mawista® Employee

Documents to Insurance Policy

The insurance purchased is documented in the insurance policy!

Overview of Benefits

mawista Employee Business / Business Premium

- Health Insurance
- Medical Assistance

We are there for you

Assistance in an emergency

If you require **help in an emergency** the Assistance is there for you. Our **24-hour emergency service** guarantees rapid and expert assistance all over the world!

Phone: +49.89.6 24 24-496
E-mail: notfall@allianz-assistance.de

Important for help in an emergency:

- Please hold the exact address and phone number of your current whereabouts ready to hand.
- Note down the name of your contacts, e.g. physician, hospital or police.
- Describe as exactly as possible the facts of the case and have the necessary information at hand.

Notification of claim

The simplest and quickest way of notifying us of your claim is via
www.mawista.com/schaden-melden
(or alternatively by post to our Claims Department – address shown on right).

Please note the following important information

Insurance cover is derived from the General Part including Health Insurance, Medical Assistance, and the applicable tariff table.

Single premium: valid for one person in each case

Insurability: Persons up to 66 years of age

Guidelines on taking out insurance: The policy can be purchased at any time, effective on the first day of any month. Insurance cover commences at the time specified in the insurance policy, but not before submitting the application and commencement of the temporary stay. When purchasing after commencing the temporary stay, waiting periods may apply. The maximum insurance term may be limited to 60 months.

Scope of validity: See Point 3 on the tariff table as well as the premium range agreed upon, Point 12 on the tariff table.

Insurance cover is provided only for the person(s) named on the insurance policy. The amount of the premium is usually based on the insurance cover selected.

The contractually agreed insurance payments are offered by AGA International S.A. in compliance with the Terms and Conditions of Insurance named below. Verbal agreements are invalid. Insurance tax is included in the premiums. No fees are charged. The premiums and service specifications documented in the insurance policy are relevant for the scope of insurance.

Olaf Nink, Chief Executive Officer

AGA International S.A.
Niederlassung für Deutschland
(Germany Branch)
Bahnhofstraße 16
D - 85609 Aschheim bei München

Chief Executive Officer: Olaf Nink
Registration Court: München HRB 4605
VAT ID no: DE 1292745288
Insurance tax no.: 9116 80200191

AGA International S.A.
Public limited company under French law
Registered Office: Paris (France)
Commercial register: R.C.S. Paris 519 490 080
Board of Management: Rémi Grenier (Vorsitzender), Laurence Maurice, Lidia Luka-Lognoné, Dr. Ulrich Delius, Roland Rykart

For all classes of insurance, the Federal Insurance Supervisory Authority, Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin), Graurheindorfer Straße 108, D - 53117 Bonn, Germany, is responsible for complaints.

The contract is governed by the laws of the Federal Republic of Germany, unless this conflicts with international law. Legal action based on the insurance contract can be brought by the policyholder or the insured person before the court with jurisdiction over the principal place of business or the branch of the insurer. If the policyholder or the insured person is a natural person, legal action can also be brought before the court in the district of which the policyholder or the insured person has his place of residence when the legal action is brought or, if he does not have a place of residence, his habitual place of abode.

Data protection:
In accordance with the provisions of the German Federal Data Protection Act, we hereby inform you that if a claim is filed your personal data which is required to implement the insurance contract will be stored. To check the application or the damage, inquiries will also be sent to other insurers and inquiries by other insurers will be answered. Moreover, data will be sent to the re-insurer.The addresses of each recipient of data will be provided upon request.

Collection, processing and use of health data and disclosure of data to other parties: Upon conclusion of contract the declarations of consent required to implement or terminate your insurance contract were given. You will find statements and information on data processing following the conditions.

Terms and Conditions of AGA International S.A., Germany Branch, for fixed-term Health Insurance Cover mawista Employee for long-term Travel

The Terms and Conditions of Insurance consist of the General Part including Health Insurance, Medical Assistance, and the applicable tariff table.

General Part including Health Insurance – applicable to all tariffs

The following provisions under Sections 1 to 13 as well as Sections 1 to 4 Medical Assistance apply to all mawista Employee tariffs.

AVB AB RK 14 ME

§ 1 Who is insured?

1. Persons up to 66 years of age can be insured. Insurance cover terminates automatically no later than the end of the month before the insured person becomes 67 years old.
2. Persons with a time-limited residence permit for Germany who have exceeded a period of 60 months, taking similar insurance contracts with other insurers into account, cannot be insured.

§ 2 What is the area to which insurance cover applies?

The insurer offers insurance cover within the scope of these Terms and Conditions of Insurance to insured persons who are staying in the scope of validity agreed upon in the context of a time-limited stay. The precise scope of validity can be found in the applicable tariff table.

§ 3 When does the insurance cover begin and end?

1. The contract can be purchased at any time. If the contract is purchased after the start of the temporary stay and not before expiration of an insurance contract that was in force starting at the beginning of the temporary stay, then a waiting period of 14 days from the beginning of the insurance contract will apply. In this case, the insurance cover begins at midnight on the 15th day. Notwithstanding the foregoing, insurance cover applies from the beginning of the insurance contract in case of accident. The insured person must document the start of the temporary stay or the prior insurance.
2. The maximum coverage period is 60 months unless otherwise agreed upon in the applicable tariff table.
3. If the stay is extended, the contract can be extended up to the maximum coverage period upon request prior to expiration of the original contract term, subject to consent by the insurer.
4. Unless otherwise agreed upon in the tariff table, the following applies:
   a) Insurance cover begins at the time stated in the insurance policy (commencement of insurance cover),
      - But not before the beginning of the stay by the insured person in the scope of validity agreed upon in the tariff table;
      - Not before occurrence of insurability of the insured person;
      - Not before payment of the premium (see Section 4 (3));
      - Not before expiration of waiting periods agreed upon in the tariff table (waiting periods are calculated from the beginning of the insurance contract);
      - Not before conclusion of the contract, particularly receipt of the insurance policy or a written statement of acceptance.

      Payment will not be made for insured events that occur or exist prior to commencement of insurance cover. Payment will not be made for insured events that occur during the waiting period agreed upon in the tariff table.
   b) Insurance cover for individual insured persons also ends for insured events not yet completed:
      - At the end of the insurance relationship of the insured person, but no later than at expiration of the maximum coverage period in the selected tariff table;
      - Upon the death of the insured person;
      - Upon lapse of the requirements for insurability of an insured person pursuant to Section 1;
      - At the end of the month following the end of the temporary stay by the insured person in the country of the stay, or the insured person's final return to his/her home country.

§ 4 What is the term of the contract and when must the premium be paid?

1. The insurance contract can be agreed upon for a number of full months.
2. The insurance contract can be terminated by the policyholder with two months' prior notice to take effect at the end of any given month.
3. The premium is due for the first time at the beginning of the insurance contract and is payable monthly in advance. If the premium is not paid when an insured event occurs, then the insurer is not obligated to pay benefits unless the policyholder is not responsible for the non-payment; this does not apply to the insured persons in relation to the business products. When payment is made using the SEPA direct debit scheme or with a credit card, payment occurs when sufficient funds are in the account specified by the policyholder at the time the premium is collected.
4. When contract terms are longer than one month, the subsequent premiums are due on the first day of each new month. If a direct debit authorization has been provided, the premium will be deducted from the policyholder's account; otherwise, the premium must be transferred. If the subsequent premium cannot be deducted on this date or if it is not paid, then the insurer can set a payment period of at least two weeks in writing. If an insured event occurs after expiration of the period and if the policyholder remains in arrears with payment of the subsequent premium, then the insurer is released from the obligation to provide benefits; this does not apply to the insured persons in relation to the business products. The insurer can terminate the contract without notice if the policyholder is still in arrears of payment after expiration of the period. If the payment is made retroactively within one month after the effective date of termination or the expiration of the payment period, then the effect of the termination shall lapse and the contract shall enter into force again. However, there is no insurance cover for insured events that occurred after expiration of the payment period; this also does not apply to the insured persons in relation to the business products.

§ 5 What is insured and to what extent does insurance cover exist?

Unless otherwise agreed upon in the tariff table, the following applies:

1. The insurer shall pay compensation, according to the respective tariff table, for insured events occurring acutely and unexpectedly during the stay in the scope of validity agreed upon in the tariff table.
2. Insurance cover is derived from the insurance policy, these Terms and Conditions of Insurance, the selected tariff, and the legal regulations of the Federal Republic of Germany.
3. An insured event is the medically necessary medical treatment of an insured person due to illness or consequences of an accident. The insured event begins with the medical treatment; it ends when there is no longer a need for treatment according to medical findings. If the medical treatment must be expanded to an illness or consequences of an accident that have no causal connection with what was already treated, then a new insured event is created to this extent.
4. If the tariff provides for corresponding benefits, then the following are also considered insured events:
   a) Medical treatment including pregnancy examinations, pregnancy treatments insofar as the pregnancy did not yet exist at the beginning of the insurance relationship of the insured person, and treatments due to miscarriage;
   b) Medically necessary pregnancy treatments and treatments due to miscarriage that were caused by acute complaints, as well as medically necessary terminations of pregnancy and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy already existed at the beginning of the insurance relationship of the insured person, insofar as the need for treatment was not established at that time;
   c) Deliveries after expiration of the waiting period agreed upon in the tariff table.
   d) Outpatient examinations for early detection of illnesses under programs implemented in the Federal Republic of Germany by law (targeted preventive medical check-ups);
   e) Death.
5. The nature and amount of the insurance benefits are derived from these Terms and Conditions and the individually selected tariff.
6. In the scope of validity agreed upon in the tariff table, the insured person has free choice of the physicians, dentists, naturopaths, and midwives located, recognized by law and licensed in the country of stay, insofar as they charge according to the applicable official fee regulation for their profession, insofar as existing, or according to usual and customary rates.
7. Medications, bandages and dressings, remedies, and medical aids must be prescribed by the persons providing treatment listed in No. 6 above; in addition, medications must be obtained from a pharmacy. Foods, tonics, mineral water, disinfectants, cosmetics, diet and infant foods and the like shall not be considered medications, even if they are prescribed as such.
8. In case of medically necessary inpatient hospital treatment, the insured person has free choice among the public and private hospitals that have permanent physician management and sufficient diagnostic and therapeutic means at their disposal, maintain medical files, and do not perform convalescence or sanatorium treatments or admit convalescents. Insurance cover exists for the general care class (shared room) without additional services (private physician treatment), unless otherwise agreed in the applicable tariff table.
9. In case of medically necessary inpatient medical treatment in hospitals that also perform convalescent or sanatorium treatments or admit convalescents, but otherwise comply with the requirements of the foregoing No. 8, the benefits under the tariff table will only be provided if the insurer has promised them in writing before commencement of treatment. In case of tuberculosis diseases, benefits will also be paid in case of inpatient treatment in tuberculosis convalescent homes and sanatoriums to the extent provided in the contract.
10. The insurer shall pay benefits up to the contractual limits for examination or treatment methods and medications that are recognized by the majority of orthodox medicine. The insurer shall further pay benefits for methods and medications that have proven themselves in practice to be equally promising or that are used because no methods or medications from orthodox medicine are available; however, the insurer can reduce its benefits to the amount that would have been incurred when using existing orthodox methods or medications.
11. The insurer shall pay benefits up to the limits agreed upon in the tariff table for transfer and burial costs insofar as the death of an insured person occurs due to an insured benefit event.
12. The insurer shall pay benefits up to the limits agreed upon in the tariff table for the additional costs for medically necessary repatriation transportation ordered by a physician to the nearest suitable hospital in the country in which the insured person has his/her customary residence or domicile. Medical necessity for repatriation transportation exists when it is shown that adequate medical care is not guaranteed in the scope of validity agreed upon. The insurer's Assistance will organise the repatriation transportation after prior coordination by the Assistance contract physician with the local treating physicians. The costs for an escort or physician escort will be paid insofar as the escort is medically necessary, ordered by a government agency, or required by the transportation firm providing services.

§ 6 In which cases does insurance cover not apply, or only with restrictions?

1. Insurance cover is not granted for losses due to active participation in strikes, wars, events similar to war, internal unrest, damage due to atomic energy, as well as for any events that are attributable to intentional acts by the insured person. Insurance cover likewise does not apply to losses in areas for which a travel warning from the German Department for Foreign Affairs was in force at the time of entry; if an insured person is in such an area at the time that a travel warning is announced, then insurance cover shall terminate 14 days after announcement of the travel warning; insurance cover shall continue in force despite the travel warning if termination of travel is delayed for reasons for which the insured person is not responsible.
2. No duty to pay benefits exists for:
   a) Illnesses, complaints, and their consequences already existing and known at the beginning of insurance cover. In addition, no insurance cover exists for the consequences of those illnesses and accidents that have been treated in the six months previous to commencement of insurance cover.
   b) Convalescent and sanatorium treatments as well as rehabilitation measures by the statutory rehabilitation providers, unless otherwise agreed upon in the tariff table.
   c) Treatments during a stay in a spa or health resort, even in an hospital stay. This restriction shall not apply if the insured person has his/her permanent residence there or becomes unable to work and needs treatment during a temporary stay due to an acute illness independent of the purpose of the stay or due to an accident occurring there, as long as departure is impossible according to medical findings. This restriction shall likewise not apply if and insofar as the insurer has promised benefits in writing prior to commencement of the stay.
   d) Treatment or accommodation caused by infirmity, need of nursing care or detention;
   e) Treatment of mental defects and disorders, as well as for hypnosis, psychoanalysis, and psychotherapy, unless otherwise agreed upon in the applicable tariff table;
   f) Immunization measures, unless otherwise agreed upon in the applicable tariff table;
   g) Medical aids, unless otherwise agreed upon in the applicable tariff table;
   h) Treatments due to sterility, including artificial insemination and related preliminary examinations and follow-up treatments;
   i) Preventive medical check-ups, unless otherwise agreed upon in the applicable tariff table;
   j) Treatments by spouses, parents, children, persons living in a common household, or persons with whom the insured person lives within his/her own family or host family. Documented costs of materials will be reimbursed according to the tariff table.
   k) Treatments due to illnesses including their consequences and the consequences of accidents that are caused by professional participation in sport competitions organised by federations and associations and their preparation, or those recognized as damage due to military service, and not expressly included in the insurance cover;
   l) Withdrawal measures, including withdrawal treatments;
   m) Treatments due to illnesses including their consequences that occur due to failure to obtain vaccinations recognized by the World Health Organisation or required by law, unless the vaccination is medically contraindicated. In this case, the medical reasons shall be provided to the insurer by a physician statement.
   n) Treatments of a dependency syndrome and its consequences;
   o) Organ donations and their consequences;
   p) Dental prostheses (such as pivot teeth, inlay fillings, crowns, implants) and orthodontic treatment, bite remedies and gnathological measures, unless otherwise agreed upon in the applicable tariff table.
3. Unless otherwise agreed in the applicable tariff table, there is no duty to pay benefits for treatments by physicians, dentists, naturopaths and health facilities, or midwives whose invoices have been excluded from reimbursement by the insurer for good cause. This requires that the insurer has notified the insured

person prior to occurrence of the insured event that invoices from this treatment provider will not be reimbursed. Insofar as an insured event has occurred prior to notification, then the duty to pay benefits under the tariff table shall apply to the affected treatment provider for a maximum of three months, calculated from the date of notification.

4. If a medical treatment or other measure for which benefits are agreed upon exceeds the medically necessary amount or if the remuneration demanded is not locally reasonable and customary, then the insurer can reduce its payments to a reasonable amount.
5. If economic, trade, or financial sanctions or embargoes of the European Union or the Federal Republic of Germany that are directly applicable to the parties to the contract oppose insurance cover, then no insurance cover shall apply. This also applies to economic, trade, or financial sanctions or embargoes that are issued by the United States of America, unless they contradict European or German legal provisions. The remaining provisions of the contract shall remain unaffected.
6. The insurer shall be exempt from its duty to pay benefits if the insured person attempts to deceive the insurer about circumstances that are significant to the basis for or the amount of the benefits.

§ 7 What must the insured person do in the event of an insured event? What obligations must be complied with?

1. After occurrence of an insured event, the insured person is obligated:
   a) To minimize the loss as far as possible and to avoid unnecessary costs;
   b) To report all losses to the insurer without undue delay;
   c) To allow the insurer or its agent any reasonable investigation of the cause and amount of its duty to pay benefits, to provide any information useful for this purpose, to submit original documents, and in case of death, to submit the death certificate.
2. Upon request of the insurer, the insured person is obligated to allow an examination by a physician commissioned by the insurer.
3. The beginning and ending of a stay in the scope of validity provided in the tariff table, as well as any interruption, shall be documented by the insured person upon request of the insurer in case of an insured event, along with evidence of insurability.
4. The insurer's Assistance must be notified of any hospital treatment without undue delay after it begins.
5. The insured person must submit appropriate documents to the insurer within three months after an individual medical treatment.
6. In case of medically necessary repatriation transportation, the insurer's Assistance must be contacted before it is carried out and all information provided that is necessary to organise and perform the repatriation transportation. If repatriation transportation is necessary, the Assistance will organise it after prior coordination by the Assistance contract physician with the local treating physicians.
7. If medical cost insurance has been purchased for an insured person from another insurer, if any such insurance exists, or if an insured person makes use of the right to insurance in the statutory health insurance plan, then the insured person is obligated to notify the insurer of the other insurance without undue delay.

§ 8 When does the insurer pay compensation?

Unless otherwise agreed upon in the applicable tariff table, the following applies:

1. The insurer is only obligated to pay benefits if the following documentation is provided (which becomes the property of the insurer):
   a) Paid original receipts that must include the last and first name and the date of birth of the treated person, the name and address of the treatment provider, the description of the illness, a statement of the services provided by the treatment provider by type, location, and treatment period. If other insurance cover exists for treatment costs and if claims are first filed under such other cover, then copies of invoices with reimbursement endorsements shall be sufficient as documentation. If invoices in foreign languages are submitted that are relevant to the insurance benefits, then German or English translations must be provided upon request of the insurer.
   b) Prescriptions must be submitted together with the physician invoice, and invoices for remedies or medical aids along with the order.
   c) Documentation of the amount of the costs that would have been incurred in case of planned return travel if benefits are claimed for medically necessary repatriation transportation. In addition, a physician's certification of the medical necessity of the repatriation transportation must be submitted.
   d) Additionally, an official death certificate and physician's statement as to the cause of death if transfer and funeral costs are to be paid.
2. Costs incurred in foreign currency will be translated at the exchange rate applicable on the date on which the documents are received at the insurer into the currency valid on that date in the Federal Republic of Germany unless the foreign currency necessary to pay the invoices is documented to have been acquired at a less favourable exchange rate and this was caused by a change in the currency parities.
3. Additional costs incurred by the insurer carrying out bank transfers to foreign countries or by special forms of bank transfer being agreed upon can be deducted from benefits.
4. Claims to insurance benefits cannot be assigned or pledged.
5. In the context of reviewing benefits, it may be necessary for the insurer to obtain personally identifiable health data to the extent permitted by law. If the insurance beneficiary or the insured person culpably does not grant consent to any such data collection, a review of benefits is not made possible in any other way, and the insurer therefore cannot conclusively determine the amount and scope of the duty to pay benefits, then the benefits will not be due.
6. One month after notification of the loss, an amount can be claimed as an advance payment that is the minimum to be paid according to the situation. This period shall not run as long as review of the claim by the insurer is hindered due to fault of the insured person.

§ 9 What applies where the insured has claims for damages against third parties?

1. If compensation can be claimed in an insured event from another insurance contract, then the other contract shall take precedence over this contract. This shall also apply if secondary liability is likewise agreed upon in one of these insurance contracts, regardless of when the other insurance contract was concluded. If the insured event is first reported to the insurer through that insurance contract, then the insurer shall be deemed to have made advance payment and will contact the other insurer directly for the purpose of dividing costs.
2. The claims of the insured person against third parties shall transfer to the insurer to the extent prescribed by law insofar as the insurer has reimbursed the loss. If necessary, the insured person is obligated to provide a letter of subrogation to the insurer.
3. The claims of the insured person against treatment providers due to excessive fees shall transfer to the insurer to the extent prescribed by law insofar as the insurer has reimbursed the corresponding invoices. The insured person is obligated to cooperate in enforcing the claims if necessary. In addition, the insured person is obligated to provide a letter of subrogation to the insurer if necessary.

§ 10 When does the insured person forfeit claims to insurance benefits due to breach of obligations and statute of limitations?

1. If the insured person intentionally breaches one of the contractually agreed upon obligations, then the insurer is not obligated to pay benefits. In case of grossly negligent breach of the obligation, the insurer is entitled to reduce the benefits in proportion to the seriousness of the fault of the insured person. The burden of proof for non-existence of gross negligence is upon the insured person.
2. Claims to insurance benefits arising from this insurance contract shall expire in three years. The expiration period begins at the end of the year in which the benefits can be claimed.

§ 11 What form must be followed for submitting declarations of intent?

Declarations of intent and notices to the insurer are required to be in text form (e.g., letter, fax, e-mail). The insured person is directly entitled to exercise the rights arising from the insurance contract.

§ 12 What legal system applies and what is the contract language?

1. German law shall apply insofar as it is not in conflict with international law.
2. The contract language is German.

§ 13 At what offices can the insured person complain?

If you are not satisfied with a benefit or decision of the insurer, please contact the insurer directly. Federal Financial Supervisory Authority (BaFin), Graurheindorfer Strasse 108, 53117 Bonn, Germany, is the supervisory authority responsible for complaints.

Medical Assistance – valid for all tariffs

AVB MAS 14 ME

§ 1 What services does the insurer provide under the Assistance?

1. The insurer provides assistance and support to the insured person for the duration of insurance cover in the event of any emergency defined below and will pay the costs according to the following Terms and Conditions. The insurer reserves the right to check coverage. Services provided and any cost assumption statements made by the Assistance as well as the commissioning of service providers do not in principle acknowledge the insurer's obligation to indemnify based on the insurance contract with the insured person.
2. The insurer has contracted the Assistance to provide the insured persons of the insurer with the services named below on a 24-hour basis.
3. The insured person must immediately contact the Assistance in an emergency in order to use the services.
4. Insofar as the insured person may be unable to claim the reimbursement of expenditures incurred from either the insurer or from any other payer, the insured person must return the amounts to the insurer within one month of invoicing.

§ 2 What help does the Assistance provide in case of illness, accident and death?

1. Outpatient treatment in the agreed scope of validity
   Upon request, the Assistance will provide information on the possibilities of medical care, and will provide the name of a German-speaking or English-speaking physician if possible. However, the Assistance will not make contact with the physician.
2. Inpatient treatment in the agreed scope of validity
   In case of inpatient treatment of the insured person at a hospital, the Assistance will provide the following benefits:
   a) Support
      As needed, the Assistance will make contact through its contract physician with each insured person's personal physician and to the hospital physicians handling the case; it will ensure that information is transmitted among the participating physicians. Upon request, the Assistance will inform relatives of the insured person.
   b) Hospital visits
      In case of inpatient treatment of the insured person, the Assistance will organise travel for a person close to the insured person to the place of inpatient treatment and back to their place of residence upon request.
   c) Cost assumption statement
      In case of inpatient treatment of the insured person, the insurer will provide the hospital with a statement of cost assumption up to €15,000.00. This statement does not imply that the insurer acknowledges that it has a duty to indemnify. The insurer will assume the task of carrying out settlement with the payer responsible in the name of the insured person. If no insurance cover is provided under the health insurance, a cost assumption statement will only be provided in return for adequate security (e.g. bank guarantee).
3. Patient repatriation transportation
   Insofar as medically necessary, the Assistance will organise return transportation using medically adequate means of transport (including air ambulances), after prior consultation between the contract physician of the Assistance and the local physicians handling the case, to the closest suitable hospital in the country where the insured person has his/her usual abode or place of residence.
4. If accompanying children under the age of 18 can no longer be taken care of as a result of the death, serious accidental injury or unexpected severe illness of the insured person, the Assistance will organise their return travel to the country in which the insured person has his/her usual abode or place of residence.
5. Death
   If the insured person dies during travel, the Assistance will organise the repatriation of the mortal remains of the insured person for burial in the home country or optionally burial locally in the country of the temporary stay.

§ 3 What support does the Assistance provide to obtain any necessary medications required?

Where possible, the Assistance arranges the procurement of prescribed medication and its dispatch to the insured person in consultation with the insured person's personal physician. The insured person must reimburse the costs of such medication and its dispatch to the Assistance within one month after completion of travel.

§ 4 What information does the Assistance provide?

1. General medical advice on travel destinations
   Upon request by the insured person, the Assistance will also provide information on
   - the general medical care available at the destination;
   - particular risks of infection at the destination;
   - the vaccinations required for the destination;
   - suitable destinations for particular syndromes.
2. General explanation of medical terms (referred to as the Medical Interpreter Service)
   Upon request by the insured person, the Assistance will explain diagnoses and other medical terms.

Tariff Table, mawista Employee Business (The tariff agreed upon in each case must be taken from the insurance policy.)

	mawista Employee Business	mawista Employee Business **Premium**
1. Policyholder:		
	Corporations and business enterprises with registered offices in Germany whose members and employees work internationally.	
2. Insurable persons / entitled persons:		
	a) Members and employees of the policyholder as well as free-lancers and self-employed persons who are staying in foreign countries on behalf of the policyholder and work under contract at least 25 hours per week, along with their family members, insofar as insurability exists under Section 1 AVB AB RK ME. Family members are defined as life partners and children living in the same household. A contract documenting the existing employment or membership relationship with the policyholder must be submitted upon request. b) The insured person is directly entitled to exercise the rights arising from the insurance contract.	
3. Scope of validity:		
	a) The insured person has insurance cover worldwide in compliance with Section 1 and Section 3 AVB AB RK ME as well as Tariff Table No. 12 for temporary stays outside of the countries in which he/she has a habitual abode or domicile. b) In countries in which the insured person has a habitual abode or domicile, insurance cover exists insofar as these countries are included by selection of the corresponding premium range (Tariff Table No. 12). c) The insured person is responsible for reviewing whether the insurance satisfies the legal requirements of the country of abode or domicile. d) This insurance does not satisfy the compulsory insurance obligation in Germany in case of habitual residence in Germany. e) If the Worldwide excluding USA / Canada tariff is selected, insurance cover exists for stays including the USA and Canada for holidays and professional reasons for a total of 42 days per insurance year. No benefits will be paid for treatments that become necessary beyond the 42nd day. However, insurance cover is limited to treatment needs arising acutely. No insurance cover exists for illnesses whose treatment was already decided upon before entry into the USA or Canada. The insurer must be notified of the stay before entry into the USA or Canada. Documentation of the beginning and end of the stay in the USA or Canada must be provided upon request.	
4. Beginning of insurance cover:		
	At the time stated in the insurance policy in compliance with Section 3 AVB AB RK ME.	
5. Joining the group insurance contract:		
	The insured person joins the group insurance contract by the policyholder so notifying the insurer.	
6. Termination of insurance cover:		
	a) The insurance cover within the scope of the insurance agreement can be terminated for individual insured persons by the policyholder giving notice to the insurer with a notice period of two months, effective at the end of any month. b) Termination is only effective once the insured person affected by the termination has obtained knowledge of the notice of termination and the policyholder documents this fact accordingly to the insurer at deregistration from the group insurance contract. c) The insurer can also terminate the group insurance contract with notice. The insured persons must be informed of the termination by the insurer in writing. d) In this case, the affected insured person has the right to continue the insurance relationship by designating a future policyholder or at the Terms and Conditions of individual insurance (insofar as legally possible). This statement must be submitted within two months after receipt of the termination notice.	
7. Premium payment:		
	The premium is a monthly premium. It is due and payable each month in advance.	
8. Statements on health status:		
	None. Please note the exclusions from benefits in Section 6 AVB AB RK ME.	
9. Different provisions on benefit exclusions:		
	For employees and members of the policyholder who leave their country of residence or country of origin in the context of a personnel placement at the behest of the policyholder, as well as for their family members, the benefit exclusion pursuant to Section 6 (2)(a) AVB AB RK ME is differently limited to the following illnesses and insured events existing at the beginning of insurance cover: a) HIV infection/AIDS and its consequences; b) Cancers or benign tumors that required treatment within the past five years prior to or at the beginning of insurance cover; c) Heart and coronary diseases and their consequences which were treated within the past twelve months before or at the beginning of insurance cover.	
10. Benefits:		
10.1 Outpatient treatment:	100% of the invoiced amount for medically necessary outpatient treatment as a private patient, medically prescribed radiation, light, and other physical treatments within the scope of the applicable official scale of medical fees for the corresponding profession.	
10.2 Inpatient treatment:	100% for medically necessary inpatient treatment and lodging due to treatment as a private patient in a double room insofar as possible, as well as for medically necessary operations, x-ray and radiation treatment and diagnostics. Notwithstanding Section 6 (2) (b) AVB AB RK ME, insurance cover exists for medically necessary follow-up therapy.	100% for medically necessary inpatient treatment and lodging due to treatment as a private patient in a single room insofar as possible, as well as for medically necessary operations, x-ray and radiation treatment and diagnostics. 100% of the costs for lodging of a parent as escort in case of inpatient treatment of insured minor children. Notwithstanding Section 6 (2)(b) AB RK ME, insurance cover exists for medically necessary follow-up therapy.
10.3 Medications, bandages and dressings, and remedies:	100% insofar as ordered by a physician and medically necessary.	
10.4 Dental treatment:	100% of the invoiced amount for medically necessary outpatient dental treatment. Inlays and onlays are not insured. A single preventive examination and treatment is included in insurance cover for each year of the contract term (including polishing and tooth cleaning).	

	mawista Employee Business	mawista Employee Business **Premium**
10. Benefits:		
10.5 Dental prostheses /orthodontic treatments:	Notwithstanding Section 6 (2)(p) AB RK ME, insurance cover exists for insured events that occurred after expiration of the waiting period of eight months for: • 80% of the invoiced amount for medically necessary dental prostheses and • up to the age of 18 years for orthodontic treatments; • but up to no more than a total of € 2,000.00 in the first two insurance years, • up to a total of € 3,000.00 in the first three insurance years, • up to no more that € 4,000.00 per insurance year starting in the fourth insurance year. However, insurance cover exists within the maximum limits without a waiting period for dental prostheses necessary due to accident. When insurance begins during a year, the maximum amounts will be pro-rated.	Notwithstanding Section 6 (2)(p) AB RK ME, insurance cover exists for insured events that occurred after expiration of the waiting period of eight months for: • 90% of the invoiced amount for medically necessary dental prostheses and • up to the age of 18 years for orthodontic treatments; • but up to no more than a total of € 3,000.00 in the first two insurance years, • up to a total of € 5,000.00 in the first three insurance years, • up to no more that € 4,000.00 per insurance year starting in the fourth insurance year. However, insurance cover exists within the maximum limits without a waiting period for dental prostheses necessary due to accident. When insurance begins during a year, the maximum amounts will be pro-rated.
10.6 Preventive medical check-ups:	Outpatient preventive medical check-ups for children as well as for early detection of cancers according to programs implemented by law in Germany.	Outpatient preventive medical check-ups for children as well as for early detection of cancers according to programs implemented by law in Germany. In addition, the following preventive medical check-ups will be reimbursed at up to € 300.00 per year of contract term and insured person: General health examination, EKG, stress test, cholesterol and blood sugar tests, urine test. Travel immunizations according to the recommendations of the Standing Committee on Immunisations (STIKO) up to € 250.00 per year of contract term, including vaccines as well as preventive measures insofar as they are recommended for the individual country visited.
10.7 Pregnancy and delivery:	Insurance cover exists for a) Medical treatment including pregnancy examinations and pregnancy treatments insofar as the pregnancy did not yet exist at the beginning of the insurance relationship of the insured person, and treatments due to miscarriage; b) Medically necessary pregnancy treatments and treatments due to miscarriage that were caused by acute complaints, as well as medically necessary terminations of pregnancy and deliveries up to the end of the 36th week of pregnancy (premature birth), even if the pregnancy already existed at the beginning of the insurance relationship of the insured person, insofar as the need for treatment was not established at that time; c) Deliveries after expiration of the waiting period agreed upon in the tariff table.	
10.8 Medical aids:	Notwithstanding Section 6 (2)(g) AVB AB RK ME, insurance cover exists for medical aids in simple form, insofar as prescribed by a physician and medically necessary, and for their repair costs up to 80% of the invoiced amount, but up to no more than a total of € 2,000.00 per insurance year. For vision aids, a benefit of no more than € 50.00 per insured person and insurance year will be paid within the maximum limits. When insurance begins during a year, the maximum amounts will be pro-rated.	Notwithstanding Section 6 (2)(g) AB RK ME, insurance cover exists for medical aids, insofar as prescribed by a physician and medically necessary, and for their repair costs up to 80% of the invoiced amount, but up to no more than a total of€ 2,000.00 per insurance year. For vision aids, a benefit of no more than € 600.00 per insured person will be paid every three insurance years after a waiting period of 12 months. When insurance begins during a year, the maximum amounts will be pro-rated.
10.9 Psychotherapy:	In case of trauma (term for a stressful external event that is characterized by confrontation with injury or danger to physical well-being of oneself or related persons, threatened or actual death): 80% of the invoiced amount for outpatient treatments up to € 2,000.00 per insurance year. When insurance begins during a year, the maximum amounts will be pro-rated. Inpatient stay of up to 30 days per contract term. The benefit exclusions pursuant to Section 6 (2)(l) and (n) AVB AB RK ME remain unaffected thereby.	80% of the invoiced amount for medically necessary outpatient treatments up to € 2,000.00 per insurance year. When insurance begins during a year, the maximum amounts will be pro-rated. Inpatient stay of up to 30 days per contract term. The benefit exclusions pursuant to Section 6 (2)(l) and (n) AVB AB RK ME remain unaffected thereby.
10.10 Other benefits:	a) Medical transportation 100% for medical transportation to inpatient treatment in the closest accessible suitable hospital and for first aid after an accident, to the closest accessible suitable physician, and return. b) Medically necessary repatriation transportation The insurer will reimburse the medically necessary repatriation transportation to the hospital in the country in which the insured person has his/her habitual abode or domicile that is closest to the place of residence of the insured person. The most cost-saving means of transport must be selected in each case insofar as possible due to medical reasons. Medical necessity for repatriation transportation exists when adequate medical care is not guaranteed in the country of the stay. The insurer's Assistance will organise the medically necessary repatriation transportation. In case of inpatient treatment, the insurer's Assistance must be contacted without undue delay. c) Transfer and burial costs The insurer will reimburse the direct costs for transfer of the insured person's mortal remains for burial in the home country, or optionally the direct costs of burial locally in the country of the temporary stay, up to a maximum amount of € 10,000.00.	
10.11 Extended liability:	If patient repatriation transportation is impossible up to the end of insurance cover due to the insured person being unfit for transport, the insurer will reimburse the costs of treatment within the scope of the Terms and Conditions up to the date the insured person is fit for transport, but for a maximum of 30 days after termination of insurance cover.	
11. Waiting period:		
	Eight months for delivery, dental prostheses and orthodontic treatments.	Eight months for delivery, dental prostheses and orthodontic treatments. Twelve months for vision aids.
12. Monthly premium (per person):		
Worldwide excluding USA / Canada:	Employee: € 122.00 Family member(s): € 162.00	Employee: € 162.00 Family member(s): € 231.00
Worldwide including USA / Canada:	Employee: € 328.00 Family member(s): € 480.00	Employee: € 393.00 Family member(s): € 571.00
13. Deductible:		
Worldwide excluding USA / Canada:	No deductible.	
Worldwide including USA / Canada:	€ 500.00 per person and insurance year in the entire premium area. When insurance begins during a year for the insured person, the deductible will be pro-rated.	

General information in the event of claim

What do you do in any case of damage?
The insured person must minimise and document the damage as far as possible. For this reason, please ensure that you have suitable proof of the occurrence of the damage (e.g. confirmation of damage, medical certificate) and of the extent of damage (e.g. bills, receipts).

What should you do if you fall ill, injure yourself or any other emergency occurs?
Please immediately contact the Assistance in case of severe injuries or serious illnesses, particularly prior to hospitalisation, so that adequate treatment or repatriation transport can be ensured. For the reimbursement of the costs you have paid at the location, please submit **original bills and / or prescriptions.**

Important: The bills must show the name of the person receiving treatment, the name of the illness, the treatment data and the individual medical services provided and the costs of these. Prescriptions must provide information on the medications prescribed, the prices and bear the stamp of the pharmacy.

Declarations and information on data processing

I. Consent to the collection and use of health data and declaration of release from secrecy.

The declarations of consent and of release from secrecy printed under I. were prepared as coordinated between the Gesamtverband der deutschen Versicherungswirtschaft e.V. (GDV) and data protection authorities.

The Insurance Contract Act, the Federal Data Protection Act and other data protection provisions do not include an adequate legal basis for the collection, processing and use of health data by the insurer. For this reason we need your consent as required by data protection laws. In the event of a claim, we may require your release from secrecy in order to obtain your health data from parties subject to secrecy (e.g. physicians).

Furthermore, we require your release from secrecy in order to disclose your health data or other data protected under Section 203 of the German Criminal Code, e.g. the fact that there is a contract with you, your customer number or other identification data, to other parties, e.g. assistance, logistics or IT service providers.

The following declarations of consent are indispensable for the implementation or termination of your insurance contract (processing of your claim). Should you not submit these, it will not usually be possible to enter into any contract.

The declarations relate to the way we handle your health data and other data subject to secrecy (under 1.), in connection with requesting these from third parties (under 2.) and when disclosing them to parties external to the insurer (under 3.)

The declarations also apply to persons legally represented by you who are included in the insurance, e.g. to your children, if they do not recognise the significance of this consent and thus cannot submit their own declarations.

1. Consent to the collection, saving and use of your health data

I consent to AGA International S.A. collecting, saving and using the health data notified by me in the future, provided that this is required to implement or terminate the insurance contract.

2. Request of health data from third parties to verify the duty to indemnify

To check our duty to indemnify it may be necessary for us to check information on your state of health which you provided to substantiate claims or which is shown in the documents submitted (e.g. bills, prescriptions, expert opinions) or notifications, e.g. by a physician or other member of the health profession.

This verification is carried out only to the extent necessary. To do so, we require your consent including a release from secrecy for us and for these parties if, in the course of these requests, health data or other information subject to secrecy are disclosed.

We will inform you in each individual case of the persons or establishments that are required to provide information and for what purpose. You can then decide in each case whether you consent to the collection and use of your health data by the insurer, release the persons or establishments named and their employees from secrecy and consent to the transfer of your health data to the insurer, or whether you will provide the required documents yourself.

3. Disclosure of your health data and other data subject to secrecy to parties outside AGA International S.A.

We contractually oblige the parties named below to observe provisions on data protection and data security.

3.1 Disclosure of data for medical assessment

To check our duty to indemnify, it may be necessary to call in medical experts. We require your consent and release from secrecy for this purpose if your health data and other data subject to secrecy are transferred in this connection. You will be informed of each transfer of data.

I hereby consent and agree that AGA International S.A. may transmit my health data to medical experts if this is necessary for reviewing the obligation to pay benefits in my insurance claim and that the health data are used there for the proper purpose and the results are sent back to AGA. I release the persons working for AGA International S.A. and the experts from their nondisclosure duty with respect to the health data and other data protected under StGB (German Criminal Code) Section 203.

3.2 Transfer of tasks to other parties (business enterprises or persons)

We do not perform in part certain tasks in the course of which your health data might be collected, processed and used. We have therefore transferred these tasks to other companies. If your data subject to secrecy are disclosed in the course of this, we require your release from secrecy for us and, where necessary, for other parties.

We carry out a constantly updated list of the parties and categories of parties that collect, process or use data subject to secrecy on our behalf as agreed. This list shows the tasks which have been transferred to the individual parties. The currently valid list is enclosed directly with the declarations.[1)] An up-to-date list can also be viewed on the Internet under www.allianz-reiseversicherung.de/datenverarbeitung or requested from us (AGA International S.A., Bahnhofstraße 16, D - 85609 Aschheim bei München, Phone +49.89.62424-460, service@allianz-assistance.de). We need your consent for the disclosure of your health data and for use of such data by the parties listed at these points.

I consent to AGA International S.A. transferring my health data to the parties named in the list mentioned above and to the collection, processing and use of my health data by those parties for the purposes stated to the same extent as AGA International S.A. would be allowed to do. Insofar as necessary, I release the employees of the parties entrusted with this task from secrecy for the disclosure of health data and other data protected under Section 203 of the German Criminal Code.

3.3 Disclosure of data to reinsurers

To ensure that your claims are satisfied, AGA International S.A. can conclude contracts with reinsurers that partially or completely assume the risk insured by us. In some cases the reinsurers use other reinsurers for this purpose to whom they also transfer your data. To allow the reinsurer to check whether AGA International S.A. has correctly assessed a claim, AGA International S.A. might be required to present your claim documents to the reinsurer.

To settle insurance claims, data on your existing contracts might also be disclosed to reinsurers.

As far as possible, anonymised and pseudoanonymised data are used for the purposes named above, but personal health data might also be used.

Reinsurers use your personal data only for the purposes named above. We will inform you of the transfer of your health data to reinsurers.

I consent to AGA International S.A. transferring my health data to the parties named in the list mentioned above and to the collection, processing and use of my health data by those parties for the purposes stated to the same extent as AGA International S.A. would be allowed to do. Insofar as necessary, I release the employees of the parties entrusted with this task from secrecy for the disclosure of health data and other data protected under Section 203 of the German Criminal Code.

Statements by the insured person(s) or the legal representative of the person(s) to be insured:
I hereby make the declarations on data processing submitted by the applicant or the person interested in insurance on my own behalf or on behalf of the person(s) to be insured

[1)] Allianz Group companies (marked with *) and service providers that use personal data on behalf of the insurer which are subject to secrecy and/or collect, process or use health data:

- Mondial Kundenservice GmbH * (claims processing)
- AWP Romania SA * (claims processing)
- Allianz Handwerker Services GmbH * (technical services for companies of the Allianz Group)
- Allianz Managed Operations & Services SE * (shared services for companies of the Allianz Group)
- AGA Service Deutschland GmbH * (assistance services)
- rehacare GmbH *, medical and professional rehabilitation company (rehab services)
- Mawista GmbH (sales and customer-related services, telephone service)
- tricontes GmbH (sales and customer-related services, telephone service)
- IMB Consult GmbH (support in the preparation of medical reports)
- ViaMed GmbH (medical consulting, support in the preparation of medical reports)
- Experts (medical and nursing assessment and preparation of expert reports)
- Nursing services and providers of medical aids (arrangement of nursing services and medical aid providers)
- Patient repatriation transports (medically advisable or necessary repatriation from abroad)

II. Disclosure of data to other insurers

Pursuant to the Insurance Contract Act the insured person must notify the insurer of all important circumstances for claim settlement in case of damage. This can also include previous illnesses and claims or notifications about other similar insurance. In certain cases, such as double insurance, legal subrogation and where there are cost sharing agreements, personal data must be exchanged between insurers. Also to prevent any misuse of insurance it may be necessary to request information from other insurers or to provide suitable information upon request. In the process, the data of the person affected are disclosed, such as his or her name and address, type of insurance cover and the risk or information on the claim (type of damage, amount of claim, date of damage).

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