

# General Conditions of Insurance (GCI)

## Health Care Insurance

### Tel Doc (KVG)

Note:

- For reasons of readability only the male pronoun is used.

The conditions of insurance are valid for the following insurers:

- Visana Ltd, Weltpoststrasse 19, 3000 15
- sana24 Ltd, Weltpoststrasse 19, 3000 15
- vivacare Ltd, Weltpoststrasse 19, 3000 15

The General Conditions of Insurance (AVB) consist of two parts:

- I. General section
- II. Supplementary provisions for the Tel Doc insurance model

## I General section

### 1. General provisions

#### 1.1 Fundamental principle

The General Conditions of Insurance (AVB) are not final and supplement the provisions of law for the insurance.

#### 1.2 Legal bases

The provisions of the Federal Law on the General Part of Social Insurance Law of 6 October 2000 (ATSG), the Federal Law on the Health Insurance of 18 March 1994 (KVG) and the implementing regulations apply in providing this insurance. The current AVB are applied supplementary to the provisions of law for the insurance.

#### 1.3 Optional deductible

The Insurer offers obligatory health care insurance with an optional annual deductible. The optional annual deductibles are offered in compliance with the provisions of the Ordinance on Health Insurance (articles 93 and 94 KVV).

## 2. Insurance relationship

### 2.1 To whom is insurance offered

The Insurer insures private persons who are resident in Switzerland.

### 2.2 Terms of admission

Admission to the obligatory health care insurance is made possible by signing the application form. The signature of the legal guardian is required for individuals who are not legally competent.

### 2.3 Beginning of insurance

- a) The insurance begins on the date agreed in the contract. The Insurer confirms the date of admission in writing.
- b) On admission to the insurance insured persons receive an insurance policy to confirm that they now have insurance cover.
- c) In cases where insured persons are admitted within three months of birth or after becoming resident in Switzerland,

the insurance commences on the date of birth or the date of becoming resident in Switzerland.

- d) In cases of belated admission the insurance begins on the date of admission. In cases of non-justifiable delay to admission the insured person has to pay a supplementary premium in compliance with the provisions of law

### 2.4 Modification of the insurance

- a) The annual deductible can be modified each year on 1 January. In the case of a change to a lower deductible, the conditions for canceling the contract as shown in paragraph 2.6 have to be adhered to.
- b) If the insured person has mandatory insurance for occupational and non-occupational accidents, he can request that accident cover be suspended and receive a premium reduction. The premium will be reduced at the beginning of the month following that in which the application is made. Suspension of accident cover can be terminated immediately when UVG accident cover expires. The Insurer should be notified of the discontinuation of accident insurance within 30 days

### 2.5 End of insurance

The insurance ends for the following reasons:

- a) Cancellation
- b) Death of the insured person
- c) If the insured person relocates out of the area served by the Insurer
- d) Discontinuation of the obligation to be insured

### 2.6 Cancellation

- a) Insured persons may cancel their insurance at year-end while observing a three month period of notice.
- b) Notice of new premiums is given at least two months before such enter into force. After receiving notice of the new premium, insured persons may cancel the insurance at the end of the month prior to that in which the new premium will take effect; a one-month period of notice must be observed.
- c) The insurance is only terminated with respect to the Insurer once the new insurer confirms that the person concerned will be insured without any interruption in insurance cover.
- d) According to article 64a paragraph 6 KVG, insured persons may not change to another insurer until all outstanding premiums, amounts due for participation in costs, interest on arrears and expenses incurred in debt collection have been paid in full.

### 2.7 How does the Insurer communicate with you? What duty to notify do you have?

- a) Official organ  
Insured persons are informed about modifications of the conditions of insurance and information of a general nature in the official newspaper of the Visana Group; such in-

formation is binding. One copy of the official newspaper is sent to each household.

- b) Insurance policy  
All insured persons receive personal confirmation of their insurance cover in the form of an insurance policy.
- c) Insured persons' duty to notify the insurer  
Insured persons have a duty to notify the organizational unit of Visana indicated on the insurance policy of all changes in personal circumstances that may affect the insurance relationship (e.g. change of domicile) within one month of such changes.
- d) Breaches of the duty to notify the insurer  
Any prejudice resulting from willful violation of the obligation to notify must be borne by the insured.

### 3. Benefits

#### 3.1 Principle

The statutory benefits will be paid for illness, accident, birth defects and cases of maternity

#### 3.2 Illness

Illness is deemed to be any impairment of physical or mental health not resulting from an accident that requires a medical examination or treatment or leads to incapacity for work.

#### 3.3 Accident and birth defects

The same benefits as would be paid for illness are paid in the case of accident or of birth defects to the extent that the accident insurance, the invalidity insurance or any third party do not pay benefits. An accident is deemed to be the sudden unintentional harmful effect of an extraordinary external factor on the human body, resulting in impairment of the physical or mental health or death.

#### 3.4 Condition for payment of services

The Insurer accepts the costs for services if such are effective, appropriate and economical. Services are economical if they are restricted to the levels necessary to meet the interests of the insured person and to fulfill the purpose of treatment.

#### 3.5 Basis for paying benefits

Insured persons who claim benefits from the Insurer have to submit detailed invoices and receipts with all the required information (insured's number). If the claim is valid, the Insurer pays the share in costs due to the insured person from the Insurer.

#### 3.6 Service providers

Recognized service providers are in particular the persons and institutions listed below:

- Doctors,
- Pharmacists,
- Chiropractors,
- Midwives,
- Laboratories,
- Agencies that issue aids and appliances which are used in diagnosis and treatment.

When prescribed by a doctor:

- Physiotherapists,
- Occupational therapists,
- Qualified nursing staff,
- Logopedists.

#### 3.7 Benefits while abroad

- a) In the case of treatment received abroad benefits are paid according to the provisions of law and are made available in case of emergency in particular. Detailed evidence of the cost of treatment has to be submitted.
- b) Invoices and paperwork issued abroad have to be submitted in German, French, Italian or English. A translation

should be included if invoices and paperwork are submitted in other languages.

#### 3.8 How is the relationship to other insurers and third-party benefits regulated (order of recourse)?

- a) Duty to give notice  
Insured persons are obliged to notify the Insurer if other insurance companies or third parties are liable to pay benefits for an insured incident. The insured person also has to inform the Insurer if benefits are received. The Insurer also has to be notified before any lump-sum settlement is accepted or before any agreement to waive payments or benefits is signed. Insured persons are obliged to notify the Insurer about any claims they may have against other insurance carriers or liable third parties. Breaches of the duty to notify can lead to benefits being reduced or refused entirely.
- b) Coordination of benefits  
The relationship between the social health insurance and other social insurances is regulated according to the provisions of law.
- c) Subrogation  
From the date of the insured incident the Insurer is subrogated to the rights of the insured in all claims of the insured person on third parties to the extent of the statutory benefits.

#### 3.9 When do you have to repay benefits received?

Benefits which are wrongfully gained or paid in error must be repaid to the Insurer.

#### 3.10 Assignment and pledging of benefits

Insured persons may not assign or pledge claims for benefits on the Insurer without the express approval of the Insurer. The right to assign claims to service providers remains reserved.

## 4. Premiums

#### 4.1 Determination of the premium

- a) Premiums are determined on the basis of the tariffs approved by the supervisory authority. Premiums are arranged in categories according to age groups and regions.
- b) If a change of domicile leads to a modification of the premium, the premium is modified on the date of the change of domicile.

#### 4.2 Payment of premiums

- a) Premiums are payable in advance. They can be paid bi-monthly, semi-annually or annually by special agreement.
- b) Premiums can be paid by direct debit processes such as LSV/DD. If a charge back is incurred for which the insured person is responsible, a fee may be charged to the insured person per charge back.
- c) A fee can be charged for installment agreements arranged in the case of premium arrears.
- d) Premiums are due for the month of admission from the actual day on which insurance cover commences. The premium for the period after the actual termination of the insurance policy or after the day of death is no longer payable for the month the insured leaves the insurance and the month in which the insured dies.

#### 4.3 Participation in costs

According to the legislation

- Adults pay the annual deductible and an excess payment, which amounts to 10%\* of the costs in excess of the deductible;
- Children pay 10%\* in excess and the annual deductible if a deductible is chosen.

\* An excess of 20% may be charged for certain original preparations and generic drugs.

The maximum annual excess payment for adults is CHF 700.– and for children CHF 350.–. If a number of children in the same family are insured with the same insurer and each has a different deductible the maximum annual participation in costs payable for children is CHF 1,000.–.

The date of treatment is valid for calculating the deductible and the excess payments.

In addition to participation in costs, the law stipulates that a payment of CHF 15.– per day be made for cases of hospitalization.

#### 4.4 Reimbursements

The Insurer remits payments to a Swiss postal account or bank account. If insured persons wish to be paid by means of an outpayment slip (ASR), the appropriate fee will be charged in full.

#### 4.5 Suspension

- a) An insured person who is subject to the military insurance for more than 60 consecutive days is freed from the obligation to pay premiums. The Insurer should be notified at least eight weeks before the insured person becomes subject to the insurance. If the insured person does not comply with this deadline, the Insurer stops charging premiums from the next possible deadline, however, at the latest eight weeks after receiving notification.
- b) If the insured person has mandatory insurance for occupational and non-occupational accidents, he can request that accident cover be suspended and receive a premium reduction. The premium will be reduced at the beginning of the month following that in which the application is made. Suspension of accident cover can be terminated immediately when UVG accident cover expires. The Insurer should be notified of the discontinuation of accident insurance within 30 days.

#### 4.6 Arrears

- a) If insured persons fail to pay premium arrears or participation in costs, after sending at least one written reminder, the Insurer will send a demand for payment for which a time limit of 30 days will be set for payment, and the insured person will be reminded of the consequences of nonpayment of arrears.
- b) If insured persons do not pay premiums, participation in costs and interest on arrears within the deadline which has been set despite being requested to do so, the insurer will be obliged to start a debt collection procedure.

#### 4.7 Administration fees, cost of debt collection and interest on arrears

The legally determined interest on arrears is payable on demands for premiums. The Insurer charges an appropriate administration fee for expenses incurred in sending reminders and for debt collection.

## 5. Jurisdiction

### 5.1 Ruling

If an insured person or an applicant disagrees with a decision, the Insurer issues a ruling in writing within 30 days on request providing the reason for the decision and information about the right of appeal.

### 5.2 Appeal

An appeal can be lodged against the ruling with the Insurer within 30 days of receipt of the ruling. Two copies of the appeal should be submitted along with the necessary documents in proof of the appeal. The Insurer considers the appeal and is-

sues a written decision on the appeal containing the reasons for the decision and information about the right of appeal.

### 5.3 Cantonal insurance tribunal

- a) Objections to decisions made by the Insurer can be lodged with the cantonal insurance tribunal at the domicile of the insured within 30 days of receipt.
- b) Appeal can also be made to the cantonal insurance tribunal if the Insurer fails to give a formal ruling or a decision on the appeal.

## 6. Final provisions

### 6.1 Data protection

- a) All employees of the Insurer are subject to the obligation to maintain professional secrecy in compliance with Art. 33 ATSG.
- b) Processing of insured persons' data is carried out in compliance with the provisions of law for data protection in the KVG, the Federal Law on the General Part of Social Insurance Law (ATSG) and in the Federal Act on Data Protection (DSG).

### 6.2 Modification of the conditions of insurance

Insured persons are informed about modifications of the conditions of insurance and other information of a binding nature in writing or it is published in the customer newspapers.

### 6.3 Correspondence

- a) All correspondence should be addressed to the Insurer.
- b) All valid correspondence from the Insurer is sent to the last address given by the insured person in Switzerland or to the new legal domicile found by the Insurer as a consequence of research.

## II Supplementary provisions for the Tel Doc insurance model

## 7. General provisions

### 7.1 Objective and purpose

- a) The objective of Tel Doc is to encourage insured persons to take the responsibility for their way of life and to adopt a healthy lifestyle. Medi24 is responsible for giving medical advice and for coordinating all questions concerning matters of health.
- b) The quality of benefits is increased and specific savings in costs in the health sector are achieved through the comprehensive advice and assistance offered by Medi24.

### 7.2 Legal bases

- a) Tel Doc is the name for a special form of insurance as described below in the sense of Article 62 paragraph 1 of the Federal Law on the Health Insurance (KVG) in connection with Article 41 paragraph 4 KVG.
- b) Within the framework of the General Conditions of Insurance (AVB), whose aim is to ensure funds are used in a targeted manner, a special feature of Tel Doc is that the clinical pathway is coordinated by Medi24.

## 8. Insurance relationship

### 8.1 To whom is insurance offered

Within the current provisions of law, Tel Doc is available to all persons interested in the insurance who are domiciled in those areas in which the Insurer offers this form of insurance.

## 8.2 Change to Tel Doc

Admission or change to Tel Doc from the obligatory health care insurance is possible on the first day of the month following that in which the application (receipt of the application by the Insured) is made.

## 8.3 Change of insurance

- a) Change from Tel Doc to another branch of insurance is possible at the beginning of a calendar year – while adhering to the deadline for cancellation of one month. Article 7 paragraphs 3 and 4 KVG remain reserved.
- b) It is possible to leave the insurance at any time:
  - if the insured person relocates to a region in which the Insurer does not offer this product;
  - if the Insurer ceases to offer the product.
- c) If the circumstances mentioned in paragraph 2 occur, the Insurer will inform the insured person. The Insurer reserves the right to cease offering Tel Doc at the end of a calendar year. The insured persons concerned will be notified about the change at least two months before the insurance is terminated.

## 8.4 Change of place of domicile

If the insured person leaves Switzerland, he is no longer obliged to be insured and the insurance is terminated. The Insurer should be informed promptly about such a change.

## 9. Basic principles and scope of benefits

### 9.1 Principle

- a) When a health problem arises, insured persons, or a third party acting on their behalf, are obliged to call Medi24 by phone before making any appointment for treatment with doctors, chiropractors and midwives, and for treatment at hospitals, provided no other arrangement is stipulated in the General Conditions of Insurance (AVB). Medi24 advises insured persons and while taking into consideration the specific situation determines the necessary clinical pathway to be followed, which is then binding upon the insured persons.
- b) If medical treatment is required after a telephone consultation, the course of treatment in the sense of Article 9.1 paragraph a) also includes the choice of service provider by Medi24 and the interval in which treatment should take place. If a treating doctor makes an appointment for a further check-up or refers the insured person to another doctor, hospital or nursing home, Medi24 has to be consulted once again by telephone. No telephone consultation with Medi24 is required in the case of medical auxiliaries such as physiotherapists, occupational therapists and logopedists who provided services on behalf of the doctor.

#### Choice of service provider

As a rule Medi24 chooses the suitable service provider for medical treatment. Gynecologists and paediatricians can be chosen freely by the insured person.

### 9.2 Special cases and exceptions

- a) Emergency treatment is insured for under the conditions of the obligatory health care insurance and Medi24 should be notified about such treatment as soon as possible, or within 20 days at the latest.
- b) No prior contact with Medi24 is necessary in connection with preventive gynecological examinations, outpatient ophthalmic examinations and for obstetrical care.
- c) Medi24 should be contacted before entering a hospital or a nursing home. Medi24 should be notified as soon as

possible on leaving a hospital or a nursing home, or within 20 days at the latest.

## 9.3 Range of benefits

Otherwise Tel Doc guarantees all the services provided under the obligatory health care insurance offered in compliance with the KVG, provided such are included in the course of treatment determined by Medi24.

## 10. Premiums

### 10.1 Discount on premiums

Insured persons with Tel Doc cover are granted a discount on the premium for the obligatory health care insurance offered in compliance with the KVG. This discount is determined in accordance with the Insurer's premium tariffs.

### 10.2 Participation in costs

Deductible, participation payment and the contribution toward the cost of hospitalization are charged in line with federal regulations.

## 11. Duty to mitigate loss and to cooperate

### 11.1 General obligations

- a) Insured persons, or a third party acting on their behalf, are obliged to comply with the instructions given by doctors or other service providers and ensure that the treatment given is economical. Before making any appointment for treatment with doctors, chiropractors and midwives, and for treatment at hospitals, insured persons are obliged to contact Medi24 to receive advice by telephone and to coordinate treatment; insured persons have to adhere to the clinical pathway determined by Medi24. If a treating doctor makes an appointment for a further check-up or refers the insured person to another doctor, hospital or nursing home, Medi24 has to be contacted and consulted once again by telephone.
- b) Medi24 should be notified as soon as possible on leaving a hospital or a nursing home, or within 20 days at the latest.

### 11.2 Contact in an emergency

Medi24 should be notified about each case of emergency treatment as soon as possible, or within 20 days at the latest.

## 12. Breach of the duty to mitigate loss and cooperate and penalties

### 12.1 Breaches of the duty to mitigate loss and cooperate

If insured persons are in breach of the duty to mitigate loss and cooperate, the obligation to pay benefits is canceled. The right of the insured person to prove that the breach of duty to mitigate loss and cooperate occurred for reasons which are justifiable is reserved.

### 12.2 Further penalties

In serious cases the Insurer can exclude insured persons from Tel Doc insurance and transfer them to the obligatory health care insurance.

## 13. Miscellaneous

### 13.1 Data transmission

- a) Medi24 adheres to the provisions of law for data protection of the KVG, the Federal Law on the General Part of Social Insurance Law (ATSG) and the Federal Act on Data Protection (DSG).
- b) For the purpose of identifying the insured person, the Insurer authorizes Medi24 to access the current personal

data of insured persons (master data and insurance cover).

- c) The Insurer transmits an overview of all medical benefits, which have been claimed by insured persons, to Medi24, so that Medi24 can check whether the prescribed course of treatment determined has been adhered to.
- d) Medi24 makes available to the Insurer the data necessary to determine the benefits, such as the date of the phone call and the interval for the consultation to take place with the specific service provider. No personal medical data nor any other sensitive personal data as defined in the Federal Act on Data Protection will be passed on. Further, the staff of Medi24 are bound to maintain professional secrecy in compliance with Article 33 ATSG.
- e) On joining Tel Doc the insured person declares that he is in agreement with the transmission of the data necessary to manage the insurance.

### **13.2 Telephone consultation**

The free advice given by telephone will be recorded and archived by Medi24.

In cases of dispute, the recordings made by Medi24 can be used as evidence.

The staff of Medi24 are bound to maintain professional secrecy in accord with

Article 33 ATSG. The Insurer's staff have no access to such data.

### **13.3 Liability**

Liability for all medical advice rests exclusively with Medi24.

## **14. Final provisions**

### **14.1 Relationship to health insurance law and entry into force**

Tel Doc is part of the obligatory health care insurance. In every case the legal regulations remain reserved. The General Conditions of Insurance (AVB) enter into force on 1.1.2021. Such may be modified by the Insurer at any time.