General Terms and Conditions of Insurance **AVB**

Attachement OD

for Healthcare Expenses and Hospital-Daily Allowance Insurance Version 1999

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The General Terms and Conditions of Insurance (GCI) form the basis of the insurance contract. The detailed provisions, particularly regarding the actual insurance benefits, can be found in the Tariff Conditions of the rate schedule selected by you.

Other arrangements differing from those respective of the individual items of the GCI can be made by special conditions to the rates or by negotiations in the insurance policy, which alter or supplement the GCI as regards the concerned items.

For your information, important provisions of the Insurance Contract Act (VersVG) applicable to your insurance contract have been inserted at the respective location in the GCI. The cited sections of the Act are clearly marked.

Supplemental Note for Group-Insureds:

Special provisions and definitions that are adapted to the nature of group insurance coverage are set forth in the Group Insurance Contract.

1. Object and Scope of Application of the Insurance Coverage

1.1.a) The event insured against is the medically indicated curative treatment of the insured party due to illness or to the consequences of accident. The insured event starts with the beginning of treatment and ends when the medical findings indicate that there no longer exists the necessity of treatment. If the curative treatment must be extended to a disorder or a consequence of an accident that is not causally connected with the one treated up to that time, a new insured event occurs.

1.1.b) Childbirth, including the medical examinations required during pregnancy and any medical curative treatment connected therewith are also considered insured events.

1.2. Curative treatment is such medical treatment that is considered appropriate in accordance with the generally accepted state of medical science to restore health, to improve a condition, or to prevent deterioration.

1.3. A disorder is an abnormal physical or psychic condition in accordance with the generally accepted state of medical science.

1.4. An accident is an event independent of the will of the insured person which unexpectedly mechanically or chemically acts upon his or her person from without and whose consequence is physical injury. The following events occurring independently of the will of the insured person are considered accidents:

Drowning,

Burns, scalds, the effects of lightning strike or electrical current,

Inhalation of gases or vapors, ingestion of toxic or corrosive substances, unless these effects occur gradually,

Dislocations of limbs as well as sprains and lacerations of the muscles, tendons, ligaments and capsules of the limbs and/or the spinal column.

The insurance coverage also extends to accidents that are caused by heart attack and to accidents that are the consequence of a stroke as well as mental disorders and disturbances of consciousness (but not due to the effects of illicit drugs or alcohol). Under no circumstance, however, is a heart attack considered a consequence of an accident.

For curative treatment after accidents:

In the event of use of aeronautical means and parachuting and when using aircraft, in so far as this does not occur as a passenger in motorized aircraft licensed for the purpose of passenger carriage (a passenger is any person who is neither in causal connection with the operation of the aircraft or a crew member, nor one who is exercising an occupational activity by means of the aircraft),

which occur at the time of participation in motor sport competitions (including qualification and rallies) and the associated training runs,

when participating in regional, national, or international ski competitions (Alpine and Nordic styles, snowboarding, biathlon, grass skiing); bobsledding, snow biking, skeletoning and in official training for these events,

there is insurance coverage as for curative treatment due to illness.

1.5. The insurance coverage extends to the insured event worldwide unless otherwise provided in the tariff. For curative treatment outside of Europe, within an insurance year there is coverage for one month from the start of such treatment (see also section 5.9.a)).

2. Limitation of Insurance Coverage

2.1. There is no insurance coverage for:

2.1.a) Curative treatment that began prior to the inception of the insurance,

2.1.b) Cosmetic treatment and operations and their consequences, in so far as the purpose of these procedures is not to remove the consequences of an accident,

2.1.c) Non-physician homecare such as geriatric procedures, rehabilitation and health education,

2.1.d) Dental implants and the procedures and consequences causally coincident therewith, in so far as their purpose is not the elimination of the consequences of an accident,

2.1.e) Illness and accident (consequence of an accident), which are the result of the abusive consumption of alcohol or illicit drugs or aggravated thereby or whose treatment is impaired by the abusive consumption of alcohol or illicit drugs, as well for drug withdrawal procedures and detox programs,

2.1.f) All forms of artificial insemination such as, for example, in vitro fertilization and insemination,

2.1.g) Commitment because of a risk to one's self or to others,
2.1.h) Illness and accident and their consequences, which occur as a result of active participation in unrest, by willful participation in disorderly conduct or commission of any legally punishable conduct which requires premeditation,

2.1.i) Illness and accident and their consequences, that occur as the result of the events of war of any kind, including violations of neutrality,

2.1.j) In-patient curative treatment in the facilities stated in section 5.10 (or the divisions of such facilities),

2.1.k) Sex change

2.2.a) Insurance coverage is provided for in-patient treatment in the facilities stated in section 5.9.a) (or the divisions of such facilities) in so far as the insured has approved same in writing prior to its start.

2.2.b) There is an entitlement to hospital-daily allowance (or hospitalization supplemental allowance) for inpatient treatment in the facilities stated in section 5.9.b) (or the divisions of such facilities) from the fifth week of treatment only in so far as the insured has agreed thereto in writing prior to the fifth week of treatment.

Insurance Contracts Act § 178l
The Insurer is released from the obligation of performance, if the Policy Holder or the Insured has intentionally caused his/her illness or his/her accident. If the Policy Holder has intentionally caused the illness or the accident of an Insured, then the Insurer is obliged to perform with respect to the Insured, then the Insured's claim against the Policy Holder for compensation passes to the Insurer in the in appropriate application of § 67. (Recourse Provision)

2.3. If the treatment exceeds the extent necessary, then the Insurer is entitled to reduce reimbursement by an appropriate amount. This also applies appropriately to accessories (treatment ancillaries).

2.4. The Insurer can, in justified cases, exclude treatment by certain physicians, dentists, or practitioners of other medical professions or treatment in certain hospitals (or the divisions of such hospitals) from coverage. This applies to treatments that are provided after service of notification. All insured events occurring before service of the notification are covered up to the lapse of the third month after service of the notification.

3. Start and End of the Insurance Coverage; Waiting Periods

3.1. The insurance contract is concluded upon notification (issuance) of the insurance policy or of a written acceptance notice. The insurance coverage begins, apart from the provisions regarding the waiting period, at the time indicated in the insurance policy (inception of insurance), in so far as the first premium has been paid prior to said time or within 14 days following notification (issuance) of the insurance policy.

3.2. The general waiting period is three months. It is waived:

3.2.a) In the event of accident, stomach or abdominal invasion that is caused or aggravated by an accident is not considered a consequence of accident.

3.2.b) In the vent of coinsurance of spouses for benefits in the scope of the existing insurance, when said insurance has been in effect for at least three months and the coinsurance is applied for within two months following the marriage with effect from the 1st of the referenced month.

3.2.c) In the event of insurance of newborn children (see Section 4).

3.3. Special waiting periods are shown in the tariff or in the insurance policy.

3.4. Insurance coverage for illnesses and the consequences of accident that are treated during the waiting period, with the exception of the cases set forth in Section 3.2 and pursuant to § 178d (3) of the Insurance Contract Act, are available only after lapse of the waiting period. The waiting period is calculated from the point of inception of insurance.

Insurance Contracts Act § 178d.
(3) If an insured event occurs prior to expiration of the waiting period, the Insurer is obliged to perform only if the Policy Holder can show that the illness was made manifest only after conclusion of the contract or that the pregnancy occurred only after that point in time.

3.5. In the event of crossover to a higher rate, there is the entitlement to higher insurance coverage after expiration of a new waiting period that is calculated from the negotiated time of the crossover.

3.6. The insurance coverage ends with the termination of the insurance contract, also for floating insured event.

4. Special Terms and Conditions for Insurance of Newborn Children

Insurance Contracts Act § 178e.
If a policyholder is, in the full scope of § 178b, para. 1 and not merely insured for expenses additional to the social insurance provide by law, then the Insurer is required on demand of the Policyholder, to insure his/her newborn child effective from the time of the birth without waiting period; said demand must be made no later than two months after the birth. The insurance coverage has the same scope as that of the Policyholder. If the child represents an increased risk, then the Insurer can require an appropriate premium surcharge.

Insurance Contracts Act § 178b.
In the event of insurance of healthcare costs the Insurer is required to reimburse, to the extent agreed, the expenses for medically necessary treatment due to illness or the consequence of accident and for other negotiated benefits, including medical care and treatment in the event of pregnancy and birthing.

In so far as in the case of the Insurer healthcare expense or hospital daily allowance insurance has been concluded for the Policyholder in addition to the benefits of social insurance under the law, the Insurer is required to insure the Policyholder's child from the point of discharge from the hospital without waiting period. The application must be made no later than two months after discharge of the newborn child from the hospital. The insurance coverage has the same scope as that of the Policyholder. The period from discharge from the hospital to the first of the next following month is premium-free. If the child represents an increased risk, then the Insurer can require an appropriate premium surcharge and/or except certain benefits from the insurance coverage.

5. Type and Extent of the Insurance Coverage

5.1. The nature and scope of the insurance coverage is provided in the tariff and the insurance policy. In so far as benefit for outpatient and/or inpatient treatment are provided therein, the following provisions apply:

A.Benefits for outpatient treatment

5.2. The insured has free choice from among the physicians and dentists approved for private practice of the medical profession. In the event of medical necessity the costs for intervention by a plurality of physicians during an insured event are covered.

5.3. The costs of physician house calls are covered only if the condition of the insured does not permit visits to the physician, otherwise only compensation for prescriptions will be made.

5.4. Physician en route fees will be reimbursed if there is not physician available in the place of domicile of the insured; the costs for travel by the insured to a physician will not be paid.

5.5. In the event of treatment by spouse, parents or children of the insured only the documented materials costs will be paid.

5.6. The costs of physiotherapeutic treatment (accessories) ordered by a physician will be paid, when they have been performed by a physician or a person authorized to professionally provide such services. Additional costs of prescriptions or house-calls are not covered in such cases.

5.7. The costs of accessories (ancillaries) prescribed by a physician will be paid. The following are included, for example, eyeglasses, contact lenses, trusses and supports, limb prostheses, hearing aids, orthopedic corsets, orthopedic shoe inserts, and the orthopedic equipping of shoes, bandages and bauchmieder, not, however, irrigators, inhalation devices, ice bags, milk pumps, oral douches, heating pads, fever thermometers, blood pressure measurement devices and apparatuses and aids for physical and sick care. If the insurer has provided reimbursement of costs for health accessories then any new claim for benefits can be brought only after expiration of the usual useful life, in so far as re-provision is not necessary at a time prior for medical reasons.

B.Benefits for Inpatient Treatment

5.8. Inpatient treatment in the sense of these terms and conditions of insurance is treatment in the scope of a medically necessary inpatient stay in a hospital or in a division of such facility recognized by the health authorities, in so far as said facilities provide constant physician presence, have adequate diagnostic and therapeutic opportunities available, and operate in accordance with generally accepted state of medical science, are not governed by the application of certain treatment methods and keep medical records. A stay is considered inpatient only when the nature of the treatment requires a stay of at least 24 hours.

An inpatient stay is not considered medically necessary, particularly if it is based merely on the lack of home care or other personal circumstances of the insured.

5.9.a) For inpatient treatment in the sense of Section 5.8 in private healthcare facilities outside of Austria and in facilities (or divisions of facilities):

that do not operate exclusively according to the generally accepted state of medical science,

in which, along with inpatient treatment, rehabilitation procedures or spa treatments are provided,

in which convalescent or care cases are accepted,

benefits are provided only in so far as the insurer has approved same in writing prior to their commencement.

5.9.b) Hospital daily allowance (or hospital supplemental daily allowance) for inpatient treatment in the sense of 5.8 in facilities (or divisions of facilities) for neurological and/or mental disorders (with the exception of their independently managed neurology and neurosurgery divisions) and in facilities (or divisions of facilities) for pulmonary disorders and persons with tuberculosis is provided after the fifth week of treatment only in so far as the insurer approves said treatment in writing prior to the start of the fifth treatment week.

5.10. There is no insurance coverage for stays:
in facilities (including their medical care facilities) or divisions of facilities:

that are principally directed at rehabilitation,

for persons with alcohol and drug dependencies,

for psychologically abnormal criminals,

for the chronically ill

for care due to age, decrepitude, invalidism or lack of home care,

and in

the health facilities of the armed forces,

correctional facilities hospitals (or divisions of correctional facilities),

independently run outpatient care centers (even if the examination or treatment makes short-term admission necessary),

spa facilities, recovery, dietary and recuperation homes,

day and night clinics.

5.11. The insurer may not invoke its release from providing benefits in accordance with Section 5.9.a) in so far as and for such time that the urgency of inpatient treatment does not permit visit to a medical care facility in the sense of Section 5.8 or obtaining the written approval in accordance with Section 5.9.a) prior to the start of the treatmetnt.

5.12. In the event of medically necessary transportation to a hospital for the purpose of inpatient treatment and in the case of necessary transportation home, the costs for ambulance, train or taxi will be reimbursed.

The prerequisite is that the transportation and inpatient treatment be ordered by a physician.

C.Common Provisions

5.13. Surgical costs are understood to be the surgeon's fees, the anesthetist's fees, the fees of the physicians assisting at the surgery and the cost of nursing staff for the operation including pre- and post-operative treatment and the material costs billed separately in the statement, except for the costs of body replacement part, implants and other therapeutic accessories such as, in particular, any apparatus that replace organs of support them in their functions.

In the event of simultaneous performance of several surgeries, the one that is classed as highest with respect to the tariff will be paid in full and each additional procedure in different surgical fields will be paid at maximum 50%, those in the same surgical fields at maximum 25% of the scope with respect to the tariff.

5.14. The costs for radiotherapy include the fees of the treating physician and the assisting physician, the costs for the use of equipment, for radiation material and other material expenditures as well as all associated costs.

5.15. The costs of the medications prescribed and dispensed from a pharmacy in the framework of treatment will be reimbursed.

The costs, in particular for spa and mineral water, medicinal wines, nutritional and restorative agents, geriatric agents, tonics, cosmetics and all unregistered medicines.

6. Changes in the Insurance Coverage

6.1.The provisions on cancellation apply appropriately (Sections 13 and 14) to partial cancellation (elimination of an insured tariff or an insured person, reduction of the insurance coverage).

6.2. Applicaction for an extension of the contract (inclusions of an additional tariff or an additional person, increase in insurance coverage) can be made with effect on the first day of the month. Acceptance of the extension application is conditional on the approval of the insurer. Applications can be rejected without having to give the reasons therefor, save for the cases set forth in Section 4.

6.3. An amended contract is valid for at least 12 months from the agreed date of amendment. Any cancellation date falling in that period of time (Section 13.1) is void. Thereafter, the insurance year (Section 13.1) is, however, governed in accordance with the principal expiration date indicated in the insurance policy.

7. Payment of the Insurance Benefits

7.1. Payment of the insurance benefits is provided on the basis of original statements or verifications of stay or admission. The insurer reserves itself to require a proof over the payment of the calculation. Said documents must show the forename and surname, the address, the insurance / registration number, the date of birth of the person receiving treatment and the identification of the disorder and performances provided as well as the date(s) of treatment.

Treated or replaced teen must be clearly indicated in the statement using the conventional dental template. In the event of extensive dental work or on request of the insurer the statement must indicate dental status.

If the insured is otherwise insured for healthcare (as provided by law or privately), duplicates together with the associated settlement or detailed payments of the other insurer can also be submitted.

7.2. The insurer can in principal consider the party presenting documents as the party entitled to receive the insurance benefits.

Insurance Contracts Act § 178a.
(2) If the insurance is taken out on the person of another party, then said person must, as the insured party must submit to the insurer a direct claim to those benefits that are to be provided to him/her in the event of an insured event. Said direct claim can be excluded in the case of hospital daily allowance insurance and a sickness benefits insurance only if disadvantages are to be covered

by the insurance benefit, which occur to the policyholder him/herself through the insured event. Otherwise §§ 74, 75 para. 1. 78 and 79 are to be applied as appropriate. (Insurance for third party statement)

7.3. The documents become the property of the insurer.

7.4. Costs for the transfer of the insurance benefit and costs for translations at the expense of the policyholder's.

7.5. Costs incurred in foreign currency are converted into the currency valid in Austria at the rate for foreign currency of the Vienna Stock Exchange effective on the last treatment day. If there is no exchange rate, the bank exchange rate published by the Austrian National Bank shall apply.

7.6. Claims to insurance benefits may not be pledged or ceded without the approval of the insurer.

The policyholder may make adjustments against the demands of the insurer only in the event of counter-demands in legal nexus with his demand and which are fixed by the courts or which have been acknowledged by the insurer.

Insurance Contracts Act § 12.
(1) Claims arising from an insurance contract expire in three years. If a third party is entitled to the claim, the time begins to expire as soon as said party learns of his right to the performances of the insurer; if the third party does not learn of said right, his claim expires only after the lapse of ten years.
(2) If a claim of the policyholder is reported to the insurer expiration is suspended until the submittal of a written determination of the insurer, that which is grounded upon at least with the indication of a state of facts and legal or contractual provision upon which the refusal is based. Notwithstanding, the limitation period shall become effective with the lapse of ten years.
(3) The insurer is released from the obligation to pay benefits if the claim to the benefits is not asserted before the courts within one year. The period begins only after the insurer vis-à-vis the policyholder with respect to the claim relative to para. 2.in appropriate manner and has refused and provided notice of the legal consequences connected with the lapse of the period; it is suspended for the duration of appeal proceedings relevant to the asserted claim and for the period in which the policyholder due to no fault of his own is impaired in the timely assertion at law of the claim.

7.7. If the policyholder or the insured violates the duty to inform pursuant to § 34 Insurance Contract Act, the insurer is released from his obligation to perform under the provisions of § 6 (3) of the Insurance Contracts Act. The duty to inform includes also the duty of the insured, on demand of the insurer, to allow him/herself to be examined by a physician hired by the insurer

Insurance Contracts Act § 34.
(1) The insurer can demand following occurrence of the insured event that the policyholder provide all information that is required for the purpose of determination of the insured events or the extent of duty of performance of the insurer.
(2) The insurer can demand supporting documents, in so far as their production may be reasonably imposed upon the policyholder.
Insurance Contracts Act § 6.
(3) If the release from payment of benefits is negociated for the event that a duty is violated which must be fulfilled with respect to the insurer following the occurrence of an insured event, if the violation is not due to intent or gross negligence, then the negotiated legal consequence does not become effective.
If the duty is unintentionally violated, to influence the insurer's duty to perform or to impede the determination of such circumstances, that are recognizably significant for the insurer's duty to perform, then the insurer is obligated to perform, in so far as the violation has not affected the determination of the insured event or affected the scope of the performance required of the insurer.

8. Suspension of Insurance Coverage

On application of the policyholder and in substantiated cases, the insurance contract can be converted into a future interest insurance for a period of up to 6 years. The detailed provisions are governed by the "Supplemental Terms and Conditions for Anwartschaftsversicherung in Health Insurance".

9. Premiums, Fees and Contributions

9.1. The premium is an annual premium and is calculated starting at the time of inception of the insurance. It can be paid in equal monthly premium installments that are considered delayed up to due date of the premium installment. The premium installments are payable and due on the 1st of each month. The first premium, together with payable fees and contributions arising from the insurance contract are payable no later than at notification (issuance) of the insurance policy.

9.2. If an insured child has completed its 18th year, the premiums must be paid from the first day of the next following month as would have to be paid for adult persons.

9.3. The premiums must be paid at the location indicated by the insurer.

9.4. Along with the premium, the insurer may charge only those cost contributions that serve in the settlement of additional expenses which are incurred by the conduct of the policyholder or by the insured (for example, payment coupon fees). Any fees and contributions arising from the insurance contract are at the policyholder's expense.

Insurance Contracts Act § 38.
(1) If the first or one-time premium with 14 days after conclusion of the insurance contract and after demand for payment of premium unpaid, then the insurer, in so far as payment has not been made, is entitled to withdraw from the contract. If the claim for the premium is not asserted at court within three months from the due date, it shall be considered withdrawal.
2) If the first or one-time premium at the time of occurrence of the insured event and after lapse of the period of para. 1 continues unpaid, then the insurer is released from the duty to perform, unless the policyholder was impaired of no fault of his own in making timely payment of the premium.
(3) The demand for payment of premium has the legal consequences provided in paragraphs 1 and 2 only if the insurer has notified the policyholder of same.
(4) Non-payment of interest or costs does not invoke the legal consequences of paras 1 and 2.

Insurance Contracts Act § 39.
(1) If a subsequent premium is not paid on time, the insurer can, at the policyholder's expense, set a time in writing for payment of at least two weeks, a facsimile of the personal signature suffices as signing. When doing this, the legal consequences in conjunction with the lapse of the period and in accordance with paras. 2 and 3 must be indicated. A determination of the time period without compliance with these prescriptions is ineffective.
(2) If the insured event occurs after lapse of the time period and if the policyholder at the time of the occurrence is in default of payment of a subsequent premium, the insurer is released from the duty to perform, unless the policyholder was impaired of no fault of his own in timely payment.
(3) The insurer can, after lapse of the time period, cancel the insurance relationship without observance of a cancellation period, if the policyholder is in default of payment. Cancellation can be connected with the determination of the payment term so that it becomes effective on expiration of the period if the policyholder is in default of payment at that point in time; the policyholder must be expressly informed in the event of cancellation. The effects of cancellation are extinguished if the policyholder makes up payment within one month

following cancellation or, in the event that cancellation was connected with time period determination, within one month after the expiration of the payment term, in so far as the insured event has not already occurred.
(4) Non-payment of interest or costs does not invoke the legal consequences of paras 1 to 3.

Insurance Contracts Act § 39a.
If the policyholder is in default of not more than 10 percent of the annual premium or, however, a maximum of 60 Euro, the a release of the insurer's duty to perform provided for in § 38 or § 39 does not become effective.

10. Duty of Disclosure before Conclusion of the Insurance Contract

10.1. Disorders, illnesses, and consequences of accident that occur prior to conclusion of the insurance contract (Section 2.1) must be reported by the policyholder or by the insured pursuant to § 16 - 18 and 20 - 22 of the Insurance Contracts Act prior to conclusion of the insurance contract. Such illnesses and consequences of accidents can be included in special terms and conditions (higher premiums, special waiting periods) in the insurance coverage.

10.2. For treatment of illnesses and the consequences of accident that are reported by the insured prior to conclusion of the insurance contract, insurance coverage may be excluded only on express written explanation by the insurer.

Insurance Contracts Act § 16.
(1) At the time of conclusion of the contract, the policyholder must inform the insurer of all circumstances known to him that are of significance in acceptance of risk. Those risk circumstances are considered significant that have an effect on the decision of the insurer to conclude the contract at all or to do so under the negotiated conditions. When in doubt, any circumstance, about which the insurer inquires expressly and in writing is considered significant.
(2) If, in contravention to this regulation, information regarding a significant circumstance is not provided, then the insurer is entitled to withdraw from the contract. The same applies if disclosure of a significant circumstance is not made, because the policyholder has willfully concealed information regarding the circumstance.
(3) Withdrawal is not available, if the insurer was aware of the undisclosed circumstance. It is also unavailable, if the disclosure due to no fault of the policyholder is not made; however, if the policyholder does not disclose a circumstance about which the insurer has not expressly and specifically inquired, then the latter may withdraw from the contract only if the disclosure was not provided with intent or due to gross negligence.

Insurance Contracts Act § 17.
(1) Moreover, the insurer can withdraw from the contract, if an incorrect disclosure is made regarding a significant circumstance.
(2) Withdrawal is not available, if the incorrectness was known to the insurer or the disclosure was made incorrectly due to no fault of the policyholder.

Insurance Contracts Act § 18.
If the policyholder were required to disclose the risk circumstances on the basis of written inquiry of the insurer, then the insurer can withdraw due to refusal to disclose a circumstance, concerning which no express and detailed inquiry was made, only in the event of deceitful non-disclosure.

Insurance Contracts Act § 20.
(1) Withdrawal must be effected within one month. The time period begins at that point in time at which the insurer becomes aware of the violation of the duty of disclosure.
(2) Withdrawal must be explained to the policyholder. In the event of withdrawal, in so far as this national law does not otherwise provide regarding the premium, both parties are required to reinstate to the other party the performances received; any money amount accrues interest starting at the point in time of its receipt.

Insurance Contracts Act § 40.
If the insurance contract is dissolved during the insurance period or otherwise prematurely dissolved, then the insurer is entitled to the premium only for the period of the contract that has run to that point in time, unless otherwise provided. The opportunity for the insurer to stipulate for such event the payment of an appropriate penalty (administrative fee) (§ 1336 ABGB) remains unaffected.

Insurance Contracts Act § 21.
If the insurer withdraws after an insured event occurs his duty to perform remains intact, if the circumstance, regarding which the duty to disclose was violated, has no effect on the occurrence of the insured event or in so far as it does not affect the scope of the insurer's performance.

Insurance Contracts Act § 22.
The right of the insurer to rescind the contract because of willful deceit regarding risk circumstances remains unaffected.

Insurance Contracts Act § 178k.
The insurer may no longer withdraw from or terminate the contract because of violation of the duty to disclose by the policyholder at the time of conclusion of the contract, once three years have lapsed since said conclusion. However, the withdrawal right remains intact if the duty to disclose was fraudulently violated.

10.3. If the requirements for withdrawal apply only to individual insured persons, then said withdrawal may be restricted to those persons only. In this event, the policyholder has the right to cancel the entire insurance contract with immediate effect within one month after receipt of notification of withdrawal.

Insurance Contracts Act § 41.
(1) If the duty to disclose incumbent upon policyholder is violated at the time of conclusion of the contract, the insurer's right to withdraw is nevertheless absent, because no fault can be imputed to the other party, then from the start of the current insurance period on the insurer can demand a higher premium, if such action is appropriate in consideration of the greater risk. The same applies if, at the time of conclusion of the contract, a significant risk for the assumption of risk was not disclosed to the insurer, because it was not known to the other party.
(2) If the greater risk pursuant to the characteristic principles of the insurer's business operations is not assumed even at a higher premium, the insurer may terminate the insurance relationship in observance of a notification period of one month.
(3) The entitlement to a higher premium is extinguished if said claim is not made within the period one month from the point in time at which the insurer became aware of the violation of the duty to disclose or of the non-disclosed circumstance. The same applies to the cancellation right, if it is not exercised within the indicated period.

11. Duty of Disclosure during the Term of the Contract

If a medical benefits insurance contract is concluded for an insured person with another insurer, then the insurer must be immediately informed of the other insurance contract. If this duty to inform is culpably violated, then the insurer is released from the duty to provide money benefits such as, for example, daily allowances during hospitalization, supplemental daily allowances during hospitalization, sickness benefits or short-term subsidies. The insurer can, furthermore, terminate the insurance contract within one month after it has become aware of the violation of said duty, without notification of intent to terminate. If the insurer does not terminate within one month, it may not take advantage of the release of performance.

12. Claims against Third Parties

12.1. If, for an insured event, along with the claim against the insurer like claims exist relative to third-parties or insurance carriers under private or public law, then said latter claims are transferred to the insurer to the extent that it reimburses the costs. The party entitled to the benefits is requires to acknowledge said reversion in writing, if the insurer so requires.

12.2. In so far as the person entitled has already received compensation of the costs incurred by him from the third-party obligated to compensate, the insurer is entitled to take such compensation into account with respect to its performances.

12.3. Points 12.1 and 12.2 do not apply to benefits, which do not require documentation of costs.

12.4. The obligation of the insurer to pay benefits for costs, whose partial reimbursement of costs that the person entitled thereto can demand from a public-law insurance carrier, becomes effective only if the latter has guaranteed the performances required of him.

12.5. If the person entitled forfeits his claim against third parties or a right serving to assure the claim without the approval of the insurer, then the insurer is released from the duty to compensate to the extent that the insurer could obtain reimbursement from said claim or right.

13. Cancellation by the Policyholder

Insurance Contracts Act § 178i.
(1) Health insurance contracts may only be concluded for the duration of the policyholder's entire lifetime, except for short-term insurances, which are limited to a period of less than one year; other limits are invalid.

Insurance Contracts Act § 8.
(2) If an insurance relationship is entered into for an unspecified time (continuing insurance), it can be terminated by both parties only to the end of the current insurance period. The term of notices must be the same for both parties and must not be less than one month and not more than three months. By agreement the parties can waive the right to give notice of termination up to a period of two years.

13.1. The period of one year is understood as the insurance period (the policy or insurance year) in the sense of § 8 (2) Insurance Contracts Act. The policy or insurance year is governed in accordance with the principal due date set forth in the insurance policy. The term of notice of cancellation is one month.

Cancellation must be done in writing and must be addressed to the management offices or to the competent regional office of the insurer.

13.2. If the policyholder or an insured person be committed to a care facility for the chronically ill, then the policyholder has the right to cancel the insurance contract at the end of the month in which he demonstrates reception into such a facility.

14. Cancellation by the Insurer

Insurance Contracts Act § 178i.
(2) Cancellation by the insurer in accordance with § 8 para 2 or on the basis of a provision of contract, or for an insured event, is allowable only in the case of group (collective) insurance contracts and sickness benefits insurance contracts. (§ 8 para 2 Insurance Contracts Act, see Section 13.)

Insurance Contracts Act § 178i.
(3) The right of cancellation for significant reason, in particular in the event of violation of duties (§ 6), in the event of default on premiums (§ 39) and in the event of non-culpable violation of the duty of disclosure (§ 41) remains intact.

In the sense § 178i (3) Insurance Contracts Act the following are also considered significant grounds:

a) If the policyholder or an insured by intentional false information, in particular by faking illness, obtains or attempts to obtain insurance benefits in a fraudulent manner or cooperates in such conduct, the insurer has the right to terminate the contract without notice and is released from performance.

b) If, in the event of illness, the policyholder or an insured intentionally or grossly negligently does not comply with the reasonable rules of conduct given by the physician or by the insurer, the insurer has the right to terminate the contract without notice and is released from performance.

c) A violation of the duty to disclose in accordance with Section 11.

d) If the policyholder cancels the insurance contract with respect to individual persons, the insurer has the right, within a period of one month, to terminate the insurance contract with respect to the remaining person at the same time.

15. Other Causes for Termination, Succession and Transfer Rights

15.1. The insurance coverage ends with the death of the insurance policyholder. In the event of the death of an insured, the insurance contract terminates with respect to that person.

Insurance Contracts Act § 178j.
If the insurance relations ends other than by withdrawal of the insurer pursuant to § 16 of § 38 or by its termination (§ 178i para 3), then the insured(s) are entitled within two months to declare the continuation of the insurance relationship after the policyholder.

15.2. The policyholder has the right, by application of the rights accrued from the life of the contract and maturation reserves, to convert to another tariff of the same type of insurance up to the previous coverage amount.

16. Form and Receiver of Statements and Communications

16.1. All policyholder statements and communications must be in writing to be effective, unless the terms and conditions of insurance elsewhere provide otherwise or the insurer dispenses with compliance with the written requirement. Written statements can be submitted in any readable form; thus, they may be faxed or sent by electronic data transfer. If a statement is received does not bear an original signature or safe electronic signature , the insurer may require re-submittal of the statement with personal (original) signature. A time period for statements is considered observed, if the request for re-submittal of the statement in the required form is complied with in an appropriate period of time.

16.2.If the policyholder changes his/her domicile, but does not inform the insurer of this fact, then for the purpose of legal effect of the insurers communications to the policyholder relative to the dispatch of letters to the last address noticed to the insurer shall be sufficient.

17. Place of Performance, Jurisdiction

The insurer's domicile is the place of performance for mutual obligations arising from the insurance contract.

18. Changes to the General Terms and Conditions of Insurance and to the Rates

18.1. The insurer is required to make changes to the General Terms and Conditions of Insurance and to the tariffs when they are made necessary by changes in the factors set forth in the tariffs, the healthcare system or the provisions of law applying thereto.

18.2. Unless otherwise provided in the tariff, the factors set forth in § 178f (2) Insurance Contracts Act are considered to be agreed.

Insurance Contracts Act § 178f.
(2) Only changes of the following factors may be negotiated as decisive circumstances for changes of premium or of insurance coverage:
1. an index named in the negotiation,
2. the average life expectancy,
3. the frequency of claiming benefits per type of benefit contractually provided and their expense, relative to the insured pursuant to said tariff,
4. the relationship between the contractually agreed performances and the corresponding reimbursement of costs by the social insurances by law,
5. the compensation or payments set by law, regulation, other official act or by contract between the insurer and the healthcare facilities stated in the insurance contract for use of said facilities and
6. the healthcare system or the provisions of law pertaining thereto.

However, only adjustments dependent on aging of the insured or on the deterioration of his condition of health may not be negotiated in order to replace aging reserves insufficiently calculated at the time of entering into the insurance relationship. However, it can be negotiated that an initially lower premium starting at a certain age of the insured can be increased to such an amount provided for by the concerned tariff and which become effective in the insurance at that age; said age may not be more than 20 years thence.

19. Refund of Premiums

19.1. Unless the tariff provides therefor, all insurance contracts participate in profit-dependent premium refunds in accordance with the following principles, when, during the expired period of consideration, the premiums are paid in full and no later than up to March 1 of the following year and, for the duration of the period under consideration, no benefits whatsoever were paid by the insurer.

The exception is insurance for premiums that had to be collected through the courts in the period under consideration.

19.2. Considered as period under consideration two consecutive calendar years;

19.3. The event of determination of participation in the profit-dependent premium refund taken place for each insured person separately.

19.4. The annual premium of the expired calendar year serves as the measure for determination of profit-dependent premium refund. The extent of the premium refund is expressed using a percent of the annual premium and can be determined at different levels depending on the number of continuously consecutive benefits-free periods.

19.5. If the profit share accorded to the individual insurance contract falls below a minimum amount, the premium refund relative to that contract does not apply.

19.6. The allocation to reserves for premium refunds is made in accordance with the relevant principles for the business operations.

19.7. Notification of premium refund occurs after publication of the annual report on the lapsed calendar year.

19.8. Premium refund is posted in principle using the current premiums. No cash payment is made. Posting of premium refunds does not start before July 1 of the year following the lapsed calendar year. Insureds withdrawing prior to that time are not entitled to premium refund. Insureds withdrawing during posting are entitled to premium refund only in so far as they can be posted with monthly premiums that become due after July 1.

20. Return of Premiums

Premium return for insureds of the former Versicherungsanstalt der österreichischen Bundesländer Versicherungs AG is arranged in the tariff provisions of each tariff which set forth the grounds for claim to premium return.

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