General terms and conditions of insurance for travel health insurance Care Discover with Advigon Versicherung AG (Advigon Insurance, Inc.) VB-KV 2018 Care Discover (CKV CD-G2018)

§ 1 Insurable persons and insurability

Unless otherwise agreed, the following shall apply:

1. The insurance covers the persons who are eligible for insurance and for whom the agreed premium has been paid and who are named in a separate list.
2. Persons eligible for insurance reside abroad worldwide;
   countries whose citizenship the insured person holds and/or in which he has a permanent residency (home countries) are not considered foreign in this sense; the country of citizenship is considered foreign if the main residency has already existed for at least 5 years in a country other than that of citizenship.
3. Persons who are not insurable and are not covered despite payment of premiums are those persons who
   a. have reached the age of 66 (66th birthday) at the beginning of the insurance coverage or when applying for an extension of the insurance cover (follow-up membership);
   b. are subject to statutory health and/or long-term care insurance in the country of destination;
   c. engage in competitive sport or, in the context of their trip, engage in physical activity in one of the professions listed in Appendix 1 or engage in a sporting activity in exchange for payment. Appendix 1 is an integral part of these conditions;
   d. have entered the country illegally or are residing illegally in the country of destination;
   e. are in constant need of care. Those in need of care are those who predominantly require help from others for the carrying out of daily tasks;
   f. are permanently residing abroad.

§ 2 Conclusion and termination of the insurance contract, membership in the group insurance contract, insurance coverage for newborns

1. The group insurance contract is concluded between the policyholder and Advigon Versicherung AG (hereinafter referred to as the "insurer").
2. The group insurance contract can be terminated with three months' notice to the end of the year. Termination by the policyholder shall only become effective if the insured persons affected by the termination have become aware of the notice of termination and the policyholder provides proof of this accordingly. The insured persons concerned have the right to continue the insurance contract under the terms of the individual insurance under the designation of a future policyholder. The declaration concerning this is to be made within 2 months of receiving notice of the continuation offer.
3. The statutory provisions on the right of extraordinary termination shall remain unaffected.
4. The application for inclusion of insured persons in the group insurance must be made before the start of the trip abroad or within one year of entering the country of destination of the trip abroad. Proof of the date of entry must be provided on request.
5. The membership of the insured persons in the group insurance must be applied for for the entire duration of the stay abroad of the insured persons.
6. The inclusion of the insured person in the group insurance occurs via explicit acceptance by the insurer responsible at the time requested, provided that
   a. the application for inclusion in the group insurance contract is made on the form (registration list) provided by the insurer and valid for this purpose or in the secure online area provided for this purpose;
   b. the form or online application, duly completed, is received by the insurer and the first premium or single premium has been paid. The form or online application form is duly completed only if it contains clear and complete information on the start and duration of membership in the group insurance contract and on the persons to be insured.
7. If the stay is extended within the maximum duration of coverage, the continued membership in the group insurance contract can be concluded for the continued, originally uninsured stay abroad in the form of a legally independent follow-up membership (extension membership) under the following conditions:
   a. The application for extended membership must be made on the form provided by the insurer and valid for this purpose or in the secured online area provided for this purpose;
   b. The application for extended membership must be submitted to the insurer before the expiry of the originally agreed membership period;
   c. The maximum duration of coverage is not exceeded by the period of extended membership;
   d. The insurer must explicitly approve the application for extended membership. If a premium is paid for a policy that has not been explicitly accepted, the amount shall be at the sender's disposal - after deduction of the insurer's costs.
8. If the original insurance coverage is extended by a legally independent follow-up membership within the maximum duration of coverage, insurance coverage shall only exist for the insured events, illnesses, complaints and their consequences which have newly occurred after application for the extension (date and time of the postmark or upon receipt on the insurer's or Care Concept AG's server). The §§ 6, 2 and 9, 1. a. and j. apply accordingly. In addition, the special waiting periods in accordance with § 8 II., 3 must be observed.
9. Unless otherwise agreed, the legal effects of the independent follow-up membership correspond to those of the first membership.
10. Insurance coverage for newborns: insurance cover for newborns begins without risk surcharges and waiting periods on the day of birth, provided that the registration for insurance of the child with the insurer, represented by Care Concept AG, has demonstrably been retroactively effected no later than two months after the birth.
    a. The prerequisite for coverage of newborns is that
       aa. Insurance coverage under the group insurance contract has existed for at least one parent on the day of birth for at least three months without interruption;
       bb. the insurance coverage applied for is not higher and more comprehensive than that of the insured parent;
       cc. no other insurance coverage exists.
    b. Adoption is equal to birth if the child is still a minor at the time of adoption. If there is an increased risk, it is possible to agree to a risk surcharge of up to 100% on the plan premium.
    c. If the application for insurance coverage is made later than two months after birth or if insurance coverage is applied for which is higher or more comprehensive, the child's insurance is subject to a separate risk assessment by the insurer, represented by Care Concept AG. In this case, the insurance coverage only becomes effective upon acceptance of the insurance contract. The provisions of this section under numbers 1 to 9 shall apply accordingly.
    d. The insurer's obligation to provide insurance coverage within the framework of insurance coverage for newborns does not apply if the newborn or adopted child is covered by other private or statutory health insurance in Germany or abroad.
11. Group contract members and/or co-insured persons can cancel their participation in the group insurance contract in text form (e-mail, fax, regular mail) within a period of three months. The member's cancellation shall only become effective if the co-insured persons affected by the cancellation have gained knowledge of the cancellation declaration and the policyholder can prove this accordingly.

§ 3 Termination

1. Ordinary termination
   The group insurance contract can be terminated by the policyholder with three months' notice to the end of the year. Termination by the policyholder shall only become effective if the insured persons affected by the termination have become aware of the notice of termination and the policyholder provides proof of this accordingly. The insured persons concerned have the right to declare the continuation of the insurance relationship by designating a future policyholder. This right shall expire two months after the insured person becomes aware of this right. If no new policyholder is named, the insured persons shall be entitled to continue the insurance relationship under the conditions of individual insurance, taking into account the rights acquired under the contract. The explanation of this is to be submitted within 2 months of being notified of the option to continue coverage. The insurer waives his ordinary right to termination.
2. Extraordinary termination
   The statutory provisions on the right of extraordinary termination shall remain unaffected for both the policyholder and the insurer.

§ 4 Premium/contribution

1. The premium for this insurance is paid by the policyholder to the insurer. The group contract member is obliged to pay the resulting contribution for the group insurance to the policyholder or to a recipient named by the policyholder (e.g. collection agency). The non-payment of the premium for the group insurance premium leads to the loss of insurance coverage within the legal framework.
2. Details of the premium/contribution payment
   a. The payment of the first or subsequent premium or the first or subsequent premium can be made either via the SEPA direct debit procedure, bank transfer, credit card payment or PayPal.
   b. If the premium or the membership fee for the group insurance contract is obtained by the insurer from a bank or credit card account via the SEPA direct debit procedure, the payment is deemed to have been made in due time if the premium can be collected on the debit date and neither the policyholder nor - in the event that the policyholder is not the owner of the account - the policyholder and/or account holder object to the collection of payment. If the premium or membership fee for the group insurance contract was not able to be collected through no fault of the policyholder, payment is still on time even if it is made immediately after the insurer has requested payment in text form (e.g. by e-mail, fax or regular mail, etc.).

§ 5 Right to premium adjustment

1. Within the framework of the contractual benefit commitment, the insurer's benefits may change, e.g. due to rising medical treatment costs or more frequent use of benefits. The insurer compares the required insurance benefits accordingly with those calculated in the technical basis for calculation. If this comparison reveals a deviation of more than 5%, the insurer may review the premiums and, if necessary, adjust them uniformly throughout the group contract. Under the same conditions, an agreed premium supplement may also be amended accordingly and the maximum amounts of benefits and daily subsistence allowances provided for in the collective agreement may be increased.
2. The adjustments pursuant to 1 shall take effect at the beginning of the second month following notification by the policyholder.
3. If the insurer increases the premiums in accordance with 1, the policyholder may terminate the insurance relationship with regard to the insured person concerned within one month of receipt of the notification of change at the time the change takes effect. Termination by the policyholder shall only become effective if the insured persons affected by the termination have become aware of the notice of termination and the policyholder provides proof of this accordingly. The insured persons concerned have the right to declare the continuation of the insurance relationship by designating a future policyholder. This right shall expire two months after the insured person becomes aware of this right. If no new policyholder is named, the insured persons shall be entitled to continue the insurance relationship under the conditions of individual insurance, taking into account the rights acquired under the contract. The declaration must be made within two months of of being notified of the option to continue coverage.

§ 6 Scope, commencement, duration and end of the insurance coverage

1. Scope of coverage
   a. Within the scope of this contract, the insurer offers insurance coverage to persons who are only temporarily residing abroad during a trip. Foreign countries within the meaning of these conditions are all states and territories of which the insured person is not a national and/or has no permanent residency or has not had a principal residency for more than 5 years.
   b. If the insured event occurs in the home country of the insured person, there is no insurance coverage. For the purposes of these contractual provisions, the home country is the country in which the insured person has a residency and to which he is willing to return and/or the territories of the countries of which the insured person is a national.
   c. Notwithstanding b., insurance coverage also exists in the home country of the insured person under the following conditions: for insurance periods of at least one year, insurance coverage also exists in the event of a temporary return to the home country of the insured person; insurance coverage in the home country is limited to a maximum of six weeks for all stays in the home country per policy year. The policy year shall be a period of twelve months calculated from the commencement of the insurance coverage, including all extensions of the original insurance coverage by at least one legally independent follow-up membership.
2. Commencement of coverage
   The insurance coverage begins at the time indicated on the list of members or on the online form (technical commencement of insurance); however
   a. not before receipt of the insurance confirmation,
   b. not before crossing the border into a foreign country,
   c. not before payment of the premium/membership fee,
   d. not before expiry of any waiting periods,
   depending on which event occurs last.
   No payments will be made for insured events that occurred before the insurance coverage commenced. For persons who do not fulfill the requirements of insurance eligibility in accordance with § 1 of these terms and conditions, insurance coverage shall not commence upon payment of the premium. If the premium is nevertheless paid for a person who is not insurable, the amount shall be at the sender's disposal, less the insurer's costs.
3. End of coverage
   The insurance coverage also ends for insurance claims that have not yet been closed
   a. at the agreed time;
   b. at the end of the trip abroad at the latest;
   c. if the conditions for a temporary stay abroad are no longer fulfilled;
   d. if at least one of the prerequisites pursuant to § 1 for the insured person's ability to be insured no longer applies. This condition shall also not apply when the person concerned has acquired the nationality of the country of destination or has transferred his permanent residency to that country;
   e. at the time of termination of the group insurance contract;
   f. at the time of termination of the group contract membership.
4. Extended liability/coverage
   If an illness requires further medical treatment which extends beyond the end of the insurance coverage because the insured person is shown to be unable to travel or be transported, we are required under these terms and conditions to continue to provide coverage at the respectively agreed upon rate
   a. for membership durations of up to six months, including all extensions of the original insurance coverage by at least one independent follow-up contract, up to the restoration of transportability, for a maximum duration of one month,
   b. for membership durations of more than six months, including all extensions of the original insurance coverage by at least one legally independent follow-up membership, up to the restoration of transportability, for a maximum duration of three months.

§ 7 Minimum and maximum duration of coverage/membership period in the group insurance contract

1. The minimum duration of coverage/minimum membership period in the group insurance contract is one month.
2. The maximum duration of coverage/maximum membership period in the group insurance contract shall be three years, including any extensions of insurance coverage by independent follow-up contracts.

§ 8 Object insured and extent of the obligation to provide coverage

I. General information

1. The insurer shall indemnify for the treatment costs incurred after expiry of the waiting period for acute insured events occurring during the trip abroad. The regulations governing the waiting period are listed in § 8 II.
2. An insured event is the medically necessary treatment of an insured person due to illness or the consequences of an accident. The insured event begins with the medical treatment; it ends when, according to medical findings, there is no longer a need for treatment. If the treatment has to be extended to an illness or the consequences of an accident which is not causally connected with the illness or the consequences of the accident previously treated, a new insured event arises. The following are also considered to be insured events:
   a. medical treatment including pregnancy examinations and pregnancy treatment, if the pregnancy did not yet exist at the time of receipt of the application for insurance coverage or at the time of receipt of the application for extension of insurance coverage by a legally independent follow-up membership (extension membership) with the insurer or Care Concept AG;

b. the delivery;
c. death.

3. The scope of the insurance coverage is determined by the group contract, the membership certificate, any separate written agreements, these General Terms and Conditions of Insurance, the provisions of the agreed plan/plan rate and the statutory provisions of the Federal Republic of Germany.
4. In the country of destination, the insured person is free to choose between locally-established, licensed doctors and dentists. Within the scope of the contract, the costs for treatment provided by the practitioner shall be covered insofar as this treatment can be billed in accordance with the current official rates for physicians and dentists valid in the country. If there is no official/legal fee schedule in the country of destinatio at the time of treatment, the costs of treatment will be reimbursed according to the fee customary in the country of destination at the time of treatment.
5. Medications, bandages, remedies and aids must be prescribed by the practitioners mentioned in 4, and medicines must also be obtained from the pharmacy. Medicinal products, even if prescribed as such, shall not include nutritional and tonic products, mineral water, disinfectants and cosmetics, dietetic and infant foods and the like.
6. In the case of medically necessary inpatient hospital treatment, the insured person has a free choice among the public and private hospitals which are generally recognised as hospitals in the country of stay, are under permanent medical supervision, have sufficient diagnostic and therapeutic facilities, keep medical records and do not carry out any cures or sanatorium treatments or admit convalescents. Insurance coverage exists for the standard care class (shared room) without optional benefits (private medical treatment). For medically necessary in-patient treatment in hospitals that also offer cures or sanatorium treatments or admit convalescents, but otherwise fulfill the requirements of sentence 1, the plan benefits shall only be granted if none of the other hospitals mentioned in sentence 1 is reasonably close, or if the insurer has agreed in writing to assume the costs before the start of treatment.
7. The insurer shall pay to the contractual extent for examination or treatment methods and medications which are predominantly recognised by orthodox medicine. The insurer shall also pay for methods and medications which have proved equally promising in practice or which are used because no conventional methods or medications are available; however, the insurer may reduce its benefits to the amount which would have been incurred if existing methods or medications had been used.
8. The insurer shall pay the contractual amount for transfer and funeral costs if the death of an insured person occurs as a result of an event that falls within the scope of this contract.

II. Waiting periods

1. The general waiting period is 31 days. It begins at the time indicated in the registration list or online form (official commencement of insurance), however
   a. not before receipt of the insurance/membership confirmation;
   b. not before crossing the border into a foreign country.
   It doesn't apply,
   aa. if the insured person proves entry into the insured country of stay within 31 days before registration or if the registration took place before the start of the trip abroad. Receipt of the registration list or the online registration by the insurer or Care Concept AG is a decisive factor in this matter;
   bb. in the event of accidents occurring after the commencement of the insurance coverage.
2. Previous insurance coverage that has existed without gaps since departure to a foreign country up to the commencement of the insurance coverage can be credited against the general waiting period. The benefit restrictions pursuant to § 9 shall continue to apply without restriction.
3. The particular waiting period for deliveries is eight months. When applying for insurance coverage for the first time, the waiting period is counted from the time the application for coverage is submitted. When applying for an extension of the insurance coverage through a legally independent follow-up membership (membership extension), the waiting period is counted from the time of application for an extension of the insurance coverage. If the initial contract and the follow-up contract or several follow-up contracts follow each other consecutively, the waiting period resulting from the respective preliminary contract or contracts shall be credited. The particular waiting period for dental prostheses is eight months. When applying for insurance coverage for the first time, the waiting period is counted from the time the application is submitted. When applying for a legally independent follow-up membership (membership extension), the waiting period is counted from the time of the application for extension of the insurance coverage. Insofar as initial membership and follow-up membership or several legally independent follow-up memberships (memberships extensions) follow each other consecutively, the waiting period resulting from the respective preliminary contract shall be credited.

III. Medical treatment costs

Unless otherwise agreed, the following shall apply:

1. The insurer will reimburse - less any deductible agreed per insured event - the costs incurred for medically necessary treatment. In accordance with § 8, I, 2, the deductible for each medically necessary treatment, each examination and each medically necessary treatment due to pregnancy as well as for births, shall be due. The amount of any agreed deductible is determined by the plan/plan rate selected. Treatment within the meaning of these terms and conditions shall be deemed:
   a. medical treatment including pregnancy examinations, pregnancy treatment and consequences, if the pregnancy did not yet exist at the time of receipt of the application for insurance coverage or at the time of receipt of the application for extension of insurance coverage with the insurer or Care Concept AG, in the form of a legally independent follow-up membership (membership extension),
   b. medical treatment caused by acute symptoms, medically necessary pregnancy treatment and treatment due to miscarriage as well as medically necessary abortions and deliveries until the end of the 36th week of pregnancy (premature birth), even if the pregnancy already existed at the time of receipt of application for inclusion in the group insurance contract or at the time of receipt of application for extension of insurance coverage in the form of a legally independent follow-up membership (membership extension), provided that the need for treatment was not determined at that time,
   c. medically prescribed medications and dressings,
   d. medically prescribed radiation, light and other physical treatments,
   e. medically prescribed massages, medical packs and inhalations,
   f. medically prescribed aids, which become necessary for the first time solely as the result of an accident and which serve the direct treatment of the consequences of the accident,
   g. diagnostic radiology,
   h. urgent in-patient treatment in the standard care class (multi-bed rooms) without optional benefits (private medical treatment),
   i. ambulance transport to the nearest suitable hospital for in-patient treatment and, in the case of first aid following an accident, to the nearest suitable physician and back,
   j. urgent operations,
   k. births, after the waiting period,
   l. costs for rehabilitation measures as medically necessary follow-up treatment.
2. Dental treatment costs
   Costs for the following measures incurred during the trip will be reimbursed, less any deductible agreed per insured event:
   a. pain-relieving conservative dental treatment including restoration of the affected tooth with non-dentin-adhesive plastic filling material (including underfilling);
   b. measures for restoring the function of dental prostheses (repairs). In total, the insurer will reimburse for the aforementioned dental treatment costs for membership durations,
      aa. of up to six months--including all extensions of the total duration of coverage by at least one legally independent follow-up membership (membership extension)-- a maximum amount of EUR 300,
      bb. of more than six months—including all extensions of the total duration of coverage by at least one legally independent follow-up membership (membership extension)—a maximum amount of EUR 600 per policy year and insured person.

   The policy year is a period of twelve months calculated from the beginning of the first registration. If the total duration of coverage is extended by at least one legally independent follow-up membership (membership extension) for a period exceeding 6 months, the larger benefits can only be paid for insured events that occur after receipt of the extension.

IV. Return transport, transportation/burial costs

The insurer will reimburse - except in the case of a stay in the home country -

1. up to EUR 55,000 in the event of the death of an insured person, the necessary additional costs incurred by the transfer of the deceased person to the home country

2. up to a maximum of EUR 55,000 the costs of a burial up to the amount of the expenses which would have arisen in the event of a transfer,
3. the additional costs of a medically prescribed and medically appropriate return transport to the home country.

§ 9 Restrictions on the obligation to provide coverage

1. No obligation to provide coverage exists:
   a. For the illnesses and symptoms and their consequences which exist and are known to the insurer or Care Concept AG at the beginning of the insurance coverage or upon receipt of the application for a legally independent follow-up membership (membership extension), as well as the consequences of such illnesses and accidents which have been treated by the insurer or Care Concept AG within the last six months prior to the beginning of the insurance coverage or prior to receipt of the application for extension by the insurer or Care Concept AG. In deviation from this, there is an obligation to pay benefits for treatments to eliminate life-threatening conditions that occurred acutely during the trip abroad. Life-threatening conditions are health conditions which, according to general life experience (e.g. heart attack) or due to the determination of a third doctor who does not directly treat the condition (e.g. medical officer of the responsible insurer), can lead immediately to the death of the sick person;
   b. For such diseases, including their consequences as well as for the consequences of accidents and deaths caused by nuclear energy, acts of war or active participation in unrest, which are not explicitely included in the insurance coverage;
   c. For spa and sanatorium treatments as well as rehabilitation measures (for follow-up treatment § 8 I. 6 applies);
   d. For withdrawal measures including withdrawal cures;
   e. For outpatient treatment in a spa or health resort. This restriction does not apply if the treatment becomes necessary as a result of an accident that occurred there. In the event of illness, it shall not apply if the insured person has stayed in the spa or health resort only temporarily and not for spa purposes;
   f. For treatment by spouses, parents or children. Proven material costs will be reimbursed in accordance with the tariff;
   g. For treatment by the policyholder or persons with whom the insured person lives within his/her own or a host family. Proven material costs will be reimbursed in accordance with the contract terms and conditions;
   h. For treatment or accommodation due to infirmity, need for care or custody;
   i. For psychoanalytic and psychotherapeutic treatment;
   j. For pregnancy and the consequences thereof existing upon receipt of the application for insurance coverage or upon receipt of the application for extension of coverage by a legally independent follow-up membership (membership extension) with the insurer or Care Concept AG. However, benefits shall be payable for complications unforeseeable during the contractual period if the pregnant woman has not completed the 36th week of pregnancy at the time of receipt of the application for insurance coverage or at the time of receipt by the insurer or Care Concept AG of the application for extension of insurance coverage by a legally independent follow-up membership (membership extension);
   k. For immunization measures;
   l. For aids that are initially necessary and not due to an accident within the period of coverage;
   m. For treatment for sterility, including artificial insemination, any related preliminary examinations and follow-up treatments as well as for disorders and/or injury to reproductive organs;
   n. For treatment of HIV infections and their consequences;
   o. For preventive medical checkups;
   p. For dentures, pivot teeth, inlays, crowns and orthodontic treatment, implants, bite aids and gnathological measures;
   q. For suicide, attempted suicide and their consequences,
   r. For organ donations and their consequences.
2. The insurer is released from the obligation to indemnify if:
   a. The policyholder or the insured person intentionally caused the insured event;
   b. The policyholder or the insured person fraudulently attempts to deceive the insurer about circumstances that are relevant to the reason for or the amount of the benefits.
3. If medical treatment exceeds the medically necessary level, the insurer may reduce its benefits to an appropriate amount.
4. If there is a claim to to statutory medical care or accident care benefits from the statutory accident or retirement insurance, the insurer may deduct the statutory benefits from the insurance benefits.

§ 10 Obligations and consequences of breaches of obligations

1. The policyholder and the insured person are obliged to
   a. The insured person must register the start and end of each trip to the home country during the contract period before the start of the trip and, in the case of a claim, provide proof of this at the insurer's request;
   b. The insurer must be notified immediately in text form of the acceptance of citizenship of the country of destination, the granting of an unlimited residency permit or the denial of the residency permit for the country of destination as well as the permanent taking up of residency in the country of destination.
2. The policyholder and the insured person are obliged, after the occurrence of an insured event,
   a. to keep the damage as low as possible and to avoid anything that could lead to an unnecessary increase in costs;
   b. to notify the insurer of the damage immediately, at the latest after completion of the trip, by submitting all relevant documents;
   c. to permit the insurer to carry out any appropriate investigation into the cause and amount of its obligation to pay benefits, to provide any information useful for this purpose, to submit original receipts and supporting documents and, in the event of death, to submit the death certificate;
   d. to contact the insurer in the event of in-patient treatment and before comprehensive diagnostic and therapeutic measures are taken;
   e. in the case the insurer approves the return transport depending on the type of illness and the need for treatment, to agree to the return transport as being to the place of residency or to the nearest suitable hospital to the place of residency, provided that the insured person is able to be transported;
   f. Further obligations are stipulated in connection with § 15 2. Please refer to this provision for further details.
   g. At the insurer's request, the insured person is obliged to have him or herself examined by a doctor appointed by the insurer.
   h. The knowledge and negligence of the insured person shall be equivalent to the knowledge and negligence of the policyholder.
3. Consequences of breach of duty
   If the policyholder or the insured person intentionally violates one of the contractually agreed obligations, the insurer is not obliged to indemnify. In the event of a grossly negligent breach of the obligation, the insurer is entitled to reduce the benefit in proportion to the seriousness of the fault of the policyholder/insured person. The burden of proof for the non-existence of gross negligence lies on the side of the policyholder.

§ 11 Requirements for the payment of insurance benefits

1. The original invoices must be submitted to:
   Care Concept AG
   P.O. Box 30 02 62
   53182 Bonn
   Germany
2. The insurer is only obliged to indemnify if the following evidence- which become the property of the insurer - has been provided:
   a. Original supporting documents/receipts, in the official currency of the country of destination, showing the name of the person treated, the name of the disease and the nature, place and period of treatment of the services provided by the attending physician. If insurance coverage for medical treatment costs exists elsewhere and is claimed first, copies of the invoice(s) with reimbursement notes shall suffice as proof;
   b. prescriptions, laboratory and X-ray invoices are to be submitted together with the medical (doctor's) invoice, the invoice for medication or medical aids and the medical prescription;
   c. an official death certificate and a medical certificate stating the cause of death, if transport and/or funeral costs are to be paid;

d. at the insurer's request, proof of the beginning and end of a trip abroad or of any stay in the Federal Republic of Germany, the countries of the European Union or the member states of the Schengen Agreement;
e. at the insurer's request, proof of the beginning and end of each stay in the home country;
f. upon request or at the latest in the event of a claim, proof of fulfillment of the requirements for insurability in accordance with § 1, 2 as well as a valid residency permit for the stay in the country of destination;
g. at the insurer's request, proof of all health insurance policies with insurance coverage for the country of destination, taken out during the stay in the country of destination.

§ 12 Due date and payment of insurance benefits

1. As soon as proof of payment of the insurance premium/membership fee and the information/documents to be provided by the policyholder or the insured person are available and the obligation to pay and the amount of the compensation have been established, payment will be made within two weeks at the latest. If the obligation to pay has been established, but the amount of the compensation cannot be established by us within one month of receipt of the notice of claim, an appropriate advance on the compensation may be demanded. If official investigations or criminal proceedings have been initiated against the policyholder or one of the insured persons in connection with the insured event, the settlement of the claim may be postponed until these proceedings have been legally concluded.
2. As part of the assessment of the claim, it may become necessary for the insurer to obtain personal health data to the extent permitted by law. If the policyholder or the insured person culpably fails to give his/her consent to such a collection of information and the insurer is unable to conclusively determine the amount and scope of the obligation to pay out benefits, the due date for payment shall be suspended. The same applies if the institutions or persons questioned are culpably not released from their duty of confidentiality towards the insurer.
3. The costs incurred in foreign currency shall be converted into the currency valid in the Federal Republic of Germany at the exchange rate of the day on which the receipts are received by Care Concept AG. For traded currencies, the official exchange rate Frankfurt/Main shall be deemed the rate of the day, for non-traded currencies, the rate according to "leading currencies of the world," publications of the Deutsche Bundesbank, Frankfurt/Main, according to the latest rate, unless the currencies necessary for payment of the invoices have demonstrably been acquired at an unfavourable rate.
4. The additional costs incurred as a result of the insurer making transfers abroad or, at the policyholder's request, choosing special forms of transfer, may be deducted from the benefits.
5. The policyholder or co-insured person is obliged, in the event of a statutory health and/or long-term care insurance obligation existing in the country of destination, to make immediate efforts to be included in the corresponding compulsory insurance system and to provide evidence of these efforts upon request. The due date of the claim shall be suspended until the requested evidence has been received.

§ 13 Assignment/Pledge of Benefits

Claims to insurance benefits may neither be assigned nor pledged.

§ 14 Statute of limitations

1. Claims arising from this insurance contract are subject to a statute of limitation of three years. The period begins at the end of the year in which the benefit can be requested.
2. If a claim of the policyholder has been filed with the insurer, the statute of limitations is suspended in text form until receipt of the insurer's decision.

§ 15 Compensation from other insurance contracts and claims against third parties

1. If, in the event of an insured event, compensation can be claimed under another insurance contract, the other contract shall take precedence over this contract. This shall also apply if subordinated liability has also been agreed in one of these insurance contracts, irrespective of when the other insurance contract was concluded. If the insured event is first reported to the insurer, the latter shall make advance payment and shall contact the other insurer directly in order to share the costs.
2. If the policyholder is entitled to a compensation claim against a third party, this claim shall pass to the insurer insofar as the insurer compensates for the loss. The transfer cannot be asserted to the detriment of the policyholder. The policyholder must safeguard his claim for compensation or the right serving to secure this claim in compliance with the applicable form and deadline regulations and, if necessary, cooperate in its enforcement by the insurer and provide evidence of such cooperation upon request.
   The consequences of a breach of this obligation are defined according to § 10, 3.
3. The insured person's or policyholder's claims against medical practitioners due to excessive fees shall pass to the insurer to the extent permitted by law to the extent that the insurer has reimbursed the costs of the corresponding invoices. If necessary, the policyholder or the insured person is obliged to assist in the assertion of the claims. Furthermore, the policyholder or the insured person is obliged, if necessary, to submit a declaration of assignment to the insurer.

§ 16 Offsetting

The policyholder may only offset claims of the insurer if the counterclaim is undisputed or has been established as final and legally binding.

§ 17 Declarations of intent and notifications

1. Declarations of intent and notifications to the insurer and Care Concept AG must be made in text form.
2. If the policyholder/insured person has not notified the insurer of a change in his/her address, proof of the postal office's corresponding non-delivery note to the policyholder's/insured person's last address known to the insurer shall suffice for a declaration of intent to be submitted to the policyholder/insured person. The declaration shall be deemed to have been received three days after dispatch of the letter. Sentences 1 and 2 shall apply accordingly in the event of a change of name of the policyholder/insured person.
3. In the case of electronic data transmission (e-mail) when there has been a change of e-mail address, 2 applies correspondingly to the sending of the e-mail and the system-technical delivery failure error message.

§ 18 Underwriting guarantee

1. In the event of termination of the group contract membership, the insurer guarantees the acceptance of the insured persons to or continuation of the insurance coverage for the insured persons by the Care Economy product of Care Concept AG. Should the Care Economy product be replaced by another, equivalent product during the period of insurance coverage, the guarantee pursuant to sentence 1 shall also apply to this product accordingly.
2. The underwriting guarantee does not extend the scope of the Care Economy product of Care Concept AG or the equivalent product replacing it.
3. The underwriting guarantee pursuant to 1 shall not apply if the insurer is entitled to terminate or adjust the original insurance relationship extraordinarily for reasons exclusively attributable to the policyholder's insured persons and/or the insured person(s) (e.g. in the event of a rescission by the insurer granting coverage). Pursuant to § 15, 2, sentence 1, the underwriting guarantee does not apply, irrespective of whether the original insurance relationship was actually terminated by the insurer or not.

§ 19 Applicable law, contract language, application for insured persons

German law shall apply insofar as international law does not conflict with it. The contract language is German. All provisions made shall apply to the co-insured persons accordingly.

§ 20 Profit sharing

The insurance policy/policies mentioned here is/are not subject to profit sharing.

Annex 1: Non-insurable professional activities in accordance with § 1, 2 c. of the Insurance Terms and Conditions

Professions	Provision regarding activities	Limitation of exclusion
performance artists	all activities	
construction workers	selected activities	Only the following activities are excluded:
		concrete builders
		roofers
		scaffolders
		building construction workers
		bricklayers
		reinforced concrete constructors
		plasterers
		civil engineers
		carpenters
miners	all activities	
professional soldiers	all activities	
commercial diver	all activities	
tamers	selected activities	only as far as originally wild animals (cats of prey, elephants, etc.) are tamed
parachutists/skydivers	all activities	
firefighters	all activities	
deep-sea fishermen	all activities	
butchers	all activities	
offshore workers	selected activities	only those directly involved in oil production
pyrotechnicians	all activities	
security staff	selected activities	only the following activities are excluded:
		bodyguards
		security guards
demolition experts	all activities	
stuntmen/stuntwomen	all activities	
surf instructors	all activities	
diving instructors	all activities	
decomposers	selected activities	activity in meat cutting

Policy terms and conditions for Care Discover travel health insurance with Advigon Versicherung AG VB-KV 2018 Care Discover (CKV CD-G2018) TB-CKV CD-G2018

No. 1 Insurance terms and conditions

The insurance terms and conditions for travel health insurance with Advigon Versicherung AG VB-KV 2018 (CKV CD-G2018) form the basis of the contract.

No. 2 Divergent agreements

The following amendments to or deviations from the insurance terms and conditions for travel health insurance with Advigon Versicherung AG VB-KV 2018 (CKV CD-G2018) have been agreed:

Regarding § 6 Geographic scope, commencement, duration and end of insurance coverage

1. Geographic scope of coverage
   The USA is excluded from the scope of coverage. Insurance coverage also does not exist in the national territory of the USA, when it concerns the home country of the insured person.

Re § 18 Guarantee of approval

(not applicable)