

MediHealth Prime Medical Expenses Tariff for Outpatient, Inpatient and Dental Treatment



(as of 01/04/2024)

Part II of the General Insurance Conditions

(only applies in conjunction with Part I AB/bKK 2024)

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Please note that the German version is legally binding.

Tariff benefits

A. Insurability

1. Who can insure themselves? Only those persons can insure themselves under this tariff who have a place of residence in the Federal Republic of Germany,

- are staying in the Federal Republic of Germany with a temporary residence permit,
- are not insured in the German statutory health insurance scheme and
- are not entitled to an allowance or free healthcare.

2. When does the insurance end? The insurance ends for the respective insured person

- as soon as one of the conditions listed in section A.1 ceases to apply, or
- if it has reached the maximum insurance period of 60 months.

You must inform us *immediately in written form* if the conditions for *insurability* cease to apply to an insured person.

If the insured person was insured under another tariff for persons with a temporary residence permit *immediately* before the start of the insurance, the contract term is shortened accordingly.

B. Outpatient services

1. Medical treatment We reimburse

100 % of the *costs* of medical treatment.

Subject to the conditions set out in the tariff, we also reimburse medical services provided by a telephone or digital service (telemedicine).

For outpatient medical treatment, we also pay in excess of the maximum rates of the applicable *scale of fees for doctors (GOÄ)* if a legally valid *fee agreement* has been concluded.

2. Preventive check-ups and immunisations **100 %** of the *costs* of outpatient preventive examinations for the targeted detection of diseases in accordance with the programmes introduced by law in Germany without the age limits specified therein.

In addition to the statutory programmes, we also pay for standard examinations for the prevention or early detection of common serious illnesses (e.g., diabetes, cancer, tuberculosis) with no age limit.

100 % of the *costs* of immunisations recommended by the Ständige Impfkommission (Standing Committee on Vaccination (STIKO)) of the Robert Koch Institute.

This also includes vaccinations that are given for a private trip *abroad*.

3. Medicines and dressings **100 %** of the *costs* for medically prescribed

- medicines and dressings,
- urine and blood test strips and
- *enteral* and *parenteral* nutrition when normal food intake is not possible.

4. Remedies **100 %** the *costs* of medically prescribed *remedies*.

Remedies are eligible for reimbursement if they are listed in the list of benefits for *remedies* in the Bundesbehilfverordnung (German Federal Benefits Ordinance (BBhV)). The *costs* will be reimbursed within the maximum amounts specified there.

In addition, in the event of the insured person becoming pregnant, we will reimburse the *costs* of

- birth preparation courses,
- pregnancy gymnastics and
- postnatal gymnastics after childbirth.

This also applies if these measures are not carried out by a midwife or a maternity nurse. In this case, we will reimburse the fees up to the maximum amount that a midwife or maternity nurse would charge.

5. Aids (with the exception of hearing and visual aids)

100 % of the *costs* of medically prescribed *aids* in a functional *standard version* up to an invoice amount of **EUR 1,000** per aid.

If an aid is likely to cost more than **EUR 1,000**, you must apply for the procurement of this aid.

This also applies if an aid *costs* less than **EUR 1,000** but has to be purchased several times and is therefore likely to incur *costs* of more than **EUR 1,000** per *insurance year*.

In this case, we are obliged to provide the aid *immediately* in a medically necessary version or, if this is not possible, to inform you that you can obtain the aid.

90 % of the *costs* if an aid or the multiple purchase of an aid of the same type is expected to exceed an invoice amount of **EUR 1,000** and you have not applied to us for its procurement.

This does not apply if the insured person receives the aid as part of *accident* or emergency primary care. In this case, the respective aid is **100 %** reimbursable.

Medical *aids* are reimbursable if they are medically necessary in order to

- ensure the success of medical treatment,
- prevent an impending disability,
- compensate for or support an impaired bodily function or
- preserve life.

An *aids* includes, among other things, artificial limbs, trained guide dogs for the blind, reading devices for the blind and blood glucose meters with sensor technology, including the necessary replacement of sensors.

The following *costs* are also reimbursable:

- acquisition and replacement,
- loan,
- repair and maintenance and
- instruction in use.

We do not pay for the following:

- products that are to be regarded as articles of daily use for a healthy person,
- devices that can be assigned to the fitness or wellness sector,
- maintenance and operating *costs* of *aids* (e.g., electricity *costs* and batteries),
- clinical thermometers, pulse measuring devices, heat lamps, heating and cooling pads,
- *aids* which are used exclusively to improve the living environment (e.g., a stair lift).

6. Hearing aids

100 % of the *costs* of hearing *aids* in functional standard design up to an invoice amount of **EUR 1,500** per ear and hearing aid.

100 % of the *costs* of hearing *aids* that are fully or partially implanted (e.g., BAHA and cochlear implants), provided that the hearing loss can only be compensated by such hearing *aids*.

7. Visual aids

100 % of the *costs* of visual *aids* (spectacle frames, spectacle lenses, contact lenses) up to a total invoice amount of **EUR 500** within two *insurance years*.

8. Surgical visual acuity correction	<p>100 % of the <i>costs</i> of refractive surgery (e.g., LASIK, LASEK or lens implants) to correct defective vision.</p> <p>In the first three <i>insurance years</i>, we will reimburse a maximum invoice amount of EUR 250 per surgical procedure and eye.</p> <p>From the fourth year of insurance, the reimbursement per surgical procedure and eye is limited to EUR 1,500.</p>
9. Digital health applications	<p>100 % of the <i>costs</i> of digital health applications, provided these are listed in the directory for digital health applications in accordance with Section 139e SGB V.</p> <p>80 % of the <i>costs</i> of digital health applications other than those mentioned above up to an invoice amount of EUR 1,000 per <i>insurance year</i>, provided we have given you prior authorisation in <i>written form</i>.</p>
10. Psychotherapy	<p>100 % of the <i>costs</i> of psychotherapeutic outpatient treatment up to 30 sessions per <i>insurance year</i>.</p> <p>90 % of the <i>costs</i> for psychotherapeutic outpatient treatment from the 31st to the 50th session per <i>insurance year</i>.</p> <p>80 % of the <i>costs</i> for psychotherapeutic outpatient treatment from the 51st session per <i>insurance year</i>.</p> <p>The following <i>costs</i> for psychotherapeutic treatment by</p> <ul style="list-style-type: none"> • medical psychotherapists, • psychological psychotherapists and • child and adolescent psychotherapists <p>are reimbursable up to the maximum rates of the respective valid <i>scale of fees for doctors (GOÄ)</i>, if a legally valid <i>fee agreement</i> has been concluded, even above the maximum rates.</p>
11. Sociotherapy	<p>100 % of the <i>costs</i> of sociotherapy if the insured person is unable to make independent use of medical or medically prescribed services due to severe mental illness and if sociotherapy avoids or shortens hospital treatment, or if hospital treatment is necessary but cannot be carried out.</p> <p>The prerequisite is that you submit a medical treatment plan to us before the start of therapy and that we give you our consent in <i>written form</i>. We will consent if the treatment is medically necessary.</p> <p>The entitlement exists for a maximum of 120 hours per insured event within three <i>insurance years</i>.</p> <p>The treatment can be carried out by a sociotherapy specialist (e.g., social worker). Within this framework, we will reimburse at most the amount that would have to be paid for the treatment of an insured person covered by German statutory health insurance.</p>
12. Naturopathy and osteopathy by specialised alternative practitioners	<p>100 % of the <i>costs</i> of medical treatment by alternative practitioners, including prescribed medication within the scope of the <i>fee schedule for alternative practitioners (GebÜH)</i> up to an invoice amount of EUR 2,000 per <i>insurance year</i>.</p> <p>We also reimburse osteopathic treatments by specialised non-medical practitioners under the above-mentioned conditions if they</p> <ul style="list-style-type: none"> • are members of a professional association of osteopaths in Germany or • have completed an osteopathic training programme that entitles them to join an osteopathic association in Germany. <p>Psychotherapeutic treatments by alternative practitioners are not eligible for reimbursement.</p>

<p>13. Midwives and maternity nurses</p>	<p>100 % of the <i>costs</i> of services provided by midwives and maternity nurses during pregnancy (pre- and postnatal care) and childbirth.</p> <p>In addition, in the event of the insured person becoming pregnant, we will reimburse the <i>costs</i> of</p> <ul style="list-style-type: none"> • birth preparation courses, • pregnancy gymnastics and • postnatal gymnastics after childbirth. <p>The fees are reimbursable within the fee limits of the applicable official German fee regulations for midwives.</p> <p>The insured person can also use a birthing centre of their choice in Germany for the delivery. The <i>costs</i> invoiced by a birthing centre are eligible for reimbursement.</p>
<p>14. Fertility treatment</p>	<p>100 % of the <i>costs</i> of medically necessary measures to achieve pregnancy (artificial insemination) using treatment methods legally authorised in Germany, provided that a treatment and cost plan is submitted before treatment begins and we have given our prior consent in <i>written form</i>.</p> <p>We will consent if</p> <ul style="list-style-type: none"> • the insured person has an organically caused sterility that can only be overcome by artificial insemination or fertilisation, • treatment is provided to married couples or couples living in a marriage-like relationship, • only egg and sperm cells of the couple are used (homologous fertilisation) and • there is a reasonable prospect of success of at least 15%. <p>Expenses for fertility treatment are limited to a total invoice amount of EUR 1,000 in the first three <i>insurance years</i>.</p> <p>If there is a claim for fertility treatment from another cost bearer, we are only liable to pay the <i>costs</i> that remain after advance payment by the other cost bearer.</p>
<p>15. Cryopreservation</p>	<p>100 % of the <i>costs</i> of cryopreservation of egg or sperm cells, including the associated medical measures, if the insured person has to undergo therapy that damages germ cells due to an illness.</p>
<p>16. Social paediatrics and early intervention</p>	<p>100 % of the <i>costs</i> of social paediatrics and early support in social paediatric centres up to the amount of the prices agreed with the statutory cost bearers, insofar as there is no claim against other cost bearers.</p>
<p>17. Outpatient spa treatment</p>	<p>100 % of the <i>costs</i> of medically necessary spa treatment.</p> <p>We only pay for medical treatment and medically prescribed medicines and dressings.</p> <p>We pay the benefit for the first time after three years of insurance and thereafter at three-year intervals.</p> <p>If there is a simultaneous claim against a statutory rehabilitation provider, we will only pay for the <i>costs</i> that remain necessary despite the benefits provided by the other funding organisation.</p>

- 18. Outpatient withdrawal programme** **100 %** of the *costs* of a withdrawal programme, if we have given prior consent in *written form* in this case.
- We will give our consent if
- the *withdrawal measure* is medically necessary,
 - no other funding organisation (e.g., statutory rehabilitation provider) is liable to pay benefits and
 - the measure is not aimed at withdrawal of nicotine dependence.
- The service can be utilised a total of three times during the contract term. This applies regardless of whether the service is provided on an outpatient or inpatient basis.
- 19. Home nursing care** **100 %** of the *costs* of medically prescribed individual medical services for *home treatment care*.
- The *costs* are reimbursable if the *home treatment care* backs up the medical treatment (backup care) or if hospital treatment is thereby avoided or shortened (hospital avoidance care).
- 100 %** of the *costs* of basic nursing and *Domestic care* as part of hospital avoidance care for up to four weeks per insured event if no other cost bearer (e.g., private compulsory long-term care insurance or supplementary long-term care insurance) is liable to pay benefits.
- We cover the *costs* of home nursing care if this is provided by a service provider (e.g., outpatient nursing service, social centre) that has a legally valid care contract with the statutory health insurance providers and charges for the services in accordance with the associated remuneration agreement.
- 20. Specialised outpatient palliative care** **100 %** of any remaining *costs* for specialised outpatient medical palliative care after advance payment by another cost bearer in accordance with the Richtlinien des Gemeinsamen Bundesausschusses (Guidelines of the German Federal Joint Committee), which aim to enable the insured person to be cared for in their familiar home environment.
- Inpatient care facilities also count as a home environment. The prerequisite is that the insured person suffers from an incurable, progressive and advanced illness and requires particularly extensive care as a result of a limited life expectancy.
- Costs* are reimbursable up to the amount that would be incurred for the treatment of an insured person covered by statutory health insurance.
- Costs* for specialised outpatient palliative care are eligible for reimbursement if they are provided by a service provider (e.g., outpatient nursing service, social care centre) that has a legally valid care contract with the statutory health insurance providers and charges for the services in accordance with the associated remuneration agreement.

C. Inpatient services

- 1. Inpatient treatment** **100 %** of the *costs* for
- general hospital services in accordance with the Krankenhausentgeltgesetz (German Hospital Remuneration Act) (KHEntgG) and the Bundespflegesatzverordnung (German Federal Hospitalisation Rate Ordinance (BPfIV)),
 - separately billable private medical services (attending physician, elective physician),
 - separately billable accommodation and catering in a single, twin or family room.
- Costs* for general hospital services in German hospitals that do not charge according to KHEntgG or BPfIV (private clinics) are reimbursable up to a maximum of two times the *costs* that can be charged according to KHEntgG or BPfIV.
- The fees for separately billable private medical services (attending physician, elective physician) are also reimbursable above the maximum rates of the applicable scale of fees for physicians (GOÄ) if a legally valid *fee agreement* has been concluded.

- 2. Rooming-in for children under the age of 12** **100 %** of the *costs* of board and lodging for an accompanying adult, provided the child insured with us is under 12 years of age at the start of the hospitalisation.
- 3. Replacement daily hospital allowance**
- If no separately billable private medical services are utilised during a medically necessary hospital stay, we will pay a substitute daily hospital allowance of **EUR 40**.
- If no separately billable accommodation is utilised during a medically necessary hospital stay, we will pay a substitute daily hospital allowance of **EUR 40** for each day on which the separately billable accommodation was not utilised.
- However, this does not apply to accommodation in an intensive care or infant ward.
- The day of admission and the day of discharge are added together and count as one day.
- 4. Inpatient spa treatment** **100 %** of the *costs* of a medically necessary cure or sanatorium treatment. The *costs* of medical treatment and medically prescribed medicines, dressings and *remedies* are eligible for reimbursement.
- Costs* for accommodation, meals and visitor's tax are not eligible for reimbursement.
- We pay the benefit for the first time after three years of insurance and thereafter at three-year intervals.
- If there is a simultaneous claim against a statutory rehabilitation provider, we will only pay for the *costs* that remain necessary despite the benefits provided by the other funding organisation.
- 5. Inpatient withdrawal programme** **100 %** of the *costs* of a *withdrawal measure*, insofar as we have given prior consent in *written form* in this case.
- We will give our consent provided that
- the *withdrawal measure* is medically necessary,
 - no other funding organisation (e.g., statutory rehabilitation provider) is liable to pay benefits and
 - the measure is not aimed at withdrawal of nicotine dependence.
- The service can be utilised a total of three times during the contract term. This applies regardless of whether the service is provided on an outpatient or inpatient basis.
- Detoxification and qualified withdrawal are not considered *withdrawal measures*, but are reimbursable as acute inpatient measures.
- 6. Hospice service** **100 %** of the remaining *costs* for care in a hospice after advance payment by the long-term care insurance.
- The insured person has a free choice of hospices that provide palliative medical treatment and have a legally valid care contract with the statutory health insurance providers and provide services in accordance with the associated health insurance regulations Calculate the remuneration agreement.
- Costs* are reimbursable up to the amount that would be incurred for the treatment of an insured person covered by statutory health insurance.

D. Dental services

1. Dental prophylaxis

- 100 %** of the *costs* for dental prophylactic services. Dental prophylaxis includes:
- sealing (fissure sealing),
 - fluoridation,
 - saliva test for germ determination,
 - creation of an oral hygiene status,
 - cavity risk diagnostics,
 - professional teeth cleaning.

2. Dental treatment

- 100 %** of the *costs* for dental treatment. Dental treatment includes the following:
- general dental services,
 - conserving services, in particular plastic and composite fillings and root canal treatments. Exception: Fissure sealing (categorised as dental prophylaxis) and inlays and crowns (categorised as dentures),
 - services for diseases of the oral mucosa and periodontium,
 - surgical services (except in connection with implantological services),

as well as the necessary imaging, anaesthesia services and dental services (material and laboratory *costs*).

3. Dentures

- 90 %** of the *costs* for dentures. Dentures include:
- inlays, crowns, telescopic crowns, partial crowns and onlays,
 - resin and ceramic veneers for all teeth (i.e. up to and including tooth 8),
 - ceramic veneers (veneers),
 - prosthetic services (in particular bridges, post teeth, full or partial dentures and the repair thereof),
 - orthodontic appliances and splints, unless they are necessary in the context of orthodontic treatment,
 - implantological services (including augmentation services, superstructures and associated surgical services),
 - functional analysis and functional therapy services,

as well as the necessary imaging, anaesthesia services and dental technical services.

4. Orthodontics

- 90 %** of the *costs* of orthodontic treatment for children and adolescents who have not yet reached the age of 18 at the start of treatment.

- 90 %** of the *costs* for orthodontic treatment as a result of an *accident*, which occurred after the start of insurance cover. The benefit will also be paid if the insured person has already reached the age of 18 at the start of treatment.

An *accident* is deemed to have occurred if the insured person suffers involuntary damage to health as a result of a sudden external event affecting the body.

As an example, orthodontic treatment includes expenses for:

- brackets (e.g. mini, plastic, ceramic brackets),
- arches,
- invisible splints (e.g., Invisalign),
- occlusal appliances and splints if necessary as part of orthodontic treatment,

as well as the necessary imaging, anaesthesia and dental technology services.

5. Payment scale for dental services

Expenses for dentures and orthodontics are limited to a total invoice amount:

- EUR 1,500** in the first year of insurance,
- EUR 3,000** in the first two years of insurance,
- EUR 4,500** in the first three years of insurance,
- EUR 6,000** per year from the fourth year of insurance.

The above limitations do not apply to treatment that is necessary due to an *accident* that occurred after the start of the insurance.

The payment scale for dental services also applies when changing tariffs. If this results in a lower entitlement to reimbursement for dental care than under the previous tariff within the first four *insurance years* following the change of tariff, the higher benefits under the previous tariff will be paid, but no more than the benefits under the MediHealth Prime tariff from the fourth *insurance year* onwards.

- 6. Fee amount for dental and technical dental services**
- The fees for dental treatment are also reimbursable above the maximum rates of the applicable *scale of fees for dentists (GOZ) or for doctors (GOÄ)* if a legally valid *fee agreement* has been concluded.
- Dental technical services are reimbursable in accordance with the provisions of the *scale of fees for dentists (GOZ)*.
- 7. Treatment and cost plan**
- We recommend that you submit a treatment and cost plan before claiming benefits for dentures and orthodontics. The treatment and cost plan should also include specified *costs* for dental technical services. We will then inform you of the amount of the *costs* that we will reimburse.

E. Patient transport and patient journeys

- 1. Inpatient treatment for emergency rescue service**
- 100 %** of the *costs* of patient transport (e.g., ambulance or helicopter) to the closest suitable hospital for inpatient treatment in an emergency.
- Any hospital within a distance of 100 kilometres is considered to be the closest.
- The *costs* are also reimbursable if the patient is not admitted to hospital after initial treatment.
- 2. Outpatient and inpatient treatment (not emergency)**
- Costs* for ambulance transport and patient journeys (taxi, public transport and private car) to and from outpatient or inpatient treatment are reimbursable if they are required due to the
- dialysis treatment,
 - radiotherapy or chemotherapy,
 - medically certified inability to walk or
 - medically certified temporary inability to participate in road traffic of the insured person.
- 2.a. Dialysis, radiotherapy or chemotherapy**
- 100 %** of the *costs* of medical travel (taxi, public transport and private car) for the insured person to and from the closest suitable hospital or doctor for dialysis, radiotherapy or chemotherapy.
- Any hospital or doctor within a distance of 100 kilometres is considered to be the closest.
- For journeys by private car, **EUR 0.35** per kilometre driven is applied.
- If medical care is required during the journey for medical reasons, the *costs* of ambulance transport are also eligible for reimbursement.
- 2.b. Other treatments**
- 100 %** of the *costs* of ambulance transport or patient journeys (taxi, public transport and private car) of the insured person to and from the closest suitable hospital, doctor or physiotherapist.
- Any hospital or doctor within a distance of 100 kilometres is considered to be the closest.
- For journeys by private car, **EUR 0.35** per kilometre driven is applied.
- The *costs* are reimbursable up to an invoice amount of **EUR 400** per *insurance year*.

F. Services abroad

1. Return transport to the Federal Republic of Germany or to the home country

100 % of the *costs* of return transport from *abroad* if required for medical reasons.

Repatriation is necessary for medical reasons if

- a special patient transport facility must be used for the return journey due to the illness,
- adequate medical treatment is not guaranteed at the place of residence or within a reasonable distance, or
- a medically necessary inpatient treatment would take longer than 2 weeks due to the nature and severity of the illness.

The insurance also covers the additional *costs* of an unscheduled return journey due to illness and the *costs* of a medically necessary accompanying person.

We will deduct *costs* that the insured person would have incurred on a normal return journey from our reimbursement amount.

The insured person can choose which of the following locations they would like to be transported to:

- to their place of residence in the Federal Republic of Germany,
- to the nearest hospital to their place of residence in the Federal Republic of Germany,
- to the insured person's original place of residence in their home country or
- to the nearest hospital to the insured person's original place of residence in the home country.

The original place of residence in the insured person's home country is deemed to be the place of residence in the home country that the insured person had *immediately* before travelling to the Federal Republic of Germany.

2. Fee amount for medical treatment abroad

In the event of a temporary stay of the insured person *abroad*, the following applies in deviation from Section 3 Para. 2 of the General Terms and Conditions of Insurance (AVB):

Our benefits for medical treatment *abroad* are not limited to the fee level in Germany. Instead, we will cover the *costs* up to the standard local rate.

If an insured person moves their place of residence to a member state of the European Union, a member state of the European Economic Area or to Switzerland, the maximum amount we will pay for treatment in these countries is what we would have had to pay for this treatment in Germany.

G. Performance-related premium refunds

Reimbursement in the event of non-performance

As a form of utilisation, the refund of premiums for insured persons who have remained benefit-free can be decided. The Executive Board then determines for which tariffs or tariff combinations and in what amount the distribution is made. Entitlement exists for each insured person if:

- a) Insurance cover under the MediHealth Prime tariff was in place for the entire calendar year just ended and no outpatient insurance benefits (see Section A) and no dental insurance benefits (see Section C) were provided for the calendar year that just ended. The distribution of premium refunds and their amount can be made dependent on this condition being met for several consecutive calendar years.

If the insurance under the MediHealth Prime tariff did not exist for the entire calendar year just ended due to insurance commencing during the year, the decisive factor is that no outpatient insurance benefits (see Section A) and no dental insurance benefits (see Section C) were utilised under the MediHealth Prime plan for the entire calendar year just ended. In addition, no insurance benefits for outpatient or dental treatment may have been paid for the past calendar year under any other comprehensive health insurance policy with the insurer.

- b) The insurance is still in force on 30 June of the following year with no premium arrears. This requirement does not apply if the insurance was terminated as a result of death, entitlement to healthcare or the commencement of compulsory insurance.

The calculation of the premium refund is based on 1/12 of the annual premium for the previous calendar year.

For the calendar year in which insurance first commenced under one of our comprehensive medical expenses insurance policies, the performance-related premium refund in the event of non-payment of benefits is paid at 1/12 for each calendar month in which the insurance was in force under the MediHealth Prime tariff.

The premium refund is recognised in the third quarter of the following financial year. Expenses for preventive examinations and immunisations (Section A.2) and dental prophylaxis measures (Section C.1) are not taken into account when determining whether benefits are waived.

H. Option right

Exercise of option

If the MediHealth Prime tariff ends in accordance with Section A.2, the insured person can switch to one of our unlimited tariffs for full medical expenses insurance.

You can enquire about the tariffs and tariff combinations available for a changeover at any time.

The change is only possible if

- the tariff is open for new business,
- the habitual residence and domicile of the insured person continues to be in the Federal Republic of Germany and proof of such residence is provided to us,
- the insured person is eligible for insurance under the new tariff,
- the premiums for the last 12 months have been paid in full.

The insured person can switch without a new medical examination if he/she applies to us in writing within one month of the end of the MediHealth Prime tariff.

If the insured person has changed tariff, he/she must pay the premium for the new tariff. Exclusions of benefits and risk surcharges in the old tariff are transferred to the new tariff and adjusted according to the agreed risk level.

Under the conditions mentioned, you also have the right to switch to the MediCompact Plus or MediCompact Premium tariff. However, the existing special contractual agreements in the MediHealth Prime tariff or the risk surcharges agreed there are not decisive. Instead, based on the state of health when applying for the MediHealth Prime tariff, the usual health check for the MediCompact Plus or MediCompact Premium tariff in new business will be carried out. Any deterioration in the state of health during the period of insurance under the MediHealth Prime plan is not taken into account.

Definitions

A	Abroad	All countries outside the Federal Republic of Germany are deemed to be foreign countries within the scope of these insurance conditions.
	Accident	An accident occurs when the insured person suffers involuntary damage to their health as a result of a sudden external event.
	Aids	Aids are movable objects that are required to <ul style="list-style-type: none">• ensure the success of medical treatment,• prevent an impending disability or• compensate for an existing disability. The objects have a replacing, supporting or relieving effect.
B	Basic care	Basic care is the nursing care of a person who is temporarily or permanently unable to perform basic everyday tasks (e.g., personal hygiene and nutrition) on their own.
	Bundesbeihilfe- verordnung	The Bundesbeihilfeverordnung (German Feder Benefits Ordinance (BBhV)) regulates medical treatment measures for civil servants. The maximum amounts for remedies specified in the BBhV apply to this tariff.
C	Costs	We only pay for expenses that are reimbursable under this tariff. This includes those items of the invoice amount for which we have promised our service within the scope of this tariff.
D	Domestic care	Domestic care includes all necessary activities that are part of the household management of a person in need of care, e.g., shopping, cooking, cleaning.
E	Enteral	<i>Enteral</i> nutrition is a form of artificial supply of nutrients or medication. The medication is administered directly into the gastrointestinal tract via the mouth or rectum.
F	Fee agreement	Doctors can use a fee agreement to charge higher or lower costs for medical treatment than stipulated in the fee schedule. This is only possible if a written contract is concluded between the doctor and the patient.
	Fee schedule for alternative practi- tioners (GebÜH)	The schedule of fees for alternative practitioners lists recognised naturopathic treatments that are provided by alternative practitioners. Although this is not a legal regulation, the list is a mandatory basis for our services in the field of naturopathy.
H	Home treatment care	Home treatment care is defined as medically prescribed individual medical services provided by nursing assistants that are aimed at curing, improving, alleviating or preventing a worsening of the illness (e.g., injections, dressings, blood pressure measurements).
I	Immediate	Immediate means without undue delay, i.e., as quickly as possible.
	Insurability	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.
	Insurance year	The <i>insurance year</i> is the calendar year. The first insurance year ends on 31 December of the year in which the contract begins.
P	Parenteral	Parenteral nutrition is a form of artificial supply of nutrients and medication. The drugs are administered by injection or infusion, bypassing the gastrointestinal tract.
R	Remedies	Remedies are medical services that are provided by a person and serve to cure an illness. Remedies include physiotherapy, physical therapy, occupational therapy and speech therapy.
S	Scale of fees for doctors (GOÄ) and dentists (GOZ)	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.

Standard version

We pay for the most cost-effective aid that is sufficient, appropriate and economical. Therefore, aids that exceed what is medically necessary and offer uneconomical advantages of use are not eligible for reimbursement. The following in particular are considered uneconomical:

- functions that exclusively increase convenience and comfort when using the aid and/or
- features that only bring aesthetic or visual advantages.

W Withdrawal measure

A withdrawal programme is medical rehabilitation for substance-related addictions (e.g., addiction to alcohol, medication or drugs).

Written form

A written message stating that you are the sender. A handwritten signature is not necessary. For example, an e-mail or fax is sufficient.