business or holiday trips outside your area of coverage. Coverage is provided up to a maximum period of sixty (60) days per trip within the maximum benefit amount and includes treatment required in the event of an accident, or the sudden beginning or worsening of a severe illness that presents an immediate threat to the Covered Person's health. Primary Members and other Covered Persons should advise the Plan Administrator (contact details below) if they move outside the zone of coverage, as listed on the Membership Certificate, for a period of more than sixty (60) days.

Coverage is only for the costs resulting from an Accident or an Emergency outside the zone of coverage when treatment was provided by a physician, medical practitioner or specialist or by Hospitalization.

Outside of the zone of coverage, treatment by a physician, medical practitioner or specialist must commence within forty-eight (48) hours of the Emergency. Coverage is not provided outside the zone of coverage for any curative or follow-up nonemergency treatment, nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth after week thirty-four (34) of pregnancy.

PLAN ADMINISTRATOR

This Policy is administered by PassportCard Deutschland GmbH (the "Plan Administrator") on behalf of the Insurer:

PassportCard Deutschland GmbH
Caffamacherreihe 8-10
20355 Hamburg
Germany
(or any additional address indicated on the company website)
Phone number: **+49 40 46 00 20 333**
WhatsApp number: **+49 170 210 1616**
Email: **kundenbetreuung@passportcard.de**

CHANGES TO THE MEMBERSHIP CERTIFICATE

If the Primary Member wishes to add additional and eligible other Covered Persons to this Policy, including newborns, a new Application Form must be completed for such additional Covered Persons, and such additional coverage shall come into effect on the date specified on the updated Membership Certificate that shall be issued to the Primary Member. In the case of a newborn, the birth certificate shall be submitted, and an Application Form must be completed and submitted within two (2) months of the child's birth.
Coverage under the newborn care benefit of the birth mother is provided within the first 60 days following the child's birth, provided that the mother has passed the waiting period for maternity services.
The newborn will be accepted for coverage under the Policy earliest from the day of receipt of the Application Form with a maximum risk load of 100% if the Application Form was submitted within 60 days of the date of birth and as long as the birth mother has been insured on the date of birth for a minimum period of 12 consecutive months.
If the birth mother has been insured for less than 12 consecutive months on the date of birth and/or the Application Form is not submitted within 60 days, acceptance of the newborn into the Policy is contingent on medical underwriting with no limitations to the risk load. Coverage will start from the day the application is received (if coverage is approved).

When a Covered Person (other than the Primary Member) reaches the age of 18, the Plan Administrator will contact such Covered Person and issue him/her with a separate Membership Certificate, if applicable. In addition, the Primary Member will receive an updated Membership Certificate showing the updated list of other Covered Persons.

The Primary Member may change the zone of coverage in which he/she is covered for insurance by notifying the Plan Administrator one (1) month in advance of such change, by way of email or phone. In such instance, the premium that the Primary Member will pay in accordance with coverage under this Policy may be affected by the change in the zone of coverage and the Primary Member will be notified of the change.

Nevertheless, the Primary Member retains the right to request the termination of membership in the Association within two (2) months following notification of the change in premium as a result of the change in zone of coverage. The change in premium as a result of a change in zone of coverage will come into effect thirty (30) days after the Primary Member is notified of such change.

BENEFITS

Scope

Benefits consist of payment or reimbursement of eligible medical and related expenses incurred by Covered Persons as set out in Appendix 2 - Table of Benefits.

For medical care to be covered under this Policy, it must be provided by medical care providers recognized by the local medical authorities and provided by authorized practitioners (in compliance with the laws and regulations of the country in which the care was provided).

The medical services must have been provided during the insurance period as stated on the Membership Certificate.

Benefit Amount

The benefit amount is determined for each itemized expense as provided for in the Table of Benefits and limited to the usual, customary, and reasonable ("UCR") expenses for each type of service.

The usual, customary and reasonable nature is determined according to the medical practice that prevails in the country where the care is provided (treatment type, care and medical equipment quality, geographical area, and country) and is subject to coding and rating standards of the medical procedures and treatments referenced or common in each country. In general, expenses for treatment or other services that are obviously disproportionate to the services performed are unusual, non-customary and unreasonable.

If the nature of the expenses is considered to be unusual, non-customary or unreasonable, this may lead

to the denial of reimbursement or a limitation on the reimbursement amount to the usual, customary and reasonable amount. If medical care for which benefits have been agreed exceeds the medically necessary level, the Insurer may further reduce the benefits to an appropriate amount.

PRIOR NOTIFICATION

Benefits may be contingent on prior notification being given on behalf of the Primary Member or other Covered Person, and the pre-approval of the Plan Administrator.

Prior notification must be given for claims relating to covered hospitalization, hospice care and transplants, and pregnancy, as described hereunder, except in the event of an "emergency".

The Primary Member or other Covered Person should notify the Plan Administrator on behalf of the Insurer at least seventy-two (72) hours before any covered hospitalization, hospice care and transplants.

In case of a covered pregnancy, the Plan Administrator should be notified within the first three (3) months of the pregnancy.

The Plan Administrator is deemed to have approved the suggested course of treatment if it has not otherwise responded to the prior notification within 5 working days following the date of receipt.

In the event that no request for pre-approval for inpatient treatment was submitted, the Plan Administrator shall be entitled to cover only 80% of the associated expenses.
In the event that no request for pre-approval for outpatient treatment was submitted and, as a result the cost for treatment covered by the Policy exceeds the cost that would have been covered had prior notification been submitted, the Plan Administrator shall be entitled to cover only 50% of the amount payable for any other similar outpatient care that should have been reimbursed in the event that excess expenses were effectively incurred by the Insurer as a result of the failure to give prior notification.

While prior notification is not necessary in cases of Emergency, the Primary Member or other Covered Person should nevertheless notify the Plan Administrator within forty-eight (48) hours following Hospitalization or, in the case of a force majeure, as soon as possible.
The Plan Administrator has the right to direct the Covered Person to a facility that would present lower treatment rates at its own discretion.

HOW TO FILE A CLAIM

Claims must be filed without undue delay, but not later than thirty-six (36) months of the date the medical services were provided.

In the case of a claim, the Plan Administrator may request the following evidence together with the claim in order for the claim to be processed:

- In case of Hospitalization: the Hospitalization supporting documents (invoices, notes of fees, etc.),
- In case of illness: the detailed invoices, or
- In case of home childbirth: a copy of the child's birth certificate.

The Plan Administrator may request, as appropriate, any additional documentation necessary for the application of this coverage.

The Primary Member and/or other Covered Person shall be liable for any information provided by him/her, or provided by the Primary Member on behalf of the other Covered Person, which appear to be false, forged or exaggerated, or any fraudulent or deceitful action by them and all undue payments paid by the Insurer on the basis of these incorrect data shall be recovered.

ASSESSMENT OF THE CLAIMS

The Plan Administrator may investigate and assess any claim on behalf of the Insurer within a reasonable time and in accordance with the terms of the Policy.

In the event of a claim, the Plan Administrator shall pay any sums due in respect of the claim within a reasonable time if required to do so in accordance with the Policy terms. In the event of a dispute concerning the claim, non-payment of the claim cannot be treated as unreasonable.
Within the context of reviewing the claim, the Plan Administrator's advising medical expert may request any other supporting documentation necessary to process the claim if the documentation listed above is incomplete, gives rise to doubt, or the Plan Administrator is unable to investigate thoroughly the Insurer's obligation to pay the claim. The Plan Administrator's advising medical expert is entitled, at its own expense, to request data from the following organizations and persons subject to Section 4 "Data Privacy Notice" hereto and the in any other Data Privacy Notice provided by the Plan Administrator:

- Doctors,
- Hospitals,

- Other medical institutions,
- Care homes,
- Caregivers,
- Other personal insurance providers,
- Statutory health insurance bodies,
- Occupational insurance organizations and/or
- Official bodies

In the event that the Primary Member and/or other Covered Persons refuses to provide concrete data collected during the course of claims processing, the benefit may not become due if the Plan Administrator is unable to determine whether and to what extent the Insurer is liable for payment of the claim. In this regard the Insurer shall not otherwise be held liable for failing to perform the services under the Policy.

By applying for coverage under the Policy, the Primary Member agrees that to refuse or fail to provide the appropriate information to the Plan Administrator may prevent the Insurer from being able to pay the claim. To the extent that the Insurer refuses to pay a claim in full it will reduce the payment in proportion to the fault of the Primary Member and any other Covered Person.

In the event the premium due to be paid under the Policy has not been paid due to the fault of the Primary Member, the benefits may not become due.

In case of any fraud, misstatement or concealment in relation to any matter affecting the insurance or in connection with any claim of the Primary Member and/or other Covered Person, the Insurer will have the right to terminate the coverage under the Policy and all rights to claims thereunder are forfeited.

LIMITATION ON ACTUAL COSTS

Expenses for which the Primary Member or other Covered Person has already been reimbursed, or is expecting to be reimbursed, by third parties, shall not be additionally reimbursed under this Policy.

Coverage of the same nature subscribed to with several insuring bodies shall be enforceable up to the limit on each benefit, no matter the date the coverage was subscribed to.

For the purpose of the aforementioned provisions, the limitation on the amount of the expenses payable by the Primary Member and/or other Covered Persons shall be determined by the Plan Administrator for each medical act, treatment or item.

PAYMENT THROUGH THE CARD

Certain benefits may be paid directly to the provider using a special prepaid card (the "PassportCard card"). Before paying the Medical Provider/Medical Service Provider, or prior to any cash withdrawal on the card, such action should be authorized by the Plan Administrator and the Primary Member or other Covered Person should either contact the Plan Administrator or open the mobile app to request funds be loaded onto the PassportCard card. The PassportCard card may only be used in accordance with the terms and conditions provided by the Plan Administrator as communicated at the time the card is distributed. Such terms and conditions include that the user must provide the Plan Administrator with any documentation it requests to support the payment through the card. If such documentation is not provided, or, the card was not used in accordance with the applicable terms and conditions, the Plan Administrator has the right to reclaim the funds from the Primary Member or the Covered Person that is equal to the amount that was charged on the card by the relevant person. Such a reclaim of funds requires that the Primary Member is unable to demonstrate that the failure to obtain prior authorization was not due to gross negligence, or – except in case of intentional non-compliance - that the breach of the obligation had no effect on the insured event or the determination of the insurance benefit. By requesting that funds be loaded onto the PassportCard card, the Primary Member agrees to the terms and conditions of the PassportCard card. If the Insurer refuses to pay a claim in full it may reduce the payment in proportion to the fault of the Primary Member and any other Covered Person.

The PassportCard card is not a credit card, cannot be loaded with your own monies, and is not linked to any deposit account or other products you may have. PassportCard is simply a method the Plan Administrator has chosen to make available as a convenience to enable the Covered Person to pay the relevant amount upfront rather than be reimbursed.

REIMBURSEMENT OF COVERED EXPENSES

Reimbursement shall be paid, if approved, to the Primary Member or other Covered Person, as applicable, following the itemized bills and receipts relating to such payments being sent to the Plan Administrator. Claims may be raised by the Primary Member or other Covered Person directly without prior consent of the Association.

If a Primary Member or other Covered Person is covered by a local national Social Security insurance, or equivalent, the benefits he/she receives from such insurance shall be deducted from the benefits payable under this Policy (this Policy may, at the discretion of the Plan Administrator, pay second).

If a Covered Person (other than the Primary Member) is employed and receives insurance from his/her employer, the benefits he/she received from such insurance shall be deducted from the benefits payable under this Policy (this Policy may, at the discretion of the Plan Administrator, pay second).

CURRENCY

Costs for medical care services may be incurred in a foreign currency. If the claim is reimbursed by the Insurer in Euro, the Insurer will use conversion rates in force on the date of the transaction. The Administrator has authorised the use of an online currency converter at the following web address, which permits date-specific conversions to be made:
www.xe.com/ucc.

In the event that the Primary Member or other Covered Person was actually charged a less favorable conversion rate at the time of provision of medical service, it is permissible to use the Covered Person's rate instead, provided that the Covered Person provides the Plan Administrator with documents to endorse the rate being claimed. In such cases the Primary Member is given the option as to which conversion rate to use. (When the difference is small the Primary Member may prefer prompt settlement using the xe.com rate rather than collating and sending evidence to support an alternative rate.)

LIMITATION ON ACTIONS

Claims may be made until they become barred by German law. In general, claims are barred at the end of the third (3rd) calendar year following the calendar year in which the claim arose and when the injured person know about the facts (or should have known about the facts) that gave rise to a claim. For more information, please consult the applicable German law.

SUBROGATION

If a Primary Member or other Covered Person has a right of indemnity against any third party, other than a family member, the Primary Member or other Covered Person shall assign this right to the Insurer (except where the Insurer acquires the right by way of subrogation).

The Insurer may not exercise this right in a manner that will prejudice the right of the Primary Member or other Covered Person to collect any indemnity from the third party that exceeds the benefits received from the Insurer.

If a Primary Member or other Covered Person receives indemnification and/or compensation from a third party that is due to the Insurer according to this paragraph, he/she will transfer it to the Plan Administrator for delivery to the Insurer. If he/she has made a settlement waiver or other action that prejudices the right that he/she transferred to the Insurer, he/she shall compensate the Insurer in that respect either fully (in case of an intentional breach) or partially in direct relation to the severity of the negligence, unless the Primary Member is able to demonstrate the absence of gross negligence.

PRE-CONTRACTUAL REPORTING DUTY

The Primary Member and/or other Covered Person are required to provide true and complete answers to the questions in the Application Form and other application documents including detailing any Previous Medical Condition/Pre-existing Condition. Any information that is not rendered or that is incorrect or incomplete may put the insurance coverage at risk.

In the event of fraud, misstatement, or concealment by the Primary Member and/or other Covered Person, the Insurer (or the Plan Administrator acting on its behalf) is entitled, pursuant to the requirements set out in Sec. 19 as modified by Sec. 194 (1) 3rd sentence German Insurance Contract Act, to declare the Primary Member's coverage under the Policy null and void, which shall equally nullify the coverage of the other Covered Persons. In the event of a negligent omission or misstatement, the Insurer (or the Plan Administrator acting on its behalf) is also entitled to continue the coverage under the Policy under new terms and conditions established by the Insurer (and in case of a grossly negligent breach, also with retroactive effect) or terminate the coverage under the Policy by refunding the premiums paid.

CONSEQUENCES OF NON-FULFILMENT OF AN OBLIGATION

The benefits under the Policy become due when the Insurer has concluded the investigations required in order to establish the insurance claim and the extent of its payment. If any of the obligations of the Primary Member or other Covered Person specified herein are not fulfilled, this may result in the Insurer being unable to determine whether or to what extent the Insurer is liable for payment of benefits.

Non-fulfilment of an obligation may result in the benefit not becoming payable.

Details on the pre-contractual disclosure obligations and the consequences of their non-fulfilment can be found in section 5 “Consequences“ of Non-Fulfilment of the Disclosure Obligation.

In the event of a breach of the pre-contractual disclosure obligation by the Primary Member or any Covered Person, the Insurer may be entitled, pursuant to Sections 19 through 22 of the German Insurance Contract Act (see section 5 “Consequences“ of Non-Fulfilment of the Disclosure Obligation pursuant to §19 of the German Insurance Contract Act (Versicherungsvertragsgesetz) either to declare the individual policy void, to terminate the individual policy or to continue applying it under new conditions established by the Insurer.

NOTICES

Notifications sent by the Plan Administrator to the Primary Member and/or other Covered Person will be either communicated by paper or in text form through digital means (e.g., email, website, log-in, mobile application) in accordance with the section “4 Data“ Privacy Notice.

WITHDRAWAL OF APPLICATION FOR MEMBERSHIP/ “COOLING OFF PERIOD”

For a period of fourteen (14) days from the date the Primary Member receives a Membership Certificate, the Primary Member may revoke the request for coverage under the Policy, without being charged a premium, by sending a registered letter with acknowledgement of receipt to the Plan Administrator or email to the address listed below. For more detailed information, see section 6 “Instruction“ on Right of Revocation.

However, a Primary Member who has already paid a premium in relation to the coverage under this Policy may withdraw from insurance coverage within a period of thirty (30) calendar days from the Policy Effective Date as detailed on the Membership Certificate, by sending a registered letter with acknowledgement of receipt to the Plan Administrator or email to the address listed below.

The Primary Member shall be reimbursed, in full, for all sums relating to the payment of premium under this Policy made within thirty (30) days from the date of acknowledgement of receipt of the registered letter, so long as no claims were made under this Policy during that time or since the inception of coverage under this Policy.

Address for Sending the Letter of Withdrawal

PassportCard Deutschland GmbH
Caffamacherreihe 8-10
20355 Hamburg
Germany
Email: kundenbetreuung@passportcard.de

Sample letter of Withdrawal (within the cooling-off period)

„I, the undersigned, Mr./Ms. (full name of the person concerned), residing at (full address of the person concerned)..., withdraw from membership to the policy number. ... subscribed with the Association.

I hereby certify that, on the dispatch date of this letter, I am not aware of any claim invoking the policy coverage since the date on which I applied for coverage under the policy.

Date:

Signature:

TERMINATION OR SUSPENSION OF COVERAGE

Except in the event of a breach of the pre-contractual disclosure obligations or non-payment of premium, the Primary Member and/or other Covered Person, once accepted, cannot be excluded from coverage under the Policy against his/her will as long as he/she continues to be eligible to be eligible for coverage.

Unless otherwise provided herein, coverage

- For each Primary Member: shall terminate on the date on which the Primary Member ceases to be eligible for coverage under the Policy; and
- For each other Covered Person: the termination of

the Policy coverage for the Primary Member shall cause a termination of the Policy coverage for the other Covered Person. If the other Covered Person is eligible to be a Primary Member, he/she can convert their coverage into a new coverage under the Policy without additional underwriting or waiting periods; and if the other Covered Person no longer meets the eligibility requirements for being a 'Covered Person' under the Policy, the coverage shall terminate immediately.

If a Primary Member and/or other Covered Person loses eligibility for coverage, the Insurer may grant a grace period of up to ninety (90) days of additional coverage, contingent on continued payment of premium.

Unless otherwise provided herein, for all persons covered under this Policy, the termination of coverage shall be effective on the date stated on the Membership Certificate or shall be effective on the termination date on which the Plan Administrator is notified that coverage has been terminated, and shall not be retroactive.

The Primary Member may cancel coverage under the Policy at any time upon giving thirty (30) days' notice to the Plan Administrator.

Termination results in the immediate cancellation of entitlement to benefits for all services provided after the termination date, even if treatment for a condition began for the Primary Member or other Covered Person prior to the termination date.

The validity of this Policy is reliant on the existence of the Masterpolicy entered into between the Insurer and the Association. In the event of termination of such Masterpolicy, coverage under this Policy in effect at the time of termination shall continue to be in force until the next Anniversary date (subject to the provisions contained in the Policy), but shall not be entitled to be renewed.

Termination of coverage under the Policy may be initiated by the Association (acting also on behalf of the Insurer) in the following circumstances:

- In the event of non-payment of the premium by the Primary Member, as set out in Sec. 37 and 38 German Insurance Contract Act;
- By giving three (3) months prior notice, on the termination date of the Membership Certificate or termination event specified in the Policy, whichever is the earlier to occur;
- With immediate effect, on the date on which the Primary Member ceases to be eligible to be a member of the Association; or
- Following a recovery plan or a compulsory liquidation of the Association.

In the event of the termination of the Masterpolicy, if the Association engages with a different insurance company to service coverage under the Policy that was in effect at the time of such termination, such coverage shall no longer be covered by the present Insurer, subject to the consent of the Primary Member. This clause does not derogate from any other provision agreed between the parties with respect to a run-off period of the coverage under the Policy.

If a Primary Member and/or other Covered Person loses eligibility for coverage, the Insurer may grant a grace period of up to ninety (90) days of additional coverage, contingent on payment of premium.

Covered Persons shall be considered to have their rights under the Policy terminated at the time the Primary Member stops being a member or, as otherwise described in the Policy, whichever is the earlier to occur.

PREMIUM PAYMENT

The premiums are paid by the Primary Member either monthly, quarterly, semi-annually or annually and are due to be paid by the Primary Member on the first day of the calendar period to which they relate.

NON-PAYMENT

In the event the Primary Member fails to pay the premiums in full within thirty (30) days following their due date, the coverage may be withdrawn thirty (30) days after the Insurer or Plan Administrator has sent a registered letter to the Primary Member constituting formal notice of said withdrawal. If within that period, the Primary Member has made the delinquent payment, the notice of withdrawal shall no longer be effective.

COMPLAINTS

In the event of a disagreement or complaint with the Insurer concerning the general terms and conditions of the Policy, the Association and/or Primary Member and/or other Covered Person shall first contact their representative at the Plan Administrator at the following address:

PassportCard Deutschland GmbH
Caffamacherreihe 8-10
20355 Hamburg
Germany
(or any other address indicated on the company website)
Email: kundenbetreuung@passportcard.de

If the proposed solution does not meet the expectations of the Primary Member and/or Covered Person, the Plan Administrator may forward the complaint to the Insurer, at the address listed below. The Insurer will respond to such complaint within a reasonable timeframe.

VYV International Benefits - Service Relations Clientèle
7 Square Max Hymans
75 748 PARIS CEDEX 15
France
Email: clients@vyv-ib.com

Primary Member or Covered Person shall first contact their representative at the Plan Administrator. If the proposed solution does not meet the expectations of the Primary Member and/or Covered Person, the Plan Administrator may forward the complaint to the Insurer, at the address listed above. The Insurer will respond to such complaint within a reasonable timeframe.

The Primary Member or the other Covered Persons also have the option to request mediation from the Ombudsmann Private Kranken-und Pflegeversicherung for health insurance disputes in relation to this Policy.

Complaints can be submitted to the German regulatory authority, Bundesanstalt für Finanzdienstleistungsaufsicht, at the following address:

Bundesanstalt für Finanzdienstleistungsaufsicht
Graurheindorfer Straße 108
53117 Bonn
Phone: +49 (0) 228 / 4108 - 0
Fax: + 49 (0)228 4108-1550
Email: poststelle@bafin.de
https://www.bafin.de

In addition, the Insurer of the health benefits under this Policy, MFPrévoyance, is a signatory to the mediation charter of the French Federation of Insurance Companies, and the Insurer of the assistance benefits under this Policy, MGEN, is a signatory to the mediation charter of the French Federation of Mutual Insurance Companies. Therefore, in the event of a persistent and definitive disagreement, the Association and/or Primary Member or other Covered Person has the option, after exhausting all other possible amicable remedies, to opt to turn to the Mediator of the French Federation of Insurance Companies or the Mediator and the French Federation of Mutual Insurance Companies, without prejudice to other possible legal action, who can be contacted at the following addresses, respectively:

La Médiation de l'Assurance
TSA 50110
75 441 Paris Cedex 09
France
or by email to the following address:
le.mediateur@mediation-assurance.org
or on the dediacted website on
https://www.mediation-assurance.org
for MFPrévoyance

CNPM - MÉDIATION – CONSOMMATION,
27 Avenue de la Libération
42400 SAINT-CHAMOND
France
or on the dedicated website
https://www.cnpm-mediation-consommation.eu
for MGEN

The filing of a complaint does not affect the right to file a claim before the responsible ordinary court.

EXCLUSIONS

Exclusion of Insurer's Liability for Providers of Medical and Other Services

The Insurer is not liable to the Association and/or the Primary Member and/or other Covered Persons for any damage that Primary Member and/or other Covered Persons and/or a third party may suffer as a result of the Primary Member and/or other Covered Person's selection of and/or referral by the Insurer to a physician, specialist, surgeon, anesthetist, Hospital, or any other in-network or out-of-network provider and/or as a result of an act or omission of the former, or advice, treatment, surgical procedure, medication or other action taken by them, including not performing a surgical procedure and/or not providing medical treatment on the date specified for any reason whatsoever. It is made clear that the service providers are not deemed to be agents or employees of the Insurer.

Forfeiture of the Right to a Benefit

The Primary Member and each Covered Person is entitled to raise claims directly against the Insurer. The Primary Member and/or other Covered Person is deprived of all rights to the benefits of a claim in the event the Primary Member or other 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 Primary Member or other Covered Person knowingly uses inaccurate documents as supporting documents for that claim.

Excluded Risks

Any costs resulting from the following events are not covered by the Insurer:

- Any exposure whatsoever to ionizing radiation, radioactive pollution, nuclear process, military nuclear matter, or any nuclear waste whatsoever or any chemical substance during the course of an illegitimate activity, and
- The consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or acts of terrorism, whatever the place of these events and their protagonists, except if the Covered Person does not take an active part in such event or if he/she is called upon to perform a maintenance or monitoring mission in order to ensure the security of people.

The Insurer reserves the right to modify the coverage under the Policy for one or more territories, subject to a fifteen (15) days prior notice sent to the Association. The Association may refuse this modification and terminate the Policy by sending the Insurer a registered letter with acknowledgement of receipt within thirty (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. Any changes will apply to the Primary Member's coverage under the Policy on the next Policy Anniversary Date, except in the event said modification is a result of a legislative or regulatory and/or international change in the law.

Excluded Benefits

The following benefits are not covered by the Policy, unless otherwise stipulated in the Membership Certificate or in the Table of Benefits:

- Elective treatments provided outside the zone of coverage as set out in the Membership Certificate.
- Any form of experimental or uncontrolled treatment that does not follow customary or traditional, commonly accepted medical practices, unless the Insurer has given its specific consent.
- Ancillary or "comfort" costs in case of Hospitalization (e.g., telephone, television, hotel, Internet, etc.).
- Treatments relating to substance abuse/addiction.
- Detoxication/detoxification treatment.
- Any surgery or treatment relating to a gender reassignment/sexual reassignment/gender confirmation.
- 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 law).
- Any elective/voluntary surgery for plastic/aesthetic purposes, except reconstructive breast surgery after a covered illness.
- Aesthetic treatments and consultations, rejuvenation cures, slimming cures.
- Thermal cures and related costs.
- Medical costs relating to a stay in thalassotherapy centre or fitness centre, even if this stay is medically prescribed.
- Medical costs relating to a stay in a rest home or a convalescent home, except if this stay results from a Hospitalization or a severe surgery assessed by the Insurer's doctor.
- 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 keratotomy (PRK).
- Non-prescription medicines and non-medicinal products.
- Diagnosis and treatment of sleep disturbances, including treatment for the prevention of sleep disturbances, medical equipment, examinations at sleep laboratories.
- A circumcision other than for medical reasons.
- Vaccinations for adults given that are not medically necessary (e.g., for travel or immigration).
- Treatments based on alternative or holistic medicine unless otherwise provided for in the table of benefits hereto.
- Care and/or treatment of intentionally caused illnesses and/or self-inflicted injuries including attempted suicide whether the Primary Member or Covered Person is of sound mind or not.
- Costs of genetic testing, unless specifically agreed otherwise in writing.
- Treatment required as a result of failing to seek or follow medical advice, or as a result of travelling against medical advice.
- Expenses caused by complications directly caused by an illness, injury or treatment which is excluded from coverage.

APPLICABLE LAW

This Policy is governed and interpreted by the German law.

German courts shall have jurisdiction for any disputes arising from or in connection with this Policy. Claims by the Insurer and/or the Plan Administrator can be raised in the courts where the Primary Member has his/her habitual residence. However, German courts shall have jurisdiction if the Primary Member has, after the commencement of coverage under the Policy, changed his/her habitual residence to a place outside of Germany.

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The present Policy may be executed in one or more counterparts, each of which shall for all purposes be deemed to be an original of the contract and all of which shall constitute the same instrument. The chapters 1-7 hereto are deemed to be incorporated and forms an integral part of the present Policy.

2. Definitions

The words and expressions employed in this policy shall have the following meanings:

Accident
Any unintentional bodily injury suffered by the Primary Member or other Covered Person and resulting from the sudden and unexpected action of an external cause, to the exclusion of any acute or chronic illness.

Application Form
An application form to become a Primary Member under the Policy. The application form will be completed with all the necessary details, including the names of each of the Covered Persons requested to be covered under the Primary Member's policy, and a health declaration and medical confidentiality waiver signed by the Primary Member and each other Covered Person (as applicable) over age 18. A declaration given by the applicant over the phone is considered as a valid signature if the call is recorded with the consent of the Primary Member.

Childbirth Costs
Medical costs incurred relating to routine vaginal childbirth as well as caesarean childbirth when medically necessary. Any complications shall be covered by the „hospitalization" benefit.

Childcare Costs
Babysitting, daycare, nanny, and/or other costs related to the supervision of a Child/Children under age 18 of a Covered Person in the following situations:

1. If the Child/Children remain in the Country of Destination while both the Covered Person and his/her Partner are outside the Country of Destination due to medical treatment,
2. During a covered Hospitalization of a parent who is a Covered Person, or
3. If the Child/Children are not with the Covered Person or his/her Partner during a covered delayed return trip.

Copay
A fixed amount or a percentage of the cost of a covered service that the Covered Person pays directly to the service provider at the time of treatment, as outlined in the table of benefits. The copay is not tied to the coinsurance.

Coinsurance
The percentage of the cost of a covered service that the Covered Person must pay. The Covered Person shares in this cost with the Insurer. There may be a maximum on the amount of coinsurance a Covered Person will pay, as outlined in the Table of Benefits.

Compassionate Family Visit
The cost of flight and hotel, for one trip for one family member, to visit the Covered Person currently receiving Medical Treatment for a serious illness or accident which endangers the life of the Covered Person, or if the stay in hospital lasts for more than 7 days.

Congenital Condition
Any disease or illness, abnormality, birth defect, premature birth or malformation present at birth including any related condition, whether diagnosed or not.

Country of Destination
The country, outside the Home Country and Country of Residence (if applicable), which was indicated on the Application Form, in which the Covered Person intends to stay for a period of more than sixty (60) consecutive days, or in which the Primary Member is already residing, and based on that information, the Insurer has agreed to accept him/her to the insurance Policy.

Country of Residence
A country in which the Covered Person legally resides and for which he/she has a permanent address (where applicable).

Covered Person
A Covered Person is the Primary Member and/or other person covered through the Primary Member's coverage as a Dependent of the Primary Member as defined herein.

Date of Occurrence of the Insured Event
The actual date the Covered Person received a medical treatment and/or other relevant service.

Deductible
Deductibles apply for each insurance year and for each Covered Person. They apply only for expenses linked to inpatient treatment/hospitalization. If a deductible is applied to an insurance policy, eligible expenses are payable under this insurance up to the respective maximum limit as per the Table of Benefits which are more than the agreed deductible amount.

Delayed Return Trip
If a Covered Person's return to the Country of Destination is delayed because of a medical emergency and they are unfit to travel, the extra costs for altering flight reservations shall be covered up to the limit as outlined in the Table of Benefits.

Dependent
A Dependent is described as follows:

a. Spouse/Civil Union Partner
A spouse not legally separated from the Primary Member, or his/her registered civil union partner, or Cohabiting Partner, as registered with the appropriate regulatory authority.

b. Cohabitating Partner (Common Law/Life Partner)
A spouse not legally separated from the Primary Member, or his/her registered civil union partner, or Cohabiting Partner, as registered with the appropriate regulatory authority.
- Both individuals are free from matrimonial ties; and
- Cohabitation has been declared by the Primary Insured to the Policyholder, who shall communicate such information to the Insurer, at the time of enrolment.

c. Dependent Child/Children
The unmarried Child/Children of the Primary Member and those of his/her spouse (or civil union partner or Cohabitating Partner) up to the age of 18, living in the household of Primary Member, whether legitimate, recognized, adopted or taken in, including minors who are under the protection of the Primary Member.
- The age limit of 18 is extended to 24 for Dependent Children who are full time students.
- The age limit of 18 is waived for handicapped/ disabled Dependent Children who are recognized by the relevant local governmental agency as legaldependents of the Primary Member.

Dog sitter costs
Costs for a dog sitter or a kennel during a covered Hospitalization of a Covered Person if nobody in the household is available.

Elective Treatment
A treatment or procedure for which the need was expected and the admission of the Covered Person to a clinic was not based on a referral from the emergency room as an urgent event, rather a referral from an outpatient specialist physician (including the outpatient clinic of a hospital).

Emergency dental treatment following an Accident
Emergency dental treatment provided within fifteen (15) days of an Accident and consisting of replacing lost or damaged natural and healthy teeth.

Emergency
A word used in case of Accident, natural disaster, and/ or beginning or sudden aggravation of an illness for which the Covered Person requires immediate medical measures and treatment. Immediate means within forty-eight (48) hours following the direct cause of the emergency.

Health checks
Screenings, tests and examinations that are performed at an appropriate age interval without any clinical symptoms being present. These include:
- Physical examination
- Vital signs (blood pressure, pulse, respiration, temperature)
- Blood test (full blood count, lipid profile, thyroid function, liver function, kidney function)
- Cardiovascular examination
- Cancer screening
- Well-child test
- Hepatitis and HIV test
- Gynaecological screening
- Neurological examination

Home Country
The country declared as the Home Country on the Application Form for which the Primary Member holds a passport and/or in which the Primary Member has a permanent address.

Hospice
Expenses for accommodation, food, care and support under the condition that the hospice works with experienced palliative medicine nurses and doctors as well as being under the technical responsibility of a nurse or other qualified person. Benefits for full or semi-inpatient hospice care shall be granted if the Covered Person is suffering from an illness that is progressive and has already reached an advanced stage, and that cannot be cured so that inpatient palliative care is necessary and only a limited life expectancy of weeks or a few months can be expected.
Hospice benefits are granted in particular for the following illnesses:
- Fully developed Aids
- Advanced stage of cancer
- Disease of the nervous system with progressive paralysis
- Terminal stage of chronic kidney, liver, heart or lung disease.

Hospital
A medical, surgical, or psychiatric institution that is recognized as a public or private hospital by the local governing body.

Hospitalization
A stay within a Hospital for diagnostic purposes and/ or to conduct an emergency and/or elective operation,

including examinations, and/or medications connected with the purpose of the hospitalization, all supervised by an attending physician. Hospitalization includes:

- Hospitalization in a public or private facility
- Surgical operations during Hospitalization, including medical care relating to trauma, and surgery performed under general or local anaesthesia
- Medical and paramedical ancillary costs incurred during Hospitalization
- Patient transportation*
- Any other medical treatment in a Hospital, and
- MRI, PET scans or similar imaging tests.

**In case of Hospitalization, transportation is covered within the same country between the patient's home or the place of Accident and the nearest health facility located in the same country. It is also covered if the hospitalized patient's condition requires his/her transfer from the host health facility to another nearby health facility.*

Implants

Dental implants (metal or ceramic) which are embedded as a substitute for the root of a tooth or in the toothless jaw.

In Network Provider

A physician, Hospital, or other service provider. that has entered into an agreement with the Plan Administrator and the name of whom will be indicated on a periodically publicized list created by the Plan Administrator.

Inpatient

Treatment for medical reasons that normally means that you have to stay in Hospital accommodations overnight or longer (not including waiting to be seen in an emergency room, or waiting for diagnosis).

Insured Event

A medical and/or other service provided to the Covered Person following a medical need as specified in the table of benefits.

Long Term Care

Services for a Covered Person who cannot care for themselves and require assistance from a third party while in a Hospital, hospice, nursing home, or being nursing at the Covered Person's personal accommodation.

Massages

Massages are only covered if they were prescribed by a doctor, and if they are carried out by a physiotherapist.

Maternity Care and Childbirth (without Complications)

A normal state of pregnancy of the Covered Person including monitoring the pregnancy, childbirth, and the treatment of the mother and child during the Hospitalization after the birth, including routine post-natal medical monitoring of the mother. In this matter, "a normal state of pregnancy" is the course of the pregnancy until childbirth for which no medical intervention is required beyond the routine monitoring checks according to the accepted criteria, including a healthy child born of a vaginal delivery (including forceps or vacuum delivery).

Maternity Care - Complications of Pregnancy and Childbirth

Any abnormal state of pregnancy; an abortion (other than for personal reasons and/or socio-economic reasons); an abnormal delivery; In this matter, the following medical situations will be deemed to be complications of pregnancy: preeclampsia, toxemia, kidney infection, gestational diabetes, anemia, bladder infection, location and/or severance of the placenta, a tear in the womb, an infection of the placenta, endometriosis, late delivery (42 weeks and more), RH sensitivity in the blood of the fetus, premature labor pains, premature rupture of membranes (more than 12 hours before the delivery), the neck of the womb has ceased to extend, labor pains for over 20 hours, stillbirth, ectopic pregnancy, extreme vomiting, or associated or similar pathologies. In this matter, the following conditions will be considered as complications of childbirth and/or the fetus and/or the newborn child: a cesarean operation, an anomalous presentation of the fetus, induction of labor for medical reasons, abnormality of the amniotic fluid, a slow or fast heartbeat, prolapse of the umbilical cord, embolism of the amniotic fluid in the lungs, a birth weight below 2 kilograms, a premature birth (before the 37th week of pregnancy), a delivery while the mother is under general anesthetic, congenital anomalies, or similar or associated pathologies.

Maximum member coinsurance

The maximum amount of coinsurance a Covered Member will need to pay during a plan year, if applicable, as outlined in the table of benefits.

Medical aids and appliances

Medical aids and appliances for the purpose of outpatient treatment shall mean: Bandages, trusses, crutches, compression stockings, artificial limbs/ prostheses (excluding dental prostheses), orthopaedic body, arm and leg support devices and speech equipment (electronic larynx). Shoe inlays are only covered under the Premium plan. The following medical aids are reimbursable only after pre-approval of the

Plan Administrator: Wheelchairs, cardiac and respiratory monitoring devices, infusion pumps, inhalation devices, oxygen equipment. Expenses for the repair of such medical aids are eligible for reimbursement within the scope of the above terms. All other medical aids and appliances are only eligible for reimbursement insofar as benefits have been approved in writing beforehand. Appliances are defined as durable medical equipment that can be used more than once, is used to serve a medical purpose, is not used in the absence of a disease, illness or injury, and is fit for use in the home/everyday life.

Medical Evacuation and Repatriation

Emergency transportation by air and/or sea, as a result of the Covered Person's state of health, to a Hospital, or to an airfield closest to the Hospital to which the Covered Person is referred, or transferred to the Country of Origin, all at the discretion of the Plan Administrator, including any emergency land evacuation that is necessary before or after the transport.
The Plan Administrator's obligation pursuant to this Section is only if all the cumulative conditions specified below have been met:

A. The Covered Person is in need of essential medical treatment to save his/her life.
B. The essential medical treatment cannot be administered to the Covered Person in the place he/she is located.
C. Transportation other than emergency evacuation is likely to end in the death of the Covered Person.
D. That stated in the above paragraphs is requested by a specialist and authorized at the discretion of the Plan Administrator.

Medical Provider/Medical Service Provider

Medical practitioners providing treatment, and medical providers and facilities, who are authorized by the local governing body.

Out of Network Provider

A physician, Hospital, or other service provider that has not entered into an agreement with the Administrator.

Outpatient

Medical treatment given at a Hospital or out-patient clinic that is recognized as an official medical institution by the local jurisdiction in which the Covered Person is receiving treatment, in accordance with the terms of this Policy. Outpatient day treatments lasting over 4 hours (i.e. dialysis) are considered as inpatient.

Over-the-counter drugs (OTC)

Medicines that can be purchased with or without prescription in the country in which the purchase is made.

Partner

A spouse, civil union partner, or cohabiting partner as described above.

Previous Medical Condition/Pre-existing Condition

Any medical condition diagnosed before completion of the Application Form. The diagnosis may be in the form of a documented medical diagnoses (no time-limit) or a documented medical procedure that was conducted in the six months that proceeded the date the Application Form was submitted.

Primary Member

The person who completed the Application Form, who was approved for Policy coverage by the Association, who is the principle insured under the Policy.

Psychiatric Treatment

Medically required treatment to treat a diagnosed mental condition of the Covered Person, including eating disorders by someone who is legally qualified and is permitted to practice as a Psychiatrist in the country where the treatment is received.

Psychotherapy Treatment

Medically Required treatment to treat a diagnosed condition of the Covered person, provided by someone who is legally qualified and is permitted to practice as a Psychotherapist, in the country where the treatment is received.

Repatriation of Remains

This shall include repatriation of mortal remains of the Covered Person to their Home Country.

Substitute hospital cash plan benefit

An amount payable by the Policy for every day actually spent in Hospital in the event a Covered Person does not claim any benefits from the Policy for a medically necessary inpatient treatment which would otherwise be covered under the Policy.

Transplants

Transplants are subject to the prior written authorization of the Plan Administrator and must be performed at an In-Network Provider. Benefit maximums outlined in the table of benefits include the assessment of a medical Specialist before the transplant, the transplant procedure, any follow up treatment, and the cost of harvesting the organ in a Hospital other than an effective purchase or acquisition of an organ or tissue.

Waiting Period

Any period, specified in days or months, beginning on the Policy Effective Date, during which the Covered Person may not be covered for specific medical services in accordance with the table of benefits.

3. Table Of Benefits

	Compact	Comfort	Premium
Medical Services	**Maximum Benefit**		
Per Insurance Year	1,000,000 €	3,500,000 €	5,000,000 €
24/7 INHOUSE ASSISTANCE			
24-hour phone and email service with experienced counsellors, doctors and specialists	✓	✓	✓
Information on medical infrastructure (local medical care and names and addresses of doctors who speak several languages)	✓	✓	✓
Medical evacuation and repatriation (in-network providers only, coordinated by the insurer)	✓	✓	✓
Support and information by our medical service (second opinion, monitoring the course of the illness)	✓	✓	✓
Guarantee of payment (GOP) (preparation for a stay in hospital)	✓	✓	✓
Online services	✓	✓	✓
Additional, appropriate medical support (information on the nature, possible causes and possible treatment of an illness)	✓	✓	✓
Help with psychological problems possibly caused by the stay in the Country of Destination	✗	✗	✓
Transport to hospital upon emergency	✓	✓	✓
INPATIENT TREATMENT			
Accommodation	Semi-private	Semi-private	Private
Medical treatment, surgery and anesthetics fees	✓	✓	✓
Imaging - consultations and diagnostic services	✓	✓	✓
Outpatient surgery instead of inpatient treatment	✓	✓	✓
Parent accommodation during inpatient treatment of a minor child	✓	✓	✓
Long-term care	Up to 20 days	Up to 40 days	Up to 60 days
Dialysis	✗	✓	✓

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,000,000 €	3,500,000 €	5,000,000 €
Bone marrow and organ transplants	Up to 150,000 € per lifetime	Up to 250,000 € per lifetime	✓
Cancer: Oncological drugs and treatment including reconstructive surgery for breast cancer	✓	✓	✓
Substitute hospital cash plan benefit	✗	✗	Up to 100 € per night
Inpatient treatment of mental or nervous disorders (12 month waiting period, requires pre-approval)	Psychiatric treatment up to 5,000 € or 30 days per year / 15,000 € max. or 90 days per lifetime (the lower of the two)	Up to 10,000 € per year	✓
Physiotherapy, including massages (requires pre-approval)	✓	✓	✓
Other inpatient therapies (includes ergo therapy, light therapy, hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy, cardio rehabilitation)	✓	✓	✓
Prescribed medical aids and appliances	Covered if needed as a life-saving measure, e.g. cardiac pacemaker	Covered if needed as a life-saving measure, e.g. cardiac pacemaker. Medical aids and appliances, such as artificial limbs and prostheses: up to 5,000 €	Covered if needed as a life-saving measure, e.g. cardiac pacemaker. Medical aids and appliances, such as artificial limbs and prostheses: up to 5,000 €
Prescribed medicines, drugs and dressings for inpatient	✓	✓	✓
Transport to the nearest suitable hospital for initial treatment following an accident or an emergency	✓	✓	✓
OUTPATIENT TREATMENT			
Medical treatment	Covered as specified below	Covered as specified below	Covered as specified below
Office visits	Family doctor/general practitioner: covered. Specialist: up to 2,000 €	✓	✓
Critical illness, following inpatient treatment	✗	✓	✓
Cancer treatment	✓	✓	✓
Maintenance of chronic conditions	✗	✓	✓
Imaging - consultations and diagnostic services	Up to 1,000 €	✓	✓
Psychiatric treatment	Up to 1,000 €, waiting period of 12 months. Requires pre-approval.	Up to 1,500 €, waiting period of 12 months. Requires pre-approval.	✓

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,000,000 €	3,500,000 €	5,000,000 €
Psychotherapy	✕	✕	Waiting period of 12 months, only by a licensed psychiatrist (MD)
Physiotherapy, including massages	Up to 5 visits, max. 70 € per visit (combined with acupuncture/ homeopathy benefits)	Up to 10 visits, max. 70 € per visit (combined with acupuncture/ homeopathy benefits)	Up to 12 visits (combined with acupuncture/ homeopathy benefits)
Other outpatient therapies	✕	✕	Up to 12 sessions
Speech therapy	✕	✕	Waiting period of 12 months, up to 30 sessions if pre-approved
Acupuncture (needle technique), homeopathy, osteopathy, chiropractic and traditional Chinese medicine (TCM)[1], reflexology	Up to 5 visits, max. 50 € per visit (combined with physiotherapy); 4 months waiting period.	Up to 10 visits, max. 70 € per visit (combined with physiotherapy); 4 months waiting period.	Up to 12 visits (combined with physiotherapy) if pre-approved
Prescribed medical aids and appliances	Up to 750 €	Up to 5,000 €	Up to 5,000 €
Vision aids and eye test	1 eye test at optometrist or optician per year, up to 30 €	Eye test at optometrist or optician and vision aids are covered up to 50 € per year	Up to 300 € in 24 months, optical examination up to 200 € per year
Hearing aids	✕	✕	Waiting period of 48 months if not caused by accident, up to 5,000 € per lifetime
Prescribed medicines, drugs and dressings for outpatient	Up to 10,000 €	Up to 50,000 €	Up to 50,000 €
Over-the-counter drugs (OTC)	Up to 50 €	Up to 50 €	Up to 100 €
HIV and AIDS drug therapy including ART	Up to 50,000 €	Up to 50,000 €	✓
Transport to the nearest suitable doctor for initial treatment following an accident or an emergency	✓	✓	✓

[1] TCM in China requires approval every 10 sessions

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,000,000 €	3,500,000 €	5,000,000 €
MATERNITY SERVICES (12 MONTH WAITING PERIOD)			
Maternity care and childbirth, services of a midwife or obstetric nurse, inpatient and outpatient	✗	Up to 5,000 € per birth, Caesarean covered only if medically necessary	Up to 25,000 € per birth, Caesarean covered only if medically necessary
Complications of pregnancy and childbirth	✗	Up to 100,000 €	✓
Outpatient childbirth cash benefit	✗	✗	500 € per newborn baby
Newborn care (Subject to a maximum risk load of 100% if application was submitted within 60 days after birth and waiting period is completed)	✗	Insured in own policy	Insured in own policy
Newborn congenital conditions	✗	✓	✓
Infertility treatment	✗	✗	Up to 5,000 € per lifetime
WELLNESS			
Well child care	✗	✓	✓
Health checks (adult)	1 per year, up to 150 €	Up to 200 €	Up to 1,000 €
Vaccinations and immunization (adult)	Up to 100 €	Up to 200 €	Up to 500 €
Vaccinations and immunization (child)	Up to 100 €	✓	✓
REHABILITATION AND NURSING			
Inpatient follow-up rehabilitation	Up to 21 days, requires pre-approval	Up to 30 days, requires pre-approval	Up to 30 days, requires pre-approval
Nursing care at home and domestic help, instead of a hospital stay	Up to 14 days	Up to 30 days	Up to 30 days
Day care	✗	✓	✓
Chronic conditions	✗	✓	✓
Hospice (requires pre-approval)	Up to 5 weeks	Up to 10 weeks	✓
DENTAL COVER			
Emergency/accidental dental treatment	up to 3,000 € pain relief only	Up to 6,000 €	Up to 6,000 €

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,000,000 €	3,500,000 €	5,000,000 €
ADDITIONAL ASSISTANCE, REPATRIATION AND COVERAGE OUTSIDE COUNTRY OF DESTINATION			
Return to Country of Destination after evacuation/repatriation	Up to 2,000 € per family	Up to 2,000 € per family	Up to 2,000 € per family
Emergency treatment outside zone of coverage	60 days coverage	60 days coverage	60 days coverage
Return of accompanying Dependent to Country of Destination if Covered Person is evacuated during travel	✕	Up to 1,000 €	Up to 2,000 €
Return of accompanying Child/Children to Country of Origin if Covered Person is evacuated/repatriated	✕	✕	Up to 2,000 € per family
Childcare costs	150 € a day up to 4 days	300 € a day up to 4 days	300 € a day up to 8 days
Dog sitter costs	Up to 50 € a day up to 4 days	Up to 50 € a day up to 4 days	Up to 50 € a day up to 4 days
Compassionate family visit	✕	✕	1 trip per condition, up to 1,500 €
Delayed return trip	✕	✕	Up to 4,000 €
Repatriation to Country of Origin in case of exceeding policy limit	For Covered Person only and only for outpatient care that is covered in Premium plan and that exceeds 10,000 €. Expenses paid up to 2,000 €.	✓	✓
Repatriation of remains	Up to 20,000 €	Up to 20,000 €	Up to 20,000 €

Unless otherwise specified, the above amounts apply per person and insurance year.
All benefits are subject to the Policy Terms, Conditions, Exclusions and UCR - Usual, Customary and Reasonable Rates.

Optional Dental Rider (6 months waiting period)

May be added to “Comfort” and “Premium” plans. Dental treatment requires pre-approval.

COVERED SERVICES	**Option 1: 2,000 € per insurance year (1st year: 1,000 €)**	**Option 2: 5,000 € per insurance year (1st year: 2,500 €)**
BASIC DENTAL SERVICES		
Two check-ups or exams per insurance year	✓	✓
X-rays	✓	✓
Scale-and-polish cleaning	✗	✓
Treating oral mucosa and periodontium	✗	✓
Simple fillings	✓	✓
Surgery, extractions, root-canal treatment	✗	✓
MAJOR DENTAL SERVICES		
Dentures (e.g. prostheses, bridges and crowns, inlays)	✗	20% copay; up to 500 € per tooth
Implants	✗	20% copay; up to 4 implants per jaw and the dentures to be secured to these implants, per lifetime
Night guard	✗	20% copay
Dental laboratory work and materials	✗	20% copay
Treatment plan	✗	20% copay

Unless otherwise specified, the above amounts apply per person and insurance year.
All benefits are subject to the Policy Terms, Conditions, Exclusions and UCR - Usual, Customary and Reasonable Rates.

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,500,000 $	3,500,000 $	5,000,000 $
REIMBURSEMENT LEVEL			
In network	80%	90%	100%
Out of network	60%	70%	80%
MAXIMUM MEMBER COINSURANCE FOR NETWORK ONLY			
Per Insurance Year	10,000 $	5,000 $	n/a
24/7 INHOUSE ASSISTANCE			
24-hour phone and email service with experienced counsellors, doctors and specialists	✓	✓	✓
Information on medical infrastructure (local medical care and names and addresses of doctors who speak several languages)	✓	✓	✓
Medical evacuation and repatriation (in-network providers only, coordinated by the insurer)	✓	✓	✓
Support and information by our medical service (second opinion, monitoring the course of the illness)	✓	✓	✓
Guarantee of payment (GOP) (preparation for a stay in hospital)	✓	✓	✓
Online services	✓	✓	✓
Additional, appropriate medical support (information on the nature, possible causes and possible treatment of an illness)	✓	✓	✓
Help with psychological problems possibly caused by the stay in the Country of Destination	✗	✗	✓
Transport to hospital upon emergency	✓	✓	✓
INPATIENT TREATMENT			
Accommodation	Semi-private	Semi-private	Private
Medical treatment, surgery and anesthetics fees	✓	✓	✓
Imaging - consultations and diagnostic services	✓	✓	✓
Outpatient surgery instead of inpatient treatment	✓	✓	✓

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,500,000 $	3,500,000 $	5,000,000 $
Parent accommodation during inpatient treatment of a minor child	✓	✓	✓
Long-term care	Up to 20 days	Up to 40 days	Up to 60 days
Dialysis	✗	✓	✓
Bone marrow and organ transplants	Up to 150,000 $ per lifetime	Up to 250,000 $ per lifetime	✓
Cancer: Oncological drugs and treatment including reconstructive surgery for breast cancer	✓	✓	✓
Substitute hospital cash plan benefit	✗	✗	Up to 100 $ per night
Inpatient treatment of mental or nervous disorders (12 month waiting period, requires pre-approval)	Psychiatric treatment up to 5,000 $ or 30 days per year / 15,000 $ max. or 90 days per lifetime (the lower of the two)	Up to 10,000 $ per year	✓
Physiotherapy, including massages (requires pre-approval)	✓	✓	✓
Other inpatient therapies (includes ergo therapy, light therapy, hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy, cardio rehabilitation)	✓	✓	✓
Prescribed medical aids and appliances	Covered if needed as a life-saving measure, e.g. cardiac pacemaker	Covered if needed as a life-saving measure, e.g. cardiac pacemaker. Medical aids and appliances, such as artificial limbs and prostheses: up to 5,000 $	Covered if needed as a life-saving measure, e.g. cardiac pacemaker. Medical aids and appliances, such as artificial limbs and prostheses: up to 5,000 $
Prescribed medicines, drugs and dressings for inpatient	✓	✓	✓
Transport to the nearest suitable hospital for initial treatment following an accident or an emergency	✓	✓	✓
OUTPATIENT TREATMENT			
Medical treatment	Covered as specified below	Covered as specified below	Covered as specified below
Office visits	Family doctor/general practitioner: covered. Specialist: up to 2,000 $	✓	✓
Critical illness, following inpatient treatment	✗	✓	✓
Cancer treatment	✓	✓	✓

	Compact	Comfort	Premium
Medical Services	**Maximum Benefit**		
Per Insurance Year	1,500,000 $	3,500,000 $	5,000,000 $
Maintenance of chronic conditions	✗	✓	✓
Imaging - consultations and diagnostic services	Up to 1,000 $	✓	✓
Psychiatric treatment	Up to 1,000 $, waiting period of 12 months. Requires pre-approval.	Up to 1,500 $, waiting period of 12 months. Requires pre-approval.	✓
Psychotherapy	✗	✗	Waiting period of 12 months, only by a licensed psychiatrist (MD)
Physiotherapy, including massages	Up to 5 visits, max. 70 $ per visit (combined with acupuncture/ homeopathy benefits)	Up to 10 visits, max. 70 $ per visit (combined with acupuncture/ homeopathy benefits)	Up to 12 visits (combined with acupuncture/ homeopathy benefits)
Other outpatient therapies	✗	✗	Up to 12 sessions
Speech therapy	✗	✗	Waiting period of 12 months, up to 30 sessions if pre-approved
Acupuncture (needle technique), homeopathy, osteopathy, chiropractic and traditional Chinese medicine (TCM)[2], reflexology	Up to 5 visits, max. 50 $ per visit (combined with physiotherapy); 4 months waiting period	Up to 10 visits, max. 70 $ per visit (combined with physiotherapy); 4 months waiting period	Up to 12 visits (combined with physiotherapy) if pre-approved
Prescribed medical aids and appliances	Up to 750 $	Up to 5,000 $	Up to 5,000 $
Vision aids and eye test	1 eye test at optometrist or optician per year, up to 30 $	Eye test at optometrist or optician and vision aids are covered up to 50 $ per year	Up to 300 $ in 24 months, optical examination up to 200 $ per year
Hearing aids	✗	✗	Waiting period of 48 months if not caused by accident, up to 5,000 $ per lifetime
Prescribed medicines and drugs for outpatient (Generic substitution unless DAW; 2 month copay for 3 month supply in mail order)	Up to 100,000 $. Copay 10 $ brand name drug; 0% generic	Up to 100,000 $. Copay 10 $ brand name drug; 0% generic	Up to 100,000 $. Copay 10 $ brand name drug; 0% generic
Over-the-counter drugs (OTC)	Up to 50 $. Copay 10 $ brand name drug; 0% generic	Up to 50 $. Copay 10 $ brand name drug; 0% generic	Up to 200 $. Copay 10 $ brand name drug; 0% generic
HIV and AIDS drug therapy including ART	Up to 100,000 $	Up to 100,000 $	✓
Transport to the nearest suitable doctor for initial treatment following an accident or an emergency	✓	✓	✓
MATERNITY SERVICES (12 MONTH WAITING PERIOD)			
Maternity care and childbirth, services of a midwife or obstetric nurse, inpatient and outpatient	✗	Up to 10,000 $ per birth, Caesarean covered only if medically necessary	Up to 25,000 $ per birth, Caesarean covered only if medically necessary

[2] TCM in China requires approval every 10 sessions

	Compact	Comfort	Premium
Medical Services		**Maximum Benefit**	
Per Insurance Year	1,500,000 $	3,500,000 $	5,000,000 $
Complications of pregnancy and childbirth	✗	Up to 200,000 $	✓
Outpatient childbirth cash benefit	✗	✗	500 $ per newborn baby
Newborn care (Subject to maximum risk load of 100% if application was submitted within 60 days after birth and waiting period is completed)	✗	Insured in own policy	Insured in own policy
Newborn congenital conditions	✗	✓	✓
Infertility treatment	✗	✗	Up to 10,000 $ per lifetime
WELLNESS			
Well child care	✗	✓	✓
Health checks (adult)	1 per year, up to 250 $	Up to 400 $	Up to 2,000 $
Vaccinations and immunization (adult)	Up to 100 $	Up to 200 $	Up to 1,000 $
Vaccinations and immunization (child)	Up to 100 $	✓	✓
REHABILITATION AND NURSING			
Inpatient follow-up rehabilitation	Up to 21 days, requires pre-approval	Up to 30 days, requires pre-approval	Up to 30 days, requires pre-approval
Nursing care at home and domestic help, instead of a hospital stay	Up to 14 days	Up to 30 days	Up to 30 days
Day care	✗	✓	✓
Chronic conditions	✗	✓	✓
Hospice (requires pre-approval)	Up to 5 weeks	Up to 10 weeks	✓
DENTAL[3]			
Emergency/accidental dental treatment	up to 5,000 $ pain relief only	Up to 8,000 $	Up to 8,000 $

[3] Outpatient dental treatment in the USA is considered out of network, the respective reimbursement level applies.

	Compact	Comfort	Premium
Medical Services	**Maximum Benefit**		
Per Insurance Year	1,500,000 $	3,500,000 $	5,000,000 $
ADDITIONAL ASSISTANCE, REPATRIATION AND COVERAGE OUTSIDE COUNTRY OF DESTINATION			
Return to Country of Destination after repatriation	Up to 2,000 $ per family	Up to 2,000 $ per family	Up to 2,000 $ per family
Emergency treatment outside zone of coverage	60 days coverage	60 days coverage	60 days coverage
Return of accompanying Dependent to Country of Destination if Covered Person is evacuated during travel	✕	Up to 1,200 $	Up to 2,400 $
Return of accompanying Child/Children to Country of Origin if Covered Person is evacuated/repatriated	✕	✕	Up to 2,400 $ per family
Childcare costs	200 $ a day up to 4 days	400 $ a day up to 4 days	400 $ a day up to 8 days
Dog sitter costs	Up to 50 $ a day up to 4 days	Up to 50 $ a day up to 4 days	Up to 50 $ a day up to 4 days
Compassionate family visit	✕	✕	1 trip per condition, up to 2,000 $
Delayed return trip	✕	✕	Up to 4,000 $
Repatriation in case of exceeding policy limit	For Covered Person only and only for outpatient care that is covered in the Premium plan and that exceeds 10,000 $. Expenses are paid up to 2,000 $.	✓	✓
Repatriation of remains	Up to 20,000 $	Up to 20,000 $	Up to 20,000 $

Unless otherwise specified, the above amounts apply per person and insurance year.
All benefits are subject to the Policy Terms, Conditions, Exclusions and UCR - Usual, Customary and Reasonable Rates.

Optional Dental Rider (6 months waiting period)

May be added to “Comfort” and “Premium” plans. Dental treatment requires pre-approval.
Outpatient dental treatment in the USA is considered out of network, the respective reimbursement level applies.

COVERED SERVICES[4]	**Option 1: 2,000 $ per insurance year (1st year: 1,000 $)**	**Option 2: 5,000 $ per insurance year (1st year: 2,500 $)**
BASIC DENTAL SERVICES		
Two check-ups or exams per insurance year	✓	✓
X-rays	✓	✓
Scale-and-polish cleaning	✗	✓
Treating oral mucosa and periodontium	✗	✓
Simple fillings	✓	✓
Surgery, extractions, root-canal treatment	✗	✓
MAJOR DENTAL SERVICES		
Dentures (e.g. prostheses, bridges and crowns, inlays)	✗	20% copay; up to 500 $ per tooth
Implants	✗	20% copay; up to 4 implants per jaw and the dentures to be secured to these implants, per lifetime
Night guard	✗	20% copay
Dental laboratory work and materials	✗	20% copay
Treatment plan	✗	20% copay

Unless otherwise specified, the above amounts apply per person and insurance year.
All benefits are subject to the Policy Terms, Conditions, Exclusions and UCR - Usual, Customary and Reasonable Rates.

[4] Outpatient dental treatment in the USA is considered out of network, the respective reimbursement level applies.

4. Data Privacy Notice of the Insurer

MGEN and **MFPrévoyance** are French authorised insurance companies providing insurance products and services on a cross-border basis. The **Association** has subscribed, as policyholder in its own name but for the benefit of its Members, to the present Group Insurance contract with the Insurer MGEN for the assistance benefits under this Policy, and the Insurer MFPrévoyance for the health benefits under this Policy.

The present contract implements the regulations and requirements on the protection of Personal Data and on the collection, processing and use of Personal Data in the performance and management of the present contract.

Protecting data and the privacy of those the Insurer insures and contracts with is a top priority. This privacy notice explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed. **Please read this notice carefully.**

In the event, the present contract provides coverage of any Dependents of the category of employees to be covered and/or includes the declaration of beneficiaries in the event of death, as applicable, the present Data Privacy Notice must be equally communicated by the Association to such third parties.

Personal data concerning the Parties to the present contract, the category of employees to be covered, their Dependents and/or beneficiaries as applicable, and/or any identified or identifiable natural living person to whom personal data relates hereto, herein referred to as "**Data Subject(s)**" including the signatories to the contractual agreements and the various schedules, exhibits, attachments and other documents referenced or incorporated herein and/or endorsements, amendments or addendums hereto, are used for the sole purpose of the management thereof, whether or not by automated means, such as collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination or otherwise making available, alignment or combination, security, relating to the collection and processing of personal data, including but not limited to the privacy and security thereof, in accordance with the Federal Data Protection Act of 30 June 2017 (Federal Law Gazette I p. 2097), Bundesdatenschutzgesetz (BDSG), German Social Security Codes (Sozialgesetzbücher), which include provisions for processing of medical, social and other personal data, as well as, provided in Section 213 of the German Insurance Contract Act, the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and all applicable laws and regulations relating to the protection and processing of Personal Data, including the General Data Protection Regulation (Regulation (EU) 2016/679) of the European Parliament and of the Council of 27 April 2016, hereinafter referred to as the "**Regulation**", sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities and as stipulated herein.

The terms used herein shall have the meaning given in the Regulation, as defined hereinafter, on the protection of natural persons with regard to the processing of personal data and on the free movement of such data as a result of, or in connection with the present contract. "Personal Data" shall be any personal and/or sensitive data in relation to Data Subjects. Please see Definitions hereinafter.

Any and all necessary endorsements, where applicable, to existing contractual agreements, including the present contract, all relevant Data Protection Agreements with third-parties, and Data Transfer Agreements relating to the collection, processing, use, storage, and/or transfer of any personably identifiable data are concluded in application of all aspects of data protection and information security regulations as stipulated herein and in application of the Regulation.

All appropriate security measures necessary to properly protect and secure the Personal Data and Sensitive data collected, processed and used shall be in application the Federal Data Protection Act of 30 June 2017 (Federal Law Gazette I p. 2097), Bundesdatenschutzgesetz (BDSG), the German Social Security Code (Sozialgesetzbücher), which include provisions for processing of medical, social and other personal data, as well as, provided in Section 213 of the German Insurance Contract Act, the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and the laws and regulations relating to the protection and processing of Personal Data, and, in particular pertaining to Sensitive data, as applicable, the implementation of confidentiality relating to medical data processing in accordance with the

Regulation, the French AERAS Agreement (Insurance and Loans with an Increased Health Risk), effective 2006, revised on 1 February 2011 and 2 February 2015 and the Code of Conduct appended to it as well as the French Code of Medical Ethics.

Data Controller

The Insurer is the Data Controller, as defined by relevant data protection laws and regulations, determines the purposes and the means of the processing personal data in the performance and management of the present contract.

Data Processor

When applicable, the Data Processor is a third-party authorised by a separate Data Protection and Administrative Agreement, to collect, process and use any personably identifiable information made available by the Data Controller to the Data Processor or collected by the Data Processor on behalf of the Data Controller (Personal Data), in relation to all aspects of data protection and information security.

Categories of Personal Data

The various types of Personal Data that may be collected and processed in the performance and management the present contract by any authorised third party Data Controller or Processor shall include but is not limited to the following information:

- **Basic Personal Details**: including Full Name, status title, address, phone number, email address, IP address via webpage without disabling cookies, age, date of Birth, gender, nationality, identification document and/or identification document number (passport, identity card), signatures;
- **Basic Employee HR Employment Details**: including Personnel number, Job title/role, Job status full time – part time, Details /description of role, language, Health Insurance Details, Grade, Policyholder/Entity, Business Unit/Division, Office Location, Country of Origin and Country of Expatriation, Reporting Manager, Start Date, Hours of Work, Relocation dates and details, End date and reason for termination, Contract type- fixed term/temporary/permanent, Correspondence, Results of Criminal Checks relating to prevention of Fraud and/or Terrorist Activities;
- **Financial Details**: including bank account/credit card information, payment information, salary/wage, bonus payments; Pay Statements, Benefits and entitlements data, share schemes data, housing/relocation or other allowances, compensation data, third-party reductions;
- **Health, Welfare and Absence Related Administrative Data**: related to the Policyholder's relationship with the Data Subject, such as an employee personnel file including performance related information, Record of absence/ leave, Reason for absence, details of physical and psychological health or medical condition, health and Safety related information and Reporting, Occupational health related information and reporting, Grievances and Complaints, harassment details, Disability, access, special requirements details, Ill health retirement pensions, retirement
- **Education & Professional Experience & Affiliations Data**: life data, which may include information related to education and training, qualification/certifications, languages, employment history, skills, awards or performance reviews or any other information relating to professional life;
- **Family, Lifestyle and Social Circumstances**: including Marital Status, Dependents/Spouse/partner/family details, next of kind/emergency contact details, Ethnicity, Religion/Religious beliefs, Other diversity and equality information...and Data relating to personal life which may include information about likes and dislikes or other information related to personal life; and
- **Sensitive Data**: may include any data that may reveal racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, genetic data, biometric data, data concerning health or data concerning a Data Subject's sex life or sexual orientation including Medical Questionnaires, Enrolment forms, consent forms, Declaration of Beneficiary forms, medical reports, medical assessments reports, or death certificates, requests for prior approvals, medical expenses invoices, claims history.

Categories of Data Subjects

The Personal Data processed by the Insurer and/or on behalf of the Insurer in order to perform its obligations under, or otherwise in connection with, the present contract, depending on the services provided, the categories of Data Subjects may include but are not limited to the following:

- Current or former personnel including directors, officers, employees, relations of employees, providers, natural persons (agents, intermediaries) agency workers, invitees, Insurers, subcontractors, representatives of business partners (providers, clients, brokers, intermediaries), policyholders, contract holders, Insureds, beneficiaries, relatives and/or dependents of contract holders, insureds or beneficiaries where applicable;
- Contacts or other personnel of customers, prospects, vendors, affiliates, business partners or other related organizations.

Insofar as Personal data and/or other sensitive data are required for the underwriting, administration, and management of the present contract, Dependents and/or beneficiaries in the event of death shall be considered "Data Subjects" for purposes of the application of the Regulation.

Consent

The collection and use of the personal data provided to the Data Controller and any authorised third party where applicable may require the express consent of the Data Subject, unless otherwise provided by the applicable laws and regulations:

Purpose	Express consent
Conclusion, performance and fulfilment of the obligations and rights of an Agreement and Insurance contract administration (e.g., quotation, underwriting, claims handling)	Required when necessary. However, where personal data is needed to be processed in order to underwrite insurance and/or process a claim the Insurer will not need to obtain Data Subject express consent.
To administer debt recoveries	Not required
To inform Data subjects, or permit the Insurer's Group companies and selected third parties to inform Data Subjects, about products and services that may interest Data Subjects in accordance with marketing preferences. Modifications to preferences may be requested at any time by contacting their Insurer's representative or by contacting the Insurer as specified hereunder.	Required
For automated decision making (including profiling) for credit scoring purposes, to personalize Data Subject experience [on the website] (by presenting products, services, marketing messages, offers, and content tailored to Data Subject), and to make other decisions about Data Subject using computerised technology such as assessing which products might be most suitable for Data Subject	Required, when necessary. However, where the Insurer or authorised third party need to process personal data in order to underwrite insurance and/or process a claim the Insurer will not need to obtain Data Subject express consent.
Fraud prevention and detection	Not required
Meet any legal obligations (e.g., tax, accounting and administrative obligations)	Not required
To redistribute risk by means of reinsurance and co-insurance	Not required

As mentioned above, the Insurer may collect and process information containing personal data received where relevant from public databases, third parties such as brokers and business partners, physicians, hospitals, other medical administrative authorities, other insurers, credit reference and fraud prevention agencies, advertising networks, analytics providers, search information providers, claims adjustors, intermediaries, delegated authorities, attorneys and notaries.

For those purposes indicated above where the Insurer has indicated that it does not require express consent from the Data Subject or where the Insurer otherwise require the personal data to underwrite insurance and/or process claim, the Insurer will process the personal data based on legitimate interests and/or to comply with legal obligations.

Access and Processing of Personal data

The Insurer will ensure that personal data is processed in a manner that is compatible with the purposes indicated above. For the stated purposes, personal data may be obtained or disclosed to the following parties through contractual arrangements to protect personal data with those who may operate as authorised third party data controllers and or processors.

- Public authorities, other Insurer's Group companies, other insurers, co-insurers, re-insurers, insurance intermediaries/brokers, and banks
- With entitles outside of the Insurer's Group that perform certain services on behalf of the Insurer such as risk assessments and claims handling that involve the collection and use of health and other data without which the Insurer would not be able to administer a policy or pay any claims
- Policyholders, employers, brokers, other Insurer's Group companies, insurance intermediaries, third party administrator to underwrite, and/ or administer the policy or process any data and discharge operations (claims, IT, postal, document management, etc.);
- Physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, professional associations and public authorities to administer the policy or process any claims;
- Other Group companies, technical consultants, experts, lawyers, loss adjustors, repairers, medical doctors; and service companies to discharge operations (claims, IT, postal, document management); and/or
- Advertisers and advertising networks to send Data Subject marketing communications, as permitted under local law and in accordance with Data Subject communication preferences. The Insurer does not share personal data with non-affiliated third parties for their own marketing use without permission from the data Subject.

The Insurer and these third parties shall perform this exchange in accordance with the data and medical confidentially obligations and procedures required to share the data and to use for the aforementioned purposes.

Finally, the Insurer may also share personal data in, including but not limited to, the following instances:

- In the event of any contemplated or actual reorganization, merger, sale, joint venture, assignment, transfer or other disposition of all or any portion of our business, assets or stock (including in any insolvency or similar proceedings); and
- To meet any legal obligation, including to the relevant ombudsman, court, arbitrator, attorney if a Data Subject makes a complaint about the products or services the Insurer has provided to the Data Subject.
- With coinsurers to distribute the coverage of the insurance risk jointly with other companies to which the Insurer issues a policy, and/or to handle claims jointly.
- With other insurers/reinsurers that may be covering the same insurance risk at the same time – multiple insurance – to distribute the payment of any compensation that may be owed to me, or to collaborate in the detection or prevention of fraud and financial crime.

Data Subject Rights

The Data Protection Regulation confers certain rights on Data Subjects, including:

- **The right to access**: the Data Subject shall have the right to obtain from the controller confirmation as to whether or not Personal Data concerning him are being processed, and, where that is the case, access to the Personal Data in a concise, transparent, intelligible and easily accessible form to learn the origin of the data, the purposes and ends of the processing, the details of the data controller(s), the data processor(s) and the parties to whom the data may be disclosed;
- **The right to Withdraw**: The Data Subject shall have the right to withdraw consent at any time where personal data is processed with express consent;
- **The right to rectify**: The Data Subject shall have the right to obtain from the controller without undue delay the rectification of inaccurate or incomplete Personal Data concerning the Data Subject;
- **The right to erase** ("right to be forgotten"): The Data Subject shall have the right to obtain the deletion or removal of Personal Data without undue delay;
- **The right to restriction of processing**: The Data Subject shall have the right to obtain from the controller restriction of processing in certain conditions;
- **The right to object**: The Data Subject shall have the right to object on grounds relating to his particular situation, at any time to processing of Personal Data concerning him. The controller shall then no longer process the Personal Data unless the controller demonstrates compelling legitimate grounds for the processing which override the interests, rights and freedoms of the Data Subject or for the establishment, exercise or defense of legal claims;
- **The right to obtain human intervention for a decision based solely on automated processing including profiling**: Data Subject shall have the right not to be subject to a decision based solely on automated processing, including profiling, which produces legal effects concerning him similarly significantly affects the Data Subject;
- **The right to data portability**: Data Subject shall have the right to receive the Personal Data concerning him, which he has provided to a controller, in a structured, commonly used and machine-readable format and have the right to transmit those data to another cont-

roller;
- **File a complaint** with the Insurer and/or the relevant Data Protection Authority.

The Data Subject may exercise these rights by contacting their Insurer's representative or by contacting the Insurer directly as specified hereunder providing the Data Subject's name, email address, account identification, and purpose of the request.

The Data Protection Officer for MGEN (Insurer of the assistance benefits under this Policy):

Délégué à la Protection des Données du Groupe VYV
(Data Protection Officer of the VYV Group)
Tour Montparnasse – 33, avenue du Maine –
BP 245 – 75755 – Paris Cedex 15
France
or at dpo@vyv-ib.com

The Data Protection Officer for MFPrévoyance (Insurer of the health benefits under this Policy):

CNP Assurances for MFPrévoyance - Délégué à la Protection des Données (Data Protection Officer)
4 Place Raoul Dautry
75716 Paris Cedex 15
France
or at dpo@cnp.fr

Objection to the Processing of Personal and/or Sensitive Data

Where permitted by applicable law or regulation, the Data Subject has the right to object to the processing of personal data, or request the Insurer to stop processing the data (including for purposes of direct marketing). Once the Data Subject has informed the Insurer, it shall no longer process the personal data of the Data Subject unless permitted by applicable laws and regulations. The Data Subject may exercise this right in the same manner as for the other rights indicated hereinabove.

Data Retention

The Insurer will retain the personal data of Data Subjects as permitted by applicable laws and regulations, and, specifically as follows:

Documents	Data Retention Duration
Proposal, Quotations	3 years
Contracts and Endorsements Covers	Life
Individual Enrollment Forms	– 5 years from the date of the termination of contract (if no claim) – 5 years from the date of the termination of the insurance coverage
Individual enrollment forms of Disabled Insured	Filed in the relevant claims file (see below: “claims files”)
Contributions and Premiums, Commissions and Fee slips and Records	5 years
Computerized Accounting Records	30 years
Claims files in the event of Death, Total and Irreversible Loss of Autonomy, Incapacity, Disability	– if the benefit has been paid: 10 years from the last date of payment – if the benefit has not been paid in totality or partially to the beneficiary(ies) in the event of death of the Insured: 30 years from the date of the recognition of the death of the Insured by the company. – if the benefit could not be paid in total or partial due to the disappearance of absence of the Insured: 30 years from the date of recognition by the company of the determination of the disappearance or absence of the Insured
Healthcare claims (illness/accident medical expenses)	3 years from the date the claims are closed
Permanent Partial Disability Due to Illness (PPDI)- Permanent Partial Disability Due to Accident Disability (PPDA) - Monthly Payments - Hospital Reimbursement - Resource Guarantees - End of Carrier Compensation - Education Allowance	– if the benefit has been paid: 10 years from the last date of payment – if not paid: 30 years
Other Contractual Documents (Administrative Agreements, Treaties, conventions, endorsements, other varied agreements).	Life

The Insurer will not retain personal data of the Data Subject for longer than necessary and will retain said data only for the purposes for which it was obtained.

Contact Information

If the Data Subject has any queries about how the Insurer uses personal data, the Data Subject can contact the Data Protection Officer as follows:

The **Data Protection Officer** for **MGEN** (for the assistance benefits under this Policy):

Délégué à la Portection des Données du Groupe VYV
(Data Protection Officer of the VYV Group)
Tour Montparnasse – 33, avenue du Maine –
BP 245 – 75755 – Paris Cedex 15
France
or at dpo@vyv-ib.com

The **Data Protection Officer** for **MFPrévoyance** (for the health benefits under this Policy):

CNP Assurances for MFPrévoyance - Délégué à la Portection des Données (Data Protection Officer)
4 Place Raoul Dautry
75716 Paris Cedex 15
France
or at dpo@cnp.fr

The Data Subject shall be informed of any an important change that may impact the personal data of the Data Subject. Otherwise the Data Subject may contact their Insurer‘s representative or by contacting the Insurer directly as specified hereinabove. This Data Protection Notice was updated on 1 May 2018.

DEFINITIONS

The following terms shall have the meaning given in the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (“the Regulation”) and as defined hereunder:

Applicable Laws

Unless otherwise stipulated herein, (a) European Union or Member State laws with respect to any Personal Data in respect of which any company of the group Legal Entities is subject to EU Data Protection Laws; and (b) any other applicable Data Protection Law with respect to any Personal Data which any company of a Group of Legal Entities is subject to.

Binding Corporate Rules

Personal Data protection policies which are adhered to by a controller or processor established on the territory of a Member State for transfers or a set of transfers of personal data to a controller or processor in one or more third countries within a group of undertakings, or group of enterprises engaged in a joint economic activity.

Confidential Information

Confidential information shall include (but not be limited to) information of a confidential nature relating to policies and policyholders and the business affairs, strategies, commercial and technical knowledge of the parties.

Consent of the Data Subject

Any freely given, specific, informed and unambiguous indication of the data subject’s wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her.

Corporate Personal Data

Any Personal Data Processed by a contracted Data Processor and/or Sub-Processor on behalf of the Data Controller or Corporate Group Member of the Data Controller pursuant to or in connection with the relevant Administrative Agreements including but not limited to the signatories to the Administrative Agreement(s) and the present DPA, and any Confidential Information which relates to the Parties’ businesses and/or customers or employees of the Parties.

Cross-Border Processing

Processing of Personal Data that takes place in the context of the activities of establishments in more than one Member State of a Data Controller or Data Processor in the European Union where the Data Controller or Data Processor is established in more than one Member State; or processing of Personal Data which takes place in the context of the activities of a single establishment of a Data Controller or Data Processor in the European Union but which substantially affects or is likely to substantially affect Data Subjects in more than one Member State.

Data

Personal data, sensitive data and other information made available by the Data Controller to the Data

Processer or made available by the Data Processor to Data Controller in connection with the Agreement, and any other data and information processed by the Data Processor in connection with the Agreement, including the personal data of the signatories to the Agreement and the present Addendum, and that which relates to the Parties' businesses and/or customers or employees of the Parties.

Data Controller

Natural or legal person, public authority, agency or other body which alone or jointly with others, determines the purposes and means of the processing of Personal Data. The role of Controller is not determined by who collects the data or who access to them, but by who determines the purposes and the means of the processing. Legal Entities without own legal personality may be controllers different from the parent company where they determine the purposes and means of the processing performed on their behalf. Where the purposes and means of such processing are determined by Union or Member State law, the controller or the specific criteria for its nomination may be provided for by Union or Member State law.

Data Processing or Process

Any operation or set of operations which is performed by a Data Processor on behalf of a Data Controller, on Personal Data or on sets of Personal Data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction.

Data Processor

A natural or legal person and/or legal entity, public authority, agency or other body which processes Personal data on behalf of the Data Controller. Existence of a Processor depends on a decision taken by the controller, who can decide either to process data within his organization or to delegate all or part of the processing activities to an external organization.

Defining elements:

- Separate legal entity
- Processing of data on behalf of the controller
- Processor is called to implement the instructions given by the controller at least with regard to the purpose of the processing and the essential elements of the means

Data Protection Law

All applicable current and/or future international, regional, federal, or national Data Protection Laws, regulatory guidance, legislation, statutes, codes, regulations, recommendations and/or opinions issued by a relevant data protection authority, in any jurisdiction, relating to the Processing of Personal Data, including the privacy and security of Personal Data, in accordance with the Federal Data Protection Act of 30 June 2017 ((Federal Law Gazette I p. 2097) Bundesdatenschutzgesetz (BDSG), German Social Security Codes (Sozialgesetzbücher), which include provisions for processing of medical, social and other personal data, as well as, provided in Section 213 of the German Insurance Act, the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and, in particular, the General Data Protection Regulation 2016/679 of 27 April 2016 and any European Union or EU Member State legislation, regulation, recommendation or opinion replacing, adding to or amending, extending, repealing or consolidating the Data Protection Law relating to the requirements on collection, processing and use of Personal Data by Data Processors on behalf of Data Controllers.

Data Protection Supervisory Authority

An independent public authority which is established by a Member State pursuant to Article 51 of the Regulation; a supervisory authority which is concerned by the processing of personal data because:

- the controller or processor is established on the territory of the Member State of that supervisory authority;
- data subjects residing in the Member State of that supervisory authority are substantially affected or likely to be substantially affected by the processing; or
- a complaint has been lodged with that supervisory authority;

The French Data Protection Authority (Commission Nationale de l'Informatique et des Libertés, hereinafter referred to as the "CNIL") is the French Supervising Authority. The CNIL is an independent administrative authority responsible for ensuring that information

technology remains at the service of citizens, and does not jeopardise human identity or breach human rights, privacy, or individual or public liberties. It supervises enforcement of Data Protection Agreement and frequently issues decisions and guidelines relating thererto. www.cnil.fr/english/

Data Subject
The identified or identifiable natural living person to whom the personal data relates; an identifiable natural living person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

Data Subject Request
A request from a Data Subject for access to, correction, amendment, transfer or Deletion of the Personal Data of the person.

Data Transfers Outside the EEA
The processing or disclosure of the personal data to any party who carries on business, outside of the European Economic Area (EEA) in compliance with applicable data protection laws. The use of standard contractual clauses in Data Transfer Agreements entered into between Parties or any other third-parties upon approval of the Data Controller for the transfer of Personal data outside of the EEA (Commission Decision 2010/87/EU), or any replacement clauses subsequently approved by the European Commission shall be required. All data processing will be in accordance with the terms and conditions stipulated in all Data Transfer Agreements providing the Information on Personal Data Processing required by GDPR articles 13 and 14.

Identifiable Natural Person
Natural person who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person, as defined in GDPR, Article 4.1

Information System
Any structured set of Personal Data which are accessible according to specific criteria, whatever the form or method of its creation, storage, organisation and access. It may be comprised of any one or more kinds of Support (e.g.: data bases, physical files, computer directories, etc.)

Legal Entities (Group of)
In respect to either Party, a related legal entity is a controlling legal entity and its controlled legal entities:

a. a controlling corporate body;
b. a controlled corporate body affiliate; or
c. a controlled corporate body affiliate of a controlling corporate body.

For the purposes of this definition:

- Corporate Body Affiliate means a legal entity that owns or controls, is owned or controlled by, or is or under common control or ownership with Company where control is defined as the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity, whether through ownership of voting securities, by contract or otherwise;
- Corporate Group Member means Corporate Body or any Corporate Body Affiliate;
- Corporate Personal Data means any Personal Data Processed by a Contracted Processor on behalf of a Corporate Group Member pursuant to or in connection with the relevant Administrative Agreements;
- One corporate body controls another when at the relevant time:
  a. it owns either directly or indirectly or is otherwise in a position to cast, or control the casting of, not less than 50% of the shares entitled to vote at general meetings of that other corporate body; or
  b. it controls the composition of a majority of the board of that other corporate body.

Pseudonymisation
The processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person.

Personal Data
Any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

Personal Data Breach
Breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, personal data transmitted, stored or otherwise processed.

Recipient
A natural or legal person, public authority, agency or another body, to which the personal data are disclosed, whether a third party or not. However, public authorities which may receive personal data in the framework of a particular inquiry in accordance with Union or Member State law shall not be regarded as recipients; the processing of those data by those public authorities shall be in compliance with the applicable data protection rules according to the purposes of the processing;

Regulator
As applicable, any person or law enforcement or other agency having Regulatory, supervisory or governmental authority (whether under a statutory scheme or otherwise) over all or any part of the Processing of Personal Data in connection with the provision or receipt of the Services, including, without limitation, the European Data Protection Supervisory Authorities.

Sensitive Data
Personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation.

- 'genetic data' means personal data relating to the inherited or acquired genetic characteristics of a natural person which give unique information about the physiology or the health of that natural person and which result, in particular, from an analysis of a biological sample from the natural person in question;
- 'biometric data' means personal data resulting from specific technical processing relating to the physical, physiological or behavioural characteristics of a natural person, which allow or confirm the unique identification of that natural person, such as facial images or dactyloscopic data;
- 'data concerning health' means personal data related to the physical or mental health of a natural person, including the provision of health care services, which reveal information about his or her health status;

Sub-Processor
Any Third Party subcontractor (excluding employees of a Data Controller or any employees of a sub-contractor of a Data Controller) appointed on behalf of a Data Controller by a Data Processor to Process Personal Data - also may be referred to as a Contracted Sub-Processor or Subcontractor for purposes of applicable Data Protection Laws.

For the purposes of applicable Data Transfers Outside the EEA, as stipulated herein, a contracted Sub-Processor means any processor engaged by a Data Importer or by any other Sub-Processor of the Data Importer who agrees to receive from the Data Importer or from any other Sub-Processor of the Data Importer Personal Data exclusively intended for Processing activities to be performed on behalf of the Data Exporter after the transfer in accordance with his instructions, the terms of the Clauses and the terms of the written subcontract.

Standard Contractual Clauses
The contractual clauses stipulated in a Data Transfer Agreement executed by and between a Data Controller and a Data Processor and/or a Data Controller and a Data Controller, transferring Personal Data from the EEA to a Data Processor or other Data Controller in a Third Country, which is subject to the Data Protection Laws of a given country or territory, to reflect (to the extent possible without material uncertainty as to the result) any change (including any replacement) made in accordance with those Data Protection Laws in particular pursuant to the European Commission's decision of 5 February 2010 on Standard Contractual Clauses for the transfer of Personal Data to processors established in Third Countries.

Technical and Organisational Security Measures
Those measures aimed at protecting Personal Data against accidental or unlawful destruction or accidental loss, alteration, unauthorised disclosure or access, in particular where the processing involves the transmission of Data over a network, and against all other unlawful forms of processing.

Third Country(ies)
A country or Recipient: (i) not recognized by the European Commission as providing an adequate level of protection for Personal Data; and (ii) not covered by a suitable framework recognized by the relevant authorities or courts as providing an adequate level of protection for Personal Data.

Third party
A natural or legal person, public authority, agency or body other than the data subject, controller, processor and persons who, under the direct authority of the controller or processor, are authorised to process personal data.

MFPREVOYANCE is a Public Limited Company, registered at the French Commercial and Company Registry RCS Paris under No 507 648 053, regulated by the provisions of the French Insurance Code, with its head office at 4, place Raoul Dautry, 75015 Paris, France.

MGEN is registered under the number SIREN 775 685 399, regulated by the provisions of Tome II of *Code de la mutualité* (the French Mutual Insurance Companies Code), with its head office at 3 square Max-Hymans, 75748 Paris, Cedex 15, France.

5. Consequences of Non-fulfilment of the Disclosure Obligation Pursuant to § 19 of the German Insurance Contract Act (Versicherungsvertragsgesetz)

Pre-Contractual Disclosure Obligations
The Insurer assumes the insurance cover based on the understanding that the Primary Member or any Covered Person answers all questions asked in conjunction with the insurance contract truthfully and completely. The Insurer relies on the information disclosed by the Policyholder and thus that of the Insured to be able to assess the risk correctly and to calculate the premium at an appropriate level. For this reason, the Primary Member or any Covered Person is required, up to the time at which the contractual declaration has been submitted, to state truthfully and completely all risk-related circumstances known to the Primary Member or any Covered Person which the Insurer has enquired about in written form (text form). If, after submission of the contractual declaration, but before contractual acceptance in written form, the Insurer enquires about risk-related circumstances, the Primary Member or any Covered Person is also obliged to disclose these accordingly. Circumstances to which the Primary Member or any Covered Person only attaches minor importance must also be disclosed. Should another person be insured, then this person – in addition to the Primary Member – is responsible for answering the questions asked in written form truthfully and in full. For purposes of the present policy, this shall include not only the Primary Member but also the eligible Covered Persons.

Possible Consequences of Breach of a Pre-contractual Disclosure Obligation

1. Withdrawal
If the Primary Member or any Covered Person does not fulfil a pre-contractual disclosure obligation, the Insurer is entitled to withdraw from the Policy. This does not apply if the Primary Member subsequently proves that neither intent nor gross negligence are involved. In the case of grossly negligent breach of the disclosure obligation, the Insurer does not have the right to withdraw if the Insurer has concluded the contract in the knowledge of the undisclosed circumstances, even in relation to other conditions. In the event of withdrawal, no insurance cover exists. Should the Insurer announce our withdrawal after the insured event has occurred, the Insurer is still obliged to pay the benefit if the Primary Member subsequently provides proof that the circumstance which was not disclosed or incorrectly disclosed was not the cause of

- either the occurrence or ascertainment of the insured event; or
- the ascertainment or scope of our payment obligation.

However, the Insurer's payment obligation becomes invalid if the Primary Member or any Covered Person has fraudulently breached the disclosure obligation.
In the event of withdrawal, the Insurer is entitled to the portion of the premium corresponding to the contractual period which has elapsed up to the time at which the declaration of withdrawal becomes effective.

2. Termination
If the Insurer is unable to withdraw from the contract because the Primary Member or Covered Person has (without any gross negligence) not fulfilled a pre-contractual disclosure obligation, the Insurer may terminate the Policy, adhering to a deadline of one month. The Insurer's right to termination is excluded if the Insurer had concluded the contract in the knowledge of the undisclosed circumstances, even in relation to other conditions.

3. Contract amendment
If the Insurer is unable to withdraw or terminate the Policy because the Insurer had concluded the contract despite having knowledge of the undisclosed risk circumstances, even in relation to other conditions, the other conditions shall become an integral part of the contract at the Insurer's request.
If the Primary Member and any Covered Person

negligently breached the disclosure obligation, the other conditions will become an integral part of the contract retrospectively. This may lead to a retrospective premium increase or to a retrospective exclusion of the risk coverage for the undisclosed circumstance, and in this regard to a retrospective lapse of the insurance cover.

If the insurance premium increases by more than 10% as a result of the contractual amendment, or if the Insurer excludes the risk cover for the undisclosed circumstance, the Primary Member may terminate the Policy within one month of receipt of our notification of the contractual amendment. The Insurer will advise the Primary Member of this right in our notification.

4. Assertion of the Insurer‘s rights

The Insurer may only assert our rights with regard to the withdrawal, termination or contractual amendment within one month in writing. This period commences at the point in time when the Insurer are made aware of the infringement of the disclosure obligation which justifies the assertion of our right. In exercising our rights, the Insurer must reveal the circumstances on which the Insurer is basing its assertion. The Insurer may, retrospectively, provide additional circumstances as justification if the deadline for these as per paragraph 1 has not lapsed. The Insurer may not invoke the rights to withdrawal, termination or contractual amendment if the Insurer was aware of the undisclosed risk circumstance or the incorrectness of the disclosure. Our rights to withdrawal, termination and contractual amendment lapse after a period of three years following conclusion of the Policy. This does not apply in the case of insurance cases which arose before this period lapsed. The period comprises 10 years if the Primary Member or any Covered Person has intentionally or fraudulently breached the disclosure obligation.

5. Contest of contract validity

If the Primary Member or any Covered Person fraudulently deceives us, the Insurer may also contest the validity of the contract.

6. Representation by another person

If the Primary Member allows another person to represent the Primary Member when the Policy is concluded, then both the knowledge and fraudulent intent of the Primary Member’s representative in addition to the Primary Member’s own knowledge and fraudulent intent are to be taken into account with regard to the disclosure obligation, withdrawal, termination, contractual amendment and the exclusion deadline for assertion of the Insurer’s rights. The Primary Member may only claim that the disclosure obligation has not been breached intentionally or as a result of gross negligence if neither the Primary Member’s representative nor the Primary Member is responsible for fraud or gross negligence.

6. Revocation Instruction

SECTION 1
RIGHT OF REVOCATION, CONSEQUENCES OF REVOCATION AND SPECIAL NOTE

RIGHT OF REVOCATION

You may revoke your request for insurance cover in text format (e.g., letter, email) within 14 days without indicating any reasons.

The revocation period commences from the time you received

- **the insurance certificate**,
- **the contract terms**, including the terms and conditions of the insurance plan, which in turn include the tariff provisions,
- **this instruction**,
- **product information sheet**, and
- **the further information listed below in section 2**

in writing.

The timely dispatch of the revocation is sufficient to comply with the revocation period.

The revocation notice is to be addressed to:
PassportCard Deutschland GmbH
Caffamacherreihe 8-10
20355 Hamburg
Germany
Email: kundenbetreuung@passportcard.de

CONSEQUENCES OF REVOCATION

In the event of an effective revocation, the insurance cover will terminate and we will refund to you the portion of the premiums attributable to the period after receipt of the revocation if you have agreed that the insurance cover will commence before the end of the revocation period. In this case, we may retain the part of the premium that is attributable to the time until receipt of the revocation; this is an amount equal to 1/30 of the monthly premium for each day that insurance cover has existed. Reimbursement of the premium will occur without undue delay, at the latest thirty (30) days following receipt of the revocation.

If the insurance cover does not begin before the end of the revocation period, the effective revocation results in the return of benefits received and the surrender of benefits derived (e.g. interest).

SPECIAL NOTE

Your right of revocation expires if the insurance cover is completely fulfilled by you and us at your express request before you have exercised your right of revocation.

SECTION 2
LIST OF FURTHER INFORMATION REQUIRED FOR THE START OF THE TIME LIMIT

With regard to the further information referred to in section 1 sentence 2, the information requirements are detailed below.
The insurer has 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 with which the legal entity is registered, and the corresponding register number;

2. the identity of a representative of the insurer in the member state of the European Union in which you are resident, if there is such a representative, or the identity of a person acting in a professional capacity other than the insurer, if you are dealing with that person, and the capacity in which such person is acting with respect to you;

3. (a) the insurer‘s address for service and any other address that is 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 a authorized representative; insofar as the notification is made by transmission of the contractual provisions including the General Conditions of Insurance, the information must be in a prominent and clear form; if the notification is made by transmission of the form;
   (b) any other address relevant to the business relationship between an agent or representative of the insurer or any other person acting in a commercial capacity pursuant to number 2 and you, in the case of legal persons, associations of persons or groups of persons, also the name of a person authorized to represent them; insofar as the communication is by transmission of the terms and conditions of the contract, including the General terms and conditions of insurance, the information must be provided in a prominent and clearly designed form;

4. the main business activity of the insurer;

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, whereby the premiums

are to be shown individually if the insurance relationship is to comprise several independent insurance contracts, or, if an exact price cannot be stated, details of the basis for its calculation, which enable you to check the price;

7. (a) if applicable, any additional costs incurred, stating the total amount to be paid, as well as any other taxes, fees or costs that have not been paid through or charged by the insurer;
(b) any costs incurred by you for the use of any means of distance communication, if such additional costs are charged;

8. details relating to payment and performance, in particular on the method of payment of the premiums;

9. the period of validity of the information provided, for example, the period of validity of limited offers, in particular with regard to the price;

10. information on how the contract is concluded, in particular on the commencement of the insurance and the insurance coverage as well as the duration of the period during which the applicant shall be bound by the application;

11. the existence or non-existence of a right of cancellation and the conditions, details of the exercise thereof, in particular the name and address of the person to whom the revocation is to be 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; if the notification is sent by transmitting the terms of the contract, including the general Conditions of Insurance, the information must be provided in a prominent and clearly highlighted and clearly designed form;

12. (a) Information on the duration of the contract;
(b) Information on the minimum term of the contract;

13. details of the termination of the contract, in particular the contractual termination conditions; insofar as the notification is made by the contractual provisions, including the general terms and conditions of insurance, the information shall be provided in a prominent and clearly designed form;

14. the member states of the European Union whose law the insurer is subject to establishing relations with you prior to the conclusion of the insurance contract;

15. the law applicable to the contract;

16. the languages in which the terms of the contract and the preliminary information referred to in this subsection are communicated, as well as the languages in which the insurer agrees, with your consent, to communicate during the term of this contract; and of this contract;

17. possible access for you to an out-of-court complaint and redress procedure and, if applicable, the conditions for such access; in this context, it must be expressly state that the possibility for you to take legal action, remains unaffected;

18. name and address of the competent supervisory authority and the possibility of a complaint to this supervisory authority.

End of the instruction on the right of revocation.

7. Zones of Coverage

- **Worldwide including USA:** Includes coverage in countries of zone 1 – 5.

- **Global excluding USA:** Coverage applies worldwide in countries of zone 1 – 5, excluding the USA.
  The premium is determined according to the pricing zone of the selected Country of Destination. Coverage includes treatment of medical emergencies outside the zone of coverage for a period of up to 60 days per trip.

- **Local coverage:** If the Country of Destination is in zone 4 or 5, coverage is limited to the countries of zone 4 or 5, respectively. It includes treatment of medical emergencies outside the zone of coverage for a period of up to 60 days per trip. If your Country of Destination is in zone 4 or 5, alternatively you can choose to opt for Global exlcuding USA coverage. Please refer to zone 3 rates.

Zone 1	China, Hong Kong, Japan, Singapore, South Korea, Taiwan
Zone 2	Australia, Belize, Brazil, British Indian Ocean Territory, Canada, Christmas Island, Coconut Islands, Cook Islands, Cuba, Ecuador, Falkland Islands, Fiji, French Guiana, French Polynesia, Guadeloupe, Guam, Guyana, Haiti, Honduras, Jamaica, Kiribati, Maldives, Malvinas, Marshall Islands, Martinique, Mayotte, Mexico, Micronesia, Minor Outl.Isl., Montserrat, Nauru, New Caledonia, New Zealand, Nicaragua, Niue, Norfolk Island, Northern Mariana Islands, Palau, Papua New Guinea, Puerto Rico, Pitcairn Islands, Reunion, S.Sandwich Isl., Saint Pierre and Miquelon, Samoa, Solomon Islands, Suriname, Tokelau Islands, Tonga, Tuvalu, United Kingdom, Vanuatu, Wallis and Futuna, Western Samoa
Zone 3	Albania, Andorra, Armenia, Austria, Belarus, Belgium, Bosnia and Herzegovina, Bouvet Islands, Bulgaria, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Georgia, Germany, Gibraltar, Greece, Greenland, Hungary, Iceland, Ireland, Israel, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, Russia, San Marino, Serbia, Slovakia, Slovenia, Spain, Svalbard, Sweden, Turkey, Ukraine, United Arab Emirates, Vatican City
Zone 4	Afghanistan, Algeria, Angola, Azerbaijan, Bahrain, Bangladesh, Benin, Bhutan, Botswana, Brunei, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Democratic Republic of Congo (Zaire), Djibouti, East Timor, Egypt, Equatorial Guinea, Eritrea, Eswatini (Swaziland), Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Heard and McDonald Islands, India, Indonesia, Iraq, Ivory Coast, Jordan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Laos, Lebanon, Lesotho, Liberia, Libya, Macau, Madagascar, Malaysia, Malawi, Mali, Mauretania, Mauritius, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Niger, Nigeria, Oman, Pakistan, Philippines, Qatar, Rwanda, Sao Tome and Principe, Saudi Arabia, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sri Lanka, Sudan, Tajikistan, Tanzania, Thailand, Togo, Tunisia, Turkmenistan, Uganda, Uzbekistan, Vietnam, Yemen, Zambia, Zimbabwe
Zone 5	Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Panama, Paraguay, Peru, Uruguay, Venezuela

The following countries under economic sanctions are excluded as countries of destination:
- Iran
- North Korea (Democratic People's Republic of Korea)
- Syria
- Territories of Crimea

The list of excluded countries is subject to change.

The Insurer shall not be held liable for the coverage of a guarantee of the insurance and shall not be liable to pay any claim or provide any benefit provided for herein to the extent that the provision of such coverage, payment of such claim, and/or provision of such benefit would expose that Insurer to any sanction, prohibition, and/or restriction under United Nations resolutions, trade or economic sanctions, laws or regulatinos of France, the European Union, United States of America, or any other applicable law or regulation.

Contact

24/7 customer service

We speak English and German – 24 hours a day.
Our customer service team is available 24/7 to assist your clients with all questions related to their policy in the event of an emergency.

Toll-free number 00800 70 60 4000
Phone +49 (0)40 46 00 20-333
WhatsApp +49 170 210 1616
Email kundenbetreuung@passportcard.de

Broker support

We are here to answer any questions:
Broker support is available on working days from 9:00 a.m. to 5:30 p.m.
Phone +49 (0)40 46 00 20-444
Fax +49 (0)40 46 00 20-100
E-mail vertrieb@passportcard.de

PassportCard Deutschland GmbH
Managing director Eithan Wolf
HRB 158858 Amtsgericht Hamburg

PassportCard

www.passportcard.de

PassportCard Deutschland GmbH
Caffamacherreihe 8-10, 20355 Hamburg
Germany

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