

# General Terms and Conditions of Insurance for Temporary Medical Expenses and Daily Hospital Benefits Insurance (AVB)

(as of 01/04/2024)

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**Please note that the German version is legally binding.**

## Insurance cover

### § 1

#### Object and scope of the insurance cover

1. We offer insurance cover for illnesses, *accidents* and other events specified in the contract.

We provide directly related additional services if agreed upon in the tariff.

In case of an insured event, we will reimburse the costs of *medical treatment* and other agreed benefits.

In the case of daily hospital benefit insurance, we pay a daily hospital benefit for inpatient *treatment* if agreed upon in the tariff.

2. An insured event is the medically necessary *medical treatment* of an insured person due to illness or the consequences of an *accident*.

The insured event begins with the *medical treatment*; it ends when the insured person no longer requires treatment according to medical findings.

If the medical treatment has to be extended to an illness or consequence of an *accident* that is not causally related to the previously treated illness, a new insured event arises in this respect.

The following also count as insured events:

- a) Examination and medically necessary treatment due to pregnancy, the birth itself, lawful termination of pregnancy and miscarriage,
- b) Outpatient check-ups for the early detection of diseases in accordance with statutory programmes (targeted check-ups),
- c) Prevention of diseases through medically necessary immunisations.

3. The scope of the insurance cover is determined by
  - your *Insurance policy*,
  - your tariff,
  - these General Terms and Conditions of Insurance for Temporary Medical Expenses and Daily Hospital Benefits Insurance,
  - subsequent written agreements and
  - the statutory provisions of the Federal Republic of Germany.

### § 2

#### Start of the insurance cover

1. The insurance contract is concluded when you have received the *Insurance policy* or we have declared acceptance of your application in writing.

Insurance cover commences on the date specified in the *Insurance policy* (commencement of insurance), but not before conclusion of the insurance contract.

We do not pay for insured events that occurred before the start of the insurance cover.

Insured events that occurred after the conclusion of the insurance contract are only excluded from the obligation to pay benefits for the part that falls within the period prior to the commencement of the insurance.

If you extend the insurance cover by amending the contract, clauses 1 to 4 apply accordingly to the additional benefits.

2. For newborns, insurance cover begins without *risk surcharges* from birth if
  - a) one parent has been insured with us for at least three months on the date of birth and the application for insurance is made retroactively no later than two months after the date of birth, or

- b) if the insured parent has not completed the 20th week of pregnancy at the time of application.

The insurance cover may not be higher or more comprehensive than that of the parent who is insured with us.

When registering a newborn for insurance, cover is also provided for birth defects and congenital illnesses.

The insurance cover also includes the costs of accommodation, meals and care for the healthy newborn in hospital.

Adoption is equivalent to the birth of a child if the child is still a minor at the time of adoption.

In view of an increased risk, a *Risk surcharge* up to the single premium amount can be agreed.

### § 3 Scope of the insurance cover

1. The insurance cover extends to *Medical treatment* in the member states of the *European Union (EU)*, the states of the *European Economic Area (EEA)* and Switzerland.

In the event of a temporary stay by the insured person in their *Country of origin*, insurance cover is provided for up to three months.

In other countries, insurance cover is provided for the first two months of a temporary stay.

If the stay has to be extended beyond the specified periods due to necessary *Medical treatment*, insurance cover is provided as long as the insured person is unable to start the return journey without jeopardising their health.

2. The most we will pay for treatment *abroad* is what we would have had to pay for this treatment in Germany.
3. If an insured person has stayed *abroad* for more than a total of six months within one year, he/she gives up his/her *Habitual residence* in the Federal Republic of Germany in accordance with these conditions.

For the calculation, all stays *abroad* within a period of 12 months are added together. Interruptions of stays *abroad* of less than 30 days are added to the stay *abroad*.

The insurance relationship concerned ends when the insured person moves their *Habitual residence abroad*.

This does not include stays *abroad* in *EU* member states, *EEA* states or Switzerland.

### § 4 Scope of the obligation to perform

1. The type and amount of the insurance benefits are set out in the tariff with tariff conditions.
2. Unless the tariff provides otherwise, the insured person has a free choice of the following service providers:
- practice-based, licensed doctors or dentists,
  - doctors in hospitals and *emergency* departments,
  - doctors in socio-paediatric centres and medical care centres,
  - *emergency* and rescue doctors,
  - “Heilpraktiker” (alternative practitioners) within the scope of the German Heilpraktikergesetz,
  - licensed psychological psychotherapists in private practice, child and adolescent psychotherapists and
  - midwives and maternity nurses.
3. Medicines, dressings, remedies and aids must be prescribed by the service providers listed in Paragraph 2.

Medicines must be obtained from the pharmacy.

4. Remedies must be provided by
  - practice-based, licensed doctors,
  - “Heilpraktiker” (alternative practitioners) according to the German Heilpraktikergesetz or
  - state-certified members of the healing and auxiliary healing professions (e.g., physiotherapists, masseurs, physiotherapists, occupational therapists, podiatrists, speech therapists, dieticians).
5. We reimburse costs for medically necessary digital health applications.

Digital health applications are low-risk medical devices whose main function is essentially based on digital technologies and which are intended to support the detection, monitoring, treatment or alleviation of diseases or the detection, treatment, alleviation or compensation of injuries or disabilities in the insured person or in the care provided by the healthcare provider.

We take benefits for digital health applications into account both when determining the absence of benefits in the context of a premium refund and when crediting the calendar-year deductible.

We provide cover for digital health applications if they have been prescribed by one of the service providers listed in paragraph 2 and are listed in the directory for digital health applications in accordance with § 139e SGB V (German Social Security Code).

The costs for digital health applications are reimbursed for a maximum of 12 months per prescription, after which a new prescription is required. If a digital health application is included in the list in accordance with § 139e SGB V, the maximum amount reimbursed is the amount specified there for the duration of use specified there.

The claim only covers the expenses for the acquisition of the rights to use the software.

Expenses in connection with the use of digital health applications, in particular for the purchase and operation of mobile devices or PCs, including internet, electricity and battery costs, are not included.

6. In the case of medically necessary inpatient treatment, the insured person has a free choice of hospitals that
  - are under permanent medical supervision,
  - have sufficient diagnostic and therapeutic options and
  - keep records of medical histories.

In hospitals that also offer *spa treatments*, *sanatorium* treatments or rehabilitation measures, we will only pay benefits if we have confirmed in writing prior to the start of treatment that we will assume the costs to you.

Prior written consent is not required if

- a) the insured person is hospitalised due to an *emergency* (e.g., an *accident* or a life-threatening illness such as a heart attack) or
- b) only medically necessary hospital treatment was carried out that required inpatient treatment or
- c) an *accident* or acute illness occurred during the stay in this hospital that required medically necessary inpatient treatment. The benefits are limited to the period of inpatient hospital treatment for this acute illness or
- d) the hospital is the only one in the area and the insured person undergoes medically necessary treatment there that can only be carried out as an inpatient, or
- e) it is a *Follow-up treatment* according to Paragraph 10.

7. General hospital services in accordance with the Bundespflegesatzverordnung (German Federal Nursing Rate Ordinance (BPfIV)) and the Krankenhausentgeltgesetz (German Hospital Remuneration Act (KHEntgG)) include:
- flat rates per case,
  - additional charges,
  - daily nursing rates (departmental and basic nursing rates),
  - separately invoiced services of an attending physician,
  - the costs of the attendant midwife and the attendant maternity nurse,
  - the medically necessary admission of an accompanying person (rooming-in).

In hospitals that do not bill according to BPfIV and KHEntgG, the following are considered to be general hospital services:

- the expenses for a stay in a three-bed or multi-bed room (general care class),
  - medical services,
  - additional costs,
  - services of a midwife and a maternity nurse,
  - the medically necessary admission of an accompanying person (rooming-in).
8. The costs of general hospital services for healthy newborns, insofar as they are not covered by the nursing rate charged to the mother, will be reimbursed for the duration of the mother's inpatient stay, provided that the newborn is registered within two months of birth and the insurance begins on the day of birth.
9. We provide transitional care in hospital if:
- necessary care services cannot be provided immediately after hospital treatment or can only be provided at considerable expense, and
  - the transitional care is provided in the hospital where the treatment took place.

Care services include home nursing care, short-term care, medical rehabilitation benefits or care benefits from private compulsory long-term care insurance.

Transitional care in hospital includes:

- the supply of medicines, remedies and aids,
- the activation of insured persons,
- basic and treatment care,
- discharge management,
- accommodation and catering and
- the *Medical treatment* required in individual cases (in each case within the scope of the standard benefit).

The entitlement exists for a maximum of ten days per hospital treatment.

The expenses are reimbursed in accordance with the respective reimbursement percentage for general hospital services.

10. Expenses for medically necessary *Follow-up treatment* are eligible for reimbursement if the treatment follows within 28 days of the end of hospital treatment for which benefits are payable.

If it is not possible to meet this deadline for medical reasons (e.g., after inpatient radiotherapy), the *Follow-up treatment* can also begin at a later date.

We will give prior written authorisation for medically necessary *Follow-up treatment* if one of the following illnesses (diagnoses) in particular is present:

- Organ transplantation (heart, liver, lung, kidney, pancreas),
- Serious heart surgery with heart-lung machine, serious heart attack, heart valve/bypass operation, operation on the arterial vascular system,
- Amputation (e.g., whole hand, arm, whole foot, leg),
- Endoprosthesis (hip, knee, shoulder),
- Repositioning osteotomy (hip, knee),
- Vertebral fractures and spinal surgery,

- Paraplegia, stroke, *accident* with severe cranial/brain injury/haemorrhage,
- Cancer operations and chemotherapy/radiotherapy.

If the above-mentioned diagnoses are present, we will also check the duration for which a prior written authorisation will be granted, taking into account the type and the nature and severity of the illness.

If there is a simultaneous claim against a statutory rehabilitation provider (see also § 5 Para. 1 d) and Para. 4)), we are only liable for the expenses that remain necessary despite the benefits provided by the other cost bearer.

11. We provide benefits within the contractual scope for examination or treatment methods and medicines that are predominantly recognised by *Conventional medicine*.

We also provide the following for methods and medicines

- which have proven to be just as promising in practice or
- which are used because no conventional medical methods or medicines are available.

We can reduce our benefits to the amount that would have been incurred if conventional medical methods or medicines had been used.

12. If an insured person is about to undergo *Medical treatment* for which the costs are likely to exceed EUR 2,000, you can ask us in advance in *written form* what costs we will cover.

We will provide you with the information after four weeks at the latest. If the insured person requires urgent treatment, the information will be provided immediately, but at the latest after two weeks.

The period begins as soon as we receive your inquiry. If we do not provide the information within the specified deadlines, it will be assumed that the intended treatment is medically necessary. This applies until we prove that the treatment is not medically necessary.

13. We may obtain expert opinions and statements to verify our obligation to pay benefits. You and the insured persons can request information and access to these documents from us.

The claim can only be asserted by the person concerned or their legal representative. If there are therapeutic or other significant reasons preventing the data subject from providing information to or inspecting the data, the data subject may be requested to provide information to or inspect the data to a named doctor or lawyer.

We will reimburse you for the costs incurred if you have obtained the expert opinion or statement at our request.

14. The expenses are allocated to the calendar year in which the services were provided or the medicines, dressings, remedies and aids were purchased.
15. If the insured person receives an organ or tissue donation, cover for the organ donor is included in the insurance cover of the organ recipient as medically necessary treatment within the scope of the tariff.

This applies regardless of whether the organ donor has private, statutory or no insurance.

## § 5

### Limitation of the obligation to perform

1. We do not pay for the following:
  - a) Such illnesses, including their consequences, as well as for the consequences of *accidents* and for deaths that
    - are caused by war events in the Federal Republic of Germany or
    - are recognised as military service injuries and are not expressly included in the insurance cover;

We also do not pay benefits if the insured person is injured outside the Federal Republic of Germany due to war events, terrorist attacks or active participation in civil unrest. This does not apply if

- the German Foreign Office has not warned against travelling to the destination before departure or
- the German Foreign Office only issues a warning for the travel area if the insured person is already on site and the insured person then leaves the area immediately or is prevented from leaving the area through no fault of their own (e.g., in the event of imminent danger to life).

- b) Illnesses and *accidents* caused intentionally, including their consequences.
- c) Treatment by service providers and hospitals whose invoices we have excluded from reimbursement for good cause. This only applies if we have informed you of this circumstance prior to the occurrence of the insured event. If an insured event is pending at the time of notification, there is no obligation to pay benefits for expenses incurred after 3 months have elapsed since notification.
- d) Spa and *sanatorium* treatments and for rehabilitation measures provided by the statutory rehabilitation organisations, unless the tariff provides otherwise.
- e) Outpatient treatment at a spa or health resort. The restriction does not apply if the insured person has their permanent residence there or if *Medical treatment* becomes necessary during a temporary stay due to an illness or *accident* occurring there that is unrelated to the purpose of the stay.
- f) Treatment by spouses, civil partners (in accordance with § 1 of the Civil Partnership Act in the version valid until 22 December 2018, see appendix), parents or children. Proven material costs are reimbursed in accordance with the tariff.
- g) Accommodation due to the *Need for care* or custody.
- h) Cosmetic treatments.
- i) Nutrients and tonics as well as cosmetic products, for sanitary requisites as well as the procurement and loan of medical equipment; the same applies to replacement batteries, chargers and similar items for hearing and speech aids.
- j) The utilisation of commercially operated private diagnostic institutes and clinics.

2. If *Medical treatment* or other measures for which benefits have been agreed exceed what is medically necessary, we may reduce our benefits to a reasonable amount.

If the expenses for the *Medical treatment* or other benefits are in a conspicuous disproportion to the benefits provided, we do not have to pay in this respect.

3. Insofar as it is permissible without jeopardising health, service providers must be visited during consultation hours, otherwise the additional costs are not reimbursable.
4. If the insured person is entitled to benefits from other cost bearers (e.g., statutory *accident* insurance, statutory pension insurance, statutory medical care or *accident* care), we will only pay for the expenses that remain necessary despite the statutory benefits.

**§ 6**  
**Payment of insurance**  
**benefits**

1. We only have to pay if you provide the evidence we require. The evidence becomes our property.
2. Invoices must be submitted in the original. Invoices must contain the following information:
  - First name and surname of the person being treated,
  - Name of the diseases,
  - Indication of the individual services provided by the doctor with the relevant treatment data and the numbers of the *Fee schedule*,
  - Care rates,
  - Optional service surcharges, if applicable,
  - Data on the length of stay and
  - Breakdown of material costs.

We may require proof of prior payment.

3. Copies of invoices showing reimbursements from a statutory or private health insurance company shall be deemed equivalent to an original invoice.
4. Further requirements for the payment of our benefits are set out in § 14 VVG (German Insurance Contract Act; see appendix).
5. We always pay benefits to you as the policyholder.

If you have named an insured person to us in *written form* as authorised to receive their insurance benefits, we are obliged to make payment to this insured person.

6. Costs incurred in foreign currency are converted into euros. The conversion is carried out at the exchange rate of the day on which we receive the vouchers. The exchange rate of the day is the euro reference rate of the European Central Bank or the exchange rate of the Deutsche Bundesbank.

The insured person can prove by means of a bank receipt that he/she has acquired the foreign currency required to pay the bills at a more expensive rate.

7. We can deduct the costs of transferring the insurance benefits to a foreign account from our benefits.

**§ 7**  
**End of the insurance cover**

1. The insurance cover ends – also for pending insured events – with the termination of the contract.
2. The *Insurance year* is the calendar year.

The first *Insurance year* ends on 31 December of the year in which the contract begins.

Changes to the insurance relationship due to the addition or change of a tariff level and the subsequent insurance of additional persons have no effect on the *Insurance year*.

**§ 8**  
**Premium payment**

1. The premium is an annual premium and is calculated from the start of the insurance. It is payable at the beginning of each *Insurance year*.

You can also pay the premium in equal monthly instalments. In this case, the premium instalments are due on the first of each month. The premium instalment shall be deemed deferred until it falls due.

If the annual premium changes during the *Insurance year*, the difference must be paid in arrears or repaid from the time of the change until the beginning of the next *Insurance year*.

2. For annual payments, we grant a discount of 4% of the premium.
3. When insuring newborns in accordance with § 2, you only have to pay the premium from the month following the birth.

4. Unless otherwise agreed, the first premium or the first premium instalment is due on the day on which the insurance begins.
5. If you are in arrears with the payment of a premium instalment, the deferred premium instalments for the current *Insurance year* will become due.

However, they shall again be deemed deferred if the overdue part of the premium, including the premium instalment for the month in progress on the day of payment, and the dunning costs have been paid.

6. We are entitled to claim the dunning costs incurred by us.
7. If you are in arrears with your premiums, this may lead to suspension of insurance cover under the conditions specified in § 193 (6) and (7) VVG (see appendix). As long as the insurance contract is suspended, the insured person is deemed to be insured under the *Emergency tariff* in accordance with § 153 VAG (German Insurance Supervision Act; see appendix). In this respect, the General Insurance Conditions for the *Emergency tariff* (AVB/NLT) apply in the currently valid version.
8. If the insurance relationship is terminated before the end of the contract term, we are entitled to the premium or premium instalment for the period in which insurance cover existed.

If the insurance relationship is terminated by cancellation on the basis of § 19 Para. 2 VVG (see appendix) or by our rescission due to fraudulent misrepresentation, we shall be entitled to the premium or premium instalment until the declaration of cancellation or rescission takes effect.

If we withdraw because you have not paid the first premium or the first premium instalment on time, we may charge a reasonable transaction fee.

9. The premiums are to be paid to the account specified by us.

## **§ 9 Calculation of premiums**

1. This insurance is calculated as a *Type of life insurance*. The calculation of premiums is set out in our technical calculation principles. The calculation corresponds to the statutory regulations in Germany.
2. The age reached by the insured person at the start of the insurance contract (number of completed years of life) is decisive for the amount of the premiums.
3. As soon as an insured person reaches the age of 16 and/or 21, he/she must pay the corresponding premium of the next higher age group from the beginning of the following month.
4. If the premiums change, e.g., due to a change or conversion of the insurance cover, we will take into account the age of the insured person at the time at which the change comes into effect.
5. If the premium changes, we can also change specially agreed *risk surcharges* accordingly.
6. If there is an increased risk in the event of changes to the contract, we shall be entitled to an appropriate surcharge in addition to the premium for the additional part of the insurance cover.

The surcharge is calculated in accordance with the principles applicable to our business operations to compensate for increased risks.

7. The monthly premium instalment is specified in the *Insurance policy* or a subsequent supplementary *Insurance policy*.

**§ 10**  
**Premium adjustment**

Within the scope of the contractual benefit commitment, our benefit expenses may change, e.g., due to

- rising *Medical treatment* costs,
- more frequent utilisation of medical services or
- increasing life expectancy.

We therefore compare the required insurance benefits with those calculated in the technical calculation bases at least once a year for each tariff.

If this comparison shows a deviation of more than 5% for an *Observation unit* of a tariff, all premiums of this *Observation unit* are reviewed by us and, if necessary, adjusted with the consent of the *trustee*.

Under the same conditions:

- a deductible fixed in terms of amount,
  - an agreed *Risk surcharge* and
  - collectively agreed maximum rates and compensation benefits
- be adapted and/or changed.

In the course of a premium adjustment, the surcharge required for the premium limits in the *Basic tariff* is also compared with the calculated surcharges and, if necessary, adjusted.

The adjustments will take effect at the beginning of the second month after we have notified you.

**§ 11**  
**Profit-related premium refunds**

The provision for performance-related premium refunds is utilised in accordance with the statutory provisions and the articles of association.

**§ 12**  
**Obligations**

1. If we so request, you or the insured person named as authorised recipient (see § 6 Para. 5 S.2) must provide us with any information we require in order to determine
  - whether an insured event has occurred,
  - whether and to what extent we perform.
2. We may require the insured person to be examined by a doctor whom we have authorised.
3. The insured person
  - must, as far as possible, minimise the damage and
  - must not do anything that hinders recovery.
4. You must inform us immediately in *written form* if
  - full medical expenses insurance is taken out for an insured person with another insurer,
  - an insured person makes use of the entitlement to insurance under the statutory health insurance scheme or
  - if the conditions for insurability cease to apply to an insured person.

**§ 13**  
**Consequences of breaches of obligations**

1. If one of the obligations specified in § 12 is breached, we shall be fully or partially exempt from liability under the conditions of § 28 Para. 2 to 4 VVG (see appendix).
2. We will attribute the knowledge or fault of the insured person to you.

**§ 14**  
**Obligations and consequences of breaches of obligations in the event of claims against third parties**

If you or an insured person have claims for compensation against third parties, you or the insured person must assign these claims to us in writing. Claims for compensation are, e.g:

- claims for damages against other insurers or private individuals or
- claims for the recovery of wrongly paid fees against service providers.

The assignment is limited to the amount of our benefit from the insurance. If this obligation is breached, we will apply the legal consequences of § 86 Para. 2 VVG (see appendix) accordingly. This provision applies irrespective of the statutory subrogation pursuant to § 86 VVG (see appendix).

**§ 15**  
**Offsetting**

You may only offset against our claims if your counterclaim is undisputed or has been recognised by declaratory judgement.

As a member of an insurance association, you cannot offset a claim arising from the obligation to pay premiums.

**§ 16**  
**Cancellation by the policyholder**

1. The contract is concluded for the first two *insurance years* (minimum insurance term). After expiry of the minimum insurance term, you can cancel the contract with three months' notice to the end of each *Insurance year*.
2. You can restrict your cancellation to individual insured persons or tariffs.
3. If an insured person is required by law to take out statutory health insurance, you can cancel the contract or an existing qualifying *Insurance policy* within three months of becoming subject to compulsory insurance, with retroactive effect from the date on which the insurance became compulsory.

The cancellation is invalid if you do not provide evidence of the commencement of compulsory insurance within two months after we have requested you to do so in *written form*. This does not apply if you are not responsible for missing the deadline.

If you exercise your right of cancellation, we will only be entitled to the premium up to the date on which the *Obligation to insure* begins.

You can later cancel the contract or an existing qualifying *Insurance policy* at the end of the month in which you provide evidence of the commencement of compulsory insurance.

In this case, we are entitled to the premium until the end of the insurance contract.

The *Obligation to insure* is the same as

- the statutory entitlement to family insurance or
- the not merely temporary entitlement to healthcare from a civil service or similar employment relationship

4. Insured persons who make use of their right of cancellation in accordance with Para. 3 have the right to continue the part of their previous insurance cover not replaced by the compulsory insurance in the statutory health insurance in our medical expenses insurance policies for which there is eligibility for insurance.

The right only exists if the application for continuation is made within three months of the cancellation taking effect.

Insurance cover shall commence at the earliest on the date on which the cancellation takes effect.

Insofar as the new insurance cover is higher or more comprehensive, we can demand a *Risk surcharge* (cf. § 9 Para. 5) or agree an exclusion of benefits in the event of an increased risk.

5. If an agreement in the insurance contract has the consequence that, upon reaching a certain age or upon fulfilment of other conditions specified therein, the premium for a different age or a different age group applies, you can terminate the insurance relationship with regard to the insured person concerned within two months of the change coming into effect if the premium increases as a result of the change.
6. If we increase the premiums on the basis of the premium adjustment clause or reduce our benefits in accordance with § 21 Para. 1, you can cancel the contract with regard to the insured person concerned within two months of receipt of the notification of change at the time the change takes effect.

In the event of a premium increase, you can also cancel the contract up to and on the date on which the increase takes effect.

7. If we declare the rescission, withdrawal or cancellation only for individual insured persons or tariffs, you can demand the cancellation of the remaining part of the insurance within two weeks of receipt of this declaration to the end of the month in which you received our declaration.

In the case of a cancellation, this applies at the time at which it becomes effective.

8. If the insurance relationship serves to fulfil the *Obligation to insure* (§ 193 Para. 3 VVG – see appendix), cancellation in accordance with Paras. 1, 2, 4, 5 and 6 requires that a new contract is concluded for the insured person with another insurer that meets the requirements of the *Obligation to insure*.

The cancellation shall only take effect if you provide evidence within two months of the notice of cancellation that the insured person is insured with a new insurer without interruption; if the date on which the notice of cancellation was given is more than two months after the notice of cancellation, the evidence must be provided by this date.

9. If you cancel the contract as a whole or for individual insured persons, the insured persons have the right to continue the contract by naming the future policyholder.

The declaration must be submitted within three months of the cancellation. The cancellation is only effective if you can prove that the insured persons concerned have been notified of the cancellation.

### **§ 17 Cancellation by the insurer**

We waive our ordinary right of cancellation.

We can only terminate the contract extraordinarily in accordance with the statutory provisions.

We can also limit ourselves to individual insured persons or tariffs.

If we cancel the contract, the insured persons have the right to continue the contract by naming the future policyholder.

### **§ 18 Other reasons for termination**

1. The contract ends on your death.

The insured persons have the right to continue the contract by naming the future policyholder.

The declaration must be submitted within two months of your death.

2. Upon the death of an insured person, this part of the contract ends.
3. If an insured person moves their *Habitual residence* to a country other than those specified in § 3 Para. 1 Clause 1, this part of the contract shall end.

### **§ 19 Declarations of intent and notifications**

Declarations of intent and notifications to us must be made in *written form*.

### **§ 20 Place of jurisdiction**

1. The court of the place of jurisdiction for legal action against us is the court at which
  - we have our headquarters,
  - you have your place of residence or
  - you have your *Habitual residence* if you do not have a domicile.
2. We may file a lawsuit against you in the competent court of the district in which
  - you have your place of residence or
  - you have your *Habitual residence* if you do not have a domicile.
3. If you move your place of residence or *Habitual residence abroad*, the court at our registered office shall have jurisdiction for legal action. This also applies if we do not know the place where you usually stay.

**§ 21**  
**Amendment of general terms and conditions of insurance**

1. In the event of a change in the circumstances of the healthcare system that is not merely temporary, we can adapt these conditions and the tariff provisions to these new circumstances.

This presupposes that

- the changes appear necessary to adequately safeguard the interests of the policyholders,
- an independent *trustee* has verified that the requirements for the changes have been met and
- this *trustee* has confirmed that these changes are appropriate.

The changes will take effect at the beginning of the second month after we have notified you of the changes and the relevant reasons for them.

2. In addition, we may replace a provision in these Terms and Conditions with a new provision if the provision to be replaced by
  - a German Supreme Court decision or
  - a final administrative actwas declared invalid.

This presupposes that

- this is necessary to continue the contract or
- the contract would represent an unreasonable hardship for one of the contracting parties without this new provision. The interests of the other party are also taken into account.

The new regulation will only take effect if

- it fulfils the contractual objective and
- the interests of the policyholders are appropriately taken into account.

Two weeks after we have notified you of the regulation and the relevant reasons for this, the regulation will become part of your contract.

**§ 22**  
**Change to the basic tariff**

You can demand that insured persons can switch to the *Basic tariff* with a maximum premium guarantee and a reduction in premiums if they are in need of assistance.

The surcharge specified in the technical calculation bases is levied to guarantee these premium limits.

You can switch at any time after fulfilling the legal requirements; insurance under the *Basic tariff* begins on the first of the month following the month in which you submitted the application.

## **Note regarding the Ombudsmann Private Kranken- und Pflegeversicherung consumer mediation board**

Policyholders who are not satisfied with the insurer's decisions or whose negotiations with the insurer have not led to the desired result can contact the Ombudsmann Private Kranken- und Pflegeversicherung (Ombudsman for Private Health and Long-Term Care Insurance) consumer mediation board.

Ombudsmann Private Kranken- und Pflegeversicherung  
Postfach 06 02 22  
10052 Berlin  
Internet: [www.pkv-ombudsmann.de](http://www.pkv-ombudsmann.de)

The Ombudsmann Private Kranken- und Pflegeversicherung (Ombudsman for Private Health and Long-Term Care Insurance) is an independent mediation board that operates free of charge for consumers. The insurer has undertaken to participate in the mediation procedure.

Consumers who have concluded their contract online (e.g., via a website) can also contact the platform <http://ec.europa.eu/consumers/odr/> with their complaint. Your complaint will then be forwarded to the Ombudsmann Private Kranken- und Pflegeversicherung consumer mediation board via this platform.

Note: The Ombudsmann Private Kranken- und Pflegeversicherung is not an arbitration board and cannot make binding decisions on individual disputes.

## **Note regarding the insurance supervisory authority**

If policyholders are not satisfied with the support provided by the insurer or if differences of opinion arise during the processing of the contract, they can also contact the competent supervisory authority. As an insurance company, the insurer is subject to supervision by the Bundesanstalt für Finanzdienstleistungsaufsicht (German Federal Financial Supervisory Authority).

Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin)  
Sektor Versicherungsaufsicht  
Graurheindorfer Street 108  
53117 Bonn  
E-mail: [poststelle@bafin.de](mailto:poststelle@bafin.de)

Note: BaFin is not an arbitration board and cannot make binding decisions on individual disputes.

## **Reference to the legal process**

Irrespective of the possibility of contacting the consumer arbitration board or the insurance supervisory authority, the policyholder is free to take legal action.

## Definitions

<b>A Abroad</b>	All countries outside the Federal Republic of Germany are deemed to be foreign countries within the scope of these insurance conditions.
<b>Accident</b>	An accident is a sudden, external impact event on the body, in which an insured person involuntarily suffers injury.
<b>B Basic tariff</b>	The <i>Basic tariff</i> has been a statutory health insurance since 1 January 2009. The benefits of the <i>Basic tariff</i> are comparable in type, scope and amount to the benefits of statutory health insurance.
<b>C Conventional medicine</b>	Conventional medicine comprises medical diagnoses and therapies based on scientifically recognised methods that are taught and developed at medical universities.
<b>Country of origin</b>	Country of origin is the country or countries of which the insured person is a national.
<b>D Duty of disclosure (pre-contractual)</b>	In order for us to be able to examine your insurance application properly, it is necessary that you answer our questions (e.g., about your state of health, your person, your profession) truthfully and completely. You should also indicate any circumstances to which you attach only minor importance.
<b>E EEA (European Economic Area)</b>	The European Economic Area comprises the member states of the EU, as well as Iceland, Liechtenstein and Norway.
<b>Emergency</b>	An <i>emergency</i> is a situation that leads to serious injury or death without immediate medical treatment.
<b>Emergency tariff</b>	<p>The Emergency tariff of private health insurance is a tariff for insured persons in financial difficulties who cannot pay their premium debts and must remain insured in private health insurance due to the existing insurance obligation.</p> <p>The scope of benefits of the <i>Emergency tariff</i> is significantly reduced. The costs of treatment for acute illnesses and pain, as well as in connection with pregnancy and maternity, are reimbursed.</p>
<b>EU (European Union)</b>	An up-to-date list of the member states of the <i>European Union</i> can be found on the Internet at <a href="https://european-union.europa.eu/principles-countries-history/country-profiles_de">https://european-union.europa.eu/principles-countries-history/country-profiles_de</a>
<b>Extraordinary cancellation</b>	The contract can be cancelled if one of the contracting parties can no longer be reasonably expected to adhere to the contract. This is particularly possible in the event of serious breaches of contract.
<b>F Fee schedule</b>	The scale of fees for doctors and dentists regulate the billing of private medical and private dental services. These are medical and dental services outside the statutory health insurance.
<b>Follow-up treatment</b>	Follow-up treatment is a special form of rehabilitation that takes place immediately after inpatient treatment in hospital.
<b>H Habitual residence</b>	A person has his/her habitual residence where he/she has his/her centre of life. If a person spends more than 6 months <i>abroad</i> , his/her centre of life is no longer in Germany.
<b>I Immediate</b>	Immediate means without undue delay, i.e., as quickly as possible.
<b>Insurable</b>	The tariff can only be taken out under certain conditions that the insured person must fulfil. The requirements are specified in the tariff. The insurance ends if one of the above conditions is no longer met.
<b>Insurance year</b>	The insurance year is the calendar year. The first insurance year ends on 31 December of the year in which the contract begins.
<b>Insurance policy</b>	The Insurance policy is a document that serves as proof of an existing insurance contract. The <i>Insurance policy</i> shows that the contract was concluded between you as the policyholder and us as the insurer.

<b>L Life partner</b>	Life partners within the scope of the Lebenspartnerschaftsgesetz (German Life Partnerships Act; § 1 LPartG – in the version valid until 22 December 2018) are two persons of the same sex who have entered into a legal partnership for life.
<b>M Medical treatment</b>	Medical treatment attempts to cure or alleviate the illness or injury or prevent it from worsening by suitable means.
<b>N Need for care</b>	People in need of care are those who have health-related impairments and therefore require assistance from others. The <i>Need for care</i> must be permanent – expected to last at least 6 months – and of a defined severity.
<b>O Obligation to insure</b>	Every person resident in Germany is obliged to have health insurance. For certain groups of people, membership of the statutory health insurance is mandatory, while others can choose between voluntary membership of the statutory or private health insurance.
<b>Observation unit</b>	Insured persons are divided into groups for the calculation of premiums: Children, teenagers and adults.
<b>R Rehabilitation programme</b>	Rehabilitation measures are medical services to prevent, eliminate, reduce or compensate for a disability or <i>Need for care</i> and to restore the ability to work. They serve the purpose of integration into professional and social life. The services can be provided on an inpatient or outpatient basis. The measure is authorised by a statutory rehabilitation provider, for example, the pension or <i>accident</i> insurance.
<b>Risk surcharge</b>	The risk surcharge is levied in addition to the premium if an insured person has been diagnosed with an increased health risk due to pre-existing conditions. The amount of the risk surcharge depends on the individual risk, which is determined by the insurer as part of a health check.
<b>S Sanatorium</b>	A sanatorium is a facility in which inpatient spa treatments are carried out. One focus is the treatment of chronically ill people or rehabilitation after <i>accidents</i> , operations or mental illnesses.
<b>Spa treatment</b>	A spa treatment is a health-oriented stay at a recognised spa or health resort. As part of a spa treatment, various therapies are used to prevent illnesses or alleviate (chronic) complaints.
<b>T Trustee</b>	In private health insurance, the interests of policyholders are represented by trustees. The trustees are independent of the insurance companies.
<b>Type of life insurance</b>	Health insurance is calculated like a life <i>Insurance policy</i> . Such insurance is subject to strict legal requirements: <ul style="list-style-type: none"> <li>• the actuarial methods must comply with the statutory minimum requirements</li> <li>• the insurer's ordinary right of cancellation is excluded</li> <li>• premium changes are made on the basis of a premium adjustment clause and require the approval of an independent trustee</li> <li>• compliance with the statutory minimum requirements is monitored by a responsible actuary.</li> </ul>
<b>W Wilful</b>	You act wilfully if you act with knowledge and intent. This is the case if they want to bring about a certain event or consider the occurrence of an event to be possible and consciously accept it.
<b>Withdrawal measure</b>	A withdrawal programme is medical rehabilitation for substance-related addictions (e.g., addiction to alcohol, medication or drugs).
<b>Written form</b>	A written message stating that you are the sender. A handwritten signature is not necessary. For example, an e-mail or fax is sufficient.

## Appendix:

### Extract from the **Lebenspartnerschaftsgesetz (German Civil Partnership Act (LPartG))** in the version valid until 21 December 2018

- § 1**  
**Life partnership**
- (1) Two persons of the same sex who declare to the registrar in person and in the presence of each other that they wish to enter into a life-long partnership (life partners) establish a life partnership. The declarations cannot be made subject to a condition or time limit.

### Extract from the **Versicherungsaufsichtsgesetz (Insurance Supervision Act (VAG))**

- § 153**  
**Emergency tariff**
- (1) Non-payers pursuant to § 193 paragraph 7 of the *Versicherungsvertragsgesetz* (German Insurance Contract Act (VVG)) form a tariff within the scope of § 155 Para. 3 Clause 1. The *Emergency tariff* only provides for the reimbursement of expenses for services required for the treatment of acute illnesses and pain conditions, as well as pregnancy and maternity. Notwithstanding, insured children and adolescents are also to be reimbursed in particular for preventive examinations for the early detection of diseases in accordance with programmes introduced by law and for vaccinations recommended by the *Ständige Impfkommision* (Standing Vaccination Commission) of the Robert Koch Institute in accordance with § 20 (2) of the *Infektionsschutzgesetz* (German Infection Protection Act).
  - (2) A standardised premium must be calculated for all insured persons in the *Emergency tariff*, otherwise § 146 (1) numbers 1 and 2 apply. For insured persons whose contract only provides for the reimbursement of a percentage of the expenses incurred, the *Emergency tariff* grants benefits amounting to 20, 30 or 50 per cent of the insured treatment costs. § 152 (3) shall apply accordingly. The calculated premiums from the *Emergency tariff* must not be higher than is necessary to cover the expenses for insured events under the tariff. Additional expenses incurred to guarantee the limits specified in Clause 3 shall be distributed equally among all policyholders of the insurer with an *Insurance policy* that fulfils an obligation under § 193 Para. 3 Clause 1 of the *Versicherungsvertragsgesetz* (German Insurance Contract Act (VVG)). The ageing provision is to be offset against the premium to be paid in the *Emergency tariff* in such a way that up to 25 per cent of the monthly premium is paid by withdrawal from the ageing provision.

### Extract from the **Versicherungsvertragsgesetz (German Insurance Contract Act (VVG))**

- § 14**  
**Due date of the cash benefit**
- (1) Cash benefits from the insurer are due upon completion of the investigations necessary to determine the insured event and the scope of the insurer's benefits.
  - (2) If these enquiries have not been completed by the end of one month after notification of the insured event, the policyholder may demand payment on account of the minimum amount that the insurer is likely to have to pay. The period shall be suspended as long as the inquiries cannot be completed due to the fault of the policyholder.
  - (3) An agreement exempting the insurer from the obligation to pay interest on arrears is invalid.
- § 19**  
**Duty of disclosure**
- (2) If the policyholder breaches his/her *Duty of disclosure* in accordance with paragraph 1, the insurer may withdraw from the contract.
- § 28**  
**Breach of a contractual obligation**
- (1) In the event of a breach of a contractual obligation to be fulfilled by the policyholder vis-à-vis the insurer prior to the occurrence of the insured event, the insurer may cancel the contract within one month of becoming aware of the breach without notice, unless the breach is not due to intent or gross negligence.
  - (2) If the contract stipulates that the insurer is not obliged to pay benefits in the event of a breach of a contractual obligation to be fulfilled by the policyholder, the insurer is not obliged to pay benefits if the policyholder has *wilfully* breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in proportion to the severity of the policyholder's fault; the burden of proof that gross negligence did not occur shall be borne by the policyholder.

- (3) Notwithstanding Paragraph 2, the insurer is obliged to indemnify if the breach of the obligation is neither the cause of the occurrence or determination of the insured event nor of the determination or scope of the insurer's obligation to indemnify. Clause 1 shall not apply if the policyholder has fraudulently breached the obligation.
- (4) In the event of a breach of an obligation to provide information or clarification existing after the occurrence of the insured event, the insurer's complete or partial release from liability in accordance with Paragraph 2 is subject to the condition that the insurer has informed the policyholder of this legal consequence by means of a separate notification in *written form*.

**§ 37**  
**Default of payment for first premium**

- (1) If the single premium or the first premium is not paid on time, the insurer is entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.
- (2) If the single premium or the first premium has not been paid when the insured event occurs, the insurer is not obliged to pay benefits unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if it has drawn the policyholder's attention to this legal consequence of non-payment of the premium by means of a separate notification in *written form* or a conspicuous reference in the *Insurance policy*.

**§ 38**  
**Default of payment for subsequent premium**

- (1) If a subsequent premium is not paid on time, the insurer may set the policyholder a payment deadline of at least two weeks in *written form* at the policyholder's expense. The provision is only effective if it specifies the outstanding amounts of the premium, interest and costs in detail and states the legal consequences associated with the expiry of the deadline in accordance with Paragraphs 2 and 3; in the case of summarised contracts, the amounts must be stated separately in each case.
- (2) If the insured event occurs after the deadline and the policyholder is in arrears with the payment of the premium or interest or costs at the time of occurrence, the insurer is not obliged to pay benefits.
- (3) The insurer may cancel the contract without notice after the expiry of this period if the policyholder is in arrears with the payment of the amounts owed. The cancellation can be combined with the stipulation of the payment deadline in such a way that it becomes effective upon expiry of the deadline if the policyholder is in default of payment at this time; the policyholder must be expressly informed of this circumstance when the cancellation is made. The cancellation shall become ineffective if the policyholder makes the payment within one month of the cancellation or, if it has been combined with the deadline, within one month of the expiry of the deadline; Paragraph 2 remains unaffected.

**§ 86**  
**Transfer of claims for compensation**

- (1) If the policyholder has a claim for compensation against a third party, this claim shall be transferred to the insurer insofar as the insurer compensates the loss. The transfer cannot be asserted to the detriment of the policyholder.
- (2) The policyholder must safeguard his/her claim for compensation or a right serving to secure this claim in compliance with the applicable formal and deadline regulations and co-operate as far as necessary in its enforcement by the insurer. If the policyholder *wilfully* breaches this obligation, the insurer is not obliged to indemnify to the extent that it cannot obtain compensation from the third party as a result. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in proportion to the severity of the policyholder's fault; the burden of proof that gross negligence did not occur shall be borne by the policyholder.
- (3) If the policyholder's claim for compensation is made against a person with whom he/she is living in the same household at the time of the occurrence of the loss, the transfer pursuant to Paragraph 1 must not be asserted unless this person intentionally caused the loss.

## § 193

### Insured person; compulsory insurance

- (3) All persons residing in Germany are obliged to take out and maintain medical expenses insurance with an insurance company authorised to do business in Germany for themselves and for the persons they legally represent, insofar as they cannot conclude contracts themselves, which covers at least reimbursement of costs for outpatient and inpatient treatment and for which the absolute and percentage deductibles agreed for outpatient and inpatient treatment for each person to be insured are limited to an amount of EUR 5,000 per calendar year. For persons entitled to benefits, the possible deductibles result from an analogous application of the one per cent share not covered by the benefit rate to the maximum amount of EUR 5,000. The obligation pursuant to Clause 1 does not apply to persons who
1. are insured by statutory health insurance or are subject to compulsory insurance or
  2. are entitled to free healthcare, are entitled to benefits or have comparable entitlements to the extent of the respective authorisation or
  3. are entitled to benefits under the Asylbewerberleistungsgesetz (German Asylum Seekers Benefits Act) or
  4. are recipients of ongoing benefits under the Third, Fourth and Seventh Chapters of the Twelfth Book of the Sozialgesetzbuch (German Social Security Code) and recipients of benefits under Part 2 of the Ninth Book of the Sozialgesetzbuch are entitled to benefits for the duration of this benefit receipt and during periods of interruption of benefit receipt of less than one month if the benefit receipt began before 1 January 2009.

A medical expenses insurance contract agreed before 1 April 2007 meets the requirements of Clause 1.

- (6) If the policyholder is in arrears with an amount equal to two months' worth of premiums for an *Insurance policy* that fulfils the obligation under Paragraph 3, the insurer must send him/her a reminder. The policyholder must pay a late payment surcharge of 1 per cent of the premium arrears for each month or part month of premium arrears instead of interest on arrears. If the premium arrears including the late payment surcharges are higher than the premium share for one month two months after receipt of the reminder, the insurer shall send a second reminder and draw attention to the consequences in accordance with Clause 4. If the premium arrears including the late payment surcharges are higher than the premium share for one month one month after receipt of the second reminder, the contract shall be suspended from the first day of the following month. The contract shall not be suspended or shall end if the policyholder or the insured person is or becomes in need of assistance within the scope of the Second or Twelfth Book of the Sozialgesetzbuch (German Social Security Code); the need for assistance must be certified by the competent institution in accordance with the Second or Twelfth Book of the Sozialgesetzbuch at the policyholder's request.
- (7) As long as the contract is suspended, the policyholder is deemed to be insured under the *Emergency tariff* in accordance with § 153 of the Versicherungsaufsichtsgesetz (German Insurance Supervision Act (VAG)). Risk surcharges, benefit exclusions and deductibles do not apply during this period. The insurer may demand that supplementary insurance policies be suspended as long as the insurance exists in accordance with § 153 of the Versicherungsaufsichtsgesetz (German Insurance Supervision Act). A change to or from the *Emergency tariff* in accordance with § 153 of the Versicherungsaufsichtsgesetz excluded. A policyholder whose policy only provides for reimbursement of a percentage of the expenses incurred is deemed to be insured under a variant of the *Emergency tariff* in accordance with § 153 of the Versicherungsaufsichtsgesetz, which provides for benefits amounting to 20, 30 or 50 per cent of the insured treatment costs, depending on which percentage is closest to the level of reimbursement agreed.