HanseMerkur

Terms and conditions for international health insurance

VB-KV 2022 (B-YT-Out-D) Basic

The scope of the insurance cover is set out in the insurance certificate, in any separate written agreements, in these insurance terms and conditions, and in the statutory provisions of the Federal Republic of Germany.

We are HanseMerkur Reiseversicherung AG based in Hamburg. You are our contractual partner, the so-called policyholder, when you conclude the insurance contract with us. An insured person is both you, if you have insured yourself, and other persons who have (co-)insured you. We also refer to any such persons in these insurance terms and conditions as "you". These insurance terms and conditions apply to you as the policyholder and to you as the insured person.

The insurance terms and conditions consist of four sections.
Section I contains an overview of the types of benefit and the levels of premium associated with them.
In Section II, you will, in particular, find explanations about the insured persons, time limits for taking out insurance, and premium payments.
The full description for the types of benefit can be found in Section III.
Section IV contains an excerpt from the German Insurance Contract Act (VVG).

Contents

HanseMerkur Reiseversicherung AG Siegfried-Wedells-Platz 1 20354 Hamburg Tel.: 040 4119-1000, Fax: -3040 www.hmrv.de

Section I – Overview of payments

The full description of the insured benefits and events is given in the relevant clauses of Section III Description of benefits.

Insured benefits of travel health insurance		Benefit levels
2.1 Out-patient medical treatment		
	Out-patient medical treatment	100%
2.2 In-patient medical treatment		
2.2.1	Inpatient medical treatment	100%
2.2.2	Ambulance services	100%
2.2.3	Alternatively, daily allowance of up to 14 days, per day	EUR 50
2.3 Dental treatments		
2.3.1	Pain-relieving preservative dental treatments	100%
2.3.2	Simple fillings	100%
2.3.3	repairs of existing dental prostheses	100%
2.3.4	Dental prosthesis due to an accident per insured event	EUR 500
2.4 Medicines, dressings, remedies or aids		
2.4.1	Medications and dressing material	100%
2.4.2	Remedy Radiation therapy, light therapy and other physical treatments	 100%
2.4.3	Resources - Accident-related aids - Repairs of existing aids per insurance year	 100% EUR 250
2.5 Pregnancy		
2.5.1	Examinations; treatments for complications, premature birth, miscarriage	100%
2.5.2	Check-ups and delivery after a waiting period of 6 months for each insured event	EUR 250
2.5.3	Medical treatment costs for a baby born prematurely	100%
2.6 Repatriation, transfer, burial		
2.6.1	Repatriation of the patient, including transport costs for an accompanying person	100%
2.6.2	Transfer or burial abroad up to the amount of the transfer costs	100%
2.7 Additional service benefits		
2.7.1	Information about doctors and hospitals at the place of stay	100%
2.7.2	Information transfer between doctors	100%
2.8 Compensation for expenses		
2.8.1	For outpatient treatments, once and regardless of the number of treatments	EUR 25
2.8.2	For inpatient treatment up to 14 days, per day	EUR 50

Section II - General provisions

1 Insurance cover

1.1 Who is covered by the insurance?

1.1.1 You are insured if
- you are named in the insurance certificate and
- it has been proven that you are temporarily abroad to carry out educational measures. These include, in particular, the following groups of people:
  - Au pairs
  - Students
  - Language students
  - Academic students
  - Scholarship recipients
  - Doctoral candidates
  - Participants in Work & Travel programs

and
- at the time of application
  - you have a permanent residence in Germany and
  - you have not yet reached the age of 35.

1.1.2 New-born infants of insured persons shall be included in the health insurance policy after birth, at the same tariff as their parents. This is subject to the following conditions:
- the insurance contract was concluded at least three months earlier without interruption and
- the newborn is insured with us within 2 months of the day of birth with retrospective effect; and
- no other insurance coverage for the new-born exists.

1.1.3 Persons who are
- not temporarily staying abroad for educational purposes, or
- who have no residence in Germany at the time of application, or
- have reached the age of 35

are not eligible for insurance. The insurance contract is also not concluded by paying the premium.

1.2 When does the insurance cover start?

Unless we have concluded another agreement with you, your insurance cover starts as soon as you have left Germany when crossing the border.

1.3 When does the insurance cover end?

1.3.1 Your insurance coverage also ends for insurance claims that have not yet been completed
- upon termination of the insurance contract,
- after the agreed duration, or
- at the end of the trip.

1.3.2 Your treatment abroad lasts longer because
- your illness requires treatment beyond the original end of insurance cover and
- you are not well enough to be transported home.

In this case, the duration of your insurance cover will be extended until you are fit for transport again. The return transport is also insured.

1.4 What trips are covered by the insurance cover?

The insurance cover is valid for trips abroad. We define a trip as a temporary absence from your permanent residence. As a foreign country, we define every country except the Federal Republic of Germany.

1.4.1 Insurance cover abroad outside of the scope of cover pursuant to the tariff

Have you taken out a tariff that exempted some countries from insurance coverage (e.g. for tariffs without cover for the USA and Canada)? You still have insurance coverage for these countries:
- for a transit stay for the duration of the transit, or
- with insurance contracts with a minimum of 6 months for stays of up to 14 days per insurance year.

1.4.2 Insurance coverage in Germany

Does your insurance have a term of at least 1 year? In this case, you also have insurance coverage if you temporarily return to Germany (e.g. home leave). This is limited to a total of 6 weeks per insurance year.
In Germany, we will reimburse the costs at the thresholds set out under the
- Scale of Fees for Doctors (Gebührenordnung für Ärzte [GOÄ]) and the
- Scale of Fees for Dentists (Gebührenordnung für Zahnärzte [GOZ]).

The following are deemed to be threshold levels for benefits
- according to the GOZ, the 2.3-fold fee rate,
- according to No. 437 and section M (laboratory services) of the GOÄ, the 1.15-fold fee rate,
- according to sections A, E and O (technical operations) of the GOÄ the 1.8-fold fee rate, as well as
- for all other benefits of the GOÄ, the 2.3-fold fee rate.

1.5 Insurance year and waiting periods

1.5.1 An insurance year is considered to be a period of 12 months calculated from the start of insurance.

1.5.2 The waiting periods begin with the start of the insurance cover.

2 The insurance policy

2.1 Until when does your policy need to be concluded?

2.1.1 The insurance contract must be completed before the start of the trip. The application for the conclusion of an insurance contract must contain all the required information in a clear and complete way.

2.1.2 If you do not comply with this provision, we can withdraw from the contract and be free of performance. Here, we observe the regulations of Sections 19-21 German Insurance Contract Act (VVG). These can be found in Section IV.

2.2 How long does your policy need to be concluded for?

2.2.1 The insurance contract must be concluded for the entire duration of the trip. It is not permitted to insure short periods of time or only specific sections of travel. Please make sure to specify the start and end of the trip correctly when concluding the contract. **Please note: False information may result in us withdrawing from the insurance contract and in the loss of your insurance cover.** Here we observe the regulations of Section 19 German Insurance Contract Act (VVG). This can be found in Section IV.

2.2.2 The longest possible insurance term is 5 years. The insurance contract ends at the agreed time.

a) If your stay abroad is extended
- further insurance cover can only be granted by way of a new insurance contract within the maximum insurance period,
- the application for the new insurance contract must be submitted to us before the expiry of the original insurance contract.

The new insurance contract is only concluded if we expressly agree to it! In this case
- any fulfilled waiting periods of the previous contract will be credited in the new contract.
- illnesses, complaints, accidents and their foreseeable consequences, which have newly occurred during the term of the previous contract, are still insured.

2.3 When do we pay compensation?

2.3.1 We will pay within two weeks. This is subject to the following conditions:
- that our obligation to pay, the reasons and the amount have been determined.
- that the necessary evidence – which becomes our property – is available.

The time to the deadline is suspended if you are responsible for our being unable to check your claim.

2.3.2 We convert your costs in a foreign currency using the exchange rate to EUR on the day the records are received. The official exchange rate applies, unless you acquired the currency to pay the bills at a less favourable rate. We may subtract the following costs from your benefit:
- Costs for the transfer of benefits abroad or
- Costs for special forms of referral that you have commissioned.

2.3.3 You may also have travel insurance with other insurers. This may for example be the statutory health insurance or another private insurer. If you consequently have claims against other insurers, these take priority.

You are not entitled to a greater total benefit than the costs actually incurred. If you have a claim to a benefit from several insurers, you can choose the insurer with which you file the claim.
If you file the claim with us first, we will reimburse you the costs insured under this tariff. After that, we will clarify with the other insurers whether they will contribute to the costs. We do not require the sharing of costs with private health insurance if this would disadvantage you, e.g. through loss of the premium refund.
For more information, see clause II.4.4.2.

2.4 Which legislation applies to the insurance policy?

In addition to these provisions, the Insurance Contract Act (VVG) and German law shall apply.
Note on data protection: We store your personal data to fulfil our obligations under the contract. Further information on data protection and your rights in this regard can be found at: www.hmrv.de/datenschutz/information or feel free to request them from us.

2.5 When do claims to benefits lapse?

Claims under this insurance policy expire in three years. The expiry is measured from the end of the year in which the claim can be made. If you have made a claim, the expiry period is suspended until our decision is sent to you.

2.6 What is the applicable court of jurisdiction?

You can submit a complaint against us to the court responsible for the district
- where we have our head office,
- where you have your place of residence or
- where you normally live, if you do not have a fixed place of residence.

2.7 What form should a statement that you make to us be in?

Declarations of intent and notifications to us must be in writing (letter, fax, email, electronic data carrier, etc.). The language of the policy is German.

3 What requirements must be met when paying the premiums?

3.1 Premium amount

The premium for an insured person is shown by the premium overview.

3.2 Payment of the first premium

3.2.1 The first premium is due as soon as you have received the insurance certificate and the premium invoice.

3.2.2 If you fail to pay the first premium, we will be entitled to withdraw from the contract and will be released from obligations if the premium remains unpaid. In doing so, we observe the provisions of Section 37 of the Insurance Contract Act (VVG). This can be found in Section IV.

3.3 Payment of subsequent premiums

If you do not pay subsequent premiums on time, we are entitled to terminate the contract and will be released from obligations. In doing so, we observe the provisions of Section 38 of the Insurance Contract Act (VVG). This can be found in Section IV.

3.4 Collection of premiums

If you have agreed with us to take a premium from an account, we will collect it as soon as we receive your direct debit mandate. This payment is considered to be on time
- if we can collect the premium and
- if collection of the correct payment is not disputed.

If we are unable to collect the premium due for a reason beyond your control, the payment shall still be considered to have been made on time if you make said payment immediately after receiving a request from us.

3.5 Offsetting

You may offset against our claims only if the counter-claim is uncontested or legally established.

4 What you have to consider in the event of an insured event (obligations)?

4.1 To whom can you direct the claim?

You can send your claims in any form to: HanseMerkur Reiseversicherung AG, Abt. RLK/Leistung, P.O. Box, 20352 Hamburg,
E-Mail: reiseleistung@hansemerkur.de.
You can also use our online form
https://mein-hmrv.de/service/schadenmeldung/.
In emergencies, our 24-hour emergency call service is here to help you. You can reach it at any time from anywhere in the world.

4.2 When is it necessary to contact us immediately?

In the case of
- in-patient treatment, please contact our emergency service immediately with regard to any necessary diagnostic and therapeutic measures
- non-emergency dental prosthetics, please submit a treatment and cost plan or cost estimate before using the services. In the event of a medical emergency, the submission of a medical and cost plan or cost estimate is not required.

In all other cases, it is sufficient to contact us after your return.

4.3 What information are you obligated to provide?

4.3.1 You must provide true and complete information concerning the claim. You must provide us with any information and suitable proof that we need to be able to determine:
- whether an insured event has occurred; and
- to what extent we shall disburse insurance benefits.

You must complete our claim form in full and return it.
If we consider it necessary, you are obliged to be examined by one of our doctors.

4.3.2 We need the following original evidence from you, which becomes our property:
- Prescriptions along with the treatment bill
- Invoices for medicines and medical aids together with the prescription.
- Official death certificate and a doctor's certificate on the cause of death if costs of repatriation of mortal remains or burial are to be paid.
- Other evidence and receipts requested by us that we need in order to check our duty to provide benefits. This applies only if obtaining this documentation can be reasonably expected of you.

The receipts must
- stipulate the name of the person treated,
- specify the illness and

– the services provided by the professional providing treatment according to
– type,
– location and
– period of treatment.

If other insurance cover for treatment costs is available and if this is used first, then copies of invoices are sufficient as evidence. These must be annotated to show which items have been reimbursed.

4.4 What does your duty of disclosure to minimise damage comprise?

4.4.1 You should make every effort to keep the claim as low as possible and avoid anything that could lead to an unnecessary increase in costs.

4.4.2 Compensation claims against third parties shall be transferred to us as per the statutory regulation in Section 86 of the Insurance Contract Act (VVG), up to the amount of the benefit paid. We shall ensure that this does not disadvantage you. You are also obligated to assist, if necessary, in asserting the claim for compensation.

4.5 What are the legal consequences of breaches of duty (breach of obligations)?

If you fail to carry out one of the duties specified above, we will be released from liability either in full or in part. In this, we comply with the regulations of § 28 (2–4) of the Insurance Contract Act (VVG). These can be found in Section IV.

Section III – Description of payments

1 General rules for insurance coverage

We provide benefits in the event of an insured event occurring abroad.

1.1 What is an insured event?

Your medically necessary treatment due to illness or the consequences of an accident is considered to be an insured event. The insured event starts with the treatment. It ends once it is medically established that no further treatment is needed. The following are also considered insured events:
– Pregnancy and childbirth if the pregnancy had not yet started at the beginning of the insurance contract,
– Medically necessary treatments for complaints during pregnancy,
– Premature births until the completion of the 36th week of pregnancy,
– Miscarriage,
– Medically necessary abortions and
– Death.

See clause 2 for details of what precise benefit we provide after an insured event. Please read clause 3 carefully as well. This regulates when we do not provide a benefit, even if an insured event has occurred.

1.2 Which doctors and hospitals can you choose between?

You can choose freely among the following legally-recognised individuals and bodies authorised to give treatment:
– Doctors,
– Dentists and
– hospitals.

The precondition is that these
– charge fees based on the relevant official, applicable fee schedule – if available – or
– based on fees generally charged in the local area.

The hospital in the country of destination must
– be recognised and approved,
– be under constant medical supervision,
– have sufficient diagnostic and therapeutic facilities and
– keep medical records.

1.3 Which methods do we cover if you need to be examined and treated?

We cover
– examinations,
– treatments and
– medication,

recognised by conventional medicine. We also cover other methods and medications,
– which have proved equally effective in practice or
– which are only available in the absence of conventional medicine.

These methods include e. g.
– homeopathic treatment
– anthroposophical medicine or
– herbal treatment.

In such cases we can, however, reduce the benefits to the amount that would have been incurred by the use of available conventional medicine.

2 What are the benefits that we pay if an insured event occurs?

We will reimburse the following payments if
– the insured event occurred after the start of insurance cover and
– the waiting times have elapsed.

Please also note the maximum payment amounts listed in Section I.

2.1 What do we pay if you are treated as an out-patient?

We will reimburse the costs of medical out-patient medical treatments, including medically necessary pregnancy treatment caused by complaints.

2.2 What do we pay if you are treated as an in-patient?

Where necessary, we will give the hospital a guarantee to assume the costs through our worldwide emergency call service.

We will reimburse the costs for the following services:

2.2.1 Medical treatment including accommodation, food and care in the hospital.

2.2.2 Transport
– to the nearest suitable hospital
– return to the respective accommodation.

2.2.3 In the case of inpatient treatment, you can decide:
– You will receive a reimbursement of the costs of the aforementioned services from us (clauses 2.2.1-2.2.2) or
– You will receive a daily allowance from the beginning of in-patient treatment.

The decision must, however, be made at the beginning of the in-patient treatment.

2.3 What do we pay if you have dental treatment?

We will reimburse the costs for the following services:

2.3.1 Pain-relieving preservative dental treatments

2.3.2 Simple fillings

2.3.3 Repairs to an existing dental prosthesis, insofar as the need for repair has arisen only after the start of the insurance cover

2.3.4 Dental prosthesis that, due to an accident
– during the insured period, have become necessary for the first time, or which
– need to be repaired.

2.4 What do we pay for medications, dressings, therapeutic products and medical aids?

We provide insurance benefits when these

– have been prescribed by one of the practitioners listed under clause 1.2
– are medically necessary.

2.4.1 Medications and dressing material

You need to obtain medications from the pharmacy. The following are considered medicines, even if they are prescribed:
– neither nutritive and tonic substances, nor
– cosmetic preparations.

2.4.2 Remedy

These are radiation, light and other physical treatments. These **do not** include
– massages,
– medicinal packs,
– inhalations,
– physiotherapy.

2.4.3 Resources

The following items count as aids:
– Bandages, broken ligaments, inlays,
– Crutches and compression stockings,
– Hearing aids,
– Corrective splints,
– Artificial limbs/prostheses,
– Seat shells and foam positioners, wheelchairs,
– Breathing monitor devices, infusion pumps, inhalation devices, oxygen devices,
– Surveillance monitors for infants,
– Orthopaedic body, arm and leg braces, as well as speech devices.

The insurance covers
a) simple remedies, provided that they
   – are prescribed by a doctor, and
   – become necessary for the first time as a result of an accident, and
   – serve to facilitate the treatment of the consequences of the accident.
b) Repairs of existing remedies, provided that our written consent has been obtained in advance.

2.5 What do we pay in the event of pregnancy?

2.5.1 We reimburse the costs
– for examinations and/or treatments for pregnancy complications,
– in case of miscarriage, as well as
– for delivery before the end of the 36th week of pregnancy.

2.5.2 If the pregnancy has occurred after the start of the insurance contract, we will pay after a waiting period of 6 months from the start of the insurance cover for
– prenatal care-examinations and
– childbirth.

We also accept examination and treatment invoices from midwives or obstetricians if the costs are not invoiced by a doctor at the same time.

2.5.3 If there is no other insurance cover, we will reimburse the costs of the necessary medical treatment of the new-born child in case of premature birth before the end of the 36th week of pregnancy. We grant this benefit
– for the period until the restoration of the transportability of the mother and child, or
– until inclusion in this insurance contract in accordance with the regulations of clause II 1.1.3.

2.6 What benefits do we do for repatriation, transfer and burial?

2.6.1 What do we pay in the event of transport home?

Do you require return transport to your place of residence or to the nearest suitable hospital at your place of residence? We will organise this and reimburse the costs if one of the following conditions is met:
– the return journey is medically reasonable and appropriate.
– According to the prognosis of the attending physician, the duration of treatment in the hospital abroad is expected to exceed 14 days.
– Further treatment abroad is likely to cost more than the repatriation.

We will also assume the cost of transport for an accompanying fellow-traveller.
We reimburse the costs for the cheapest suitable means of return transport.

2.6.2 What do we do if the insured person dies?

We organise the transfer of the deceased person to the permanent place of residence and cover the costs for this. Alternatively, we will reimburse the costs to bury the deceased person in the country of travel. However, we only reimburse at most the costs that would have been incurred by repatriation of mortal remains.

2.7 What additional benefits do we offer?

2.7.1 Information about doctors and hospitals in your area

If there is an insured event, we will inform you about possible medical treatment. If possible, we will name a German or English-speaking doctor. Call our worldwide emergency assistance hotline.

2.7.2 Information transfer between doctors

Are you being treated as an in-patient? At your request, we will establish contact via the emergency call service between
– a doctor commissioned by us,
– your family doctor and
– the attending hospital doctors.

During the hospital stay, we ensure the transmission of information between the doctors involved. On request, we will also inform your relatives.

2.8 When do you otherwise receive reimbursement for costs?

You pass all treatment costs first to another service insurer participating in the reimbursement of costs. Then we will issue a reimbursement.

2.8.1 In the case of out-patient treatment, we provide a one-time expense allowance regardless of the number of treatments and diseases.

2.8.2 In the case of in-patient hospital treatment, we provide an expense allowance per day of hospitalisation.

3 What do we not cover or only provide restricted cover for?

3.1 In which cases can we reduce the scope of benefits?

3.1.1 We can reduce the payments to an appropriate amount if
– the medical treatment exceeds the medically necessary level or
– the expenses for medical treatment exceed those generally charged in the local area.

3.1.2 If you do not use conventional medicine, we can reduce the payment. We will reimburse the amount incurred for existing conventional medical methods or medicines (for more details, see section 1.3).

3.2 In which cases do we not provide cover?

In the following cases we do not provide benefit, even if an insured event has occurred:

3.2.1 When you
– try to fraudulently deceive about circumstances that are important for the reason or the amount of the benefit, or
– you have caused the damage intentionally.

3.2.2 For treatments that were
– the sole reason, or

– one of the reasons,
for making the trip.

3.2.3 For treatments,
– whose necessity was evident before departure and
– were due to an illness that had already been medically diagnosed when the trip started.
Exception:
You are taking the trip because of the death of the spouse or a relative of the 1st degree.

3.2.4 For diseases, including their consequences, as well as for the consequences of accidents caused by
– a predictable war,
– predictable internal unrest, or
– active participation in internal unrest or in war.
Acts of war and internal civil unrest are considered to be foreseeable if the German Foreign Ministry issues a travel warning for the country in question before the start of the journey.

3.2.5 For cures and treatments in a sanatorium.
Exception:
These treatments are made following in-patient treatment due to
– a severe stroke,
– a serious myocardial infarction or
– a serious illness of the skeleton (disc operation, hip replacement)
and they serve to reduce the length of stay in the hospital. In these cases, you have insurance cover, if
– you inform us of the planned stay before the treatment and
– we have agreed to the treatments in writing.

3.2.6 For withdrawal measures including withdrawal cures.

3.2.7 For out-patient healing treatments in a spa or health resort.
Exception:
– The healing treatment is necessary due to an accident occurring there, or
– You were only visiting the spa or health resort briefly and were not staying for the purposes of treatment when you fell ill.

3.2.8 For treatments through
– Spouse
– Parents
– Children
– Persons with whom you are living in your own home or a home being visited.
We will also pay for documented material costs in these cases.

3.2.9 For treatment or accommodation due to
– infirmity,
– need for care or
– dependency.

3.2.10 For immunisation measures.

3.2.11 For psychoanalytic and psychotherapeutic treatments.

3.2.12 For
– dental prosthesis,
– pivot teeth,
– inlays,
– crowns,
– orthodontic treatments,
– prophylactic services,
– dental splints and braces,
– function analytical and function therapeutic treatments and
– implantological dental services
insofar as there are no other tariff regulations.

Section IV - Extract from the Insurance Contracts Act

§ 19 Duty of notification

(1) [1]Up to the submission of his contractual declaration, the policyholder must notify the insurer of the risk circumstances known to him that are relevant for the decision by the insurer to conclude the contract with the agreed content and which the insurer has asked about in text form. [2]If the insurer asks questions pursuant to sentence 1 after the contractual declaration by the policyholder, but before the acceptance of the contract, the policyholder is also obligated to give notification in this regard too.

(2) If the policyholder breaches his duty of notification pursuant to paragraph 1, the insurer can withdraw from the contract.

(3) [1]The insurer's right of withdrawal is excluded if the policyholder has not breached the duty of obligation in a wilful or grossly negligent manner. [2]In this case, the insurer has the right to terminate the contract giving a period of notice of one month.

(4) [1] The insurer's right of withdrawal due to a grossly negligent breach of the duty of obligation and his right of termination pursuant to paragraph 3 clause 2 are excluded if he would have concluded the contract even if he was aware of the undisclosed circumstances, even if under different conditions. [2]The other conditions, at the insurer's request, become part of the contract retrospectively, with a breach of duty for which the policyholder is not responsible from the current insurance period.

(5) [1]The insurer is entitled to the rights pursuant to paragraphs 2 to 4 only if it has pointed out to the policyholder by separate notification in text form the consequences of a breach of the duty of notification. [2]The rights are excluded if the insurer was aware of the circumstance not notified or knew of the incorrectness of the notification.

(6) [1]If in the case of paragraph 4 clause 2 the premium increases by more than 10 per cent or if the insurer excludes the protection against risks for the circumstance that was not notified, the policyholder can terminate the contract within a month after receipt of the notification from the insurer without giving a notice period. [2]The insurer must point out this right to the policyholder in the notification.

§ 20 Representative of the policyholder

[1]If the contract is concluded by a representative of the policyholder, when applying § 19 (1 to 4), and § 21 (2) Sentence 2 as well as (3) Sentence 2 to take into account both the knowledge and the malice of the representative and the knowledge and malice of the policyholder. [2]The policyholder can only rely on the fact that the duty of notification was not violated intentionally or through gross negligence, if neither the representative nor the policyholder is guilty of intent or gross negligence.

§ 21 Exercise of the rights of the insurer

(1) 1The insurer must assert the rights to which it is entitled under § 19 (2 to 4) in writing within one month. [2]The period begins from the moment when the insurer becomes aware of the violation of the duty to notify, which establishes the right asserted by him. [3]When exercising his rights, the insurer must state the circumstances on which he bases his declaration; he may subsequently state further circumstances to substantiate his declaration if the period under sentence 1 has not elapsed for these.

(2) [1]In the event of withdrawal in accordance with Section 19 (2) after the occurrence of the insured event, the insurer shall not be obliged to provide a benefit unless the breach of the duty of notification relates to a circumstance that is not the cause of either the occurrence or the determination of the insured event, or the determination or the scope of the insurer's obligation to indemnify. [2]If the policyholder fraudulently violates the duty of notification, the insurer is not obliged to pay.

(3) [1]The rights of the insurer according to Section 19 (2 to 4) elapse after the expiration of five years after conclusion of the contract; this does not apply to insurance claims that occurred before the expiration of this period. [2]If the policyholder has intentionally or fraudulently violated the obligation to notify, the period is ten years.

§ 28 Non-observance of a contractual obligation

(2) Where the contract provides that the insurer is not obligated to effect payment in the event of the non-observance of a contractual obligation on the part of the policyholder, the insurer shall be released from the liability if the policyholder intentionally breached the obligation. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits

payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) Notwithstanding subsection (2), the insurer shall be liable for performance insofar as the failure to honour the obligation caused neither the occurrence nor the establishment of the insured event nor the establishment or the extent of the insurer's obligation to effect payment. Sentence 1 shall not apply if the policyholder fraudulently breached the obligation.

(4) The condition on which the insurer's entire or partial release from liability in accordance with subsection (2) is based shall, in the event of a violation of an existing duty to provide information or duty of disclosure after the occurrence of an insured event, be the fact that the insurer instructed the policyholder in separate correspondence and in writing of this legal consequence.

§ 37 Delayed payment of first insurance premium

(1) If the single premium or the first premium is not paid in good time, the insurer shall be entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.

(2) If the single premium or first premium has not been paid when the insured event occurs, the insurer shall not be obligated to effect payment, unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if he had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

§ 38 Delayed payment of first insurance premium

(1) [1]If a follow-up premium is not paid on time, the insurer may, at the policyholder's expense, specify a payment period in writing to the policyholder, which must be at least two weeks. [2]The provision is only effective if it quantifies the outstanding amounts of the premium, interest and costs in detail and indicates the legal consequences associated with the expiry of the period in accordance with paragraphs 2 and 3; in the case of combined contracts, the amounts must be indicated separately in each case.

(2) If the insured event occurs after expiry of the deadline and if the policyholder is in default with the payment of the premium or interest or costs, the insurer is not obliged to pay benefits.

(3) [1]The insurer may terminate the contract after the deadline has expired without observing a deadline, provided that the policyholder is in default with the payment of the amounts owed. [2]The termination can be combined with the determination of the payment deadline in such a way that it becomes effective upon expiry of the deadline if the policyholder is in default of payment at this time; the policyholder must be expressly informed of this upon termination. [3]The termination shall become ineffective if the policyholder makes the payment within one month after the termination or, if it has been combined with the deadline provision, within one month after expiry of the deadline; Paragraph 2 shall remain unaffected.

§ 86 Assignment of claims

(1) If the policyholder is entitled to claim damages from a third party, this claim shall be assigned to the insurer insofar as the insurer compensates for the loss. The claim may not be assigned to the detriment of the policyholder.

(2) The policyholder shall safeguard his claim for damages or a right serving to safeguard this claim in accordance with the applicable form and time requirements, and he shall assist the insurer wherever necessary in asserting them. If the policyholder intentionally breaches this obligation, the insurer shall not be obligated to effect payment insofar as he cannot, as a result, claim compensation for it from a third party. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) If the policyholder claims compensation from a person with whom he is sharing a common household when the loss occurs, assignment in accordance with subsection (1) cannot be asserted, unless that person intentionally caused the loss.

Arbitration bodies

We would like to draw your attention at this point to the possibility of out-of-court dispute resolution.

For health insurance, the voluntary membership of HanseMerkur in the Verband der Privaten Krankenversicherung e.V (Association of Private Health Insurers) requires, according to the statutes, participation in mediation procedures through a consumer mediation office.

Ombudsman

Private Kranken- und Pflegeversicherung (Private Health & Care Insurance)

Postfach 060222

10052 Berlin

Hotline: +49 1802 550 444

HanseMerkur

Terms and conditions for international health insurance

VB-KV 2022 (B-YT-Out-D) Profi

The scope of the insurance cover is set out in the insurance certificate, in any separate written agreements, in these insurance terms and conditions, and in the statutory provisions of the Federal Republic of Germany.

We are HanseMerkur Reiseversicherung AG based in Hamburg. You are our contractual partner, the so-called policyholder, when you conclude the insurance contract with us. An insured person is both you, if you have insured yourself, and other persons who have (co-)insured you. We also refer to any such persons in these insurance terms and conditions as "you". These insurance terms and conditions apply to you as the policyholder and to you as the insured person.

The insurance terms and conditions consist of four sections.
Section I contains an overview of the types of benefit and the levels of premium associated with them.
In Section II, you will, in particular, find explanations about the insured persons, time limits for taking out insurance, and premium payments.
The full description for the types of benefit can be found in Section III.
Section IV contains an excerpt from the German Insurance Contract Act (VVG).

Content

HanseMerkur Reiseversicherung AG Siegfried-Wedells-Platz 1 20354 Hamburg Tel.: 040 4119-1000, Fax: -3040 www.hmrv.de

Section I – Overview of payments

The full description of the insured benefits and events is given in the relevant clauses of Section III Description of benefits.

Insured benefits of travel health insurance		Benefit levels
2.1 Out-patient medical treatment		
2.1.1	Out-patient medical treatment	100%
2.1.2	Ambulance services	100%
2.1.3	Rehabilitation measures	100%
2.1.4	Check-ups - for the early detection of cancer diseases per insurance year - for children	 EUR 200 100%
2.1.5	Psychoanalytic or psychotherapeutic treatments up to 10 sessions per insurance year	EUR 2,000
2.2 In-patient medical treatment		
2.2.1	Inpatient medical treatment	100%
2.2.2	Ambulance services	100%
2.2.3	Accompanying person in hospital for children up to the age of 18	100%
2.2.4	Sick leave and up to 10 hotel nights	EUR 2,500
2.2.5	Hotel accommodation for a maximum of 10 days	EUR 1,000
2.2.6	Rehabilitation measures	100%
2.2.7	Alternatively, daily allowance of up to 14 days, per day	EUR 75
2.3 Dental treatments		
2.3.1	Pain-relieving preservative dental treatments	100%
2.3.2	Simple fillings	100%
2.3.3	repairs of existing dental prostheses	100%
2.3.4	Dental prosthesis due to an accident	EUR 2,000
2.3.5	Dental prosthesis with 80% of the refundable invoice amount - in the first two insurance years in total for both years - in each subsequent insurance year	 EUR 1,000 EUR 1,500
2.4 Medicines, dressings, remedies or aids		
2.4.1	Medications and dressing material	100%
2.4.2	Remedy Radiation therapy, light therapy and other physical treatments Massages, packs, inhalations, physiotherapy	 100% 100%
2.4.3	Resources - Accident-related aids - Repairs of existing aids per insurance year - Initial purchase of aids	 100% EUR 500 100%
2.4.4	Visual aids	EUR 200
2.5 Pregnancy		
2.5.1	Examinations; treatments for complications, premature birth, miscarriage	100%

Insured benefits of travel health insurance		Benefit levels
2.5.2	Preventive examinations and delivery	100%
2.5.3	Medical treatment costs for a baby born prematurely	100%
2.6 Repatriation, transfer, burial		
2.6.1	Repatriation of the patient, including transport costs for an accompanying person	100%
2.6.2	Transfer or burial abroad up to the amount of the transfer costs	100%
2.7 Recovery costs		
	Search, rescue and recovery costs	EUR 5,000
2.8 Childcare		
	Care costs of minor children and their additional return travel costs or accommodation costs of the children with the caregivers in the hospital	100%
2.9 Additional services		
2.9.1	Telephone costs in contacting the emergency assistance hotline	100%
2.9.2	Shipping of medicines (shipping costs)	100%
2.9.3	Information about doctors and hospitals at the place of stay	100%
2.9.4	Information transfer between doctors	100%
2.9.5	Retrieval of luggage	100%
2.9.6	Psychological assistance	100%
2.9.7	Medical interpreting service	100%
2.10 Compensation for expenses		
2.10.1	For outpatient treatments, once and regardless of the number of treatments	EUR 25
2.10.2	For inpatient treatment up to 14 days, per day	EUR 50

Section II - General provisions

1 Insurance cover

1.1 Who is covered by the insurance?

1.1.1 You are insured if
- you are named in the insurance certificate and
- it has been proven that you are temporarily abroad to carry out educational measures. These include, in particular, the following groups of people:
  - Au pairs
  - Students
  - Language students
  - Academic students
  - Scholarship recipients
  - Doctoral candidates
  - Participants in Work & Travel programs

and
- at the time of application
  - you have a permanent residence in Germany and
  - you have not yet reached the age of 35.

1.1.2 Newborn infants of insured persons shall be included in the policy after birth, on the same plan as their parents. This is subject to the following conditions:
- the insurance contract was concluded at least three months earlier without interruption and
- You insure the new-born with us retroactively within 2 months after the day of birth.

1.1.3 Persons who are
- not temporarily staying abroad for educational purposes, or
- who have no residence in Germany at the time of application, or
- have reached the age of 35

are not eligible for insurance. The insurance contract is also not concluded by paying the premium.

1.2 When does the insurance cover start?

Unless we have concluded another agreement with you, your insurance cover starts as soon as you have left Germany when you cross the border.

1.3 When does the insurance cover end?

1.3.1 Your insurance coverage also ends for insurance claims that have not yet been completed
- upon termination of the insurance contract,
- after the agreed duration, or
- at the end of the trip.

1.3.2 Your treatment abroad lasts longer because
- your illness requires treatment beyond the original end of insurance cover and
- you are not well enough to be transported home.

In this case, the duration of your insurance cover will be extended until you are fit for transport again. The return transport is also insured.

1.4 What trips are covered by the insurance cover?

The insurance cover is valid for trips abroad. We define a trip as a temporary absence from your permanent residence. As a foreign country, we define every country except the Federal Republic of Germany.

1.4.1 Insurance cover abroad outside of the scope of cover pursuant to the tariff

Have you taken out a tariff that exempted some countries from insurance coverage (e.g. for tariffs without cover for the USA and Canada)? You still have insurance coverage for these countries:
- for a transit stay for the duration of the transit, or
- with insurance contracts of at least 6 months for a stay of up to 14 days per insurance year.

1.4.2 Insurance coverage in Germany

Does your insurance have a term of at least 1 year? In this case, you also have insurance coverage if you temporarily re-

turn to Germany (e.g. home leave). This is limited to a total of 6 weeks per insurance year.
In Germany, we will reimburse the costs at the thresholds
– of the Scale of Fees for Doctors (Gebührenordnung für Ärzte [GOÄ]) and the
– of the Scale of Fees for Dentists (Gebührenordnung für Zahnärzte [GOZ]).
The following are deemed to be threshold levels for benefits
– according to the GOZ, the 2.3-fold fee rate,
– according to No. 437 and section M (laboratory services) of the GOÄ, the 1.15-fold fee rate,
– according to sections A, E and O (technical operations) of the GOÄ the 1.8-fold fee rate, as well as
– for all other benefits of the GOÄ, the 2.3-fold fee rate.

1.5 Insurance year and waiting periods

1.5.1 An insurance year is considered to be a period of 12 months calculated from the start of insurance.

1.5.2 The waiting periods begin with the start of the insurance cover.

2 The insurance policy

2.1 Until when does your policy need to be concluded?

2.1.1 The insurance contract must be completed before the start of the trip. The application for the conclusion of an insurance contract must contain all the required information in a clear and complete way.

2.1.2 If you do not comply with this provision, we can withdraw from the contract and be free of performance. Here, we observe the regulations of Sections 19-21 German Insurance Contract Act (VVG). These can be found in Section IV.

2.2 How long does your policy need to be concluded for?

2.2.1 The insurance contract must be concluded for the entire duration of the trip. It is not permitted to insure short periods of time or only specific sections of travel. Please make sure to specify the start and end of the trip correctly when concluding the contract. **Please note: False information may result in us withdrawing from the insurance contract and in the loss of your insurance cover.** Here we observe the regulations of Section 19 German Insurance Contract Act (VVG). This can be found in Section IV.

2.2.2 The longest possible insurance term is 5 years. The insurance contract ends at the agreed time.
a) If your stay abroad is extended
   – further insurance cover can only be granted by way of a new insurance contract within the maximum insurance period,
   – the application for the new insurance contract must be submitted to us before the expiry of the original insurance contract.

The new insurance contract is only concluded if we expressly agree to it! In this case
   – any fulfilled waiting periods of the previous contract will be credited in the new contract.
   – illnesses, complaints, accidents and their foreseeable consequences, which have newly occurred during the term of the previous contract, are still insured.

b) Is your stay extended for reasons for which you are not responsible?
   – Upon request, we will also extend your insurance contract beyond the maximum insurance period.
   – The application for an extension must be made within the contract period with appropriate proof.
   – The extension will only take place if we expressly agree to it.

2.3 When do we pay compensation?

2.3.1 We will pay within two weeks. This is subject to the following conditions:
– that our duty to provide an insurance benefit is established on the basis and in the amount, and
– that the necessary evidence – which becomes our property – is available.
The time to the deadline is suspended if you are responsible for our being unable to check your claim.

2.3.2 We convert your costs in a foreign currency using the exchange rate to EUR on the day the records are received. The official exchange rate applies, unless you have purchased the foreign currency to pay the bills at a less favourable rate. We may subtract the following costs from your benefit:
– Costs for the transfer of benefits abroad or
– Costs for special forms of referral that you have commissioned.

2.3.3 You may also have travel insurance with other insurers. This may for example be the statutory health insurance or another private insurer. If you consequently have claims against other insurers, these take priority.

You are not entitled to a greater total benefit than the costs actually incurred. If you have a claim to a benefit from several insurers, you can choose the insurer with which you file the claim.
If you file the claim with us first, we will reimburse you the costs insured under this tariff. After that, we will clarify with the other insurers whether they will contribute to the costs. We do not require the sharing of costs with private health insurance if this would disadvantage you, e.g. through loss of the premium refund.
For more information, see clause II.4.4.2.

2.4 Which legislation applies to the insurance policy?

In addition to these provisions, the Insurance Contract Act (VVG) and German law shall apply.
Note on data protection: We store your personal data to fulfil our obligations under the contract. Further information on data protection and your rights in this regard can be found at: www.hmrv.de/datenschutz/information or feel free to request them from us.

2.5 When do claims to benefits lapse?

Claims under this insurance policy expire in three years. The expiry is measured from the end of the year in which the claim can be made. If you have made a claim, the expiry period is suspended until our decision is sent to you.

2.6 What is the applicable court of jurisdiction?

You can submit a complaint against us to the court responsible for the district
– where we have our head office,
– where you have your place of residence or
– where you normally live, if you do not have a fixed place of residence.

2.7 What form should a statement that you make to us be in?

Declarations of intent and notifications to us must be in writing (letter, fax, email, electronic data carrier, etc.). The language of the policy is German.

3 What requirements must be met when paying the premiums?

3.1 Premium amount

The premium for an insured person is shown by the premium overview.

3.2 Payment of the first premium

3.2.1 The first premium is due as soon as you have received the insurance certificate and the premium invoice.

3.2.2 If you fail to pay the first premium, we will be entitled to withdraw from the contract and will be released from obligations if the premium remains unpaid. In doing so, we observe the provisions of Section 37 of the Insurance Contract Act (VVG). This can be found in Section IV.

3.3 Payment of subsequent premiums

If you do not pay subsequent premiums on time, we are entitled to terminate the contract and will be released from obligations. In doing so, we observe the provisions of Section 38 of the Insurance Contract Act (VVG). This can be found in Section IV.

3.4 Collection of premiums

If you have agreed with us to take a premium from an account, we will collect it as soon as we receive your direct debit mandate. Payment is considered timely if
– we can debit the premium and
– if collection of the correct payment is not disputed.
If we are unable to collect the premium due for a reason beyond your control, the payment shall still be considered to have been made on time if you make said payment immediately after receiving a request from us.

3.5 Offsetting

You may offset against our claims only if the counter-claim is uncontested or legally established.

4 What you have to consider in case of an insured event (obligations)?

4.1 To whom can you direct the claim?

You can send your claims in any form to: HanseMerkur Reiseversicherung AG, Abt. RLK/Leistung, P.O. Box, 20352 Hamburg,
E-Mail: reiseleistung@hansemerkur.de.
You can also use our online form
https://mein-hmrv.de/service/schadenmeldung/.
In emergencies, our 24-hour emergency call service is here to help you. You can reach it at any time from anywhere in the world.

4.2 When is it necessary to contact us immediately?

In the case of

– in-patient treatment, please contact our emergency service immediately with regard to any necessary diagnostic and therapeutic measures

– non-emergency dental prosthetics, please submit a treatment and cost plan or cost estimate before using the services. In the event of a medical emergency, the submission of a medical and cost plan or cost estimate is not required.

In all other cases, it is sufficient to contact us after your return.

4.3 What information are you obligated to provide?

4.3.1 You must provide true and complete information concerning the claim. You must provide us with any information and suitable proof that we need to be able to determine
– whether an insured event has occurred; and
– to what extent we shall disburse insurance benefits.
You must complete our claim form in full and return it.
If we consider it necessary, you are obliged to be examined by one of our doctors.

4.3.2 We need the following original evidence from you, which becomes our property:
– Prescriptions along with the treatment bill
– Invoices for medicines and medical aids together with the prescription.
– Official death certificate and a doctor's certificate on the cause of death if costs of repatriation of mortal remains or burial are to be paid.
– Other evidence and receipts requested by us that we need in order to check our duty to provide benefits. This applies only if obtaining this documentation can be reasonably expected of you.

The receipts must
– stipulate the name of the person treated,
– specify the illness and
– the services provided by the professional providing treatment according to
– type,
– location and
– period of treatment.

If other insurance cover for treatment costs is available and if this is used first, then copies of invoices are sufficient as evidence. These must be annotated to show which items have been reimbursed.

4.4 What does your duty of disclosure to minimise damage comprise?

4.4.1 You should make every effort to keep the claim as low as possible and avoid anything that could lead to an unnecessary increase in costs.

4.4.2 Compensation claims against third parties shall be transferred to us as per the statutory regulation in Section 86 of the Insurance Contract Act (VVG), up to the amount of the benefit paid. We shall ensure that this does not disadvantage you. You are also obligated to assist, if necessary, in asserting the claim for compensation.

4.5 What are the legal consequences of failures of duty (breaches of obligations)?

If you fail to carry out one of the duties specified above, we will be released from liability either in full or in part. In this, we comply with the regulations of § 28 (2–4) of the Insurance Contract Act (VVG). These can be found in Section IV.

Section III – Description of payments

1 General rules for insurance coverage

We provide benefits in the event of an insured event occurring abroad.

1.1 What is an insured event?

Your medically necessary treatment due to illness or the consequences of an accident is considered to be an insured event. The insured event starts with the treatment. It ends once it is medically established that no further treatment is needed. The following are also considered insured events:
– Pregnancy and childbirth if the pregnancy had not yet started at the beginning of the insurance contract,
– Medically necessary treatments for complaints during pregnancy,
– Premature births until the completion of the 36th week of pregnancy,
– Miscarriage,
– Medically necessary abortions and
– Death.

See clause 2 for details of what precise benefit we provide after an insured event. Please read clause 3 carefully as well. This regulates when we do not provide a benefit, even if an insured event has occurred.

1.2 Which doctors and hospitals can you choose between?

You can choose freely among the following legally-recognised individuals and bodies authorised to give treatment:
– Doctors,
– Dentists and
– Hospitals and
– Naturopaths,
– Chiropractors and
– Osteopaths.

The precondition is that these
– charge fees based on the relevant official, applicable fee schedule – if available – or
– based on fees generally charged in the local area.

The hospital in the country of destination must
– be recognised and approved,
– be under constant medical supervision,
– have sufficient diagnostic and therapeutic facilities and
– keep medical records.

1.3 Which methods do we cover if you need to be examined and treated?

We cover
– examinations,
– treatments and
– medication,
recognised by conventional medicine. We also cover other methods and medications,
– which have proved equally effective in practice or
– which are only available in the absence of conventional medicine.
These methods include e.g.
– homeopathic treatments
– anthroposophical medicine or
– herbal treatment.
In such cases we can, however, reduce the benefits to the amount that would have been incurred by the use of available conventional medicine.

2 What are the benefits that we pay if an insured event occurs?

We will reimburse the following benefits if the insured event occurs
– after the start of the insurance cover, and
– the waiting times have elapsed.
Please also note the maximum payment amounts listed in Section I.

2.1 What do we pay if you are treated as an outpatient?

We will reimburse the costs for the following services:

2.1.1 Healing treatment

2.1.2 Transport
– to/from the nearest suitable doctor
– to the nearest suitable hospital
– return to the respective accommodation.

2.1.3 Medically necessary rehabilitation measures

2.1.4 Check-ups
– for the early detection of cancer diseases according to programmes introduced by law in Germany after the waiting period of 6 months from the beginning of the insurance coverage has expired
– for children according to programmes introduced by law in Germany.

2.1.5 Psychoanalytic or psychotherapeutic treatments after the expiry of the waiting period of 6 months from the beginning of the insurance coverage. The waiting time is eliminated if you are directly effected by

– an accident,
– violent crimes, or
– natural disasters
at the place of stay.

2.2 What do we pay if you are treated as an inpatient?

Where necessary, we will give the hospital a guarantee to assume the costs through our worldwide emergency call service.

We will reimburse the costs for the following services:

2.2.1 Medical treatment including accommodation, food and care in the hospital.

2.2.2 Transport
– to the nearest suitable hospital
– return to the respective accommodation.

2.2.3 Accommodation and meals of an accompanying person in the hospital, if the insured person is younger than 18 years old.

2.2.4 Sick leave if it is established that you will have to stay in the hospital for more than 14 days. In this case
– on request, we can organise the trip of a close person to the place of hospitalisation and back to the place of residence,
– cover the round trip costs in economy class and
– cover the cost of hotel accommodation.
This is, however, provided that you are still in hospital by the time the relative or friend arrives.

2.2.5 Hotel accommodation of fellow travellers in case the booked stay has to be interrupted or extended due to their hospitalisation

2.2.6 Medically necessary rehabilitation measures

2.2.7 In the case of inpatient treatment, you can decide:
– You will receive a reimbursement of the costs of the aforementioned services from us (sections 2.2.1-2.26) or
– You will receive a daily allowance from the beginning of inpatient treatment.
The decision must, however, be made at the beginning of the in-patient treatment.

2.3 What do we pay if you have dental treatment?

We will reimburse the costs for the following services:

2.3.1 Pain-relieving preservative dental treatments

2.3.2 Simple fillings

2.3.3 Repairs to an existing dental prosthesis, insofar as the need for repair has arisen only after the start of the insurance cover

2.3.4 Dental prosthesis that, due to an accident
– during the insured period, have become necessary for the first time, or which
– need to be repaired.

2.3.5 Dental prosthesis after a waiting period of 6 months from the beginning of the insurance coverage. A dental prosthesis within the meaning of this tariff includes
– pivot teeth,
– inlays,
– crowns,
– dental bridges,
– orthodontic treatments,
– function analytical and function therapeutic treatments and
– implant treatment.

2.4 What do we pay for medications, dressings, therapeutic products and medical aids?

We provide insurance benefits when these
– have been prescribed by one of the practitioners listed under section 1.2 and
– are medically necessary.

2.4.1 Medications and dressing material

You need to obtain medications from the pharmacy. The following are considered medicines, even if they are prescribed:
– neither nutritive and tonic substances, nor
– cosmetic preparations.

2.4.2 Remedy

These are radiation, light and other physical treatments. This also includes
– massages,
– medicinal packs,
– inhalations, as well as
– physiotherapy.

2.4.3 Resources

The following items count as aids:
– Bandages, broken ligaments, inlays,
– Crutches and compression stockings,
– Hearing aids,
– Corrective splints,
– Artificial limbs/prostheses,
– Seat shells and foam positioners, wheelchairs,

– Breathing monitor devices, infusion pumps, inhalation devices, oxygen devices,
– Surveillance monitors for infants,
– Orthopaedic body, arm and leg braces, as well as
– speech devices.

The insurance covers

a) simple remedies, provided that they
   – become necessary for the first time as a result of an accident, and
   – serve to facilitate the treatment of the consequences of the accident.
b) Repairs of existing remedies, provided that our written consent has been obtained in advance.

We will refund the rental fees for the first necessary and prescribed aids in a simple version. If a loan transfer is not possible or the costs for the loan exceed the acquisition costs, the expenses for the purchase of aids in simple form will be reimbursed.

2.4.4 Visual aids

We will reimburse the cost of visual aids, such as glasses and contact lenses, if the visual acuity has changed by at least 0.5 diopters.

2.5 What do we pay in the event of pregnancy?

2.5.1 We reimburse the costs
– for examinations and/or treatments for pregnancy complications,
– in case of miscarriage, as well as
– for delivery before the end of the 36th week of pregnancy.

2.5.2 If the pregnancy has occurred after the start of the insurance contract, we will provide insurance cover for
– prenatal care-examinations and
– childbirth.

We also accept examination and treatment invoices from midwives or obstetricians if the costs are not invoiced by a doctor at the same time.

2.5.3 If there is no other insurance cover, we will reimburse the costs of the necessary medical treatment of the new-born child in case of premature birth before the end of the 36th week of pregnancy. We grant this benefit
– for the period until the restoration of the transportability of the mother and child, or
– until inclusion in this insurance contract in accordance with the regulations of section II1.1.3.

2.6 What benefits do we do for repatriation, transfer and burial?

2.6.1 What do we pay in the event of transport home?

Do you require return transport to your place of residence or to the nearest suitable hospital at your place of residence? We will organise this and reimburse the costs if one of the following conditions is met:
– the return journey is medically reasonable and appropriate.
– According to the prognosis of the attending physician, the duration of treatment in the hospital abroad is expected to exceed 14 days.
– Further treatment abroad is likely to cost more than the repatriation.

We will also assume the cost of transport for an accompanying fellow-traveller.

We reimburse the costs for the cheapest suitable means of return transport.

2.6.2 What do we do if the insured person dies?

We organise the transfer of the deceased person to the permanent place of residence and cover the costs for this.

Alternatively, we will reimburse the costs to bury the deceased person in the country of travel. However, we only reimburse at most the costs that would have been incurred by repatriation of mortal remains.

2.7 What do we pay in the event of rescue?

If you have incurred costs for search or rescue operations by rescue services organised under public or private law after an accident, we will reimburse the costs for this.

2.8 What do we pay if children need care?

2.8.1 If all accompanying caregivers cannot continue (or end) the trip as planned due to an insured event, we will organise and pay for the care of the insured minor children, so that they

– continue the trip or
– interrupt

the trip. We also cover the additional return travel costs of the children.

2.8.2 If all accompanying caregivers are in the hospital for inpatient treatment, we will alternatively take over the accommodation costs of the children in the hospital for the duration of the inpatient treatment of the caregivers instead of the services according to section 2.8.1 at your request.

2.9 What additional benefits do we offer?

2.9.1 Telephone costs in contacting the emergency assistance hotline

If an insured event occurs, we will reimburse the telephone costs incurred by you when calling the emergency assistance hotline.

2.9.2 Delivery of medication

Have you lost prescribed medications during the journey? We will procure them in consultation with the general practitioner and send them to you or, at your request, appoint replacement medicines that are available on site. You are responsible for the costs for obtaining the medication. You must reimburse them to us within 1 month of the end of the trip.

2.9.3 Information about doctors and hospitals in your area

If there is an insured event, we will inform you about possible medical treatment. If possible, we will name a German or English-speaking doctor. Call our worldwide emergency assistance hotline.

2.9.4 Information transfer between doctors

Are you being treated as an in-patient? At your request, we will establish contact via the emergency call service between
– a doctor commissioned by us,
– your family doctor and
– the attending hospital doctors.

During the hospital stay, we ensure the transmission of information between the doctors involved. On request, we will also inform your relatives.

2.9.5 Retrieval of luggage

Have all the insured adults been repatriated or died? In this case, we will organise the collection of the luggage and assume the costs for this.

2.9.6 Psychological assistance

Are you in a difficult situation? We will provide you with psychological support via our emergency call service and, if possible, appoint for you a German- or English-speaking psychotherapeutic specialist. Psychoanalytical and psychotherapeutic treatment are not insured.

2.9.7 Medical interpreting service

Have you not understood the medical terms of the doctor treating you? We explain the diagnosis and other medical terms to you via our emergency call service.

2.10 When do you otherwise receive reimbursement for costs?

You pass all treatment costs first to another service insurer participating in the reimbursement of costs. Then we will issue a reimbursement.

2.10.1 In the case of out-patient treatment, we provide a one-time expense allowance regardless of the number of treatments and diseases.

2.10.2 In the case of in-patient hospital treatment, we provide an expense allowance per day of hospitalisation.

3 What do we not cover or only provide restricted cover for?

3.1 In which cases can we reduce the scope of benefits?

3.1.1 We can reduce the payments to an appropriate amount if
- the medical treatment exceeds the medically necessary level or
- the expenses for medical treatment exceed those generally charged in the local area.

3.1.2 If you do not use conventional medicine, we can reduce the payment. We will reimburse the amount incurred for existing conventional medical methods or medicines (for more details, see section 1.3).

3.2 In which cases do we not provide cover?

In the following cases we do not provide benefit, even if an insured event has occurred:

3.2.1 When you
- try to fraudulently deceive about circumstances that are important for the reason or the amount of the benefit, or
- you have caused the damage intentionally.

3.2.2 For treatments that were
- the sole reason, or
- one of the reasons,

for making the trip.

3.2.3 For treatments,
- whose necessity was evident before departure and
- were due to an illness that had already been medically diagnosed when the trip started.

Exception:
You are taking the trip because of the death of the spouse or a relative of the 1st degree.

3.2.4 For diseases, including their consequences, as well as for the consequences of accidents caused by
- a predictable war,
- predictable internal unrest, or
- active participation in internal unrest or in war.

Acts of war and internal civil unrest are considered to be foreseeable if the German Foreign Ministry issues a travel warning for the country in question before the start of the journey.

3.2.5 For cures and treatments in a sanatorium.
Exception:
These treatments are made following in-patient treatment due to
- a severe stroke,
- a serious myocardial infarction or
- a serious illness of the skeleton (disc operation, hip replacement)

and they serve to reduce the length of stay in the hospital. In these cases, you have insurance cover, if
- you inform us of the planned stay before the treatment and
- we have agreed to the treatments in writing.

3.2.6 For withdrawal measures including withdrawal cures.

3.2.7 For out-patient healing treatments in a spa or health resort.
Exception:
- The healing treatment is necessary due to an accident occurring there, or
- You were only visiting the spa or health resort briefly and were not staying for the purposes of treatment when you fell ill.

3.2.8 For treatments through
- Spouse
- Parents
- Children
- Persons with whom you are living in your own home or a home being visited.

We will also pay for documented material costs in these cases.

3.2.9 For treatment or accommodation due to
- infirmity,
- need for care or
- dependency.

3.2.10 For immunisation measures.

Section IV – Extract from the Insurance Contract Act (VVG)

§ 19 Duty of notification

(1) [1]Up to the submission of his contractual declaration, the policyholder must notify the insurer of the risk circumstances known to him that are relevant for the decision by the insurer to conclude the contract with the agreed content and which the insurer has asked about in text form. [2]If the insurer asks questions pursuant to sentence 1 after the contractual declaration by the policyholder, but before the acceptance of the contract, the policyholder is also obligated to give notification in this regard too.

(2) If the policyholder breaches his duty of notification pursuant to paragraph 1, the insurer can withdraw from the contract.

(3) [1]The insurer's right of withdrawal is excluded if the policyholder has not breached the duty of obligation in a wilful or grossly negligent manner. [2]In this case, the insurer has the right to terminate the contract giving a period of notice of one month.

(4) [1] The insurer's right of withdrawal due to a grossly negligent breach of the duty of obligation and his right of termination pursuant to paragraph 3 clause 2 are excluded if he would have concluded the contract even if he was aware of the undisclosed circumstances, even if under different conditions. [2]The other conditions, at the insurer's request, become part of the contract retrospectively, with a breach of duty for which the policyholder is not responsible from the current insurance period.

(5) [1]The insurer is entitled to the rights pursuant to paragraphs 2 to 4 only if it has pointed out to the policyholder by separate notification in text form the consequences of a breach of the duty of notification. [2]The rights are excluded if the insurer was aware of the circumstance not notified or knew of the incorrectness of the notification.

(6) [1]If in the case of paragraph 4 clause 2 the premium increases by more than 10 per cent or if the insurer excludes the protection against risks for the circumstance that was not notified, the policyholder can terminate the contract within a month after receipt of the notification from the insurer without giving a notice period. [2]The insurer must point out this right to the policyholder in the notification.

§ 20 Representative of the policyholder

[1]If the contract is concluded by a representative of the policyholder, when applying § 19 (1 to 4), and § 21 (2) Sentence 2 as well as (3) Sentence 2 to take into account both the knowledge and the malice of the representative and the knowledge and malice of the policyholder. [2]The policyholder can only rely on the fact that the duty of notification was not violated intentionally or through gross negligence, if neither the representative nor the policyholder is guilty of intent or gross negligence.

§ 21 Exercise of the rights of the insurer

(1) 1The insurer must assert the rights to which it is entitled under § 19 (2 to 4) in writing within one month. [2]The period begins from the moment when the insurer becomes aware of the violation of the duty to notify, which establishes the right asserted by him. [3]When exercising his rights, the insurer must state the circumstances on which he bases his declaration; he may subsequently state further

circumstances to substantiate his declaration if the period under sentence 1 has not elapsed for these.

(2) [1]In the event of withdrawal in accordance with Section 19 (2) after the occurrence of the insured event, the insurer shall not be obliged to provide a benefit unless the breach of the duty of notification relates to a circumstance that is not the cause of either the occurrence or the determination of the insured event, or the determination or the scope of the insurer's obligation to indemnify. [2]If the policyholder fraudulently violates the duty of notification, the insurer is not obliged to pay.

(3) [1]The rights of the insurer according to Section 19 (2 to 4) elapse after the expiration of five years after conclusion of the contract; this does not apply to insurance claims that occurred before the expiration of this period. [2]If the policyholder has intentionally or fraudulently violated the obligation to notify, the period is ten years.

§ 28 Non-observance of a contractual obligation

(2) Where the contract provides that the insurer is not obligated to effect payment in the event of the non-observance of a contractual obligation on the part of the policyholder, the insurer shall be released from the liability if the policyholder intentionally breached the obligation. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) Notwithstanding subsection (2), the insurer shall be liable for performance insofar as the failure to honour the obligation caused neither the occurrence nor the establishment of the insured event nor the establishment or the extent of the insurer's obligation to effect payment. Sentence 1 shall not apply if the policyholder fraudulently breached the obligation.

(4) The condition on which the insurer's entire or partial release from liability in accordance with subsection (2) is based shall, in the event of a violation of an existing duty to provide information or duty of disclosure after the occurrence of an insured event, be the fact that the insurer instructed the policyholder in separate correspondence and in writing of this legal consequence.

§ 37 Delayed payment of first insurance premium

(1) If the single premium or the first premium is not paid in good time, the insurer shall be entitled to withdraw from the contract as long as the payment has not been made, unless the policyholder is not responsible for the non-payment.

(2) If the single premium or first premium has not been paid when the insured event occurs, the insurer shall not be obligated to effect payment, unless the policyholder is not responsible for the non-payment. The insurer shall only be released from liability if he had informed the policyholder of the legal consequence of non-payment of the premium in writing in a separate communication or by means of a conspicuous note in the insurance policy.

§ 38 Delayed payment of first insurance premium

(1) [1]If a follow-up premium is not paid on time, the insurer may, at the policyholder's expense, specify a payment period in writing to the policyholder, which must be at least two weeks. [2]The provision is only effective if it quantifies the outstanding amounts of the premium, interest and costs in detail and indicates the legal consequences associated with the expiry of the period in accordance with paragraphs 2 and 3; in the case of combined contracts, the amounts must be indicated separately in each case.

(2) If the insured event occurs after expiry of the deadline and if the policyholder is in default with the payment of the premium or interest or costs, the insurer is not obliged to pay benefits.

(3) [1]The insurer may terminate the contract after the deadline has expired without observing a deadline, provided that the policyholder is in default with the payment of the amounts owed. [2]The termination can be combined with the determination of the payment deadline in such a way that it becomes effective upon expiry of the deadline if the policyholder is in default of payment at this time; the policyholder must be expressly informed of this upon termination. [3]The termination shall become ineffective if the policyholder makes the payment within one month after the termination or, if it has been combined with the deadline provision, within one month after expiry of the deadline; Paragraph 2 shall remain unaffected.

§ 86 Assignment of claims

(1) If the policyholder is entitled to claim damages from a third party, this claim shall be assigned to the insurer insofar as the insurer compensates for the loss. The claim may not be assigned to the detriment of the policyholder.

(2) The policyholder shall safeguard his claim for damages or a right serving to safeguard this claim in accordance with the applicable form and time requirements, and he shall assist the insurer wherever necessary in asserting them. If the policyholder intentionally breaches this obligation, the insurer shall not be obligated to effect payment insofar as he cannot, as a result, claim compensation for it from a third party. In the event of a grossly negligent failure to honour the obligation, the insurer shall be entitled to reduce any benefits payable commensurate with the severity of the policyholder's fault; the burden of proof that there was no gross negligence shall be on the policyholder.

(3) If the policyholder claims compensation from a person with whom he is sharing a common household when the loss occurs, assignment in accordance with subsection (1) cannot be asserted, unless that person intentionally caused the loss.

Arbitration bodies

We would like to draw your attention at this point to the possibility of out-of-court dispute resolution.

For health insurance, the voluntary membership of HanseMerkur in the Verband der Privaten Krankenversicherung e.V (Association of Private Health Insurers) requires, according to the statutes, participation in mediation procedures through a consumer mediation office.

Ombudsman

Private Kranken- und Pflegeversicherung (Private Health & Care Insurance)

Postfach 060222

10052 Berlin

Hotline: +49 1802 550 444