General Terms and Conditions of Insurance for Healthcare Costs and Daily Hospital Benefits

Part I 2009 German standard conditions (MB/KK 2009)
Part II Tariff Conditions (TB/KK)

Version of January 2023

Contents

These General Terms and Conditions of Insurance consist of: Part I (German standard conditions 2009 of the Association of Private Health Insurance [MB/KK 2009]), Part II (Tariff conditions [TB/KK 2013]) and Part III (Rates). The Tariff Conditions shall supplement the German standard conditions and moreover contain variations in favor of the insured persons.

The insurance coverage

§ 1 Subject, scope and scope of application of insurance coverage

I

(1) The insurer offers insurance coverage for illnesses, accidents and other events mentioned in this Agreement. As agreed, the insurer shall perform additional services directly related thereto. In an insurance event, the insurer shall render:

a) in the case of healthcare cost insurance the reimbursement of expenses for medical treatment and other agreed benefits;

b) in the case of daily hospital benefit insurance a daily hospital allowance for in-patient medical treatment.

(2) An "insurance event" shall mean the medically necessary treatment of an insured person due the consequences of an illness or accident. The insurance event shall commence with the medical treatment and cease when no further need for treatment exists in accordance with the medical findings. If the medical treatment has to be expanded to any consequence of an illness or accident that does not relate in a causal fashion to the treated consequence to date, a new insurance event shall arise in this regard. The following shall also be considered as an insurance event:

a) examinations and medically necessary treatment due to pregnancy and delivery;

b) out-patient checkups for early detection of illnesses in accordance with programs introduced by law (deliberate preventative checkups);

c) death, insofar as benefits are agreed in this case.

(3) The scope of the insurance coverage shall result from the insurance certificate, later written agreements, these General Terms and Conditions of Insurance (German standard conditions with the tariff annexes and Tariff Conditions) and the provisions of law. The insurance relation shall be subject to German law.

(4) The insurance coverage shall extend to medical treatment in Europe. The insurance coverage may be extended by agreement to non-European countries (however, cf. § 15 (3)). During the first months of any temporary stay outside of Europe, insurance coverage shall exist even without any separate agreement. If the stay must be prolonged for more than one month due to necessary medical treatment, the insurance coverage shall exist so long as the insured person cannot travel back without risk to his or her health, though at maximum for an additional two months.

(5) If an insured person relocates his or her habitual place of residence to another member state of the European Union or to another contracting state of the Agreement on the European Economic Area, the insurance relation shall continue, subject to the condition that the insurer shall remain obliged at maximum to render those benefits which the insurer would have had to render had the insured person stayed in Germany.

(6) The policyholder may request the transformation of the insurance policy into a similar type of insurance coverage, provided the insured person fulfills the prerequisites for the insurance eligibility. The insurer shall accept the application for transformation within a reasonable period. The acquired rights shall be retained; the provision formed in accordance with the technical bases for calculating the risk accruing as the insured person ages (aging provisions) shall be added in accordance with these bases of calculation. If the new insurance coverage is higher or more comprehensive, a risk premium may be requested (§ 8a, para. 3 and 4) or an exclusion of benefits may be agreed; furthermore, waiting periods must be kept for the added part of the insurance coverage (§ 3 (6)). This right of transformation does not exist for qualifying period insurances and for suspension insurances, if the reason for the qualifying period or suspension is still given, this right does also not exist for limited insurance contracts. The transformation of the insurance coverage from a rate for which the premiums are calculated independently of sex to another rate for which this is not the case shall be excluded hereby.

Any transformation of the insurance coverage to an emergency tariff in accordance with § 153 of the Insurance Supervision Act (Versicherungsaufsichtsgesetz; VAG – see annex) shall likewise be excluded.

II

(1) If the risk is increased, for example, through prior illnesses, the insurer may make the acceptance of the insurance application contingent on the agreement of special conditions (e.g. risk surcharges).

(2) As insured event also apply

a) Examinations for the early detection of ilness (preventive medical checkups), whereby - unless otherwise agreed in the tariff - the benefit statement is not limited to the statutory established programs and is not dependent on a specific age. In tariffs with benefits for in-patient treatment, however, in-patient preventive medical checkups are only deemed to be an insured event if they have to be performed as in-patient treatment for medical reasons,

b) miscarriages and abortions which are not unlawful,

c) in substitutive health insurance, specialized outpatient palliative care and in-patient care in a hospice.

(3) Without need of any separate agreement, the insurance coverage shall extend to worldwide medical treatment.

(4) Switzerland shall be equivalent to an all provisions to the states mentioned in § 1 (5) MB/KK 2009 and/or to the other member states of the European Union and the other contracting states of the Agreement on the European Economic Area.

(5) A stay in one of the states mentioned under § 1 (5) MB/KK 2009 of a maximum duration of six months shall not be considered as a relocation of the habitual place of residence. Temporary interruptions shall be included in the calculation of the length of a stay.

If there is no relocation of the habitual place of residence, insurance coverage shall exist pursuant to § 1 (4) MB/KK 2009 and § 1 (3) of the Tariff Conditions.

(6) In substitute health insurance, the insured person shall receive when relocating his or her habitual place of residence to one of the states mentioned under § 1 (5) MB/KK 2009 the full reimbursement pursuant to the tariff. The policyholder or the insured person must inform the insurer at the latest within six months after the relocation of the habitual place of residence. The insurer may request an adequate premium surcharge for states in which benefits would regularly be restricted pursuant to § 1 (5) MB/KK 2009 for the duration of the habitual place of residence. The premium surcharge shall be offered one time. If the policyholder refuses a potential premium surcharge on behalf of the insured person or if the policyholder or the insured person fail to inform the insurer about the relocation of the habitual place of residence in due time, the insurer shall be obliged at most to render the benefits which the insurer would have had to render in the case of a stay in Germany.

If the relocation of the habitual place of residence to the states mentioned in § 1 (5) MB/KK 2009 is only temporary, the insurance relation shall also be transformed upon request into a qualifying period insurance policy. The transformation into a qualifying period insurance policy must be requested within six months after the relocation of the habitual place of residence.

In the event of a relocation of the habitual place of residence to a state other than those mentioned in § 1 (5) MB/KK 2009, § 15 (3) MB/KK 2009 and the related Tariff Conditions shall apply as of the start of the residence.

§ 2 Start of insurance coverage

I

(1) The insurance coverage shall commence upon the date specified in the insurance certificate (starting date of insurance), though not before the conclusion of the insurance agreement (particularly receipt of the insurance certificate or a written acceptance declaration) and not before the expiry of the waiting periods. Benefits shall not be rendered for insurance events that occur before the start of the insurance protection. Insurance events occurring after the conclusion of the insurance agreement shall only be excluded for the portion of the duty to render benefits which falls in the period before the starting date of insurance or in waiting periods. In the event of contractual modifications, Sentences 1 to 3

shall apply to the added portion of the insurance coverage.

(2) In the case of infants, the insurance coverage shall commence without risk surcharges and waiting periods as of the completion of the birth, provided one parent has been insured with the insurer for at least three months on the date of birth and the notification to the insurer is made retroactively no later than two months after the date of the birth. The insurance coverage may not be higher or more comprehensive than that of an insured parent.

(3) An adoption shall be equivalent to the birth of a child, provided the child is still a minor on the date of the adoption. With regard to any elevated risk, a risk surcharge up to the simple amount of the premium may be agreed.

II

(1) At variance with § 2 (1) MB/KK 2009, insurance events that occurred even before the conclusion of the insurance agreement shall only be excluded for that portion of the duty to render benefits which falls in the period before the start of the insurance coverage. This shall only apply, however, if these insurance events are duly notified to the insurer and no special terms and conditions to the contrary have been agreed. This provision shall apply accordingly to the additional benefit after any change in the existing insurance coverage.

(2) Through the modification in the insurance coverage in the course of the coverage period, the insurance year determined upon the original closing of the agreement shall not change.

(3) If the assistance calculation rate or the assistance claim is eliminated, upon application of the policyholder the insurance coverage shall be adjusted within the framework of the existing healthcare cost rates to the altered assistance calculation rate or the eliminated assistance claim, though only insofar as the assistance calculation rate or assistance claim eliminated as a result is compensated. The insurance coverage may not be higher than is necessary for full cost coverage. Such an application shall be accepted without any repeated risk assessment or waiting periods, provided it is submitted no later than 6 months after the change in the assistance calculation rate or elimination of the assistance claim as of the first of the month in which the assistance calculation rate changes or the assistance claim has been eliminated or as of the first of the following month; however, the application may become effective earlier as of the start of the month in which it is received by the insurer. From the date of the contractual modification onward, the additional benefits shall also be granted for ongoing insurance events, provided a duty to render benefits exists within the framework of the already insured tariffs.

The grounds for the modification of the assistance calculation rate or the elimination of the assistance claim must be specified and documented upon request.

(4) If a child is co-insured pursuant to § 2 MB/KK 2009 within the framework of the existing healthcare cost rates, the insurance coverage shall also begin without any waiting periods immediately after the completion of the birth if a lower or no annual deductible is selected for the child.

(5) For infants co-insured as of birth pursuant to § 2 (2) MB/KK 2009 or pursuant to § 2 (7) of the Tariff Conditions, the monthly premium installments shall be payable from the month following the birth.

(6) For infants co-insured as of birth pursuant to § 2 (2) MB/KK 2009 or pursuant to § 2 (7) of the Tariff Conditions, insurance coverage shall exist as of the birth also for all impairments, birth defects, congenital diseases and anomalies arising prior to the completion of the birth.

(7) At variance with § 2 (2) MB/KK 2009, insurance coverage for newborns shall begin upon completion of the birth without risk assesment or waiting periods and without adherence to the minimum insurance period of 3 months for an insured parent if the 20th week of pregnancy had not been completed at the time of application by the insured parent.

§ 3 Waiting periods

I

(1) The waiting periods shall be calculated from the starting date of insurance.

(2) The general waiting period shall be three months. It shall not be applicable:

a) in cases of accidents;

b) to the spouse or life partner pursuant to § 1 of the Life Partnership Act (see annex) of a person who has been insured for at least three months, provided equivalent insurance is requested within two months after the marriage or entry into the life partnership.

(3) The special waiting periods for delivery, psychotherapy, dental treatment, dentures and orthodontics shall amount to 8 months.

(4) If the tariff so provides, the waiting periods may be waived based on separate agreement provided a medical certificate about the state of health is presented.

(5) Persons who withdraw from the statutory health insurance scheme or any other comprehensive healthcare cost agreement shall be credited the uninterrupted insurance time verifiably accrued there towards the waiting periods. The insurance must have been requested no more than two months after the cessation of the prior insurance and the insurance coverage shall begin at variance with § 2 (1) immediately thereafter. This shall also apply in the event of any withdrawal from a public service agreement with the claim to health benefits.

(6) In the case of contractual modifications, the waiting period rules for the added portion of the insurance coverage shall apply.

II

(1) At variance with § 3 (2) and (3) MB/KK 2009, the insurer waives the observance of the waiting periods in the comprehensive healthcare costs insurance if the insurance commences immediately following the previous insurance; comprehensive healthcare costs insurance in the terms of these Tariff Conditions shall exist if insurance coverage exists for the insured person with the insurer for out-patient and in-patient medical treatment as basic insurance.

(2) In the case of contractual modifications, the insurance time accrued to date in tariffs with equivalent benefits shall be credited towards the waiting periods.

(3) The waiver of the general waiting period for the spouse or life partner pursuant to the § 1 Life Partnership Act (see annex) shall also apply analogously to the special waiting periods.

(4) The waiver of waiting periods foreseen in § 3 (4) MB/KK 2009 must be requested in connection with any medical examination findings which are to be submitted on the form foreseen for this purpose. The costs of the medical examination for the person to be insured shall be borne by the applicant.

§ 4 Scope of the duty to render benefits

I

(1) The type and amount of insurance benefits shall arise from the tariff with the Tariff Conditions.

(2) The insured person shall have the choice among established and approved physicians and dentists. Unless determined otherwise by the Tariff Conditions, alternative practitioners in the terms of the German Alternative Practitioners Act may be used.

(3) Pharmaceuticals, dressings, therapies and aids must be prescribed by the attending specialists mentioned in para. 2; medications must moreover be procured from the pharmacy.

(4) In the case of medically necessary in-patient medical treatment, the insured person may freely choose among public and private hospitals which are under standing direction by physicians, possess sufficient diagnostic and therapeutic possibilities and keep medical records.

(5) For medically necessary in-patient medical treatment in hospitals which also perform curative or sanatorium treatment or accept reconvalescent patients but which otherwise meet the conditions in para. 4, the benefits according to the tariff shall only be granted if the insurer has promised such benefits in writing before the start of treatment. In the case of TB diseases, benefits shall also be rendered in the contractual scope for inpatient treatment in TB sanitariums.

(6) The insurer shall render benefits in the contractual scope for examination or treatment methods and medications which are largely recognized by conventional medicine. The insurer shall moreover render benefits for methods and medications that have been successfully proven or applied in practice when no conventional methods or medications are available; however, the insurer may reduce the benefits to the amount which would have been incur-

red upon application of existing conventional methods or medications.

(7) Before the start of medical treatment tentatively to exceed € 2,000 in costs, the policyholder may request in writing information about the scope of the insurance coverage for the planned medical treatment. The insurer shall provide the information within four weeks at the latest; if the performance of medical treatment is urgent, the information shall be provided without delay, though at the latest within two weeks. The insurer shall thereby use an obtained cost estimate and other documents. The period shall commence upon receipt of the request for information by the insurer. If the information is not provided within the period, it shall be presumed until proven otherwise by the insurer that the foreseen medical treatment is necessary.

(8) At the request of the policyholder or the insured person, the insurer shall provide information on and the opportunity to inspect opinions or assessments which the insurer has obtained for the review of the duty to render benefits about the necessity of a medical treatment. If significant therapeutic or other significant grounds oppose the provision of information to or the inspection by the policyholder or the insured person, merely the provision of information to or an inspection by a named physician or attorney may be requested. The claim may only be asserted by the relevant person or the legal representative thereof. If the policyholder has obtained an opinion or assessment at the instigation of the insurer, the insurer shall reimburse the costs incurred.

II

(1) The costs for the accommodation, meals and expenses of the healthy infant are co-insured in the case of a subsequent insurance policy pursuant to § 2 (2) MB/KK 2009, except in the case of daily hospital benefits.

(2) At variance with § 4 (2) MB/KK 2009, in tariffs with benefits for psychotherapy, benefits shall also be rendered for the use of approved Psychological Psychotherapists and Pediatric and Youth Psychotherapists. Benefits shall be rendered for psychotherapy based on depth analysis and analytical psychotherapy and for systemic therapy and behavioral therapy.

(3) If a tariff provides benefits for remedies, these must be rendered by established and approved physicians, alternative practitioners in the terms of the German alternative practitioner act or state-accredited members of the healing and auxiliary health care professions (e.g. masseuses, physiotherapists, occupational therapists, speech therapists, podiatrists, dietitians, ecotrophologists, nutritionists).

(3a) If a tariff provides benefits for digital health applications, such an application must be a low-risk medical device (I or IIa) whose main function is essentially based on digital technologies and must be intended to support the detection, monitoring, treatment or alleviation of illnesses or the detection, treatment, alleviation or compensation of injuries or disabilities in the insured people or in the care provided by the service providers named in Article 4 (3) of the tariff conditions.

(4) Hospital outpatient clinics, medical care centers, and social pediatric centers for outpatient medical treatment, army hospitals for in-patient medical treatment and service providers covered by the tariff may be used.

(5) As medications in the terms of § 4 (3) MB/KK 2009 shall also be considered certain urine and blood test strips and medication-like foodstuffs that are necessary to avoid serious health defects, e.g. in the case of enzyme deficiency diseases, Morbus Crohn and cystic fibrosis, and which are administered enterally or parenterally. The insurer shall offer support in procuring such foodstuffs.

(6a) Sanatoriums shall mean institutes which are under the standing management and supervision of physicians and in which curative treatments are carried out on an in-patient basis.

b) For the reimbursement of sanatoriums costs, provided the tariff provides for benefits in this regard, the medical necessity must be documented through a medical certificate and be recognized by the insurer.

(7) A written commitment to provide benefits in accordance with § 4 (5) MB/KK 2009 shall not be required if:

a) the matter concerns an emergency referral or if the hospital is the only health care institution in the vicinity of the insured person and exclusively

medically necessary medical treatments are to be performed which require inpatient admission and therapy, or

b) if an accident or an acute illness occurs during the stay in the hospital, as long as this event requires medically necessary in-patient treatment, irrespective of the actual purpose of the treatment; or

c) if the in-patient treatment is medically necessary for the purpose of a surgical operation; or

d) in the case of a follow-up treatment as far as § 5 (7) of the Tariff conditions provides this.

(8) The contingent premium reimbursement shall be made in accordance with the Bylaws.

§ 5 Restriction of the duty to render benefits

I

(1) No duty shall exist to render benefits:

a) for those illnesses and the consequences thereof and for the consequences of accidents and fatal events caused by events of war or recognized as a military injury which are not expressly included in the insurance coverage;

b) for illnesses and accidents based on intentional action and the consequences thereof and for detoxification measures, including detoxification programs;

c) for treatment by physicians, dentists, alternative practitioners and in hospitals whose invoices the insurer has excluded for good cause from reimbursement, provided the insurance event occurs after the notification of the policyholder about the benefit exclusion. If on the notification date, an insurance event is pending, no duty to render benefits shall exist for the expenses incurred three months after the notification;

d) for spa treatment and sanatorium treatment and for rehabilitation measures of statutory rehabilitation agencies, unless the tariff foresees otherwise;

e) for out-patient medical treatment in a spa town or health resort. This restriction shall not be applicable if the insured person has his or her habitual place of residence there or if medical treatment becomes necessary during a temporary stay through an illness or accident that occurs there independently of the purpose of the stay;

f) (deleted)

g) for treatments by spouses, life partners pursuant to § 1 of the Life Partnership Act (see annex), parents or children. Documented material costs shall be reimbursed according to the tariff;

h) for accommodations conditioned by care dependency or custodianship.

(2) If a medical treatment or other measure for which benefits are agreed exceeds the medically necessary degree, the insurer may reduce its benefits to a reasonable amount. If the expenses for the medical treatment or other benefits are conspicuously disproportionate to the services rendered, the insurer shall not be obliged to render benefits.

(3) If a claim exists to benefits from statutory accident insurance or statutory pension insurance, to statutory therapeutic or accident-related care, the insurer shall be obliged, without prejudice to the claims of the policyholder to daily hospital benefits, to render benefits only for expenses that remain necessary despite the statutory benefits.

(4) If the insured person has a reimbursement claim against several parties, the total reimbursement may not exceed the total expenses.

II

(1) The benefit restriction pursuant to § 5 (1a) MB/KK 2009 shall not apply to events of war abroad if:

a) no travel advisory by the German foreign service exists for the affected country of stay; or

b) a travel advisory for the area of stay is first declared during the stay abroad, and the insured person immediately leaves the area of stay or is prevented from leaving the affected country due to reasons for which the insured person is not responsible. Such a reason is given if e.g. leaving the area of stay is only possbile under a significant endangerment of one's own person.

Terrorist attacks and the consequences thereof shall not be counted among events of war in the terms of § 5 (1a) MB/KK 2009.

(2) If the insured person has no other claim to cost reimbursement or a benefit in kind, at variance with § 5 (1b) MB/KK 2009 in the substitutive health insurance for the first three detoxification measures (out-patient or in-patient withdrawal treatment or withdrawal cures) for substance-related addictions, if

- *the in-patient withdrawal measure in an institution approved by a statutory rehabilitation agency for the respective withdrawal measure, or*
- *the out-patient withdrawal measure by professionally appropriate services and institutions*

takes place.

There shall be no obligation to render benefits in the event of nicotine addiction.

In the case of in-patient withdrawal measures, the insurer is only liable to pay for general hospital benefits, irrespective of the insured inpatient tariff.

For the first withdrawal measure, 100% of the rate benefit is reimbursable. In the second and third withdrawal measures, 80% of the rate benefit is reimbursable. The remaining 20% is reimbursable after the termination of the measure, if the termination was neither for disciplinary reasons nor prematurely without medical consent.

(3) In tariffs for out-patient medical treatment, benefits shall also be rendered for medically necessary out-patient medical treatment in a spa or health resort.

(4) A claim to benefits shall also exist for treatments by spouses, life partners pursuant to § 1 of the Life Partnership Act (see annex), parents or children. However, this shall not apply to the tariffs AE, BISS, CAE, MA, MAN, MAS, MS, MSW, NK, PRIMO, PRIMO M, ZV and ZVH.

(5a) No duty to render benefits shall exist for additional costs of medical treatment abroad, provided the insured person has traveled abroad for medical treatment. Additional costs shall be considered the cost shares for treatment abroad which exceed the plan benefit for adequate treatment in the Federal Republic of Germany.

b) The reduction authorization pursuant § 5 (5a) of the Tariff Conditions shall apply correspondingly to deliveries. If a parent is a citizen of the country of stay, this restriction shall not be applicable, provided the policyholder documents the citizenship.

c) In the case of any medically necessary medical treatment abroad which would not have been performable or would only have been partially performable in the Federal Republic of Germany or for which the insurer promised to assume the costs in writing before the start of the trip, § 5 (5a) of the Tariff Conditions shall not apply.

d) If, within the framework of an emergency, i.e. unplannable treatment, a foreign hospital is the closest suitable place of treatment, § 5 (5a) of the Tariff Conditions shall likewise not be applicable.

(6) The restriction pursuant to § 5 (1c) MB/KK 2009 shall apply to all other benefit providers named in the the Tariff conditions and the rates.

(7) The benefit restriction pursuant to § 5 (1)a MB/KT 2009 shall not apply for out-patient and in-patient medically necessary follow-up treatment (AHB). There is an entitlement to the benefits according to the collective agreement,

a) if the insurer has promised such benefits in writing before the start of treatment.

b) for the first three weeks of a medically necessary follow-up treatment (AHB) beginning within 28 days after acute in-patient treatment under the following conditions: The AHB takes place in an institution which is licensed by a statutory rehabilitation agency for the respective follow-up treatment. If a statutory rehabilitation provider is obliged to provide benefits, an application for benefits will be submitted to it in writing and a decision will be made before the start of the AHB. As far as benefits are granted, these are to be taken up with priority. If these conditions are not met for reasons for which the insured person is responsible, the insurer is only liable to pay the amount of the reimbursable expenses that would remain after deduction of the benefits otherwise approved by the statutory rehabilitation institution.

If an request for prolongation is made in combination with such an AHB, the insurer will review

the medical necessity. If the prolongation of the AHB is medically necessary, a promise of benefits is issued for this period. This also applies to requests for subsequent prolongations.

If it is not possible to commence the AHB within 28 days for medical reasons (e.g. following radiotherapy for tumour treatment) or due to the lack of availability of a suitable institution, the insurer will review these reasons and issue a confirmation of benefits for a later commencement, as far as a AHB is medically necessary.

§ 6 Disbursement of the insurance benefits

I

(1) The insurer shall only be obliged to render benefits if the documents requested by the insurer have been provided; these shall become the property of the insurer.

(2) Otherwise, the prerequisites for the maturity of the benefits of the insurer shall arise from § 14 of the Insurance Contract Act (see annex).

(3) The insurer shall be obliged to render benefits to the insured person if the policyholder has named the insured person in text form as a person entitled to receive his or her insurance benefits. If this prerequisite is not met, only the policyholder may request the benefit.

(4) The health care costs incurred in a foreign currency shall be converted into euro at the exchange rate on the day the vouchers are received by the insurer.

(5) Costs for the remittance of the insurance benefits and for translations may be deducted from the benefits.

(6) Claims to insurance benefits may not be assigned or pledged.

II

(1) Invoices must be submitted in the original. They must contain the names of the treated persons, the designation of the illnesses, the treatment dates and information on the individual benefits or the numbers from the fee schedules. It must be evident from hospital invoices which separately calculable elective benefits have been used and/or which care class was selected.

(2) If insurance exists elsewhere, duplicate invoices confirming the benefits of the other insurance agency shall also be recognized.

(3) Expenses for pharmaceuticals, dressings and remedies shall only be reimbursed if the corresponding invoices are presented together with those of the attending specialist.

(4) If only a daily hospital benefit insurance policy exists, a confirmation from the hospital about the length of the hospital stay with the exact designation of the illness in the name of the treated person shall suffice.

(5) The costs incurred in a foreign currency shall be converted into euro at the current exchange rate on the day on which the vouchers are received by the insurer. The daily exchange rate shall be the official euro exchange rate of the European Central Bank. For non-traded currencies for which no reference rate is determined, the exchange rate pursuant to the latest version of the "Foreign Currency Statistics," published by the German Bundesbank, Frankfurt/Main, shall apply, unless the insured person documents by way of a bank voucher that he or she purchased the foreign currency necessary to pay the invoices at a less favorable exchange rate.

(6) Remittance costs shall not be deducted if the policyholder names and domestic bank account on which the amounts are to be remitted. The prohibition of assignment pursuant to sentence 1 shall not apply to contracts concluded on or after October 1, 2021; statutory prohibitions of assignment shall remain unaffected.

§ 7 End of insurance coverage

I

The insurance coverage shall cease, also for pending insurance events, upon the cessation of the insurance relation.

Duties of the policyholder

§ 8 Payment of premiums

I

(1) The premium is an annual premium and will be charged from the start of the insurance. The premium shall be payable at the start of each insurance year, but may be paid in equal monthly premium installments, which shall each be considered as deferred until the maturity of the premium installments. The premium installments shall be due on the first of each month. If the annual premium is re-determined during the insurance year, the difference must be subsequently paid or repaid from the modification date until the start of the next insurance year.

(2) If the agreement is concluded for a specific period subject to the condition that the insurance relation shall be tacitly extended by one year after the expiry of a specific period of time unless the policyholder terminates the agreement in due time, the tariff may foresee monthly premiums in lieu of annual premiums. The shall be due on the first of each month.

(3) If a healthcare cost insurance agreement serving to fulfill the insurance requirement (§ 193 (3) of the Insurance Contract Act – see annex) is requested later than one month after the origination of the insurance requirements, a premium surcharge in the amount of one month's premium for each further initiated month of non-insurance must be paid; as of the sixth month of non-insurance, one-sixth of the monthly premiums shall be payable for each further initiated months of noninsurance. If the length of the non-insurance cannot be determined, it must be assumed that the insured person was not insured for at least five years; periods before 1 January 2009 shall not be taken into account. The premium surcharge shall be payable one time in addition to the current premium. The policyholder may request from the insurer the deferment of the premium surcharge, provided the interests of the insurer can be taken into account through the agreement of an additional installment payment. The deferred amount shall accrue interest.

(4) Unless stipulated otherwise, the initial premium or the initial premium installments shall be due without delay two weeks after the receipt of the insurance certificate.

(5) If the policyholder is in default with the payment of a premium installments, the deferred premium installments of the current insurance year shall be due. However, they shall be considered as deferred again if the premium portion in arrears and the premium installments for the current month on the payment date and the payment reminder costs are paid.

(6) If the policyholder is in arrears with respect to healthcare cost insurance serving to fulfill the insurance requirement (§ 193 (3) of the Insurance Contract Act – see annex) in the amount of premium shares for two months, the insurer shall send the policyholder payment reminder. The policyholder must pay for each initiated month that premiums are in arrears a default surcharge of 1% of the premium in arrears and payment reminder costs. If two months after the receipt of this reminder the premium in arrears and the default surcharge are higher than the premium share for one month, the insurer shall send a second reminder with reference to the potential dormancy of the insurance agreement. If one month after receipt of the second reminder the premium in arrears and the default surcharges are higher than the premium share for one month, the insurance agreement shall be dormant from the first day of the ensuing months. So long as the insurance agreement is dormant, the insured person shall be considered as in short in the emergency tariff in accordance with § 153 VAG of the Insurance Contract Act (see annex). In this regard, the General Terms and Conditions for the Emergency Tariff Plan (AVB/NLT) shall apply as amended.

The dormancy of the insurance agreement shall not occur or shall cease if the policyholder or the insured person is or becomes in need of assistance in the terms of Title II or XII of the Social Code. Without prejudice to this, the agreement shall be continued from the first date of the second month thereafter within the tariff in which policyholder or insured person was insured before the occurrence of the dormancy, provided all premium shares in arrears and the default surcharges and collection costs has been paid. In the cases of Sentences 7 and 8, matters are to be arranged for the policyholder or the insured person as they existed for the policyholder or insured person before the insurance in the emergency

tariff in accordance with § 153 VAG of the Insurance Contract Act (see annex), irrespective of the shares of the provision for aging consumed during the dormancy period. Premium adjustments or modifications of the general terms and conditions of insurance made during the dormancy period into a tariff in which the policyholder or the insured person was insured before the occurrence of the dormancy shall apply as of the date of the continuation of the insurance in such tariff.

The need for assistance is to be documented through a confirmation of the competent agency in accordance with the Title II or XII of the Social Code; at adequate intervals, the insurer may request the presentation of the new confirmation.

(7) In the case of insurance policies other than those mentioned in para. 6, the untimely payment of the initial premium or a subsequent premium can lead under the prerequisites in §§ 37 and 38 of the Insurance Contract Act (see annex) to the loss of the insurance coverage. If a premium or premium installments is not paid in due time or if the policyholder is sent a reminder in text form, the policyholder shall be obliged to pay the payment reminder costs, the amount of which shall result from the tariff.

(8) If the insurance relation ceases before the expiry of the term of contract, the insurer shall only be entitled for this contractual term to that portion of the premium or premium installments corresponding to the period in which the insurance coverage existed. If the insurance relation ceases by a rescission based on § 19 (2) of the Insurance Contract Act (see annex) or through voidance by the insurer due to fraudulent deception, the insurer shall be entitled to the premium or premium installments up to the effective date of the rescission or voidance declaration. If the insurer rescinds the agreements because the initial premium or initial premium installments have not been paid in due time, the insurer may request a reasonable transaction fee.

(9) Premiums shall be payable to the office designated by the insurer.

II

(1) For the determination of the premiums, the age at entry shall be considered the difference between the year of birth and the calendar year in which the insurance relation begins.

(2) Unless stipulated otherwise in the tariff, children shall pay the premium for the age group 0-16 until the end of the year in which they turn 16 years of age. From the start of the next year until the end of the year in which they turn 20 years of age, the premium for the age group 17-20 shall be payable. Thereafter, the premium for age 21 must be paid.

(3) In the case of an annual premium payment, a premium (cash) discount of 3% shall be granted.

(4) The policyholder may agree in the healthcare cost tariff for each insured person up to and including the age of 59 on a premium reduction in accordance with the "Special Terms and Conditions for Modified Premium Payment."

(5) If the insurance agreement is concluded before the start of insurance, the first premium or the first premium installment shall be due on the starting date of the insurance. If the starting date of insurance is before the closing of the agreement, the initial premium or initial premium installment shall be due on the closing date of the agreement.

§ 8a Calculation of premiums

I

(1) The premiums shall be calculated in accordance with the provisions of the Insurance Supervision Act as determined in the insurer's technical bases of calculation.

(2) In the event of a change in the premiums, also through the modification of the insurance coverage, the sex and the age (age group) according to the tariff reached by the insured person on the effective date of the change shall be taken into account; this does not apply in view of the sex to tariffs, whose premiums are raised independently of sex.

In this regard, the age of entry of the insurance person shall be taken into account by crediting an old-age reserve pursuant to the principles set out in the technical bases of calculation. However, an increase in the premiums or a reduction in the benefits of the insurer due to the aging of the insured person shall be ruled out throughout the insurance relation, provided a old-age reserve is to be established.

(3) In the event of changes in premiums, the insurer may also change separately agreed risk surcharges accordingly.

(4) If risk is increased in the case of contractual modifications, the insurer shall be entitled to a reasonable surcharge in addition to the premium for the additional portion of the insurance coverage. This surcharge shall be calculated in accordance with the principles applicable in the insurer's business operations for compensation of the increased risks.

II

(1) In order to finance a qualifying period to a reduction of premiums in the old age or to avert or limit premium increases, in addition to the statutory surcharge levied in accordance with §§ 149 and 338 VAG of the Insurance Supervision Act (see annex) for substitute health insurance, additional amount shall be transferred and applied to the old-age reserve in accordance with the provisions of the Insurance Supervision Act (VAG; see annex § 150 VAG).

(2) The age reached according to the tariff shall mean the difference between the year of birth and the calendar year in which the change of the premiums occurs.

§ 8b Premium adjustments

I

(1) Within the framework of the promise contractual benefits, the benefits of the insurer may change. e.g. due to increasing medical treatment costs, more frequent recourse to medical benefits or increasing life expectancy. Accordingly, the insurer compares at least on an annual basis for each tariff the necessary insurance benefits and mortality rates with those calculated in the technical bases of calculation. If this comparison results for a unit under observation of a tariff in a percentage variance more than that stipulated by law or in the tariff, all premiums of this unit under observation shall be reviewed by the insurer and, if necessary, adjusted with the approval of the trustee. Under the same prerequisites, the determined amount of a deductible may be adjusted and an agreed risk surcharge may be modified accordingly. In the course of a premium adjustment, the surcharge necessary for the premium guarantee in the standard tariff (§ 19 (1), Sentence 2) and the surcharge necessary for the premium limits in the basic tariff (§ 20, Sentence 2) are to be compared with the calculated surcharges and adjusted if necessary.

(2) A premium adjustment may be waived if, in the concurrent assessment of the insurer and the trustee, the change in the insurance benefits is to be viewed as temporary.

(3) Premium adjustments and changes in deductibles and then the agreed risk surcharges shall become effective at the start of the second month following the notification of the policyholder.

II

If the comparison pursuant to § 8b (1), Sentence 2 of the MB/KK 2009 results in a change of more than 5% of the insurance benefits calculated in the technical bases of calculation, all premiums according to the rates plan for the unit under observation shall be reviewed by the insurer and adjusted, if necessary, with the approval of the trustee.

In all cases, the review and any necessary adjustment shall also extend to the premiums for the premium reduction agreed pursuant to § 8 (4) of the Tariff Conditions.

§ 9 Obligations

I

(1) Any hospital treatment must be notified within 10 days after the start thereof.

(2) The policyholder and the insured person reported as entitled to receive information (cf. § 6 (3)) must provide any information at the request of the insurer which is necessary to determine the insurance event or the duty to render benefits on the part of the insurer and the scope thereof.

(3) At the request of the insurer, the insured person shall be obliged to have him or herself examined by a physician commissioned by the insurer.

(4) If feasible, the insured person must ensure that the mitigation of the damage and desist from all acts hindering recovery.

(5) If a healthcare cost insurance agreement is concluded for an insured person with a further insurer or if an insured person avails him- or herself of the insurance authorization in the statutory health insurance scheme, the policyholder shall be obliged to inform the insurer of the other insurance without delay.

(6) A further daily hospital benefit insurance policy may only be taken out with the approval of the insurer.

II

(1) The notice of hospital treatment shall be waived (however, cf. § 4 (5) MB/KK 2009).

(2) The approval requirement pursuant to § 9 6) MB/KK 2009 shall be restricted to the conclusion of a daily hospital benefit insurance policy in the private health insurance scheme.

§ 10 Consequences of breaches of obligations

I

(1) With the restrictions stipulated in § 28, Para. 2 to 4 of the Insurance Contract Act (see annex), the insurer shall be free in whole or in part from the obligation to render benefits if one of the obligations mentioned in § 9, Para. 1 to 6 is breached.

(2) If one of the obligations mentioned in § 9, para. 5 and 6 is breached, the insurer may also terminate without notice an insurance relation which does not serve to meet the insurance requirement (§ 193 (3) of the Insurance Contract Act – see annex), under this prerequisite in § 28 (1) of the Insurance Contract Act (see annex) within one month after becoming aware of the breach of the obligation.

(3) The knowledge and fault of the insured person shall be equivalent to the knowledge and fault of the policyholder.

§ 11 Obligations and consequences of breaches of obligations in the case of claims against third parties

I

(1) If the policyholder or an insured person has compensation claims against third parties, the obligation shall exist, without prejudice to the transfer of claims stipulated by law pursuant to § 86 of the Insurance Contract Act (see annex), to assign these claims to the insurer in writing up to the amount in which compensation is rendered based on the insurance agreement (cost reimbursements and benefits in kind and service).

(2) The policyholder or the insured person must safeguard his or her compensation claim or a right serving to secure such claim with due regard to the applicable formalities and deadlines and collaborate in the enforcement by the insurer if necessary.

(3) If the policyholder or an insured person intentionally breaches the obligations mentioned in para. 1 and 2, the insurer shall not be obliged to render benefits in this regard insofar as the insurer cannot obtain any compensation from the third party as a consequence thereof. In the event of any grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in proportion to the severity of the negligence.

(4) If the policyholder or an insured person is entitled to a claim to repayment of charges paid with no legal basis against the benefits provider for whom the insurer rendered reimbursement benefits based on the insurance agreement, para. 1 to 3 shall apply accordingly.

§ 12 Set-off

I

The policyholder may only set off claims of the insurer with counterclaims that are undisputed or declared by non-appealable judgment. A member of the Assurance Association may not set off any claim based on the duty to pay premiums.

End of insurance

§ 13 Termination by the policyholder

I

(1) The policyholder may terminate the insurance relation effective as of the close of any insurance year, though at the earliest as of the expiry of an agreed term of contract of up to two years, upon notice of three months.

(2) The termination may be limited to individual insured persons or tariff.

(3) If an insured person is required to be insured by operation of law in the statutory health insurance scheme, the policyholder may terminate within three months after the occurrence of the insurance requirement a healthcare cost insurance policy or an entitlement insurance policy exiting for healthcare costs retroactively effec-

tive from the occurrence of the insurance requirement. The termination shall be invalid if the policyholder does not document the occurrence of the insurance requirement within two months after the insurer has requested the policyholder to do so in text form, unless the policyholder is not responsible for the failure to meet this deadline. If the policyholder avails itself of its termination right, the insurer shall be entitled to the premium only until the date of the occurrence of the insurance requirement. The policyholder may later terminate the healthcare cost insurance or an entitlement insurance exist for health costs effective from the end of the month in which the policyholder documents the occurrence of the insurance requirement. The insurer shall be entitled to the premium in this event until the cessation of the insurance agreement. The statutory claim to family insurance or a non-temporary claim to therapeutic care based on civil service law or a similar employment relation shall be equivalent to the insurance requirement.

(4) If a covenant in the insurance agreement has the consequence that the premium for a different age or age group shall apply when a specific age is reached or other prerequisites mentioned therein occur or if the premium is calculated with due regard to an old-age reserve, the policyholder may terminate the insurance relationship in relation to the affected insured person within two months after the change as of the effective date thereof, if the premium increases through the change.

(5) If the insurer increases the premiums based on the premium adjustment clause or if the insurer reduces its benefits pursuant to § 18 (1), the policyholder may terminate the insurance relationship in relation to the affected insured person within two months after receipt of the change notice as of the effective date of the change. In the event of a premium increase, the policyholder may terminate the insurance relation also up to and as of the effective date of the increase.

(6) If the insurer declares the voidance, rescission or termination only with respect to individual insured persons or tariffs, the policyholder may request within two weeks after receipt of such declaration the rescission of the other portion of the insurance effective as of the close of the month in which the policyholder received the declaration from the insurer; in the event of the termination, as of the date on which such termination becomes effective.

(7) If the insurance relation serves to fulfill the insurance requirement (§ 193 (3) of the Insurance Contract Act – see annex), the termination in accordance with para. 1, 2, 4, 5 and 6 shall require that a new agreement is concluded for the insured person with another insurer which satisfies the requirements. The termination shall only be effective if the policyholder documents within two months after the termination declaration that the insured person is insured without interruption with a new insurer; if the date on which the termination was pronounced is more than two months after the termination declaration, the documentation must be provided prior to such time.

(8) Upon the termination of comprehensive healthcare cost insurance and simultaneous conclusion of a new substitute agreement (§ 195 (1) of the Insurance Contract Act – see annex), the policyholder may request that the insurer transfer they calculated the old-age reserve of the insured person the amounts of the transfer value accrued after 31 December 2008 as of the start of the insurance in the respective tariff in accordance with § 146 (1) No. 5 of the Insurance Supervision Act (see annex) to his or her new insurer. This shall also apply to the agreements concluded before 1 January 2009.

(9) If upon the cessation of the insurance relations premiums are in arrears, the insurer may retain the transfer value until the full payment of the premiums.

(10) If the policyholder terminates the insurance relation as a whole or for individual insured persons, the insured persons shall have the right to continue the insurance relation by naming the future policyholder. The declaration must be issued within two months after the termination. The termination shall only be valid if the policyholder documents that the affected insured persons have received knowledge of the termination declaration.

(11) If the health insurance is provided on the model of life insurance, the policyholder and the insured person shall have the right to continue the terminated agreement in the form of entitlement insurance.

II

(1) The minimum term of contract shall be two years.

(2) In the case of a termination in due time pursuant to § 13 (3) MB/KK 2009, the comprehensive healthcare cost insurance shall technically cease in relation to the affected insured persons and the affected insured tariff at the end of the month in which the insurance requirement has occurred. This provision shall apply accordingly if a claim to family assistance is obtained for an insured person as a consequence of an insurance requirement by a operation of law.

The premium components attributable to the period as of the occurrence of the insurance requirement until the technical cessation of the agreement shall be repaid or, upon the continuation of health insurance, netted out with future premiums. The insurance coverage shall then cease, also for pending insurance events, upon the date of the occurrence of the insurance requirement; the insurer shall point this out to the policyholder in the confirmation of the termination.

(3) An ended insurance agreements may be put into effect again while maintaining the original age of entry and waving the observance of new waiting periods, if this is requested within 6 months after the cessation thereof and the reanimation becomes effective after this period at the latest. For this purpose, a new insurance application must be submitted.

(4) The insurance requirements in one of the states mentioned in § 1 (5) MB/KK 2009 shall be equivalent to the insurance requirement in § 13 (3) MB/KK 2009.

(5) The continuation of a terminated insurance relation in the form of entitlement insurance in accordance with § 13 (11) MB/KK 2009 must be requested at the latest within two months after the cessation of the insurance relation. The continuation shall directly follow the previous insurance.

(6) For insurance agreements for substitute health insurance policies concluded before 1 January 2009, the following shall apply: At variance with § 13 (8) MB/KK 2009, the policyholder may request that the insurer transfer the calculated old-age reserves of the insured person in the amount of the portion of the insurance the benefits of which correspond to the basic tariff to the new insurer, provided the insured person switches to the basic tariff of the new insurer and the termination of the existing insurance relation is declared in the period from 1 January 2009 to 30 June 2009 effective as of the next possible date.

(7) In the event of termination in accordance with § 13 (3) MB/KK 2009, the insurer agrees to accept an application for additional insurance without a renewed risk review and without renewed waiting periods, provided the additional insurance and the statutory insurance coverage do not together exceed the previous scope of benefits. In doing so, the calculated old-age reserves of the performance range, that is also included in the additional insurance, is credited to the corresponding extent. The additional insurance must thereby begin immediately after the terminated tariff and the insurer must receive the application within three months after the occurrence of the insurance at the latest.

§ 14 Termination by the insurer

I

(1) In healthcare cost insurance serving to fulfill the insurance requirement (§ 193 (3) of the Insurance Contract Act – see annex) and in substitute healthcare cost insurance pursuant to § 195 (1) of the Insurance Contract Act (see annex), a right to routine termination shall be excluded. This shall also apply to daily hospital benefit insurance existing in addition to comprehensive healthcare cost insurance.

(2) If the prerequisites in accordance with para. 1 do not exist for daily hospital benefit insurance or partial healthcare cost insurance, the insurer may terminate the insurance relation only within the first three insurance years upon notice of three months effective from the end of an insurance year.

(3) The provisions of law on the right to extraordinary termination shall not be prejudiced hereby.

(4) Termination may be limited to individual insured persons or tariffs.

(5) If the insurer terminates the insurance relation as a whole or for individual insured persons, § 13 (10), Sentences 1 and 2 shall apply correspondingly.

II

(1) The insurer shall waive the routine termination right in the entire partial healthcare cost insurance.

(2) The rights of the insurer pursuant to § 19, para. 2 to 4 of the Insurance Contract Act (see annex) in the event of a negligent breach of the contractual notification duty shall expire three years after the closing date of the agreement or the increase of the insurance coverage. This shall not apply to insurance events that occur before the expiry of this period. If the policyholder has intentionally or fraudulently breached the notification duty, the period shall be 10 years.

§ 15 Miscellaneous grounds for termination

I

(1) The insurance relation shall cease with the death of the policyholder. However, the insured persons shall have the right to continue the insurance relation by naming the future policyholder. The declaration must be issued within two months after the death of the policyholder.

(2) In the event of the death of an insured person, the insurance relation shall cease in this regard.

(3) If an insured person relocates his or her habitual residence to state other than the states mentioned in § 1 (5), the insurance relation shall cease in this regard, unless continued based on an arrangement to the contrary. Within the framework of this arrangement to the contrary, the insurer may request a reasonable premium surcharge. In the event of a merely temporary relocation of the habitual place of residence to a state other than those mentioned in § 1 (5), it may be requested to transform the insurance relation into an qualifying period insurance.

II

(1) In the tariffs CK, MA, MAN, MAS, MKH, MS, MSW, PRIMO M and ZV, the insurance relation shall also cease upon the elimination of the insurance eligibility pursuant to Section I of the tariff. The insured persons shall have the right to extend, in the amount of the previous insurance coverage, the reclassification to other healthcare cost rates with the same benefits opened for new applicants; the length of the preliminary insurance shall be credited towards the waiting periods and taken into account when determining the premium pursuant to § 8a (2) MB/KK 2009.

The application for reclassification must be submitted within two months after the cessation of the preliminary insurance. § 15 (3) MB/KK 2009 shall not be prejudiced hereby.

(2) If a divorce judgment or a judgment for the rescission of a life partnership exists, then the affected spouses or life partners shall have the right to continue their portions of the contract as independent insurance relations. This shall also apply if the spouses or life partners live separately.

(3) A stay in a state other than those mentioned in § 1 (5) MB/KK 2009 for a maximum of 6 months shall not be considered as the relocation of the habitual place of residence. Temporary interruptions shall be included when calculating the length of this day.

If the habitual place of residence is not been relocated, insurance coverage shall exist pursuant to § 1 (4) MB/KK 2009 and § 1 (3) of the Tariff Conditions.

(4) In the substitute health insurance, the insurer agrees to reach a different arrangement in accordance with § 15 (3) MB/KK 2009 if this is requested at the latest within 6 months after the relocation of the habitual place of residence and the granting of insurance cover in the other country is permissible. The different arrangements may foresee a change in the tariff to a different tariff and commence immediately after the previous insurance relation.

If the insurer is no longer permitted to offer insurance cover in the country to which the insured person has transferred his or her habitual place of residence, then the insurance relationship will end at the time from which the insurer is no longer permitted to insure the insured person.

In both cases, in order to preserve the acquired rights and the old-age reserves due to a later relocation of the habitual place of residence to Germany, it can be agreed on an additional qualifying period insurance policy for the previous insurance relation. The prospective insurance must be applied for at the latest within 6 months after the transfer of the habitual place of residence or after the termination of the insurance relationship and must immediately follow the previous insurance.

(5) The transformation to an qualifying period insurance in accordance with § 15 (3) MB/KK 2009 must be requested at the latest within six months after the relocation of the habitual place of residence.

Miscellaneous provisions

§ 16 Declarations of intent and notices

I

Declarations of intent and notices to the insurer must be made in text form.

§ 17 Place of jurisdiction

I

(1) The courts of the place where the policyholder has his or her domicile or, in the absence of any domicile, his or her habitual place of residence shall be competent for actions based on the insurance relation against the policyholder.

(2) Actions against the insurer may be filed with the court at the domicile or habitual place of residence of the policyholder or at the court at the registered office of the insurer.

(3) If the policyholder relocates his or her domicile or habitual place of residence after the closing of the agreement to a state which is not a member state of the European Union or a contracting state of the Agreement on the European Economic Area, or if his or her domicile or habitual place of residence is not known at the time the action is filed, the court at the registered office of the insurer shall be competent.

§ 18 Modifications of these General Terms and Conditions of Insurance

I

(1) In the event of any change in the circumstances of the health care system to be viewed as not merely temporary, these General Terms and Conditions of Insurance and the Tariff Conditions may be adjusted to the altered circumstances, provided the changes appear necessary to sufficiently safeguard the interests of the policyholders and an independent trustee reviews the prerequisites for the changes and their adequacy. The changes shall be effective at the start of the second month following the notice to the policyholders of the changes and the applicable grounds.

(2) If a provision in the General Terms and Conditions of Insurance is declared invalid by a Supreme Court decision or by non-appealable administrative act, the insurer may replace such provision through a new provision, provided such provision is necessary for the continuation of the agreements or provided adherence to the agreement would represent an unreasonable hardship for either party without the new provision, also with due regard to the interests of the other party. The new provision shall only be valid if it adequately takes into account, while safeguarding the purpose of the agreement, the interests of the policyholder. Two weeks after the new provision and the applicable grounds have been communicated to the policyholder, the new provision shall form an integral component of the agreement.

§ 19 Switch to the standard tariff

I

(1) The policyholder may request for insured persons of his or her agreement who meet the prerequisites mentioned in § 257, para. 2a (2), 2a and 2b of Title V of the Social Code as amended prior to 31 December 2008 (see annex) to be able to switch to the standard tariff with the maximum premium guarantee. To warrant this premium guarantee, the surcharge determined in the technical bases of calculation shall be charged. In addition to the standard tariff, no further healthcare costs or comprehensive

insurance may exist pursuant to Sections 1 (5) and 9 of the Tariff Conditions of the standard tariff for an insured person. The switch shall be possible at any time after the fulfillment of the statutory prerequisites; the insurance in the standard tariff shall begin as of the first of the month following the application of the policyholder to switch to the standard tariff.

(2) Para. 1 shall not apply to agreements concluded as of 1 January 2009.

§ 20 Switch to the basic tariff

I

The policyholder may request for insured persons of his or her agreement to be able to switch to the basic tariff with the maximum premium guarantee and premium reduction, if the existing comprehensive healthcare cost insurance was concluded as of 1 January 2009 or the insured person has turned 55 years of age or has not reached the age of 55 but fulfills the prerequisites for the claim to pension in the statutory pension insurance scheme and has applied for such pension or procures a pension in accordance with civil servant or comparable provisions of law or is in need of assistance in accordance with Title II or XII of the Social Code. To warrant these premium limitations, the surcharge determined in the technical bases of calculation shall be charged. § 19 (1), Sentence 4 shall apply correspondingly.

Reference to the consumer arbitration board Ombudsman Private Health and Nursing Care Insurance

Policyholders who are not satisfied with decisions made by the insurer, or whose negotiations with the insurer have not led to the desired result, can turn to the Private Health and Nursing Care Insurance Ombudsman.

Ombudsman Private Health and Nursing Care Insurance
PO Box 06 02 22
10052 Berlin
Web: www.pkv-ombudsmann.de

The ombudsman for Private Health and Nursing Care Insurance is an independent arbitration board that works free of charge for consumers. The insurer has undertaken to participate in the arbitration proceedings.

Consumers who have concluded their contract online (e.g. via a website) can also submit their complaint online to the http://ec.europa.eu/consumers/odr/ platform. Your complaint will then be forwarded via this platform to the Private Health and Nursing Care Insurance Ombudsman.

Note: The Private Health and Nursing Care Insurance Ombudsman is not an arbitration board and cannot make binding decisions on individual disputes.

Reference to the insurance supervision

If policyholders are not satisfied with the service provided by the insurer or if disagreements arise during the processing of the contract, they can also contact the supervisory authority responsible for the insurer. As an insurance company, the insurer is subject to supervision by the German Federal Financial Supervisory Authority.

Federal Financial Supervisory Authority (BaFin)
Sector Insurance Supervision
Graurheindorfer Straße 108
53117 Bonn
Mail: poststelle@bafin.de

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

Reference to the legal process

Regardless of the possibility of turning to the consumer arbitration board or the insurance supervisory authority, taking legal action is open to the policyholder.

Annex – Legislative texts

Insurance Agreement Act [Versicherungsvertragsgesetz, VVG]

§ 14 Due date of the cash benefit

(1) Cash benefits of the insurer shall be due upon the cessation of the investigations necessary to determine the insurance event and the scope of the benefits to be rendered by the insurer.

(2) If these investigations are not completed within one month after the notification of the insurance event, the policyholder may request installment payments in the minimum amount tentatively payable by the insurer. The running of the period shall be interrupted so long as the investigations cannot be completed as a consequence of the negligence of the policyholder.

(3) Any agreement through which the insurer is released from the duty to pay default interest shall be invalid.

§ 19 Notification duty

(2) If the policyholder breaches his or her notification duty in accordance with para. 1, the insurer may rescind the agreement.

(3) The rescission right of the insurer shall be excluded if the policyholder has not breached the notification duty either intentionally or due to gross negligence. In such event, the insurer shall have the right to terminate the agreement in observance of a notice period of one month.

(4) The rescission right of the insurer due to a grossly negligent breach of the notification duty and its termination right in accordance with para. 3, Sentence 2 shall be excluded if the insurer would have concluded the agreement had it had knowledge of the undisclosed circumstances, if at other terms and conditions. The other terms and conditions shall form an integral component of the agreement retroactively at the insurer's request; in the case of a breach of duty for which the policyholder is not responsible, as of the current insurance period.

§ 28 Breach of a contractual obligation

(1) In the event of a breach of a contractual obligation which is to be fulfilled by the policyholder in relation to the insurer before the occurrence of the insurance event, the insurer may terminate the agreement without notice within one month after which the insurer receives knowledge of the breach, unless the breach is not based on intentional action or gross negligence.

(2) If the agreement stipulates that the insurer is not obliged upon the breach of a contractual obligation to be fulfilled by the policyholder to render benefits, the insurer shall be free of the duty to render benefits, provided the policyholder has intentionally breached the obligation. In the event of a grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in corresponding proportion to the severity of the negligence of the policyholder; the burden of proof for the non-existence of gross negligence shall be borne by the policyholder.

(3) At variance with para. 2, the insurer shall be obliged to render benefits if the breach of the obligation was not the cause of the occurrence or the determination of the insurance event order for the determination or scope of the insurer's duty to render benefits. Sentence 1 shall not apply if the policyholder has fraudulently breached the obligations.

(4) In the event of a breach of a duty to provide information or clarification existing after the occurrence of an insurance event, the full or partial freedom of the insurer from the duty to render benefits in accordance with para. 2 shall be contingent on the prerequisite that the insurer has instructed the policyholder through separate notice in text form of this legal consequence.

§ 37 Default in payment of initial premium

(1) If the one-time or initial premium is not paid in due time, the insurer shall be entitled as long as the payment is not affected to rescind the agreement, unless the policyholder is not responsible for the non-payment.

(2) If the one-time or initial premiums are not paid upon the occurrence of the insurance event, the insurer shall not be obliged to render benefits, unless the policyholder is not responsible for the non-pay-

ment. The insurer shall only be free of the duty to render benefits if the insurer has made the policyholder aware through separate notice in text form or through a conspicuous indication in the insurance certificate of this legal consequence of the failure to pay the premium.

§ 38 Default in the payment of subsequent premiums

(1) If a subsequent premium is not paid in due time, the insurer may establish for the policyholder at the latter's cost in text form of payment period amounting to at least two weeks. The determination shall only be valid if the premium, interest and cost amounts in arrears are specified in detail along with the legal consequences associated with the expiry of the deadline in accordance with para.s 2 and 3; in the case of summarized agreements, the amounts must be specified separately.

(2) If the insurance event occurs after the expiry of the deadline and the policyholder is in default upon the occurrence with the payment of the premium or the interest or costs, the insurer shall not be obliged to render benefits.

(3) After expiration of the deadline, the insurer may terminate the agreement without notice, provided the policyholder is in default with the payment of the owed amounts. The termination may be associated with the determination of the payment period in such fashion that the termination becomes effective upon the expiry of the deadline, provided the policyholder is in default with the payment on such date; the policyholder must be expressly referred to this consequence upon the termination. The termination shall be invalid if the policyholder renders payment within one month after the termination or, if the termination is associated with the established deadline, within one month after the expiry of the deadline; para. 2 shall not be prejudiced hereby.

§ 86 Transfer of compensation claims

(1) If the policyholder is entitled to a compensation claim against the third party, such claim shall pass to the insurer if the insurer compensates the damage. The transfer may not be asserted to the detriment of the policyholder.

(2) The policyholder must safeguard its compensation claim or any right serving to secure such claim with due regard to the applicable formalities and deadlines and collaborate in the enforcement thereof by the insurer if necessary. If the policyholder intentionally breaches this obligation, the insurer shall not be obliged to render benefits insofar as the insurer cannot obtain any compensation in this regard as a consequence thereof. In the event of any grossly negligent breach of the obligation, the insurer shall be entitled to reduce its benefits in proportion to the severity of the policyholder's negligence; the burden of proof for the non-existence of any gross negligence shall be borne by the policyholder.

(3) If the compensation claim of the policyholder against a person with whom the policyholder is living in a household community upon the occurrence of the damage, the transfer may not be asserted in accordance with para. 1, unless this person has caused the damage intentionally.

§ 193 Insured person; insurance requirement

(3) Every person domiciled in Germany shall be obliged to take out and maintain with an insurance company licensed to do business in Germany for him- or herself and for the persons legally represented by him or her, insofar as such persons cannot conclude agreements themselves, healthcare cost insurance which must encompass at minimum a cost reimbursement for out-patient and in-patient medical treatment and in which the absolute and percentage deductibles agreed for benefits foreseen in the tariffs for out-patient and in-patient medical treatment are limited for each person to be insured to the amount of EUR 5,000 per calendar year; for persons entitled to assistance, the potential deductibles shall result through analogous application of the percentage share not encompassed by the assistance rate to the maximum amount of EUR 5,000. The duty in accordance with Sentence 1 shall not exist for persons who:

1. are insured or subject to insurance in the statutory health insurance scheme; or
2. have a claim to free therapeutic care, are entitled to assistance or have comparable claims in the scope of the respective entitlement; or
3. have a claim to benefits in accordance with Asylum Seeker Benefits Act (Asylbewerberleistungsgesetz); or

4. are recipients of current benefits in accordance with Chapters 3, 4, 6 and 7 of Title 12 of the Social Code for the duration of the benefit procurement and during periods of interruptions of the benefit procurement of less than one month, provided the benefit procurement began before 1 January 2009.

A healthcare cost insurance agreement concluded prior to 1 April 2007 shall satisfy the requirements in Sentence 1.

§ 195 Duration of insurance

(1) The health insurance, which may replace the health or nursing care insurance coverage foreseen in the statutory social security insurance system in whole or in part (substitute health insurance), shall be temporally unlimited subject to para. 2 and 3 and §§ 196 and 199. If the non-substitute health insurance is provided on the model of life insurance, Sentence 1 shall apply accordingly.

Insurance Supervision Act [Versicherungsaufsichtsgesetz, VAG]

§ 146 Substitute health insurance

(1) Insofar as the health insurance may replace the health or nursing care insurance coverage foreseen in the statutory social security insurance system in whole or in part (substitute health insurance), the health insurance may only be provided in Germany, subject to para. 3, on the model of life insurance, whereby [...]

5. the insurance contract must stipulate the conveyance of the transfer value of that portion of the insurance the benefits of which correspond to the basic tariff in the terms of § 152 para. 1 upon the switch of the policyholder to another private health insurance company. The shall not apply to contracts concluded before 1 January 2009 and [...]

§ 149 Premium surcharge in the substitute health insurance

In substitute healthcare cost insurance a surcharge is to be charged for the insured person of 10% of the annual zillmerized gross premium at the latest at the start of the calendar year following the year in which the insured person turns 21 years of age and ending in the calendar year in which the insured person turns 60 years of age. This surcharge is transferred directly each year to the old-age reserce in accordance with § 341f(3) of the Commercial Code and used for premium reductions in old age in accordance with § 150(3). Sentence 1 and 2 shall not apply to insurance policies with temporally limited terms of contract in accordance with § 195, para. 2 and 3 of the Insurance Contract Act or to tariffs which regularly end at the latest when the statutory retirement age is reached or to the emergency tariff in accordance with § 153.

§ 150 Credit for oldd-age reserve; direct credit

(1) The insurance company must credit insured persons in healthcare cost and voluntary nursing care insurance provided on the model of life insurance (nursing care cost and daily nursing benefit insurance) the annual interest income incurred on the aggregate positive old-age reserve from the affected insurance policies existing as of the close of the previous financial year. This credit note shall amount to 90% of the average principal amounts beyond the notional return (surplus interest).

(2) Of the amount computed in accordance with para. 1, insured persons who have rendered the premium surcharge in accordance with § 149 are to be directly credited each year until the close of the financial year in which they turn 65 years of age the full share attributable to the portion of the old-age reserve which arose based on this premium surcharge. Fifty percent (50%) of the residual amount is to be credited directly each year to the old-age reserve of all insured persons. The percentage in accordance with Sentence 2 shall increase as of the financial year of the insurance company beginning in 2001 each year by 2% until it has reached 100%.

(3) The amounts in accordance with para. 2 are to be used when the insured person reaches the age of 65 for the temporally unlimited financing of additional premiums from premium increases or a portion of the additional premiums, to the extent the existing funds are not sufficient for the complete financing of the additional premiums. Unconsumed amounts are to be used when the insured person reaches the age of 80 to reduce the premiums. Write-ups after this point in time are to be used to immediately reduce premiums. In the voluntary daily nursing benefit insurance, the terms and conditions of insurance may provide for corresponding

increase in benefits in lieu of a reduction in premiums.

(4) The portion of the interest income computed in accordance with para. 1 remaining after deduction of the amounts used in accordance with para. 2 is to be established for the insured persons who have reached the age of 65 on the balance sheet date as a contingent premium reimbursement and to be used within three years to avert or limit premium increases or for premium reductions. The premium reduction pursuant to Sentence 1 may only be restricted provided the premium of the insured person does not sink below the original premium upon the age at entry; the unconsumed portion of the credit is then to be credited additionally pursuant to para. 2.

§ 153 Emergency tariff

(1) Non-payers in accordance with § 193(7) of the Insurance Contract Act shall form a tariff in the terms of § 155(3), Sentence 1. The emergency tariff provides exclusively for the reimbursement of expenses for services necessary for the treatment of acute illnesses and pain as well as during pregnancy and motherhood. At variance therefrom, expenses are to be reimbursed for insured children and youth particularly for preventative checkups for early detection of illnesses in accordance with legally initiated programs and for vaccinations recommended by the Standing Vaccination Commission at the Robert Koch Institute pursuant to § 20(2) of the Infection Protection Act.

(2) For all insured persons in the emergency tariff, a uniform premium is to be calculated; otherwise § 146(1), Nos. 1 and 2 shall apply. For insured persons whose agreement only provides for the reimbursement of a percentage of the expenses incurred, the emergency tariff grants benefits in the amount of 20, 30 or 50% of the insured treatment costs. § 152(3) shall apply accordingly. The calculated premiums from the emergency tariff may not be higher than necessary to cover the expenses for insurance events from the tariff. Additional expenses arising to warrant the limits mentioned in Sentence 3 are to be distributed equally among all policyholders of the insurer with an insurance meeting a requirement from § 193(3), Sentence 1 of the Insurance Contract Act. The old-age reserve is to be credited towards the premiums payable in the emergency tariff in such fashion that up to 25% of the monthly premium is rendered through withdrawals from the aging provision.

§ 338 Surcharge in the health insurance

If the substitute health insurance agreement was concluded before 1 January 2000, § 149 shall be applicable, subject to the condition that:

1. the surcharge is initially to be charged on the first of January of the calendar year following 1 January 2000,
2. the surcharge amounts in the first year to 2% of the gross premium and increases on each first of January of the following year by 2%, though to no more than 10% of the gross premium, unless it is no longer applicable due to reaching 60 years of age,
3. the insurance company is obliged to notify the policyholder in due time before the initial charging of the surcharge of the amount thereof and the annual increments, and
4. the surcharge is only to be charged if the policyholder does not object in writing within three months after the receipt of the notice in accordance with No. 3.

Life Partnership Act [Lebenspartnerschaftsgesetz, LPartG]

§ 1 Form and prerequisites

(1) Two persons of the same sex, who declare to the civil registrar in person when simultaneously present that they want to maintain a partnership with each other for life (life partners) shall establish a life partnership. The declarations may not be issued under any condition or defined time.

(2) The civil registrar shall ask the life partners individually whether they want to establish a life partnership. If the life partners answer this question in the affirmative, the civil registrar shall declare that the life partnership has now been established. The establishment of the life partnership may occur in the presence of up to two witnesses.

(3) A life partnership cannot be validly established:

1. with a person who is a minor or with a third person who is married or already maintains a life partnership with another person;

2. between persons who are related to each other in direct line;

3. between full or half siblings;

4. if the life partners agree during the establishment of the life partnership that they do not want to establish any obligations pursuant to § 2.

(4) No petition for the establishment of a life partnership may be filed based on the promise to establish a life partnership. Section 1297(2) and §§ 1298 to 1302 of the Civil Code shall apply accordingly.

Social Code – Title V [Sozialgesetzbuch – Fünftes Buch, SGB V]

§ 257 Premium supplements for employees [valid until 31 December 2008)]

(2a) The supplement in accordance with para. 2 shall only be paid as of 1 July 1994 for a private health insurance policy if the insurance company:

2. agrees to offer for insured persons who have reached the age of 65 and who have preliminary insurance time of at least 10 years in a substitute insurance coverage (§ 12 (1) of the Insurance Supervision Act) or who have reached the age of 55, whose total annual income (§ 16 of Title IV) does not exceed the annual salary limit in accordance with § 6 (7) and have this preliminary insurance time a standard tariff, uniform throughout the industry, the contractual benefits of which are comparable to the benefits of this Title for illness and the premium for which for individuals does not exceed the average maximum premium of the statutory health insurance scheme and for spouses or life partners does not exceed in total 150% of the average maximum premium of the statutory health insurance scheme, provided the annual total income of the spouses or life partners does not exceed the annual salary limit;

2a. agrees to offer the standard tariff, uniform throughout the industry, under the prerequisites mentioned in No. 2 also to persons who have not reached the age of 55, who meet the prerequisites for the claim to pension in the statutory pension insurance scheme and have applied for this pension or procure a pension in accordance with the provisions of civil service or comparable law; this shall also apply to family members who were insured as a family through the insurance requirement of the policyholder in accordance with § 10;

2b. agrees to also offer insured persons who have a claim upon illness to assistance in accordance with the provisions or principles of civil service law and their eligible relatives under the prerequisites set forth in No. 2 a standard tariff, uniform throughout the industry, the contractual benefits of which supplementing the assistance are comparable upon illness to the benefits of this Title and the premium for which results from the application of the percentage share not covered by the assistance rate to the maximum premium set forth in No. 2;