Terms and conditions of insurance for the InboundMed Best 100 rate (group insurance)

As part of the InboundMed Best 100 rate (group insurance), we offer insurance cover for illness, accidents and other events set out in the policy and provide, if agreed, additional services that are directly related to such events. In an insured event, we provide indemnity for expenses associated with curative treatment and, if agreed, provide other services.

These terms and conditions of insurance are aimed at you, the main insured person under the group insurance policy. The Policyholder also has to observe the terms and conditions of insurance. If other policies are in place for the insured person in addition to the InboundMed Best 100 rate (group insurance), other terms and conditions of insurance may be agreed for these. The terms and conditions of insurance for the InboundMed Best 100 rate (group insurance) do not apply to these policies.

This rate is abbreviated to IMB100U.

The premiums for this rate do not contain any shares to set up ageing provisions.

Section A – Benefits

Here, you can find provisions on the scope of cover and a description of the benefits that we provide in an insured event.

Section B - Your obligations

Here, you can find provisions on the duties and rules of conduct (obligations) associated with the insurance and the consequences if these are breached.

Part C - General provisions

This section sets out the regulations governing the inception of cover.
You and the Policyholder can also find the provisions governing the adjustment of the premium and the terms and conditions of insurance, as well as general provisions on the execution of the insurance policy here.

Explanation of specialist terms

We have tried to make the terms and conditions of insurance as comprehensible as possible and to use as few specialist terms as possible. Not every specialist term can be replaced by an expression used in everyday language. This is why you will find explanations of specialist terms that cannot be avoided at the end of your terms and conditions of insurance. We have marked specialist terms that are explained in this section with a "→" in the text.

Example: "→written form"

Section A – Benefits

Here, you can find provisions on the scope of cover and a description of the benefits that we provide in an insured event.

1. Provisions governing the insured event and insurance cover

Content of this part:

1.1 When is an insured event deemed to have occurred?

(1) Insured event
The insured event is a situation in which the →insured person undergoes medically necessary curative treatment due to illness or an accident.

The term "insured event" also covers
- examinations and medically necessary treatment due to pregnancy and childbirth,
- medically necessary out-patient check-ups for the early recognition of illnesses and
- death.

In addition to the insured events set out in sentence 2, the term "insured event" shall also include the lawful termination of pregnancy due to
- a medically necessary indication (e.g. risk to the pregnant woman's life) or
- a criminological indication (e.g. pregnancy due to rape).

(2) Beginning and end of the insured event
The insured event starts at the time of curative treatment. It ends when the →insured person no longer requires treatment based on the medical findings. If the treatment has to be extended to cover an illness, or consequences of an accident that has/have no causal link to the illness or consequences of an accident for which the individual was previously undergoing treatment, this is deemed to constitute a new insured event.

1.2 What is the scope of cover based on?

The scope of cover is based on
- the insurance certificate,
- the →written agreements,
- the terms and conditions of insurance for the InboundMed Best 100 rate (group insurance),
- the statutory provisions governing insurance law and
- the other statutory provisions.

1.3 Which characteristics does the insured person have to meet for insurance under this rate and what happens if such a characteristic no longer applies (eligibility for insurance)?

The →insured person is eligible for insurance at this rate for as long as
- he/she has a foreign citizenship,
- he/she has his/her habitual place of abode in Germany and
- he/she has a fixed-term residence permit for this purpose pursuant to § 4.1 of the German Residence Act (AufenthG).

If one of these characteristics no longer applies, the rate will expire for the insured person affected.

1.4 How significant is membership of the group of individuals eligible for insurance?

The →insured person must belong to the group of individuals eligible for insurance pursuant to the →group insurance policy. If this characteristic no longer applies, the rate shall end pursuant to section C item 3.4.4.

1.5 When does participation in the group insurance policy begin (inception of cover)?

Participation in the →group insurance policy shall commence, for the IMB100U rate, at the point in time agreed for this rate (inception of cover). The inception of cover cannot be before the start date of the group insurance policy.

2. Prerequisites for indemnification and scope of benefits

2.1 Out-patient treatment in Germany

Content of this section:

We provide insurance cover based on the following provisions in the event of medically necessary out-patient treatment.

2.1.1 Which date is decisive for the occurrence of insured expenses?

The date that is decisive for the occurrence of insured expenses is the date on which the →insured person received treatment or a service.

2.1.2 Which service providers can the insured person choose from?

The →insured person can choose freely from the following service providers.

(1) Selection of doctors or alternative practitioners
The→insured person is free to choose a licensed doctor irrespective of whether they are community-based or working in hospital outpatient departments or medical care centers and an alternative practitioner within the meaning of the German Alternative Medical Practitioners Act (HeilprG).

(2) Selection of legal entities
The expenses for services provided by the following →legal entities are also insured:
- Institutions that provide physical medical services, laboratory or x-ray services at the instigation of a doctor, and
- medical care centers.

We have no duty to reimburse any remaining expenses incurred because the →insured person made use of the services of other legal entities.

2.1.3 For which examination and treatment methods do we provide indemnity?

We provide benefits, within the scope of the rate, for examination or treatment methods and drugs that are largely recognized by conventional medicine, and for
- cupping,
- acupuncture for pain relief,
- chiropractic treatment,
- autohaemotherapy and
- therapeutic local anesthesia.

We also provide benefits for methods and drugs that have proven to be just as successful in practice or methods and drugs that are used because there are no conventional medical methods or drugs available. We are, however, entitled to reduce our benefits to the amount that would have been incurred had conventional medical methods or drugs been used.

2.1.4 Which expenses do we reimburse in the event of medical treatment?

(1) Expenses for out-patient treatment
In respect of medically necessary out-patient treatment - with the exception of artificial insemination (in this respect, see item 2.1.5) and psychotherapy (in this respect, see item 2.1.7) and out-patient follow-up treatment (in this respect, see item 2.1.12) - we reimburse 100 percent of the expenses for medical services that can be charged in accordance with the valid German scale of medical fees (GOÄ).

Medical services include, by way of example, advice, visits (including house calls), examinations, special services (e.g. the application of dressings, taking of blood, injections and sonographic services), surgery, dialysis and home dialysis, as well as the doctor's travel expenses and allowances.

The medical services also include surgical measures to correct visual acuity (e.g. lasik, lasek or lens implants).

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(2) Expenses for check-ups
We reimburse 100 percent of the expenses for medically necessary check-ups performed by a doctor for the early detection of illnesses (e.g. check-ups based on programs introduced by law, albeit without the age limits that apply under such programs) that can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(3) Expenses for vaccinations

We will reimburse 100 percent of the expenses for
- vaccinations recommended by the Standing Committee on Vaccination of the Robert Koch Institute,
- vaccinations against Hepatitis B and
- vaccinations for travel

that can be charged in accordance with the valid German scale of medical fees (GOÄ), including the expenses for the vaccine.

Vaccinations due to the professional activity of the →insured person – with the exception of vaccinations against Hepatitis B - and malaria prevention are not reimbursable.

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

2.1.5 Which expenses do we reimburse in the event of artificial insemination performed by a doctor?

(1) Special preconditions of indemnification
The reimbursement of expenses for medically necessary artificial insemination pursuant to sub-sections 2 through 4 is subject to the proviso that
- the →insured person is organically sterile,
- based on the findings of a gynecology specialist, the treatment offers a sufficient chance of resulting in pregnancy and
- the female who is to be treated is not yet 41 years of age at the time the treatment begins.

(2) Insured benefits
We provide reimbursement for 50 percent of the expenses associated with medical services that can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(3) Maximum limit for our duty to indemnify
The reimbursement of expenses for artificial insemination is limited to a maximum of 4 attempts per →insured person and reproductive medical procedure (e.g. insemination following hormonal stimulation, in-vetro fertilization or in-vetro fertilization with intracytoplasmic sperm injection). We have no duty to reimburse any remaining expenses incurred because the insured number of attempts per insured person and reproductive medical procedure has been exceeded.

Furthermore, we have no duty to indemnify if we have provided insured benefits for reproductive medical procedures that have already resulted in 2 births.

(4) Subordinated duty to indemnify in the event of other benefit providers
If the partner of the →insured person for whom no →substitutive medical expenses insurance has been taken out with us is entitled to benefits for reproductive medical procedures from
- a health insurance fund within the meaning of the German Social Code (SGB),
- another private health insurer or
- another benefit provider,

this entitlement shall take precedence over our duty to indemnify. In such cases, we are only obliged to provide indemnity for those expenses that remain following the preliminary coverage provided by the other benefit provider.

(5) Submission of a treatment and cost plan
We recommend that a treatment and cost plan be submitted to us before the start of treatment. We will inform you without delay of the scope of the reimbursable expenses.

2.1.6 Which expenses do we reimburse in the event of treatment carried out by alternative practitioners?

In respect of medically necessary out-patient treatment - with the exception of artificial insemination and psychotherapy (in this respect, see item 2.1.7) and out-patient follow-up treatment - we reimburse 100 percent of the expenses for treatment performed by alternative practitioners that can be charged in accordance with the current valid German fee scale for alternative practitioners (GebüH).

The expenses for the remuneration charged by alternative practitioners are reimbursable up to the maximum amounts set out in the German fee scale for alternative practitioners (GebüH). We have no duty to reimburse expenses which exceed the maximum insured amount.

2.1.7 Which expenses do we reimburse for psychotherapy?

In the event of medically necessary out-patient psychotherapy, the following applies:

(1) Reimbursement percentage
We will reimburse 100 percent of the reimbursable expenses.

(2) Reimbursable expenses

a) Medical services
We provide reimbursement for expenses associated with medical services that can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

b) Treatment provided by alternative practitioners
The expenses for treatment provided by alternative practitioners that can be charged pursuant to the current valid German fee scale for alternative practitioners (GebüH) are reimbursable.

The expenses for the remuneration charged by alternative practitioners are reimbursable up to the maximum amounts set out in the German fee scale for alternative practitioners (GebüH). We have no duty to reimburse expenses which exceed the maximum insured amount.

c) Services provided by psychological psychotherapists or psychotherapists for children and young people
We provide reimbursement for expenses associated with services provided by psychological psychotherapists or psychotherapists for children and young people that can be charged in accordance with the valid scale of fees for psychological psychotherapists and psychotherapists for children and young people (GOP).

The expenses for the remuneration paid to psychological psychotherapists and psychotherapists for children and young people are reimbursable beyond the maximum rates under the German scale of fees for psychological psychotherapists and psychotherapists for children and young people (GOP) in conjunction with the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

2.1.8 Which expenses do we reimburse for sociotherapy?

If measures as part of out-patient sociotherapy are performed by a doctor, item 2.1.4 applies. The following also applies for medically necessary out-patient treatment:

(1) Insured benefit
We will reimburse 100 percent of the expenses for the following sociotherapy:
- The treatment is classed as sociotherapy pursuant to the valid guidelines of the Joint Federal Committee pursuant to § 92 SGB V.
- It is provided by the suitable non-medical service providers (e.g. social education specialists, specialist psychiatric nurses) (see also sub-section 2).

(2) Prerequisites for indemnification
The following prerequisites for indemnification must be met for the entitlement pursuant to sub-section 1:

- Serious psychiatric condition
  The →insured person is suffering from a serious psychiatric condition within the meaning of the guidelines of the Joint Federal Committee (e.g. schizophrenia). Due to the illness, he/she is unable to make use of medical services or services prescribed by a doctor of his/her own accord.

- Substitution, prevention or shortening of hospital treatment
  In-patient treatment is necessary for the insured person but cannot be performed. If this is not the case, the sociotherapy must prevent or shorten in-patient treatment.

- Suitable service provider
  The sociotherapy is provided by a service provider that has concluded an agreement pursuant to § 132 d SGB V. We also have a duty to indemnify if this service provider is organized in the legal form of a →legal entity. In such cases, the exclusion set out in item 2.1.2.2 sentence 2 shall not apply.

(3) Maximum limit for our duty to indemnify
The reimbursement of the expenses for sociotherapy is limited to a maximum of 120 hours within 3 calendar years for each →insured person and insured event. The limit set out in sentence 1 shall include trial hours. We have no duty to reimburse expenses which exceed the insured maximum duration.

2.1.9 Which expenses do we reimburse for alternative medical procedures?

If out-patient alternative medical procedures are performed by a doctor, item 2.1.4.1 applies. Expenses for out-patient alternative medical procedures that are performed by an alternative practitioner are reimbursable pursuant to item 2.1.6. The following also applies to medically necessary out-patient treatment:
We will reimburse 100 percent of the costs for alternative medical procedures provided by
- midwives,
- male midwives or
- members of accredited medical support occupations,

if they are prescribed by one of the service providers set out in item 2.1.2.1.

2.1.10 Which expenses do we reimburse for aids (excl. visual aids)?

We offer insurance cover based on the following sub-sections for every aid that is medically necessary for the →insured person in an insured event.

In this respect, the insurance cover includes the expenses for the purchase of the aid in question, the expenses for the repair and maintenance of the aid and for instructing the insured person on the use of the aid.

Expenses for the use of the aid, on the other hand, are not insured.

(1) Prescription as a prerequisite for benefits
The expenses for aids - with the exception of visual aids (in this respect, see item 2.1.11) - pursuant to sub-sections 2 and 3 are reimbursable if the aid has been prescribed by one of the service providers referred to in item 2.1.2.1.

(2) Expenses for aids in cases in which we do not need to be involved

We will reimburse 100 percent of the expenses for the following aids:

- bandages,
- blood pressure measuring devices,
- blood glucose measuring devices,
- orthopedic insoles,
- hernia trusses,
- compression stockings,
- walking aids,
- TENS devices,
- inhalers,
- peak flow meters,
- milk pumps,
- ready-made medical shoes,
- orthopedic shoe modifications,
- wigs in the event of pathological hair loss, and
- hearing aids. These include the hearing aid devices (the device itself) including the corresponding earpieces (earmolds).

(3) Expenses for aids in cases in which we should be involved

a) Reimbursement of 80 percent of the expenses (basic principle)
We reimburse 80 percent of the expenses for all aids (also for life-sustaining aids) that are not listed in sub-section 2.

b) Reimbursement of 100 percent of the expenses
We shall, however, reimburse 100% of the costs if the aid pursuant to sub-section a)
- was purchased or obtained via us,
- cannot be purchased or obtained via us or,
- had to be obtained as part of treatment due to an accident or emergency within 2 days of the accident or emergency.

2.1.11. For which visual aid expenses do we provide indemnity?

(1) Insured benefits
We will reimburse 100 percent of the expenses for
- lenses
- frames and
- contact lenses,

if the visual aid was prescribed by an ophthalmologist or there is a refraction measurement that was taken by an optician.

(2) Maximum sum insured
The reimbursement of expenses for visual aids is limited to a maximum of EUR 300 per →insured person within 24 months.

We determine the maximum reimbursement amount by
- basing our calculation on the date on which the visual aid for which the reimbursement is being claimed was purchased, and
- considering all reimbursements for the purchase of visual aids made to the insured person in the 24-month period prior to this date.

The entitlement to the reimbursement of expenses and the individual reimbursement amount thus depend on the reimbursement amounts paid during the last 24 months in each case.

We have no duty to reimburse expenses which exceed the maximum insured amount.

2.1.12 Which expenses do we reimburse in the event of out-patient follow-up treatment as part of medical rehabilitation?

Out-patient follow-up treatment refers to a scenario in which, in respect of further treatment with a close temporal connection to the previous acute in-patient treatment undergone by the →insured person,
- further out-patient treatment is medically necessary and
- treatment success cannot also be achieved by way of individual medical or physical medical measures (see item 2.1.14.1).

Key indications for follow-up treatment include, by way of example:
- conditions affecting the heart and circulatory system (cardiology),
- degenerative rheumatic conditions and conditions following surgery on, or the consequences of the accident affecting, the locomotor system (orthopedics),
- neurological conditions and conditions following surgery to the brain, spinal cord and the peripheral nerves (neurology) and
- oncological diseases (initial aftercare for cancer).

The following applies in the event of medically necessary out-patient follow-up treatment:

(1) Special prerequisite for benefits
The reimbursement of expenses for medically necessary out-patient follow-up treatment pursuant to sub-sections 2 and 3 is subject to the proviso that this treatment is performed in a rehabilitation center.

Rehabilitation centers, pursuant to sentence 1, are institutions that have concluded a care agreement on the provision of services for out-patient medical rehabilitation with a statutory social security carrier (e.g. statutory health or pension insurer).

We also have a duty to indemnify if the rehabilitation center pursuant to sentence 1 is organized in the legal form of a →legal entity. In such cases, the exclusion set out in item 2.1.2.2 sentence 2 shall not apply.

(2) Expenses for services provided by the rehabilitation center

a) Insured benefits
We will reimburse 100 percent of the expenses for
- medical services charged as part of the services provided by the rehabilitation center,
- the provision of medication and remedies other than drugs, and
- advice and training (e.g. nutritional or social counseling, patient training and health education).

b) Insured maximum amounts

aa) Neurological and geriatric follow-up treatment
If neurological or geriatric follow-up treatment is performed, the reimbursement of expenses for services provided by the rehabilitation center is limited to a maximum of EUR 200 per →insured person and day of treatment. We have no duty to reimburse expenses which exceed the maximum insured amount.

bb) Other follow-up treatment

If follow-up treatment other than the follow-up treatment set out in sub-section aa) is performed, the reimbursement of expenses for services provided by the rehabilitation center is limited to a maximum of EUR 150 per →insured person and day of treatment. We have no duty to reimburse expenses which exceed the maximum insured amount.

(3) Expenses for medical services that are charged separately
We also provide reimbursement for 100 percent of the expenses associated with medical services that are charged separately and can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

2.1.13 Which expenses do we reimburse in the event of specialized out-patient palliative care?

(1) Insured benefit
We reimburse 100 percent of the expenses for medical and nursing services associated with specialized out-patient palliative care within the meaning of § 37 b sub-sections 1 through 3 of the Fifth Book of the German Social Code (SGB V).

(2) Prerequisites for indemnification
The following prerequisites for indemnification must be met for the entitlement pursuant to sub-section 1:

- Incurable condition
  The →insured person is suffering from an incurable, progressive condition that has already progressed so far that his/her life expectancy is limited as a result. As a result, he/she requires particularly intensive care.

- Prescription by a doctor
  The specialized out-patient palliative care was prescribed by a doctor. The limitation to affiliated doctors and hospital-based doctors pursuant to § 37 b sub-section 1 sentence 2 SGB V shall not apply in this respect.

- Suitable service provider
  The specialized out-patient palliative care is provided by a service provider that has concluded an agreement pursuant to § 132 d SGB V. We also have a duty to indemnify if this service provider is organized in the legal form of a →legal entity. In such cases, the exclusion set out in item 2.1.2.2 sentence 2 shall not apply.

2.1.14 Which other expenses do we reimburse in the event of out-patient treatment?

(1) Expenses for physical medical services (remedies other than drugs - *Heilmittel*)
If physical medical services (remedies other than drugs) are provided by a doctor, item 2.1.4.1 applies. Expenses for physical medical services (remedies other than drugs) that are performed by an alternative practitioner are reimbursable pursuant to item 2.1.6. The following also applies to medically necessary out-patient treatment:

We shall reimburse 100 percent of the expenses for physical medical services (remedies other than drugs) which
- are listed in the schedule of remedies other than drugs (*Heilmittelverzeichnis*) for rate IMB100U (see item 7),
- are performed by members of accredited medical support occupations and
- are prescribed by one of the service providers set out in item 2.1.2.1.

(2) Expenses for dressings, drugs and urine and blood test strips
We shall reimburse 100 percent of the reimbursable expenses for the products specified in sub-sections a) and b) if they are prescribed by one of the service providers set out in item 2.1.2.1.

a) Reimbursable expenses (basic principle)
Expenses for dressings and licensed drugs purchased from a pharmacy within the meaning of the German Drug Act (*Arzneimittelgesetz*) are reimbursable insofar as they are medically necessary to identify, cure or ease illnesses. Reimbursement is provided for expenses for urine and blood test strips - for the purposes of self-testing in each case. This shall not include pregnancy tests.

b) Special features applying to certain nutriments and nutrients
Expenses for dietary nutrients and nutriments that are similar to drugs are only reimbursable subject to one of the following conditions:

- Prevention of serious damage to health
  The dietary nutrient is urgently required in order to prevent serious harm to health, e.g. enzyme deficiency diseases, Crohn's disease and cystic fibrosis.

- Enteral nutrition
  The →insured person requires the nutriment that is similar to drugs because a medical indication requires full or supplementary feeding via the gastro-intestinal tract (enteral nutrition). Nutriments that are similar to drugs pursuant to sentence 3 include tube feeding, amino acid mixtures, protein hydrolysates and elementary diets.

- Parenteral nutrition
  The →insured person requires the nutriment that is similar to drugs because a medical indication requires full or supplementary feeding outside of the gastro-intestinal tract (parenteral nutrition). Nutrition is generally provided using special solutions (e.g. water, electrolytes, carbohydrates, vitamins or trace elements) that are administered intravenously.

c) Non-reimbursable expenses
If the case in question does not relate to drugs pursuant to sub-section a) or certain nutrients and nutriments pursuant to sub-section b), there shall be no duty to indemnify for nutriments, nutrients, food supplements or substances that are taken as a preventative measure, or for cosmetic products, even if they have been prescribed by a doctor or an alternative practitioner and contain medicinal substances.

(3) Expenses for home nursing (incl. nursing treatment)

a) Insured benefits
We shall reimburse 100 percent of the expenses for medically necessary home nursing pursuant to the valid guidelines of the Joint Federal Committee pursuant to § 92 SGB V.

Pursuant to the above, home nursing includes
- basic care, nursing treatment and household assistance if this prevents or shortens the medically necessary in-patient treatment required by the →insured person or
- medical services that enable the insured person to undergo out-patient medical treatment and help to ensure the outcome of such treatment, e.g. wound care, injections or catheter changes.

b) Prerequisites for indemnification
The following prerequisites for indemnification must be met for the entitlement pursuant to sub-section a):

- Prescription by a doctor
  The home nursing has been prescribed by a doctor. The limitation to affiliated doctors and hospital-based doctors pursuant to the guidelines of the Joint Federal Committee shall not apply in this respect.

- Suitable service provider
  The nursing care is provided by a service provider that has concluded an agreement pursuant to § 132 a SGB V.

We also have a duty to indemnify if this service provider is organized in the legal form of a →legal entity. In such cases, the exclusion set out in item 2.1.2.2 sentence 2 shall not apply.

- No other care
  The nursing care is provided insofar as the →insured person cannot be cared for and attended to by someone living in his/her own household to the extent necessary.

c) Maximum limit for our duty to indemnify
The expenses are reimbursable per →insured person up to a maximum amount corresponding to the amount that the service provider can charge based on the latter's remuneration agreement pursuant to § 132 a SGB V.

(4) Expenses for home helps

a) Insured benefit
We will reimburse 100 percent of the expenses for home helps pursuant to § 38.1 Fifth Book of the German Social Code (SGB V).

b) Prerequisites for indemnification
The following prerequisites for indemnification must be met for the entitlement pursuant to sub-section a):

aa) Inability to manage a household due to serious illness
The →insured person is unable to manage his/her household due to serious illness or the acute deterioration of an existing illness, in particular after
- a stay in hospital,
- out-patient surgery, or
- out-patient hospital treatment.

This is also subject to the proviso that no other person living in the same household can assume responsibility for managing it.

bb) Inability to manage a household for other reasons

A child who has not yet turned 12 years old, or is disabled and depends on assistance, at the time the home help services commence is living in the →insured person's household. In addition, the insured person is unable to continue managing the household for one of the following reasons:

- hospital treatment,
- follow-up treatment and rehabilitation,
- preventive medical treatment,
- preventative medical treatment for mothers and fathers,
- medical rehabilitation for mothers and fathers,
- pregnancy and childbirth,
- nursing care provided at home.

This is also subject to the proviso that no other person living in the same household can assume responsibility for managing it.

c) Maximum limit for our duty to indemnify
aa) Insured maximum duration
In the event that home help services are provided pursuant to sub-section b) aa), our duty to indemnify is limited, per insured event, to a duration of up to 4 weeks. If a child who has not yet turned 12 years old, or is disabled and depends on assistance, at the time the home help services commence is living in the →insured person's household, then our duty to indemnify is limited, per insured event, to a duration of up to 26 weeks. We have no duty to reimburse expenses which exceed the insured duration pursuant to sentence 1 or sentence 2.

In cases involving home help services pursuant to sub-section b) bb), these limits do not apply.

bb) Maximum sum insured
The expenses are reimbursable per →insured person up to a maximum amount corresponding to the amount that does not exceed the relevant amount pursuant to § 38.1 and § 132 SGB V. We have no duty to reimburse expenses which exceed the maximum insured amount.

2.1.15 Which expenses do we reimburse for ambulance services, patient transportation and journeys undertaken by an emergency doctor?

(1) Expenses for ambulance services and patient transportation

a) Indemnification requirement
The expenses for ambulance services pursuant to sub-section b) and patient transportation pursuant to sub-section c) are only reimbursable if they are incurred for
- out-patient dialysis,
- out-patient radiotherapy to treat cancer,
- out-patient chemotherapy,
- inability to walk which has been certified by a doctor or
- an accident or emergency
  involving the →insured person.

b) Expenses for ambulance services
We will reimburse 100 percent of the expenses for the medically necessary transportation of the →insured person to and from the nearest suitable doctor, physiotherapist or hospital
- in an ambulance,
- in a rescue helicopter or
- by transportation companies if the insured person has to be accompanied by medically trained staff for medical reasons.

Every doctor, psychotherapist or hospital within a distance of 100 kilometers is deemed to be the "nearest" within the meaning of sentence 1. This service provider also has to be suitable. If no such service provider is available within this distance, transportation to and from the nearest suitable doctor, psychotherapist or hospital shall be reimbursable.

c) Expenses for patient transportation

aa) Insured benefits
We will reimburse 100 percent of the expenses for the medically necessary transportation of the →insured person to and from the nearest suitable doctor, physiotherapist or hospital
- in a taxi,
- by public transport or
- in a private vehicle.

Every doctor, psychotherapist or hospital within a distance of 100 kilometers is deemed to be the "nearest" within the meaning of sentence 1. This service provider also has to be suitable. If no such service provider is available within this distance, travel to and from the nearest suitable doctor, psychotherapist or hospital shall be reimbursable.

bb) Maximum limit for our duty to indemnify
The reimbursement of expenses for patient transportation due to inability to walk which has been certified by a doctor is limited, for the return trip, to a maximum total of EUR 50 per →insured person and trip. If these trips are made using a private vehicle, we shall base our calculation of the maximum reimbursement amount on an amount of EUR 0.30 per kilometer covered. We have no duty to reimburse expenses which exceed the maximum insured amount.

(2) Expenses for trips made by the emergency doctor
We shall reimburse 100 percent of the expenses for trips made by an emergency doctor to treat the →insured person following an accident or emergency.

2.1.16 Which expenses do we reimburse in the event of out-patient treatment due to pregnancy and in the event of out-patient childbirth?

In line with the rate benefit commitment in respect of medically necessary out-patient treatment (items 2.1.4.1, 2.1.6, 2.1.9 through 2.1.11 and 2.1.14), we shall reimburse 100 percent of the expenses for

- medically necessary out-patient examinations and treatment due to pregnancy and
- out-patient childbirth or home birth

including the expenses for antenatal classes and postnatal exercises, as well as for the services connected with the aforementioned services as provided by (male) midwives which can be charged based on the valid official fee scale for midwives.

The expenses for remuneration paid to midwives are reimbursable beyond the maximum rates set out in the official fee scale for midwives. If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

2.2 In-patient treatment in Germany

Content of this section:

We provide insurance cover based on the following provisions in the event of medically necessary in-patient treatment.

2.2.1 Which date is decisive for the occurrence of insured expenses?

The date that is decisive for the occurrence of insured expenses is the date on which the →insured person received treatment or a service.

2.2.2 Which service providers can the insured person choose from?

The →insured person can choose freely from the following service providers.

(1) Selection of doctors
The→insured person is free to choose a licensed doctor irrespective of whether they are community-based or working in medical care centers.

(2) Selection of legal entities
The expenses for services provided by the following →legal entities are also insured:

- institutions that provide laboratory or x-ray services at the instigation of a doctor, and
- medical care centers.

We have no duty to reimburse any remaining expenses incurred because the →insured person made use of the services of other legal entities.

(3) Selection of hospitals
If in-patient treatment is medically necessary, the →insured person can choose freely from among all state and private hospitals which

- have their own permanent medical management,
- have sufficient diagnostic and therapeutic facilities of their own and
- keep medical records.

2.2.3 For which examination and treatment methods do we provide indemnity?

We provide benefits, within the scope of the rate, for examination or treatment methods and drugs that are largely recognized by conventional medicine, and for

- cupping,
- acupuncture for pain relief,
- chiropractic treatment,
- autohaemotherapy and
- therapeutic local anesthesia.

We also provide benefits for methods and drugs that have proven to be just as successful in practice or methods and drugs that are used because there are no conventional medical methods or drugs available. We are, however, entitled to reduce our benefits to the amount that would have been incurred had conventional medical methods or drugs been used.

2.2.4 Which expenses do we reimburse if the hospital is subject to the German Hospital Fees Act (*Krankenhausentgeltgesetz*) or the Federal Ordinance on Hospital and Nursing Charges (*Bundespflegesatzverordnung*)?

In the event of medically necessary in-patient treatment, we reimburse the following expenses (also for pre and post-discharge treatment in hospital pursuant to § 115a of the Fifth Book of the German Social Code - SGB V):

(1) Expenses for private medical services
We provide reimbursement for 100 percent of the expenses associated with private medical services that can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for private medical remuneration are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(2) Expenses for optional services - accommodation in a ward with one or two beds
We will reimburse 100 percent of the expenses for

- accommodation in a ward with one or two beds, which can be charged separately,
- a telephone line,
- the rent for radio and television and
- the special meals offered by the hospital.

(3) Expenses for services performed by a doctor with hospital affiliation
We provide reimbursement for 100 percent of the expenses associated with services performed by a doctor with hospital affiliation that can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for remuneration paid to doctors with hospital affiliation are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(4) Expenses for services provided by midwives with hospital affiliation

We provide reimbursement for 100 percent of the expenses associated with services provided by midwives with hospital affiliation that can be charged in accordance with the valid official fee scale for midwives.

The expenses for remuneration paid to midwives with hospital affiliation are reimbursable beyond the maximum rates set out in the official fee scale for midwives. If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(5) Expenses for general hospital services

We shall reimburse 100 percent of the expenses for general hospital services that can be charged under the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV).

This also includes expenses for general hospital services for the medically necessary admittance of an accompanying individual for the →insured person. If the insured person is younger than 10 years old at the time of in-patient treatment, the admittance of the accompanying individual is deemed medically necessary.

2.2.5 Subject to which requirements do we pay a daily allowance for stays in hospital instead?

Instead of the reimbursement of expenses, we can pay a daily allowance for stays in hospital of up to EUR 110 for each day of medically necessary entirely in-patient treatment in a hospital that is subject to the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), as follows:

(1) No accommodation which can be charged separately

We shall pay EUR 70 if no use is made of accommodation in a ward with one or two beds which can be charged separately.

If the →insured person has not yet reached the age of 16, however, we shall only pay EUR 35.

(2) No private medical services or services performed by a doctor with hospital affiliation

We shall pay EUR 40 if

- no private medical services that can be charged separately are used and
- no reimbursement of expenses is claimed for services performed by a doctor with hospital affiliation that can be charged separately.

If the →insured person has not yet reached the age of 16, however, we shall only pay EUR 20.

(3) Exceptions

There shall be no entitlement to alternative daily allowance for stays in hospital pursuant to sub-section 1

- for the day on which the →insured person is discharged from hospital or
- for the period in which the insured person undergoes treatment in intensive care or neonatal care unit.

Furthermore, there shall be no entitlement to an alternative daily allowance for stays in hospital pursuant to sub-sections 1 and 2

- for days on which the insured person is completely absent from the hospital or,
- if the in-patient treatment covers a period of less than 24 hours a day (partially in-patient treatment).

2.2.6 Which expenses do we reimburse if the hospital is not subject to the German Hospital Fees Act (*Krankenhausentgeltgesetz*) or the Federal Ordinance on Hospital and Nursing Charges (*Bundespflegesatzverordnung*)?

In the event of medically necessary in-patient treatment - with the exception of in-patient follow-up treatment (in this respect, see item 2.2.7) - we shall reimburse the following expenses:

(1) Expenses for medical services that are charged separately

We provide reimbursement for 100 percent of the expenses associated with medical services that are charged separately and can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for this medical remuneration that is charged separately are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(2) Expenses for services provided by midwives with hospital affiliation

We provide reimbursement for 100 percent of the expenses associated with services provided by midwives with hospital affiliation that can be charged in accordance with the valid official fee scale for midwives.

The expenses for remuneration paid to midwives with hospital affiliation are reimbursable beyond the maximum rates set out in the official fee scale for midwives. If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(3) Expenses for hospital services

a) Insured benefits

We will reimburse 100 percent of the expenses for

- accommodation in a ward with one, two or more beds,
- meals,
- hospital care,
- the provision of medication and remedies other than drugs,
- ancillary costs for which there are medical grounds, including the costs of the medically necessary admittance of an accompanying individual for the →insured person and
- the parts of services performed by doctors employed at the hospital charged as a component of the hospital services.

If the insured person is younger than 10 years old at the time of in-patient treatment, the admittance of the accompanying individual is deemed medically necessary.

b) Maximum sum insured

Our benefits are subject to the following limits if the →insured person does not require in-patient treatment due to an emergency:

The expenses pursuant to sub-section a) are reimbursable up to a maximum of the amount which does not exceed

- the relevant fee for general hospital services,
- which can be charged under the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), by more than 100 percent.

The calculation is based on the fee that the maximum care hospital closest to the habitual place of abode of the insured person would have charged for its treatment.

The term "maximum care hospital" is a term used in statutory hospital planning and refers to a hospital that offers an extensive, diverse range of services and has corresponding medical technical facilities (e.g. university hospitals).

We have no duty to reimburse expenses which exceed the maximum insured amount.

2.2.7 Which expenses do we reimburse in the event of in-patient follow-up treatment as part of medical rehabilitation?

In-patient follow-up treatment refers to a scenario in which, in respect of further treatment with a close temporal connection to the previous acute in-patient treatment undergone by the →insured person,

- treatment success cannot also be achieved by way of out-patient measures and
- partly or entirely in-patient further treatment is medically necessary.

Key indications for follow-up treatment include, by way of example:
- conditions affecting the heart and circulatory system (cardiology),
- degenerative rheumatic conditions and conditions following surgery on, or the consequences of the accident affecting, the locomotor system (orthopedics),
- neurological conditions and conditions following surgery to the brain, spinal cord and the peripheral nerves (neurology) and
- oncological diseases (initial aftercare for cancer).

In the event of medically necessary in-patient follow-up treatment in a hospital that is subject to the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), item 2.2.4 applies.

In addition, in the event of medically necessary in-patient follow-up treatment in a hospital that is not subject to the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), the following applies:

(1) Expenses for medical services that are charged separately
We provide reimbursement for 100 percent of the expenses associated with medical services that are charged separately and can be charged in accordance with the valid German scale of medical fees (GOÄ).

The expenses for this medical remuneration that is charged separately are reimbursable beyond the maximum rates set out in the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(2) Expenses for hospital services

We will reimburse 100 percent of the expenses for
- accommodation in a ward with one, two or more beds,
- meals,
- hospital care,
- the provision of medication and remedies other than drugs,
- ancillary costs for which there are medical grounds, including the costs of the medically necessary admittance of an accompanying individual for the →insured person and
- the parts of services performed by doctors employed at the hospital charged as a component of the hospital services.

If the insured person is younger than 10 years old at the time of in-patient treatment, the admittance of the accompanying individual is deemed medically necessary.

2.2.8 Which expenses do we reimburse for hospice care?

(1) Insured benefit
We will reimburse 100 percent of the expenses for the in-patient care of the →insured person in hospices.

(2) Prerequisites for indemnification
The following prerequisites for indemnification must be met for the entitlement pursuant to sub-section 1:

- Incurable condition
  The →insured person is suffering from an incurable, progressive condition that has already progressed so far that his/her life expectancy is limited as a result.

- Care provided in a hospice
  The insured person is cared for in a hospice. A hospice is an independent institution with the distinctive mandate to provide palliative medical care to patients with incurable diseases in the final phase of their lives. We also have a duty to indemnify if the hospice is organized in the legal form of a →legal entity. In such cases, the exclusion set out in item 2.2.2.2 sentence 2 shall not apply.

- No other care
  The in-patient treatment of the insured person in hospital is not medically necessary and out-patient care cannot be provided in the household, or within the family, of the insured person.

(3) Primary duty to indemnify of compulsory long-term care insurance

If the →insured person is entitled to benefits under private compulsory long-term care insurance, this entitlement shall take precedence over our duty to indemnify. In such cases, we are only obliged to provide indemnity for those expenses that remain following the preliminary coverage provided by the private compulsory long-term care insurance.

2.2.9 Which expenses do we reimburse for ambulance services?

We will reimburse 100 percent of the expenses for the medically necessary transportation of the →insured person to and from the nearest suitable hospital
- in an ambulance,
- in a rescue helicopter or
- by transportation companies if the insured person has to be accompanied by medically trained staff for medical reasons.

Every hospital within a distance of 100 kilometers is deemed to be the "nearest" within the meaning of sentence 1. The hospital also has to be suitable. If no suitable hospital is available within this distance, transportation to and from the nearest suitable hospital shall be reimbursable.

2.2.10 Which expenses do we reimburse in the event of in-patient treatment due to pregnancy and in the event of in-patient childbirth?

In line with the rate benefit commitment in respect of medically necessary in-patient treatment (items 2.2.4 and 2.2.6), we shall reimburse 100 percent of the expenses for
- medically necessary in-patient examinations and treatment due to pregnancy and
- in-patient childbirth in a hospital or birthing center.

Furthermore, item 2.2.5 shall apply accordingly to the payment of a daily allowance for stays in hospital as an alternative.

2.2.11 Which benefits are insured for healthy newborns immediately after delivery?

If the healthy newborn receives care immediately after in-patient delivery in hospital, the following applies:

- We will reimburse 100 percent of the expenses for accommodation and meals for the newborn.
- The reimbursement of expenses shall be based on this rate which has been taken out with us for the newborn's parent.

This is subject to the proviso that that the healthy newborn has been insured with us with retroactive effect from the time of birth.

Our duty to indemnify in respect of the medically necessary treatment of the newborn due to illness or the consequences of an accident shall, however, be based exclusively on the medical expenses rates taken out for the newborn.

2.3 Out-patient and in-patient dental treatment in Germany

Content of this part:

We provide insurance cover based on the following provisions in the event of medically necessary dental treatment.

2.3.1 To what extent does our benefit commitment apply to out-patient and in-patient dental treatment in Germany?

In the case of expenses for out-patient and in-patient dental treatment in Germany, then, irrespective of whether the treatment is performed by a

- dentist,
- doctor or
- maxillofacial surgeon,

our benefit commitment pursuant to item 2.3 shall apply exclusively.

2.3.2 Which date is decisive for the occurrence of insured expenses?

The date that is decisive for the occurrence of insured expenses is the date on which the →insured person received treatment or a service.

2.3.3 Which service providers can the insured person choose from?

The →insured person can choose freely from the following service providers.

(1) Selection of doctors or dentists
The→insured person is free to choose a licensed doctor or dentist, irrespective of whether they are community-based or working in hospital outpatient departments or medical care centers.

(2) Selection of legal entities
The expenses for services provided by the following →legal entities are also insured:

- institutions that provide laboratory or x-ray services at the instigation of a doctor or dentist, and
- medical care centers.

We have no duty to reimburse any remaining expenses incurred because the →insured person made use of the services of other legal entities.

(3) Selection of hospitals
If in-patient treatment is medically necessary, the →insured person can choose freely from among all state and private hospitals which

- have their own permanent medical management,
- have sufficient diagnostic and therapeutic facilities of their own and
- keep medical records.

2.3.4 For which examination and treatment methods do we provide indemnity?

We provide benefits, within the scope of the rate, for examination or treatment methods and drugs that are largely recognized by conventional medicine.

We also provide benefits for methods and drugs that have proven to be just as successful in practice or methods and drugs that are used because there are no conventional medical methods or drugs available. We are, however, entitled to reduce our benefits to the amount that would have been incurred had conventional medical methods or drugs been used.

2.3.5 Which expenses do we reimburse for dental treatment, preventative dental treatment, inlays and orthodontic treatment?

We shall reimburse the insured expenses up to the maximum amount provided for pursuant to item 2.3.8 as follows:
In the event of medically necessary dental treatment, we will reimburse the following expenses that can be charged in accordance with the valid German scale of dental fees (GOZ) and the German scale of medical fees (GOÄ).

The expenses for remuneration paid to dentists and doctors is reimbursable beyond the maximum rates set out in the German scale of dental fees (GOZ) and the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(1) Expenses for dental treatment
We will reimburse 100 percent of the expenses for

- general dental services,
- services for conservation purposes (including synthetic, composite and enamel dentin adhesive fillings),
- dental surgical services,
- services in the event of conditions affecting the oral mucosa and parodontium,
- professional dental cleaning,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

The term "professional dental cleaning" refers to

- the removal of deposits on tooth and root surfaces,
- interdental cleaning,
- the removal of biofilm,
- surface polishing and
- fluoride treatment.

(2) Expenses for preventative dental treatment
We will reimburse 100 percent of the expenses for

- dental services pursuant to the section of the fee schedule of the valid German scale of dental fees (GOZ) that deals with preventative services,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

(3) Expense for inlays
We will reimburse 100 percent of the expenses for
- inlays,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

(4) Expenses for orthodontic services
We will reimburse 100 percent of the expenses for
- orthodontic services for →insured persons who have not yet turned 18 at the start of treatment,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

The age limit of 18 does not apply in the following cases:

- Accident
  In the case of dental treatment that is required as a result of an accident. A situation in which eating (e.g. biting on a cherry pit) causes damage to teeth is not deemed to constitute an accident.

- Serious illness
  For dental treatment that is required due to congenital malformations of the face or jaw, skeletal dysgnathia or jaw malposition due to injury and is performed as part of combined maxillo-facial surgical/orthodontic treatment.

In these cases, we shall reimburse the expenses pursuant to sentence 1 even if the insured person involved in the accident, or affected by the serious illness, is already over the age of 18.

2.3.6 Which expenses do we reimburse for dental prosthesis and gnathology?

We shall reimburse the insured expenses up to the maximum amount provided for pursuant to item 2.3.8 as follows:
In the event of medically necessary dental treatment, we will reimburse the following expenses that can be charged in accordance with the valid German scale of dental fees (GOZ) and the German scale of medical fees (GOÄ).

The expenses for remuneration paid to dentists and doctors is reimbursable beyond the maximum rates set out in the German scale of dental fees (GOZ) and the German scale of medical fees (GOÄ). If, however, the expenses are disproportionately high, we can reduce our indemnity to an appropriate amount pursuant to item 4.3.

(1) Expenses for dental prosthesis
We will reimburse 80 percent of the expenses for
- prosthetic work, including, in particular, crowns, partial crowns and veneers, prosthesis, bridges and pivot teeth,
- implantology services, including the surgical services performed within this context, e.g. development of the jaw bone,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

(2) Expenses for functional analytical and functional therapeutic services (gnathology)
We will reimburse 80 percent of the expenses for
- functional analytical and functional therapeutic services (gnathology), including bite remedies and splints,
- prior and subsequent treatment in relation to the abovementioned services and
- drugs prescribed in connection with the above services if they are prescribed by one of the service providers set out in item 2.3.3.1 and were purchased from a pharmacy.

2.3.7 Which expenses do we reimburse for technical dental services?

We reimburse the expenses for technical dental services
- up to the maximum amount provided for in item 2.3.8
- within the framework of the rate benefit commitment pursuant to items 2.3.5 and 2.3.6

as with the expenses for the services in connection with which they have been provided.

2.3.8 What maximum amount applies to all insured benefits?

(1) Maximum reimbursement amount
With regard to expenses pursuant to items 2.3.5 through 2.3.7, a maximum reimbursement amount of EUR 5,000 applies per →insured person and insurance year.

(2) No maximum reimbursement amount for treatment due to accidents
The maximum reimbursement amount pursuant to sub-section 1 shall not apply to dental treatment that is required as a result of an accident. The following shall not constitute accidents:
- a situation in which eating (e.g. biting on a cherry pit) causes damage to teeth or
- a situation in which damage is caused while cleaning a dental prosthesis that can be removed.

2.3.9 In which cases do we recommend that a treatment and cost plan be submitted?

We recommend that a treatment and cost plan be submitted, after a diagnosis, for the following services:
- inlays pursuant to item 2.3.5.3,
- orthodontic services pursuant to item 2.3.5.4
- dental prosthesis pursuant to item 2.3.6.1,
- functional analytical and therapeutic services (gnathology) pursuant to item 2.3.6.2, and
- technical dental services pursuant to item 2.3.7.

We will inform you without delay of the scope of the reimbursable expenses. The expenses for the preparation of the treatment and cost plan shall be reimbursed by us in line with the rate conditions.

2.3.10 Which expenses do we reimburse for in-patient dental treatment in a hospital that is subject to the German Hospital Fees Act (*Krankenhausentgeltgesetz*) or the Federal Ordinance on Hospital and Nursing Charges (*Bundespflegesatzverordnung*)?

In the event of medically necessary in-patient dental treatment, we shall reimburse the following expenses:

(1) Expenses for private medical services
We shall reimburse the expenses for private medical services in line with the rate benefit commitment for medically necessary out-patient dental treatment (items 2.3.5 through 2.3.8).

(2) Expenses for optional services - accommodation in a ward with one or two beds
We will reimburse 100 percent of the expenses for
- accommodation in a ward with one or two beds, which can be charged separately,
- a telephone line,
- the rent for radio and television and
- the special meals offered by the hospital.

(3) Expenses for services performed by a doctor with hospital affiliation

We shall reimburse the expenses for services performed by a doctor with hospital affiliation in line with the rate benefit commitment for medically necessary out-patient dental treatment (items 2.3.5 through 2.3.8).

(4) Expenses for general hospital services

We shall reimburse 100 percent of the expenses for general hospital services that can be charged under the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV).

This also includes expenses for general hospital services for the medically necessary admittance of an accompanying individual for the →insured person. If the insured person is younger than 10 years old at the time of in-patient treatment, the admittance of the accompanying individual is deemed medically necessary.

2.3.11 Subject to which requirements do we pay a daily allowance for stays in hospital instead?

Instead of the reimbursement of expenses, we can pay a daily allowance for stays in hospital of up to EUR 110 for each day of medically necessary entirely in-patient dental treatment in a hospital that is subject to the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), as follows:

(1) No accommodation which can be charged separately

We shall pay EUR 70 if no use is made of accommodation in a ward with one or two beds which can be charged separately.

If the →insured person has not yet reached the age of 16, however, we shall only pay EUR 35.

(2) No private medical services or services performed by a doctor with hospital affiliation

We shall pay EUR 40 if

- no private medical services that can be charged separately are used and
- no reimbursement of expenses is claimed for services performed by a doctor with hospital affiliation that can be charged separately.

If the →insured person has not yet reached the age of 16, however, we shall only pay EUR 20.

(3) Exceptions

There shall be no entitlement to an alternative daily allowance for stays in hospital pursuant to sub-section 1 for the day on which the →insured person is discharged from hospital.

Furthermore, there shall be no entitlement to an alternative daily allowance for stays in hospital pursuant to sub-sections 1 and 2

- for days on which the insured person is completely absent from the hospital or,
- if the in-patient treatment covers a period of less than 24 hours a day (partially in-patient treatment).

2.3.12 Which expenses do we reimburse for in-patient dental treatment in a hospital that is not subject to the German Hospital Fees Act (*Krankenhausentgeltgesetz*) or the Federal Ordinance on Hospital and Nursing Charges (*Bundespflegesatzverordnung*)?

In the event of medically necessary in-patient dental treatment, we shall reimburse the following expenses:

(1) Expenses for medical services that are charged separately

We shall reimburse the expenses for medical services in line with the rate benefit commitment for medically necessary out-patient dental treatment (items 2.3.5 through 2.3.8).

(2) Expenses for hospital services

a) Insured benefits

We will reimburse 100 percent of the expenses for

- accommodation in a ward with one, two or more beds,
- meals,
- hospital care,
- the provision of medication and remedies other than drugs,
- ancillary costs for which there are medical grounds, including the costs of the medically necessary admittance of an accompanying individual for the →insured person and
- the parts of services performed by doctors employed at the hospital charged as a component of the hospital services.

If the insured person is younger than 10 years old at the time of in-patient treatment, the admittance of the accompanying individual is deemed medically necessary.

b) Maximum sum insured

Our benefits are subject to the following limits if the →insured person does not require in-patient treatment due to an emergency:

The expenses pursuant to sub-section a) are reimbursable up to a maximum of the amount which does not exceed

- the relevant fee for general hospital services,
- which can be charged under the German Hospital Fees Act (KHEntgG) or the Federal Ordinance on Hospital and Nursing Charges (BPflV), by more than 100 percent.

The calculation is based on the fee that the maximum care hospital closest to the habitual place of abode of the insured person would have charged for its treatment.

The term "maximum care hospital" is a term used in statutory hospital planning and refers to a hospital that offers an extensive, diverse range of services and has corresponding medical technical facilities (e.g. university hospitals).

We have no duty to reimburse expenses which exceed the maximum insured amount.

2.4. Treatment abroad

Content of this part:

We provide insurance cover based on the following provisions in the event of medically necessary in-patient treatment.

2.4.1 To what extent does our benefit commitment apply to treatment abroad?

We shall also provide the benefits within the scope of the rate for illnesses (including chronic illnesses) or consequences of an accident that were pre-existing at the start of the stay abroad. This also applies if the insured person's state of health deteriorates considerably while he/she is abroad.

2.4.2 What provisions apply in the event of a temporary stay abroad outside of Europe?

(1) Insurance cover in Europe

Insurance cover is provided in all European countries.

(2) Insurance cover outside of Europe

Insurance cover is provided during the first 6 months of a temporary stay in a country outside of Europe. If there is a medical need for the →insured person to undergo medical treatment beyond the first 6 months, and return travel would pose a risk to his/her health, then insurance cover is provided as long as the return journey would pose a risk to his/her health.

2.4.3 Which expenses do we reimburse in the event of treatment abroad?

If insurance cover is provided for stays abroad pursuant to item 2.4.2, we shall reimburse the expenses that are also insured for treatment within Germany pursuant to items 2.1 through 2.3.

We shall reimburse the reimbursable expenses based on the percentages agreed pursuant to items 2.1 through 2.3 for treatment in Germany insofar as the expenses for the treatment abroad are in line with the standard local costs.

In this respect, our duty to indemnify pursuant to items 2.1 through 2.3 is not limited to
- the fee rates based on valid fee scales or fee schedules, and
- the maximum amounts pursuant to items 2.2.6.3 b) and 2.3.12.2 b).

2.4.4 Which special information obligation do you have to observe?

You must inform us without undue delay after the →insured person starts in-patient treatment abroad.

2.4.5 Which expenses do we reimburse for repatriation?

We will reimburse 100 percent of all expenses for the repatriation of the →insured person (including in an ambulance aircraft)
- to his/her permanent habitual place of abode in Germany,
- to the insured person's place of residence in his/her home country before he/she traveled to Germany or
- to the nearest suitable hospital to that place.

including the expenses associated with another person to accompany the insured person during repatriation.

The reimbursement of expenses is subject to the proviso that
- the repatriation is medically necessary or
- following consultation between the affiliated doctor in our emergency call center and the treating doctor, the treatment of the insured person in hospital abroad is likely to last for more than 14 days.

The cheapest means of transport must be chosen for the repatriation, provided that there are no medical reasons arguing against this. We shall provide the reimbursement without deducting the costs that would have been incurred in connection with the originally planned return journey.

2.5 Benefits for organ transplants

In the case of organ transplants, we provide insurance cover based on the following provisions.

2.5.1 Which benefits do we provide for organ transplants?

In the event of a medically necessary organ transplant, we shall provide the insurance benefits based on the following sub-sections. The term "organ transplant" pursuant to sentence 1 is the surgical transfer of organs or tissue from another living person (organ donor) to the →insured person.

(1) Expenses for treatment

a) Treatment of the insured person
For services provided in connection with an organ transplant involving the →insured person, items 2.1, 2.2 and 2.4 apply.

b) Treatment of the organ donor

aa) Rate benefit commitment (basic principle)
The rate benefit commitment in respect of the medically necessary treatment of the insured person (items 2.1 and 2.2, as well as item 2.4) applies accordingly to:
- services provided with a direct link to the removal of the organ or tissue to be transferred,
- including the associated prior and subsequent treatment of the organ donor (also in the event of medical complications that arise with a direct link to the removal of the organ or tissue).

bb) Special provision if the organ donor has higher or more extensive insurance cover
If the organ donor, based on his/her private or statutory health insurance,
- is entitled to insurance benefits for medically necessary treatment
- that are higher or more extensive than the insurance benefits set out in items 2.1, 2.2 and 2.4,

the following shall apply:

In respect of the benefits pursuant to sub-section aa), the scope of cover based on the health insurance that is in place for the organ donor shall apply instead of the rate benefit commitment pursuant to items 2.1, 2.2 and 2.4.

(2) Expenses for the provision of the donated organ or tissue
We shall also reimburse 100 percent of the expenses for the provision of the donated organ or tissue that can be charged within the framework of the German Transplant Act (TPG).

This is subject to the proviso that the services have not been charged as part of the fee for general hospital services.

(3) Indemnity due to the inability to work of the organ donor

a) Loss of earnings on the part of the organ donor (basic principle)
If the organ donor is unable to work due to the removal of the organ or tissue and incurs a loss of earnings as a result, we shall reimburse him/her for the actual loss of earnings as substantiated vis-à-vis us. The term "loss of earnings" refers to the net income earned by the organ donor from his/her professional activity.

We shall also pay, for the period of the loss of earnings, indemnity in the amount of the substantiated contributions to be paid by the organ donor for
- statutory health insurance and social compulsory long-term care insurance or →substitutive health insurance,
- statutory or private pension insurance or a professional pension fund and
- statutory unemployment insurance,

insofar as the contributions are not already covered via the net income from professional activity.

b) Continued salary payment by the employer
If, however, the organ donor is entitled to continued salary payment in the event of illness from his/her employer during the period of inability to work, we shall not pay any indemnity pursuant to sub-section a).

Instead, we shall reimburse, for the period of the inability to work, the organ donor's employer for the actual continued salary payments and for the pro rata contributions assumed by the employer for the following protection for the organ donor in the actual substantiated amount:

- statutory health insurance and social compulsory long-term care insurance or →substitutive health insurance,
- statutory pension insurance or the professional pension fund and
- company old-age provision and provision for surviving dependents.

There shall only be an entitlement pursuant to sentence 2 if the employer applies to us for it.

(4) Primary duty to indemnify of other benefit providers
If the organ donor is entitled to benefits for the organ or tissue donation from other benefit providers, this entitlement takes precedence over our duty to indemnify in this respect. In such cases, we are only obliged to provide indemnity for those expenses and compensation amounts that remain following the preliminary coverage provided by the other benefit provider.

2.6 Transfer and funeral

If the →insured person dies, we shall reimburse 100 percent of the direct expenses associated with the transfer of the deceased to that person's permanent habitual place of abode in Germany or place of residence in his/her home country before the start of the trip to Germany.

If no reimbursement of expenses is claimed for a transfer pursuant to sentence 1, we shall reimburse 100 percent of the expenses directly associated with the funeral. The reimbursement of expenses for the funeral is limited to a maximum of the expenses that would have been incurred for transfer pursuant to sentence 1.

3. Due dates and processing of our benefits, your special right to information and the right to disclosure

Content of this part:

3.1 When do our benefits fall due?

(1) Due dates of our benefits
We provide our benefits after we have completed the investigations involved in determining the insured event and the scope of our duty to indemnify. This requires us to be provided with the required evidence in this regard (see item 3.2). This evidence becomes our property.

(2) Your claim to interim payments for monetary benefits
If we have not completed our investigations within one month of the notification of the insured event, you can request interim payments corresponding to the minimum amount we are likely to have to pay. If, however, you are to blame for the fact that our investigations are delayed, the one-month deadline shall be postponed accordingly.

3.2 Which evidence is required?

(1) Evidence
The term "evidence", within the meaning of item 3.1.1, includes original invoices, in particular. The invoices - including unpaid invoices - must be clearly marked as originals, meet the statutory requirements and contain, in particular, the following information:

- Name of the person treated,
- Description of the illness,
- Type of treatment and
- The treatment/purchase dates.

(2) Evidence for alternative daily allowance for stays in hospital

If you assert a claim to a daily allowance for stays in hospital as an alternative, confirmation of in-patient treatment must be submitted as evidence. The confirmation must include, in particular, the following information:

- Name of the person treated,
- Description of the illness,
- The date of admission and discharge and
- Dates on which treatment was suspended, where appropriate.

(3) Evidence for other claims for indemnity

If the insured person has another claim for indemnity for the same insured event and this claim is asserted first, the submission of invoice copies showing the reimbursement information shall be sufficient as a form of evidence.

3.3 To whom can we provide the benefits?

We provide benefits to you or to the person who furnishes the required evidence. If we have justified doubts as to the identity of the person furnishing the evidence, we shall only provide benefits to you.

3.4 How do we convert costs incurred in a foreign currency?

Costs incurred in a foreign currency are converted into euros at the rate that applies on the date on which we receive the documentary evidence. The daily rate is the official euro exchange rate of the European Central Bank.

In the case of currencies for which no reference rates are set, the following applies:

- We convert the costs based on the current rate quoted in the "Exchange rate statistics" (Bundesbank publication).
- If the foreign currency used to settle the invoices was purchased at a less favorable rate and evidence of this is submitted in the form of a bank receipt, the costs shall be converted into euros based on this rate.

3.5 What provisions apply to bank transfer and translation costs?

The bank transfer of the insurance benefits is free of charge for you if you provide us with a domestic bank account. The costs associated with bank transfers into foreign accounts and the translation of invoices and confirmations may be deducted from the benefits.

3.6 What right to prior information do you have if treatment is associated with higher costs?

If you are due to undergo treatment giving rise to costs which are likely to exceed EUR 2,000, then the following applies:

(1) Your right to written information
You shall receive information from us on the scope of cover for the planned treatment.

You can request the information before the start of treatment. We shall provide you with the information in written or electronic form (e.g. by letter, fax, e-mail), providing grounds. If we have received a cost estimate or other documents regarding the treatment, we will also provide details of these in the information.

As a general rule, we will provide you with information after 4 weeks at the most. If, however, the treatment has to be performed urgently, we will provide you with the information without delay - but after 2 weeks at the most.

These periods will start as soon as we receive your request in each case.

(2) If we miss a deadline
We will do everything in our power to provide you with the information by the deadlines set out in sub-section 1. If we do not manage to do so and fail to meet the 2-week or 4-week deadline, it is presumed that the planned treatment is medically necessary. This shall apply until we prove that the treatment is not medically necessary.

3.7 What is the right to disclosure in respect of expert opinions and statements and who has to pay for these documents?

(1) Right to information and inspection (disclosure)
We disclose expert opinions and statements (documents). Disclosure is effected by way of information provided to, and inspection by, the eligible individual (in this respect, see sub-section 2).

Disclosure requires us to have obtained the document because we are assessing our duty to indemnify regarding the necessity of medical treatment.

(2) Eligible individuals
Disclosure can only be requested by the individual to whom the document relates (affected individual). This individual's statutory representative can also request disclosure in his/her place.

Subject to this proviso, we disclose the document to the following individuals:
- the →insured person or his/her statutory representative. This does not apply if there are material treatment-related or other material reasons running contrary to such disclosure.
- a doctor or lawyer whose name has been provided to us.

(3) Assumption of costs by us
If we obtain the document ourselves, we shall bear the costs. If you have obtained the expert opinion or the statement because we asked you to do so, we shall reimburse you for the expenses incurred in this regard.

4. Exclusions and restrictions

Content of this part:

4.1 In which cases is our duty to pay out benefits excluded?

We do not pay out benefits
a) for illnesses, consequences of illnesses or consequences of accidents, as well as fatalities, caused by events of war.

We do, however, pay out benefits in the event that the →insured person is caught off guard by the occurrence of the war event outside of Germany and is prevented from leaving the affected area for reasons for which he/she is not responsible.

The war event is deemed to have caught the individual off guard if, for example, the German Foreign Office has not issued any travel warning due to (imminent) war for the destination and period of travel. If this sort of warning is only published during the trip, the war event is deemed to have caught the individual off guard up until then.

Terrorist attacks do not constitute war events pursuant to sentence 1.

b) for illnesses, consequences of illnesses or consequences of accidents, as well as fatalities, recognized as injuries sustained while on military service.

c) for illnesses and accidents caused by the →insured persons themselves with willful intent, including their consequences.

d) if the treatment is carried out by doctors, dentists, alternative practitioners, service providers of specialized out-patient palliative care, in hospitals or hospices whose invoices we have excluded from the reimbursement of expenses for good reason. This is subject to the proviso that we have informed you about the exclusion prior to the occurrence of the insured event. If an →insured event is pending at the time of the notification, we are not obliged to reimburse expenses that were incurred 3 months after the notification.

e) for treatment performed by spouses, registered partners, parents or children. Substantiated non-personnel costs and expenses shall be reimbursed in accordance with the rate.

f) in the event of a stay due to a need for long-term care or compulsory detention.

g) for stays in health resorts or sanatoriums.

h) for rehabilitation measures provided by the statutory rehabilitation providers.

i) for treatment carried out by doctors and dentists whose authorization to practice their profession has been withdrawn in Germany or another member state of the European Economic Area.

4.2 What limited duty to indemnify applies in the event of withdrawal measures?

(1) Commitment requirement
As a general rule, we do not provide indemnity for withdrawal measures, including withdrawal programs. We shall, however, provide indemnity for withdrawal measures if we have issued a →written commitment for our benefits prior to the start of treatment.

We shall issue a commitment if the following requirements are met and we are obliged to provide indemnity in line with the other contractual provisions:

- Withdrawal measure
  The measures involves in-patient or out-patient treatment aimed at curing the →insured person from addiction to drugs, alcohol or other addictive substances (withdrawal measure). The withdrawal treatment is not, however, being performed exclusively as a result of the insured person's addiction to nicotine.

- Sufficient chances of success
  The withdrawal measures have sufficient chances of success - where appropriate based on an expert opinion drawn up by a doctor commissioned by us.

- No more than a total of 3 withdrawal measures during the policy term.
  We have provided the reimbursement of expenses for no more than 2 withdrawal measures for the insured person during the entire period of insurance with us. This means that we will offer insurance cover for no more than a total of 3 withdrawal measures. This applies irrespective of whether the withdrawal measures are conducted on an out-patient or on an in-patient basis.

(2) Scope of our duty to indemnify
There shall be no duty to indemnify for withdrawal measures insofar as these are to treat the →insured person's addiction to nicotine. If the insured person is addicted to nicotine and also to another addictive substance, this means that we shall only provide indemnity for the measures relating to withdrawal from the other substance.

a) Reimbursement of expenses for withdrawal measures
Insofar as we have issued a previous →written commitment for our benefits, we shall reimburse 100 percent of the reimbursable expenses.

The following expenses are reimbursable:

aa) Out-patient withdrawal measures
Insofar as out-patient withdrawal measures are performed, the expenses are reimbursable in line with the benefit commitment for out-patient treatment pursuant to item 2.1.

bb) In-patient withdrawal measures
Insofar as in-patient withdrawal measures are performed, the expenses for general hospital services are reimbursable. The expenses are, however, only reimbursable up to the following maximum amounts:

1. **Withdrawal in hospitals with a care agreement**

   If the withdrawal measures are performed in a hospital that has concluded a care agreement on medical rehabilitation pursuant to § 111 SGB V, the expenses are reimbursable, per →insured person and day of treatment, up to a maximum of the amount that does not exceed the relevant daily rate pursuant to § 111.5 SGB V.

2. **Withdrawal in hospitals without a care agreement**

   If the withdrawal measures are performed in a hospital that has not concluded a care agreement on medical rehabilitation pursuant to § 111 SGB V, the following applies:

The expenses are reimbursable per →insured person and day of treatment up to a maximum amount corresponding to the amount that does not exceed the relevant daily rate pursuant to § 111.5 SGB V
- which the hospital with a care agreement on medical rehabilitation pursuant to § 111 SGB V
- that is closest to the habitual place of abode of the insured person
- would have charged for the treatment.

b) Primary duty to indemnify of other benefit providers

If the →insured person is entitled to benefits from other benefit providers (for example, the statutory pension insurance system), this entitlement takes precedence over our benefits. In such cases, we are only obliged to provide indemnity for those expenses that remain following the preliminary coverage provided by the other benefit provider.

4.3 In which cases can we reduce our indemnity to an appropriate amount?

(1) Our right to reduce our benefits
We can reduce our indemnity to an appropriate amount,
- if medical treatment or another measure for which indemnity was agreed exceeds the level that is medically necessary or
- if, for a medically necessary treatment or other measures for which indemnity was agreed, inordinately high remuneration has been charged.

(2) Measurement criteria for determining appropriate remuneration
Expenses pursuant to
- the German scale of medical fees (GOÄ) and
- the German scale of dental fees (GOZ),
- the scale of fees for psychological psychotherapists and psychotherapists for children and young people (GOP),
- the official fee scales for midwives and
- the fee scale for alternative practitioners (GebüH)

are only deemed to be reasonable if they are medically justified based on the measurement criteria set out therein.

Other expenses for treatment in Germany are deemed to be reasonable if they do not exceed the level that is normal for Germany. Expenses for treatment abroad (see item 2.4) are deemed to be reasonable if they do not exceed the level that is normal there.

5. Total reimbursement amount if several parties are obliged to provide indemnity

What is the total reimbursement amount if several parties are obliged to provide indemnity?

If the →insured person has a claim against several parties obliged to provide indemnity on the basis of the same insured event, the total reimbursement may not exceed the total expenses.

6. Subordinated duty to indemnify in the event of claims against statutory providers

What is the order of priority if claims can also be asserted against statutory providers?

(1) Subordinated duty to indemnify
If, in an insured event, the →insured person can claim
- benefits under the statutory accident or pension insurance schemes,
- medical assistance for civil servants (*Heilfürsorge*) or accident assistance for civil servants (*Unfallfürsorge*),

then these claims take precedence over our duty to indemnify. In such cases, we are only obliged to provide indemnity for those expenses that have to be incurred despite the payments made by the statutory health insurer. Claims to alternative daily allowance for stays in hospital remain in place.

(2) Duty to assign the claim
If we provide preliminary coverage, the claim for indemnity against the statutory provider must be assigned to us →in writing. This obligation applies up to the level of the reimbursement made by us.

(3) Other cases of a subordinated duty to indemnify

Other cases in which we only have a subordinated duty to indemnity are:
- artificial insemination (item 2.1.5) and
- organ transplantation (item 2.5).

7. List of benefits

Schedule of remedies other than drugs (*Heilmittelverzeichnis*) for rate IMB100U

Important information:
In the event of a change in the healthcare environment that cannot be considered as merely temporary, we are entitled to adjust this list pursuant to section C item 2.2.

Services that are not included in the schedule of remedies other than drugs are not reimbursable.

Performance

Physiotherapy

- Inhalations

Inhalation therapy as individual inhalation

Inhalation therapy as room inhalation in a group, per participant

Inhalation therapy as room inhalation in a group - but using local spa water - per participant

Radon inhalation in tunnels

Radon inhalation using hoods

- Physical therapy, motion exercises

Physical therapy treatment (also on a neurophysiological basis, breathing treatment) as individual treatment - including the required massage

Physical therapy treatment on a neurophysiological basis for central motor disturbances acquired after the brain has reached maturity as individual treatment, at least 30 minutes

Physical therapy treatment on a neurophysiological basis for congenital central motor disturbances, or central motor disturbances acquired before an individual's 14th birthday, as individual treatment, at least 45 minutes

Physical therapy in a group (2 to 8 people) - also orthopedic gymnastics, per participant

Physical therapy in a group in the event of cerebral dysfunction (2 to 4 people) - at least 45 minutes, per participant

Physical therapy (breathing treatment) to treat cystic fibrosis as individual treatment, at least 45 minutes

Physical therapy (breathing treatment) in a group (2 to 5 people) to treat severe bronchial diseases, at least 45 minutes, per participant

Motion exercises

Physical therapy treatment/motion exercises in a hydrotherapy pool as individual treatment - including the required rest afterwards

Physical therapy treatment/motion exercises in a group in a hydrotherapy pool (up to 5 people), per participant - including the required rest afterwards

Manual therapy to treat blocked joints, at least 30 minutes

Chiro exercises - including the required rest afterwards

Extended out-patient physiotherapy (EAP in German), at least 120 minutes, per treatment day

Equipment-based physical therapy (including medical rehabilitation (MAT in German) or medical training therapy (MTT in Germany), per session for parallel individual treatment (up to 3 people, at least 60 minutes)

Extension treatment (e.g. traction slings)

Extension treatment using larger devices (e.g. slanting board, extension table, Perl's equipment, sling table)

- Massages

Massages of individual or several parts of the body, also special massages (connective tissue massage, segmental massage, periosteum massage, brush and colonic massage)

Manual lymphatic drainage based on the Dr. Vodder method

- Extensive treatment, at least 30 minutes

- Full treatment, at least 45 minutes

- Full treatment, at least 60 minutes

- Compression bandaging of an extremity

Underwater jet pressure massage - including the required rest afterwards

- Packing, hydrotherapy, baths

Hot bandages - including the required rest afterwards

Warm packing of one or more parts of the body - including the required rest afterwards - with the use of reusable packing material

- with the use of single-use natural peloids without the use of foil or fleece between the skin and the peloid as partial packing

- with the use of single-use natural peloids without the use of foil or fleece between the skin and the peloid as large-scale packing

Perspiration packing - including the required rest afterwards

Cold packs

- e.g. use of clay or quark

- with the use of single-use natural peloids without the use of foil or fleece between the skin and the peloid

Hayflower sack, peloid dressing

Poultices, supports, dressings, also with extras

Dry packing

Partial affusion, partial flash affusion, partial interchangeable affusion

Full affusion, full flash affusion, full interchangeable affusion

Clapping off, rubbing off, washing off

Ascending or descending partial bath - including the required rest afterwards

Ascending or descending full bath (hyperthermal bath) - including the required rest afterwards

Alternating partial bath - including the required rest afterwards

Alternating full bath - including the required rest afterwards

Brush massage bath - including the required rest afterwards

Natural mud half-bath - including the required rest afterwards

Natural mud full bath - including the required rest afterwards

Sand baths - including the required rest afterwards - partial bath

Sand baths - including the required rest afterwards - full bath

Brine phototherapy - including the required rest afterwards

Medical baths with extras

- Partial bath (hand, foot bath) with extras

- Hip bath with extras - including the required rest afterwards

- Full bath, half-bath with extras - including the required rest afterwards

- further extras, per extra

Gaseous baths

- Gaseous bath (e.g. carbonic bath, oxygen bath) - including the required rest afterwards

- Gaseous bath with extras - including the required rest afterwards

- Carbon dioxide gas bath (carbonic gas bath) - including the required rest afterwards

- Radon bath - including the required rest afterwards

- Added radon, per 500,000 millistat

- Cold and thermal treatment

Use of ice, cold treatment (e.g. dressings, ice packs, direct rubbing)

Use of ice, cold treatment (e.g. cold gas, cold air), large joints

Partial ice bath

Hot air treatment or use of heat (incandescent light, spotlights - also infrared) on one or more parts of the body

- Electrotherapy

Ultrasound treatment - also phonophoresis

Treatment of one or more parts of the body with high-frequency current (short, decimetric waves or microwaves)

Treatment of one or more parts of the body with low-frequency current (e.g. electro-stimulation, diadynamic current, interferential current, galvanization)

Targeted low-frequency treatment, electrogymnastics for spastic or flaccid paralysis

Iontophoresis

Two or four-cell bath

Full hydroelectric bath (e.g. "Stangerbad" (combination of electro- and hydrotherapy)) also with extras - including the required rest afterwards

- Phototherapy

Treatment with ultra-violet light

- as an individual treatment

- in a group, per participant

Stimulus treatment of a defined areas of the skin with ultra-violet light

Stimulus treatment of several defined areas of the skin with ultra-violet light

Quartz lamp pressure radiation of a field

Quartz lamp pressure radiation of several fields

- Ergotherapy

Functional analysis and initial consultation, including advice and treatment plan, once per treatment case

Individual treatment

- for motor disorders, at least 30 minutes

- for sensorimotor/perceptive disorders, at least 45 minutes

- for psychological disorders, at least 60 minutes

Mental training as individual treatment, at least 30 minutes

Group treatment

- at least 45 minutes, per participant

- for psychological disorders, at least 90 minutes, per participant

- Speech therapy

Initial consultation with treatment plan and discussions, once per treatment case

Standardized procedure for treatment planning, including analysis, only if specifically prescribed by a doctor in the event of suspected central speech disorders, once per treatment case

Detailed report

Individual treatment in the event of language disorders, speech impediments and voice disorders, - at least 30 minutes

- at least 45 minutes

- at least 60 minutes

Group treatment for language disorders, speech impediments and voice disorders with provision of advice to the patient and, where appropriate, the parents, per participant

- children's group, at least 30 minutes

- adult group, at least 45 minutes

- Podiatry

Callus removal on both feet

Callus removal on one foot

Nail treatment on both feet

Nail treatment on one foot

Complex podiatry treatment on both feet (callus removal and nail treatment)

Complex podiatry treatment on one foot (callus removal and nail treatment)

Visit to several patients in the same social community (e.g. old people's home) with a direct temporal link, per person

- House calls/travel expenses

House call described by a doctor

Travel expenses (only for house calls prescribed by a doctor) if a vehicle is used in the amount of EUR 0.30 per kilometer up to a maximum of 50 kilometers or otherwise, the lowest costs of regular means of transport up to a maximum of 50 kilometers

Section B - Your obligations

Here, you can find provisions on the duties and rules of conduct (obligations) associated with the insurance and the consequences if these are breached.

1. Duties in connection with premium payment

Content of this section:

1.1 Where can you find the premium to be paid?

The monthly premium that is to be paid is set out in the valid insurance certificate.

1.2 How is the premium calculated?

The premiums are calculated based on the provisions set out in the German Insurance Supervision Act (VAG) and the principles set out in our →technical basis of calculation.

1.3 Are ageing provisions set up?

The premiums for rate IMB100U do not contain any shares to set up →ageing provisions.

1.4 What does the Policyholder have to bear in mind as far as premium payments are concerned?

(1) Payment period
The premiums for the policy must be paid as ongoing monthly premiums.

(2) Due date for insurance premiums

a) Initial premium
The initial premium must be paid without delay once the policy has been taken out. If the →Policyholder has agreed with us that the insurance cover shall not commence until a later date, the initial premium shall not fall due until this date.

b) Subsequent premiums
Unless otherwise agreed, subsequent premiums are due for payment on the first of each month.

(3) Timeliness of payment
Premium payments are deemed to have been made in a timely manner if the →Policyholder immediately takes all of the measures required to make sure that we receive the amount on the due date.

If it has been agreed that the premium is to be collected from an account (direct debit), the premium payment is deemed to have been made in a timely manner if

- we can collect the premium on the due date and
- the account holder does not object to an authorized debit.

If we cannot collect a premium that is due for payment and if this is not the Policyholder's fault, the payment is deemed to have been made in a timely manner if it is made immediately after we have issued the Policyholder with a payment request in written or electronic form (e.g. by letter, fax, e-mail).

(4) Special obligation for payment by direct debit

If it has been agreed that the premium is to be debited from an account (direct debit), we must have been issued with a SEPA direct debit authorization. We can request that this authorization be issued in written or electronic form (e.g. by letter, fax, e-mail).

(5) Transfer risk
The premiums shall be transferred at the →Policyholder's own risk and expense.

(6) Calculation of the daily premium
If we are only entitled to the premium on a pro rata basis, then the daily premium shall correspond to 1/30 of the monthly premium to be paid in each case. When calculating the daily premium, the amounts are rounded up to full cents.

2. Obligations

Content of this section:

2.1 Which obligations have to be observed after the occurrence of the insured event?

The following →obligations have to be observed after the occurrence of the insured event:

(1) Provision of information
You are obliged to provide us, on request, with any information that is required in order to determine

- whether an insured event has occurred or
- whether or not, and to what extent, we have a duty to indemnify.

(2) Medical examination
The →insured person is obliged to undergo an examination by a physician commissioned by us at our request.

(3) Mitigation of damage
The →insured person must do everything possible to help mitigate the damage and must refrain from taking any action that could hinder his/her recovery.

(4) Claim for indemnity under other private health insurance policies
If, in an insured event, you can also claim benefits under other private health insurance policies, you must inform us without delay. This notification should include the name of the other insurer.

2.2 What are the legal consequences of breaches of obligation?

If you breach an →obligation, this may result in us being released from our duty to indemnify in full or in part. In detail, the following applies:

- If you breach the obligation with willful intent, we have no duty to indemnify.
- If you breach the obligation in a grossly negligent manner, we are entitled to reduce our insurance benefits. The reduction is based on the severity of your fault. It may result in the total loss of the claim. The payment shall not be reduced if you furnish proof that you did not act with gross negligence.

Even in the event of willful intent or gross negligence, we are still obliged to indemnify if you furnish proof that the act in breach of obligation

- was not the cause of the occurrence or the determination of the insured event
- or the cause of the ascertainment or the scope of our duty to indemnify.

This does not apply if you fraudulently breached the obligation.

2.3 How is the knowledge and conduct of the individual included in the scope of cover imputed to you?

The knowledge and the conduct of the →individual included in the scope of cover shall be considered tantamount to your knowledge and conduct. As a result, the →obligations have to be met not only by you, but also by the individual included in the scope of cover.

3. Transfer of claims vis-à-vis third parties to us

Subject to which conditions are claims vis-à-vis third parties transferred to us and which obligations to you have to bear in mind in this respect?

(1) Transfer of claims to indemnity
If you have a claim to indemnity vis-à-vis a third party, this claim shall be transferred to us to the extent that we pay provide indemnification for the damage. The transfer cannot be asserted to your disadvantage.

If your indemnity claim is directed at an individual with whom you are sharing a household at the time the loss/damage occurs, we can only assert the transferred claim against this person if the latter caused the loss/damage with willful intent.

(2) Your obligations in connection with claims to indemnity
You must observe the valid formal requirements and requirements governing deadlines in respect of any claims to compensation or rights that serve to secure these claims. This means, for example, that you are not entitled to dispose of the claim or a right securing the claim by way of assignment, a waiver, remission or settlement. Furthermore, you must not prevent the realization of the claim by simply failing to act.

Once the claim has been transferred to us, you are also obligated to cooperate with us in enforcing the right to the extent necessary.

(3) Consequences of breaches of obligation
In derogation of item 3.2, the following applies to breaches of →obligation pursuant to sub-section 2:
If you breach these obligations with willful intent, we are not subject to any obligation to provide indemnity to the extent that we cannot claim compensation from a third party as a result of your breach of obligation.

If we cannot claim compensation from a third party because you breached these obligations in a grossly negligent manner, we are entitled to reduce our benefits. The reduction is based on the severity of your fault. It may result in the total loss of the claim. The payment shall not be reduced if you furnish proof that you did not act with gross negligence.

(4) Transfer of claims based on unjust enrichment
If you

- have paid remuneration to a service provider without legal grounds for such remuneration and
- therefore have a repayment claim against the service provider,

this claim shall be transferred to us to the extent that we have provided indemnity for this remuneration. Sub-sections 2 and 3 apply accordingly.

(5) Claims of the individual included in the scope of cover
Sub-sections 1 through 4 apply accordingly if the individual included in the scope of cover is entitled to the claims to indemnity or claims based on unjust enrichment.

Part C - General provisions

This section sets out the regulations governing the inception of cover. You and the Policyholder can also find the provisions governing the adjustment of the premium and the terms and conditions of insurance, as well as general provisions on the execution of the insurance policy here.

1. Inception of cover

1.1 When does the insurance cover commence?

(1) Basic principle
The insurance cover shall commence on the agreed date, provided that the Policyholder pays the initial premium in good time within the meaning of Section B item 1.4.2 a).

(2) Insured events before the inception of cover

We shall not provide benefits for insured events that occurred before the inception of cover as a general rule.

Provisions to the contrary only apply if these are set out in the →group insurance policy.

(3) Extension of insurance cover
If the scope of insurance cover is extended at a later date, sub-sections 1 and 2 shall also apply to this extension of insurance cover.

1.2 Do waiting periods apply?

No waiting periods apply.

2. Adjustment of the premium and terms and conditions of insurance

Content of this part:

2.1 Subject to what conditions can we adjust the premium?

(1) Requirements
If the insurance benefits change, we will adjust the premium during the policy term. The requirements set out in § 203.2 of the German Insurance Contract Act (VVG) must be met in respect of the adjustment.

The adjustment is made separately for each →observation unit in a rate. Children and young people are grouped to form one observation unit. In order for the adjustment to be made, a comparison of the required and calculated insurance benefits for the observation unit in question must show a deviation of more than 5 percent.

(2) Entry into force of a premium adjustment
We will inform the Policyholder in written or electronic form (e.g. by letter, fax, e-mail) of

- the adjustment of the premium, and
- the grounds for the adjustment.

The adjustment shall become effective at the start of the second month after this information is provided. The adjustment shall become effective at the start of the second month after this information is provided.

(3) Policyholder's right to termination
If we increase the premium pursuant to sub-section 1, the →Policyholder has a right to termination subject to the prerequisites set out in item 3.1 sub-sections 1 and 4.

2.2 Subject to what conditions are we entitled to amend the terms and conditions of insurance?

(1) Adjustment with the consent of the trustee
The terms and conditions of insurance, including the accompanying benefit schedules, can be adjusted with the consent of an independent →trustee pursuant to § 203.3 of the German Insurance Contract Act (VVG).

(2) Replacement of the terms and conditions of insurance
The terms and conditions of insurance, including the accompanying benefit schedules, can be replaced by new provisions pursuant to § 203.4 in conjunction with § 164 of the German Insurance Contract Act (VVG).

(3) Effectiveness of the amendments
We will inform the →Policyholder of any amendments pursuant to sub-section 1 in written or electronic form (e.g. by letter, fax, e-mail). The adjustment shall become effective at the start of the second month after we provide this information.

We will inform the Policyholder of any replacement pursuant to sub-section 2 in written or electronic form (e.g. by letter, fax, e-mail). The replacement shall become effective 2 weeks after we provide this information.

(4) Policyholder's right to termination
If we reduce our benefits pursuant to sub-section 1, the →Policyholder has a right to termination subject to the prerequisites set out in item 3.1 sub-sections 1 and 4.

3. End of the insurance policy and the insurance cover

Content of this part:

3.1 Subject to what conditions is the Policyholder entitled to terminate the policy or demand its rescission?

(1) General requirements
All notices of termination pursuant to sub-sections 2 through 4 and requests for rescission pursuant to sub-section 5 must be in writing (for example, by letter, fax or e-mail).

If the →Policyholder terminates the rate for individual →insured persons, the termination shall only be effective if the Policyholder proves that the insured persons in question are aware of the notice of termination. This shall apply accordingly if the Policyholder demands rescission pursuant to sub-section 5.

(2) Termination for convenience
The →Policyholder is entitled to terminate the rate with effect from the end of each insurance year, subject to a notice period of 3 months. The termination can be limited to individual →insured persons.

(3) Situation in which a compulsory statutory health insurance requirement, an entitlement to family insurance or to medical assistance for civil servants arises

If the →insured person becomes subject to compulsory insurance under the statutory health insurance in system, the →Policyholder is entitled to terminate the rate within 3 months of the individual becoming subject to compulsory insurance with retroactive effect from the point in time at which the individual becomes subject to compulsory insurance.

The termination shall be ineffective if the Policyholder does not provide us with evidence of the compulsory insurance requirement within two months of us asking the Policyholder to do so in written or electronic form (e.g. letter, fax, e-mail). This shall not apply if the Policyholder is not to blame for this deadline being missed.

If the Policyholder exercises its right to termination, we are only entitled to the premium up until the time at which the compulsory insurance requirement arises. The calculation of the daily premium shall be based on Section B item 1.4.6.

Later, the Policyholder can terminate the rate taken out for the insured person to the end of the month in which it provides us with evidence of the compulsory insurance requirement. In such cases, we shall be entitled to the premium until the termination of this rate.

The following are deemed equivalent to the compulsory insurance requirement:

- the statutory entitlement to family insurance or
- the entitlement - which must be of a not only temporary nature - to medical assistance for civil servants under an employment relationship under civil service law or a similar employment relationship.

(4) Increase in premium and reduction in our benefits
If we increase the premium pursuant to item 2.1, the →Policyholder is entitled to terminate the rate under this component that is affected by the increase for the →insured person in question at the time at which the change comes into force. For this to happen, we must have received the notice of termination within 2 months of receipt of the amendment notice.

If we reduce our benefits pursuant to item 2.2.1, the Policyholder is entitled to terminate the rate under this component that is affected by the reduction in benefits for the insured person in question at the time at which the change comes into force. For this to happen, we must have received the notice of termination within 2 months of receipt of the amendment notice.

(5) Right to rescission
If we only contest, withdraw from or terminate the policy in respect of individual insured persons, the Policyholder is entitled, within 2 weeks of receiving our notice to this effect, request the rescission of all of the insurance policies taken out with us with effect from the end of the month in which the Policyholder received our notice, and in the case of termination, at the time at which the termination becomes effective.

3.2 How is the insurance year determined?

The first insurance year shall begin on the agreed policy inception date. It shall end on December 31 of the calendar year in question. The subsequent insurance years shall correspond to the calendar year in question.

3.3 Subject to what conditions can we terminate the policy?

(1) Right to termination for convenience
We shall waive our right to termination for convenience.

(2) Right to extraordinary termination
The statutory provisions governing the right to extraordinary termination shall remain unaffected. The termination can be limited to individual →insured persons.

3.4 In which other cases does the insurance policy end?

(1) Maximum insurance period
The rate will end after the expiry of the maximum insurance period of 5 years. The maximum insurance period shall start on the agreed policy inception date agreed for the →insured person.

If, prior to this rate being taken out, the insured person already has a fixed-term health insurance policy that has been taken out with another insurer for the stay in Germany pursuant to § 195 (3) of the German Insurance Contract Act (VVG), the period of insurance under that policy shall count towards the maximum insurance period pursuant to sentence 1.

(2) Death
The rate shall end at the end of the day on which the →main insured person dies. In the event of the death of →individuals included in the scope of cover, the rate taken out for them shall end at the end of the day on which they die.

(3) Termination of the group insurance policy
The rate shall end when the →group insurance policy ends.

(4) Individual leaves the group of people eligible for insurance

The rate taken out for the →insured person shall end when the latter no longer belongs to the group of individuals eligible for insurance pursuant under the →group insurance policy.

(5) Termination
The rate taken out for the →insured person shall end at the time of termination for convenience and extraordinary termination.

(6) Withdrawal and contestation
The rate taken out for the →insured person shall end as a result of withdrawal and contestation.

3.5 When does the insurance cover end?

The insurance cover provided under the IMB100U rate shall end for the →insured person - also for →pending insured events - at the time at which the rate ends.

For pending insured events, we provide the insured benefits for a further 4 weeks if the rate ends because the →group insurance policy has been terminated.

This is subject to the proviso that there are no claims to further insurance based on the terms and conditions of individual insurance.

4. Continuation of the insurance policy

In which cases can continuation in an individual insurance policy be requested?

(1) Termination due to default in payment
If we effectively terminate the rate for individual →insured persons due to default in payment, the insured persons in question shall have the right to continue the IMB100U rate based on the terms and conditions of individual insurance policies and specifying the future →Policyholder.

A continuation notice must be submitted, specifying the future Policyholder, within 2 months of the time at which you become aware of this right. The premium must be paid from the time of continuation.

We must, however, inform you of the termination and continuation right in written or electronic form (e.g. letter, fax, e-mail).

(2) Death of the main insured person
If the rate ends due to the death of the →main insured person, the →individuals included in the scope of cover shall have the right to request continued insurance cover, preserving those rights that have been acquired under the policy, based on the terms and conditions of individual insurance.

The application for continued insurance must be submitted within 2 months after the rate has been terminated.

If an application is made for continued insurance under an individual insurance policy that provides higher or more extensive benefits (additional benefits) than the previous insurance cover, we can make the continued insurance dependent on special agreements being reached for the additional benefits.

We shall count the uninterrupted period for which you have already been insured with us towards the waiting periods under the individual insurance policy and shall take these into account when determining the premium.

(3) Statutory continuation rights
If, in addition to the right to continued insurance pursuant to sub-sections 1 and 2, the insured person has a right to continuation based on the terms and conditions of individual insurance under the statutory provisions, these shall continue to apply unchanged.

5. German law

What law applies to the insurance policy?

German law applies to the insurance policy.

6. Competent court

Where can the main insured person or we assert claims before a court of law?

(1) Competent court for your claims
You can assert claims under this insurance policy or insurance mediation before the court which has jurisdiction over our registered office or our branch responsible for managing your policy.

Alternatively, you can assert claims before the court in the district in which you have your place of residence or, in the absence of such place of residence, your habitual place of abode at the time the claim is asserted. If the main insured person is a legal entity (e.g. a stock corporation act or a German limited liability company (GmbH) or a partnership that can be party to legal proceedings (e.g. a general commercial partnership (*offene Handelsgesellschaft*) or a limited partnership (*Kommanditgesellschaft*), the competent German court is determined by its registered office.

If further places of jurisdiction exist by law and cannot be excluded by way of an agreement, you may also bring legal action at such places.

(2) Competent court for our claims
We can assert claims under the insurance policy before the court in the district in which you have your place of residence or, in the absence of such place of residence, your habitual place of abode at the time the claim is asserted. If the main insured person is a legal entity (e.g. a stock corporation act or a German limited liability company (GmbH) or a partnership that can be party to legal proceedings (e.g. a general commercial partnership (*offene Handelsgesellschaft*) or a limited partnership (*Kornmanditgesellschaft*), the competent German court is determined by its registered office.

If, at the time the action is brought, neither your place of residence nor your habitual place of abode is known, we can bring action before the court that is responsible for our registered office or branch responsible for managing the insurance policy. This shall apply accordingly if the main insured person is a legal entity or a partnership that can be party to legal proceedings and its registered office is unknown.

(3) Main insured persons outside of the European Community, Iceland, Norway or Switzerland
If you move your place of residence to a country outside of the European Communities, Iceland, Norway or Switzerland, both you and we can only assert claims under this insurance policy or insurance mediation before the court which has jurisdiction over our registered office.

(4) Damaging event abroad
If upon conclusion of the policy, you have your place of residence, habitual place of abode or registered office in Germany and an insured damaging event occurs abroad, legal action in this connection can only be brought before a German court.

If, at the time the action is brought, you have your place of residence, habitual place of abode or registered office in Germany, the competent German courts are those set out in sub-sections 1 and 2.

If, at the time the action is brought, you do not have your place of residence, habitual place of abode or registered office in Germany, action can be brought before the court that has jurisdiction over our registered office.

If further places of jurisdiction in Germany exist by law and cannot be excluded by way of an agreement, you may also bring legal action at such places.

7. Limitation

What limitation period applies by law to claims under the policy?

(1) Limitation period and applicable statutory provisions

Claims arising from the insurance policy are subject to a limitation period of 3 years pursuant to § 195 of the German Civil Code (*Bürgerliches Gesetzbuch*— BGB). Details on the commencement, duration and suspension of the limitation period are based on §§ 195 through 213 of the German Civil Code.

(2) Suspension of the statute of limitations during our assessment of our obligation to perform
If a claim arising from the policy has been reported to us, the limitation period is suspended until you or the claimant have/has received our decision in written or electronic form (e.g. by letter, fax, e-mail).

8. Offsetting

What provisions apply to offsetting vis-à-vis us?

Only undisputed counterclaims that have been established with res judicata effect can be offset against our claims.

9. Transfer of contractual claims to third parties

Can claims to insurance benefits be transferred to third parties?

Claims to insurance benefits can neither be assigned nor pledged. The non-assignment clause does not apply to the use of the "Card for private health insurance policyholders" (*Card für Privatversicherte*) in accordance with its intended purpose.

Explanation of specialist terms

This document provides you with explanations of specialist terms used in the terms and conditions of insurance for the IMB100U rate.

Ageing provision.
The premiums for this rate do not contain any shares to set up ageing provisions. For other health insurance policies, however, this requirement applies by law. For these insurance policies, the premiums in the first few years are higher than the current risk premium (savings phase). To the extent that an ageing provision has been set up in the savings phase, the missing amount in subsequent years in which the premium is lower than the required risk premium will be taken from these ageing provisions (payout phase). Premium increases due to the insured person growing older are excluded to this extent.

Observation unit.
This is a statutory term that is relevant for the purposes of premium calculation. The question as to what constitutes an observation unit is based on risk aspects and is set out in our technical basis of calculation.

Card for private health insurance policyholders ("AllianzCard").
This is a hospital ID card that we provide to our customers - depending on the insurance cover that has been agreed. The "AllianzCard" contains a benefit commitment, expressed as a percentage, for in-patient treatment and serves purely as an ID card for out-patient treatment. If the hospital takes part in the direct billing procedure, we settle the accommodation expenses directly with the invoice issuer. Simply present your "AllianzCard" in the hospital. The direct billing procedure does not cover the reimbursement of invoices for treating physicians. Please submit these to us separately for settlement.

Group insurance policy.
A policy we have taken out with a company or organization (e.g. association, club, society). The group insurance policy sets out, among other things, who can be insured (e.g. a company's employees) and the special policy content, in particular which special conditions apply or based on which conditions additional individuals (e.g. relatives) can be insured.

Main insured person.
The person who has a direct entitlement to the insurance benefit under the group insurance policy (e.g. an employee of our Policyholder). This is why the terms and conditions of insurance are aimed at the main insured person under the group insurance policy. The Policyholder also has to observe the terms and conditions of insurance.

Individuals included in the scope of cover.
Individuals who are insured based on the same terms and conditions as the main insured person under the group insurance policy. They cannot, however, demand the insurance benefits as a general rule.

Obligation.
This is a conduct-related duty incumbent upon the insured person that is contractually agreed. Any breach of this duty has unfavorable consequences that are based on § 28 of the German Insurance Contract Act (VVG) and are described in the terms and conditions of insurance.

In writing.
The declaration must be provided in a document or another form suitable for permanent reproduction in written characters. This includes, for example, letter, fax or e-mail. The person making the declaration must be made and the end of the declaration must be marked as such.

Pending insured event.
A pending insured event describes an insured event that has occurred but has not yet ended.

Substitutive.
Health insurance that can replace the health or long-term care insurance cover provided under the statutory social security system either in full or in part (§ 195.1 (VVG)).

Technical basis of calculation.
An umbrella term for all documents and data that we use to calculate premiums.

Trustee.
The use of a trustee is required by law. Trustees are particularly important when policy amendments have to be made (such as adjustments to terms and conditions of insurance or premiums). Only individuals with suitable professional qualifications who are independent of the insurance company can be appointed as trustees. The supervisory authorities are provided with the name of the trustee.

Insured person.
The person directly covered by the insurance cover afforded under the insurance policy as agreed. This person is named in the insurance certificate.

Eligibility for insurance.
A characteristic that is specific to a certain individual as set out in Section A. This characteristic must be exhibited by the insured person during the term of the insurance. If it no longer applies, the insured person can no longer remain insured in the rate.

Policyholder.
Our partner for the group insurance policy. The Policyholder is the company or organization (e.g. association, club, society) with which we have concluded the group insurance policy. Although the terms and conditions of insurance are aimed at the main insured person under the group insurance policy, as this is the person entitled to the insurance benefits, the Policyholder, as our contractual partner, also has to observe the terms and conditions of insurance.