General Terms and Conditions of the Supplementary Insurance for Travel Abroad according to the Tariff URZ.

Version of January 2019

Essential Parts of the Tariff URZ.

Insurance cover for holiday trips abroad lasting up to 8 weeks

Out-patient medical treatment

- 100% cost reimbursement for out-patient medical treatment
- 100% cost reimbursement for remedies as itemised in the tariff
- 100% cost reimbursement for medicines and dressings

Dental benefits

- 100% cost reimbursement for pain-relieving dental treatment
- 100% cost reimbursement for the repair of dentures

In-patient medical treatment

- 100% cost reimbursement for accommodation
- 100% cost reimbursement for medical treatment
- 100% cost reimbursement for ambulance services

Return transport of patients from abroad

Not insured are

- dentures including crowns, inlays and orthodontics
- psychotherapy
- treatment at a spa resort or sanatorium
- aids

Contents

§ 1 Subject, scope and applicability of the insurance cover

(1) The insurer provides insurance cover for illnesses, accidents and other events that are specified in the policy. The insurer shall provide additional, directly associated services if this is agreed. In the event of an unforeseen insured event occurring abroad, the insurer will provide reimbursement of medical treatment costs and other agreed services.

(2) The insurance cover shall apply in relation to foreign countries. Countries where the insured person has his permanent place of residence are not deemed to be foreign countries, and nor is the Federal Republic of Germany.

(3) An "insured event" shall mean the medically necessary treatment of an insured person due to an illness or the consequences of an accident. The insured event shall commence with the medical treatment and it shall cease when no further need for treatment exists in accordance with the medical findings. An insured event is also deemed to include death.

(4) The scope of the insurance cover is as set out in these General Terms and Conditions of Insurance and in written agreements as well as the in the legal provisions of the Federal Republic of Germany.

(5) The insurance cover applies to any trips abroad in which each individual stay abroad does not exceed an uninterrupted duration of 8 weeks. In the case of a longer stay abroad, insurance cover is provided for the first 8 weeks (cf. in this regard § 7 para. 2).

(6) The persons who are eligible for the insurance are any persons who are resident in the area where the insurer operates its business, provided that they are also accepted for insurance under a health insurance, daily sickness benefit insurance or long-term care insurance policy, or that they are insured under at least one of these tariffs. **When the insurances specified in sentence 1 ends, the insurance under the tariff URZ. also ends.**

§ 2 Taking out, duration, and nature of the insurance policy

(1) The insurance policy must be taken out before the start of the journey. It comes into being once the proposal and the quotation are accepted.

The proposer or the party who receives the quotation is deemed to be the policyholder.

(2) The insurer may cancel the insurance relationship with effect from the end of an annual period of insurance – but not prior to the expiry of an agreed policy period – by giving 3 months' prior notice.

(3) The insurance under the tariff URZ. is a health insurance policy with a fixed premium in accordance with the provisions of the insurer's Articles of Association.

§ 3 Inception of insurance coverage

(1) The insurance coverage shall commence on the date and at the time that is specified in the insurance certificate (inception of the insurance), but not before the concluding of the insurance policy (in particular the receipt of the insurance certificate or of a written letter of acceptance). No benefit shall be paid in respect of insured events which have occurred before the inception of the insurance cover. Insured events which occur after the concluding of the insurance policy shall only be excluded in relation to the portion of the duty to provide benefits which relates to the period before the inception of the insurance.

(2) In the case of new-born infants, the insurance coverage shall commence as from the completion of the birth, provided that, on the date of the birth, one of the parents has been insured with the insurer for at least 3 months, and the notification of the child to the insurer is made retrospectively no later than 2 months after the date of the birth. Insurance cover is also provided for any health impairments which arise before the birth is completed and in respect of any birth defects, congenital diseases and anomalies. The insurance coverage must not provide higher benefits or wider cover than those provided under the policy of one of the insured parents.

(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.

§ 4 Scope of the duty to provide benefits

(1) The insured person shall be entitled to be treated by any doctor or dentist who is licensed to provide medical treatment in the country where he is staying.

(2) Medicines, dressings, remedies and aids must be prescribed by the parties providing treatment who are specified in para. 1, and furthermore, medicines must be obtained from a chemist/pharmacy.

(3) In the case of medically necessary medical treatment, the insured person is free to choose any hospitals which are under permanent medical direction, have sufficient diagnostic and therapeutic facilities, and keep patient records. The hospital which is situated at the location where the insured person is staying or the nearest available suitable hospital must be used.

(4) Reimbursement can be paid for

4.1 medically necessary expenses for

a) medical treatment.

b) medicines, remedies and dressings based on a doctor's prescription. Remedies are deemed to include radiation therapy, inhalations and electrophysical measures.

c) pain-relieving dental treatment and any necessary tooth fillings of a basic design, as well as denture repairs.

d) accommodation, food and care in the hospital.

e) the medically necessary transportation for inpatient treatment to the nearest available suitable hospital or to the nearest available emergency doctor.

4.2 a) 100% of the necessary costs of repatriation which is necessary for medical reasons (transportation of ill or injured persons who are unable to undertake travel as a normal passenger using their own means of transport or public transport) to the Federal Republic of Germany if the insured person has his habitual place of residence in the Federal Republic of Germany, and if adequate medical treatment cannot be guaranteed in the immediate locality or within a reasonable distance and there is a risk this will have an adverse impact on the person's health. The claim to the reimbursement of costs shall be reduced by the return travel costs that would have been incurred in the normal course of the journey, provided that the insured person is entitled to reimbursement due to not having made use of those arrangements. If the insured person transfers his habitual place of residence to another member state of the European Union or to another state which is party to the Agreement on the European Economic Area or to Switzerland, sentences 1 and 2 shall apply accordingly to return transportation to the state to which the habitual place of residence has been relocated.

b) 100% of the necessary costs of a transfer to the Federal Republic of Germany in the event of death if the insured person has his habitual place of residence in the Federal Republic of Germany, up to an amount of € 5,000 in the case of a transfer from another European country, and otherwise up to € 10,000. If the insured person relocates his habitual place of residence to another member state of the European Union or to another state which is party to the Agreement on the European Economic Area or to Switzerland, sentence 1 shall apply accordingly to a transfer in the event of death to the state to which his habitual place of residence has been transferred.

c) 100% of the expenses for a funeral outside of the Federal Republic of Germany in the event of death during a temporary stay abroad, up to the amount that would have been reimbursed for return transportation if the insured person had his habitual place of residence in the Federal Republic of Germany. If the insured person transfers his habitual place of residence to another member state of the European Union or to another state that is party to the Agreement on the European Economic Area or to Switzerland, sentence 1 shall apply accordingly to a funeral outside of the state to which the habitual place of residence has been transferred.

d) In respect of payments according to § 4 para. 4.2 a) to c) the limitation to a travel period of 8 weeks (see § 1 para. 5) does not apply if in addition to the tariff URZ. there is a Comprehensive Health Insurance policy in force with Hallesche Krankenversicherung.

§ 5 Restriction of the duty to provide benefits

(1) There shall be no obligation to provide benefits in relation to:

1.1 illnesses and their consequences or the consequences of an accident which have been caused by

events of war or by involvement in unrest, or those which are caused by active participation in types of sport which are not generally viewed as being part of a normal holiday, unless the insurer has provided its agreement in advance.

The restriction of the duty to provide benefits according to sentence 1 shall not apply to events of war abroad if:

a) there is no travel warning in force that has been issued by the Federal Foreign Office in relation to travel to and stays in the area concerned; or

b) a travel warning advising people not to travel to or stay in the area concerned is only issued during the stay, and the insured person leaves the area of his stay without delay, or if is prevented by reasons beyond his control from leaving the area concerned. Such a reason exists, for example, if leaving the area is only possible at considerable risk to personal safety.

Terrorist attacks and their consequences are not deemed to be events of war within the meaning of sentence 1.

1.2 illnesses and accidents, including their consequences, which are due to intentional acts or to dependency, or to drug addiction/rehabilitation and detoxification treatments.

1.3 examinations and treatment due to pregnancy, the termination of pregnancy, miscarriage and childbirth. However, expenses are reimbursed if unforeseen medical care is required in the country in which the insured person is staying due to complications which arise suddenly during pregnancy, and if it is required subsequently in the event of a miscarriage or premature birth or a termination of pregnancy (which is not unlawful).

1.4 dentures including crowns, inlays and in respect of orthodontic treatment.

1.5 the treatment of mental disorders and emotional disturbances, or in the case of psychotherapy.

1.6 treatments which are not immediately necessary in order to treat illnesses, in particular those for the rectification of cosmetic defects and physical anomalies, or benefits relating to care staff, medical reports and certificates, disinfection measures and vaccinations, or travel costs associated with outpatient treatment (excluding emergency transport following an accident).

1.7 foodstuffs and dietary supplements, cosmetic preparations and substances which are taken on a prophylactic or habitual basis.

1.8 treatment at a spa or sanatorium as well as rehabilitation measures.

1.9 out-patient medical treatment at a spa or health resort. The restriction no longer applies if medical treatment becomes necessary during a temporary stay abroad due to an illness which is not linked to the purpose of the stay or due to an accident that has occurred there.

1.10 treatments for spouses or life partners pursuant to § 1 of the Life Partnership Act (see Annex), or for parents or children; proven material costs will be reimbursed according to the tariff.

1.11 for treatment or accommodation that is required due to a need for care or secure accommodation.

1.12 aids.

(2) If a medical treatment or another measure for which benefits are agreed goes beyond what is medically necessary, the insurer may reduce its benefits to a reasonable amount. The insurer shall not be obliged to provide benefits insofar as any expenses for medical treatment or other services are clearly disproportionate to the services provided. This is based on the circumstances in the respective country in which the insured person is staying.

(3) If there is an entitlement to benefits under the statutory health, accident or pension insurance or an entitlement to civil service medical cover or accident cover, the insurer is only obliged to reimburse expenses which are still necessary despite such benefits.

(4) If the insured person has a claim against several parties that are liable to provide reimbursement, the total reimbursement may not exceed the total expenses that have been paid.

(5) In the event of an insured event, can compensation be paid from other insurance contracts are claimed, these performance obligations take prece-

dence. If there is an entitlement to payments from funding agencies other than the ones which are specified in § 5 para. 3, the policyholder is free to decide to which one it reports the loss. If the policyholder initially reports the loss to Hallesche Krankenversicherung a.G., the latter will make advance payment in accordance with its obligations. As a supplement to this, § 12 of the Terms and Conditions of Insurance shall apply.

(6) If the insured person has already received reimbursement of his expenses from third parties who are liable to pay compensation, the insurer is entitled to deduct the reimbursement from the amounts that it pays. The policyholder may not demand any reimbursement in overall terms which exceed the overall loss.

§ 6 Payment of the insurance benefits

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

(2) Original versions of the invoices must be submitted. They must contain the first name and surname of the treated person, the designation of the illnesses (diagnoses), details of the individual services provided by the party which has provided treatment, and the treatment details. The receipts must clearly show the prescribed medicine(s), its/their price, and the note confirming payment. In the case of dental treatment, the receipts must designate the teeth in respect of which treatment has been provided as well as the treatment that has been provided in relation to them.

Appropriate evidence must be provided in respect of other services. If there is also another insurance policy which provides cover, duplicate invoices confirming the benefits paid by the other insurance provider shall also be recognised. They will also be recognised in the case of other countries where the originals have been retained.

(3) In addition to the cost receipts, a medical certificate confirming the cause of death or an official death certificate must be submitted for the reimbursement of repatriation expenses or of burial expenses which are incurred abroad.

(4) The insurer shall be obliged to pay benefits to the insured person if the policyholder has designated the insured person in writing to it as the person who is entitled to receive payments under his insurance policy. If this condition does not apply, only the policyholder may demand the benefit payment.

(5) The costs which are incurred in a foreign currency shall be converted into euros at the current exchange rate on the day on which the receipts 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 rates are specified, the exchange rate pursuant to the latest version of the "Foreign Currency Statistics" published by the German Bundesbank, Frankfurt am Main, shall apply, unless the insured person shows by means of a document supplied by the bank that he has purchased the foreign currency that is necessary to pay the invoices at a less favourable exchange rate.

(6) The expenses for transferring insurance payments to foreign countries or for special forms of transfer which are chosen in accordance with the policyholders instructions may be deducted from the payments that are made.

(7) Entitlements to insurance benefits may not be assigned or pledged.

§ 7 End of the insurance cover

The insurance cover ends

1. when the insurance policy ends. This also applies to outstanding claims. If an illness or the consequences of an accident requires the extension of a stay abroad beyond the end of the insurance policy owing to an inability to travel or to be transported, insurance cover is extended in respect of the illness concerned or in respect of the consequences of the accident for a further period of no more than 4 weeks, or for a maximum of 8 weeks if the insurance policy is ended by the insurer.

2. at the end of an uninterrupted stay abroad of 8 weeks' duration.

If the insured event occurs during the first 8 weeks and if an illness in respect of which a benefit is payable or the consequences of an accident requires the stay abroad to be extended beyond 8 weeks owing to medical reasons, the duty to provide benefits is extended in relation to that illness or the consequences of that accident until the insured per-

son is once again able to undertake the return journey. § 7 para. 1 remains unaffected by this.

§ 8 Ending of the insurance policy / the insurance relationship

(1) The insurance policy ends upon the policyholders' death or when the eligibility for insurance ends according to § 1 para. 6. However, the insured persons shall have the right to continue the insurance policy by naming the person who is to be the future policyholder. The declaration must be submitted within two months after the death of the policyholder.

(2) If, after the policy is concluded, the insured person relocates his habitual place of residence to another member state of the European Union or to another state which is party to the Agreement on the European Economic Area or to Switzerland, the insurance relationship shall end in respect of the insured person in the absence of any agreement to the contrary. § 1 para. 6 remains unaffected by this.

In the case of any provisions under this policy, Switzerland shall be equivalent to the member states of the European Union and the states which are party to the Agreement on the European Economic Area.

§ 9 Payment of premiums

(1) The premium is an annual premium and will be charged as from the inception of the insurance. It shall be payable at the start of each insurance year, but it may also be paid in equal monthly premium instalments, each of which shall be deemed to be deferred until the premium instalments are due. The premium instalments shall be due on the first of each month.

(2) The monthly premium instalment is € 1.50 per person until the end of the year in which the insured person reaches his 65th birthday. As from the beginning of the next year it is € 4.

§ 10 Obligations

(1) The policyholder and the insured person who is named as being entitled to receive payment (cf. § 6 para. 4.) must, at the request of the insurer, provide any information which is necessary in order to ascertain the insured event or the insurers duty to provide benefits and the extent of that duty.

(2) At the request of the insurer, the insured person shall be obliged to have himself examined by a doctor who is commissioned by the insurer.

(3) Upon request, the insurer shall be authorized to grant any information which is necessary for ascertaining the insured event, or the insurers duty to provide benefits and the extent of such benefits, from doctors, hospitals and other healthcare institutions, care homes and care staff, and from other providers of personal insurances and from statutory health insurance providers as well as employment injuries and occupational sickness insurance funds and authorities.

(4) In the event of a benefit being paid, evidence must be provided of the start and finish of each journey abroad if this is demanded by the insurer.

§ 11 Consequences of breaches of obligations

(1) Subject to the restrictions which are specified in § 28, paras. 2 to 4 of the VVG (Insurance Contract Act) (see Annex), the insurer is either fully or partially released from the duty to pay benefits if one of the duties that is referred to in § 10 is breached.

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

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

If the policyholder or an insured person has compensation claims against third parties, he must – irrespective of the transfer of claims that is legally stipulated by pursuant to § 86 of the Insurance Contract Act (see Annex) – assign those claims to the insurer in writing up to the amount for which compensation is provided under the insurance policy (cost reimbursements, benefits in kind and services).

The policyholder or the insured person must safeguard his compensation claim, or any right serving to secure such claim, having due regard to the applicable formalities and deadlines, and he must assist with the asserting of the claim by the insurer insofar as this is required.

If the policyholder or an insured person deliberately surrenders such a claim, or any right serving to secure such claim, the insurer is accordingly either fully or partially released from the duty to provide benefits insofar as it is unable as a result to demand reimbursement from third parties. In the case of a grossly negligent breach of the duty, the insurer is entitled to reduce the benefits that it pays in proportion to the degree to which the policyholder is to blame.

If the policyholder or an insured person is entitled in relation to a provider of services to the repayment of fees in respect of which the insurer has provided reimbursement under the policy without there having been any legal reason for the fees to have been paid, paras. 1 to 3 shall apply accordingly.

§ 13 Set-off

The policyholder may only offset against claims of the insurer provided that the counterclaim is undisputed or is established by means of a non-appealable judgment.

§ 14 Declarations of intent and notices

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

§ 15 Place of jurisdiction

(1) 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 which has jurisdiction at the location of the insurers registered office.

(2) For actions against the policyholder which are based on the insurance policy, the competent court is the court which has jurisdiction at the place where the policyholder has his place of residence, or in the absence of any place of residence, his habitual place of residence.

(3) If the policyholder relocates his place of residence or habitual place of residence to a state which is neither a member state of the European Union nor a state which is party to the Agreement on the European Economic Area, or if his place of residence or habitual place of residence is not known at the time when the action is filed, the court at the registered office of the insurer shall have jurisdiction.

(4) § 15 para. 3 shall not apply if the place of residence or habitual place of residence is transferred to Switzerland after the policy is concluded.

(5) Out-of-court settlement of disputes:

Hallesche Krankenversicherung a.G. takes part in the arbitration procedure of the consumer arbitration board "OMBUDSMAN for Private Health and Health Care Insurance", which you can reach as follows:

OMBUDSMAN for Private Health and Health Care Insurance
P.O. Box 060222
10052 Berlin
Phone: 0800/255 04 44
(free of charge from German telephone networks)
Fax: 030/20458931
E-Mail: ombudsmann@pkv-ombudsmann.de
Website: www.pkv-ombudsmann.de

If you have concluded your contract online, for example via our website, you can use the online dispute resolution platform set up by the European Commission. The platform can be accessed via the following link: http://ec.europa.eu/consumers/odr/

§ 16 Amendments to the General Terms and Conditions of Insurance

(1) The General Terms and Conditions of Insurance and the insurance premiums listed under § 9 may be altered by the insurer. The changes shall be effective as from the start of the second month following the notification of the changes to the policyholder.

(2) Within 2 months after the notification of the change the policyholder may give notice of the cancellation of the insurance relationship as from the time when the change takes effect; otherwise the change will take effect. The notification of the change will also refer to this fact.

Annex – Legislative texts

Insurance Agreement Act [Versicherungsvertragsgesetz, VVG]

§ 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.

§ 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.

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.