

General Conditions of Insurance (GCI)

Obligatory Health Insurance (FLHI/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 Berne 16
- sana24 Ltd, Weltpoststrasse 19, 3000 Berne 16
- vivacare Ltd, Weltpoststrasse 19, 3000 Berne 16
- Galenos Ltd, Weltpoststrasse 19, 3000 Berne 16

1. General conditions

1.1 What is the legal basis for the insurance?

The Obligatory Health Insurance is based on the legal stipulations of the current Federal Law on Health Insurance (FLHI/KVG), the Federal Law governing the General Part of Social Insurance Law (ATSG) and the relevant administrative regulations, and the General Conditions of Insurance (GCI).

1.2 Who is the insurer?

The name of the insurer can be found on your insurance policy.

1.3 Where does the insurer conduct business?

The insurer offers the Obligatory Health Insurance throughout Switzerland.

1.4 Which special forms of insurance does the insurer offer?

The insurer offers the obligatory healthcare insurance with a restricted choice of service providers, a choice of annual deductibles and as a bonus insurance (Visana only). Specific GCI apply to the forms of insurance with a restricted choice of service providers and to bonus insurance.

The bonus insurance and insurance with optional deductibles may not be combined.

The higher annual deductibles charged are offered in compliance with the conditions of the Ordinance on Health Insurance (OHI/KVV).

2. Insured relationship

2.1 Who is insured?

The insurer insures natural persons who have their legal residence in the area in which the insurer conducts its business. Inasmuch as this is provided for under the health insurance legislation further individuals may take out insurance.

2.2 What are the conditions for admission to the insurance?

Individuals are only admitted to the healthcare insurance provided they have no other such insurance. Each person must sign a written application for insurance. The application may be withdrawn during the seven day period after it is signed; this is done by means of a registered letter to the insurer. Any incidental guarantees of cover already given expire retrospectively on sending the letter of cancellation. The signature of the legal guardian is required for individuals who are not legally competent. All the paperwork required for admission to the insurance must be sent to the insurer.

2.3 Which age groups apply?

The following age groups have been established:

- Children up to completion of the 18th year of life
- Insureds aged from 19 to the end of the 25th year of life
- Insureds from the age of 26 upward

Transfer from age group I to II or from II to III takes place at the end of the calendar year in which the insured attains the age of 18/25.

2.4 When does the insurance commence and when does it terminate?

The commencement of insurance and the termination of the insurance are regulated in the legislation. Admission to the insurance has to take place within three months of individuals taking up residence in Switzerland or within three months of birth. To observe this condition of membership the written insurance application must be received by the insurer within the aforementioned time period. In such cases the insurance commences on the date of birth or on the date of taking up residence in Switzerland.

In cases of belated admission the insurance begins at the time of admission, which means the insurance begins at the earliest on the day the insurer receives the insurance application. The insurer charges a supplementary premium in cases of inexcusable belated admission.

The insurance is terminated for the following reasons:

- Valid notice to terminate the insurance
The insurance may be terminated semi-annually by giving written notice three months prior to the end of a calendar semester. Bonus insurance, insurance with a restricted choice of service providers or as the case may be with an increased annual deductible may only be terminated at the end of a calendar year by serving notice to terminate while observing a three-month period of notice. After receiving notice of new premiums the insured may change to another insurer at the end of the month prior to that in which the new premiums take effect; a one-month period of notice must be observed. Notice of termination must be received by the insurer at the latest on the last working day before the period of notice begins.
- Death of the insured person
- Moving out of the area where the insurer conducts business.
The insurance continues to exist until the insured person has established his new domicile.
- When the requirement to be insured ends
The insured relationship terminates when written notice is served.

2.5 How does the insurer communicate with you? What duty to notify do you have?

- Official newspaper
Insured persons are informed about modifications of the conditions of insurance and about information of a general nature in the Visana Group's official newspaper; such information is binding. One copy of the official newspaper is sent to each household.
- Insurance policy

Each insured receives personal confirmation of his insurance protection in the form of an insurance policy.

3. Duty of insured persons to notify the insurer
Insured persons have a duty to notify the organizational unit of the insurer indicated on the insurance policy of all changes in personal circumstances that may affect the insured relationship (e.g. change of domicile) within one month of such changes.
4. 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 person.

2.6 Who can you consult if you need advice?

The organizational unit responsible for the insured is available to answer questions or give advice.

3. Benefits

3.1 What are you insured for?

The insurance covers the risks arising from sickness, accident, congenital defects, pregnancy and maternity.

3.2 What is the scope of benefits?

Entitlement to benefits is regulated by the Federal Law on Health Insurance (FLHI/KVG), the pertinent ordinances and the General Conditions of Insurance.

3.3 May accident cover be suspended?

Insured persons that have accident risk cover under the provisions of the Federal Law on the Accident Insurance (FLAI/UVG) may suspend accident cover. The insurer suspends the cover on application by the insured if the insured can provide evidence that he has full cover in compliance with the FLAI. The premium is reduced appropriately. Accident cover is available as soon as cover pursuant to the FLAI ceases in whole or in part. The social health insurance accepts the costs for the consequences of those accidents for which cover was provided before the insurance was suspended.

3.4 When does the duty to provide benefits commence?

Entitlement to benefits begins on the day the insurance commences.

3.5 How do you claim benefits?

The insured person has to give the insurer all the information necessary to clarify entitlement to benefits and determine the benefits due, including the appropriate paperwork, and to this end the insured person authorizes the insurer to access files of other insurers and of authorities and to obtain the necessary information from service providers. Insured persons may stipulate that treating doctors and other medical personnel may only divulge medical information to the insurer's medical advisor. The insurer shall be notified about all accidents that occur.

3.6 Where are benefits provided?

As a matter of principle benefits will be paid for treatment received in Switzerland.

3.7 What benefits will be provided for treatment abroad?

During stays in EU member states, Iceland or Norway insureds are entitled to medically necessary treatment; in this respect the type of benefit and the envisaged length of the stay will be taken into consideration. In all other countries insureds are only entitled to emergency treatment. An emergency is said to exist if situations arise in which insured persons need medical treatment during a temporary stay abroad and it would be unreasonable for them to return to Switzerland. No emergency exists in situations where insured persons go abroad expressly to receive treatment.

The obligatory health insurance accepts the cost of childbirth abroad as laid down in the legislation if this is required to ensure the child gains citizenship rights.

The level of benefits is regulated by the Federal Law on Health Insurance (FLHI/KVG).

3.8 Are benefits subject to any restrictions?

1. Economical treatment
Benefits are provided for treatment that corresponds with the principle of economic treatment established in the health insurance legislation.
2. Overinsurance
Payment of benefits by various social insurance may not lead to over-indemnification of the insured. Benefits will be reduced by the amount that constitutes an over-indemnification of the insured.
3. Authorized service providers
No benefits will be paid for services provided by service providers who are not authorized to supply services at the expense of the obligatory health insurance.

3.9 Will benefits be reduced or refused in cases involving willful injury or gross negligence?

Benefits will not be reduced or refused in cases where willful injury or gross negligence leads to an insurance claim.

3.10 How do you receive refunds?

Payment is made exclusively in Swiss francs after entitlement to the claim has been checked. Insured persons undertake to provide the insurer with a Swiss bank or post office account as the payment address. If insured persons neglect to inform the Insurer of such, the cost of payment has to be borne by the insured persons.

If insured persons are responsible for making payments ("tiers garant" system), all invoices and receipts should be sent to the insurer. Reimbursement is made directly to insured persons. Before paying invoices insured persons have the right to submit such to the insurer to be checked and to clarify entitlement to payment.

If the insurer is responsible for payment on the basis of agreements made with service providers ("tiers payant" system) payment will be made directly to service providers provided the insured is entitled to benefits.

3.11 When do claims for benefits expire?

Claims to benefits expire five years after the end of the month for which the benefit was due.

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

1. Duty to give notice
The insured is obliged to inform the insurer if other insurance companies or third parties are liable to pay benefits for an insured incident. The insured also has to inform the insurer if benefits are received. The insurer also has to be informed before any lump-sum settlement is accepted or before any agreement to waive payments or benefits is signed. Insured persons are obliged to provide information about any claims they may have against other bearers of insurance or liable third parties. Breaches of the duty to notify can lead to benefits being reduced or refused entirely.
2. Coordination of benefits
The relationship between the social health insurance and other social insurances is regulated in the legislation.
3. Subrogation
From the date of the insured incident the insurer is subrogated to the rights of the insured in all claims of the in-

sured on third parties to the extent of the statutory benefits.

3.13 When do benefits have to be repaid?

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

4. Premiums and participation in costs

4.1 What premiums do you have to pay?

The valid premium for your insurance, which is payable at least one month in advance, can be found on your insurance policy; 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.

4.2 When are payments due?

Premiums are payable either monthly, bimonthly, quarterly, semi-annually or annually. The dates of payment are indicated on the premium invoice. The insurer grants a discount if premiums are paid semi-annually or annually. The insurer determines the conditions that apply in such cases.

4.3 What amount has to be paid for premiums?

The amount to be paid for premiums is determined in the tariffs approved by the supervisory authority. Premiums are arranged in categories according to age groups and regions.

Individuals who are subject to the military insurance for more than 60 consecutive days are freed from the obligation to pay premiums from the day subjection to the insurance begins provided the insurer is notified at least eight weeks before they become subject to the insurance. If this deadline is ignored the insurer ceases to charge premiums from the date notification is received, but at the earliest when military service begins.

4.4 What amount has to be paid for premiums for special forms of insurance?

Insureds who opt for insurance with a restricted choice of service providers or a higher deductible receive reductions on premiums.

The scale of premiums for the bonus insurance is published in a separate set of regulations.

4.5 How much do you have to pay in participation?

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 from the same family are insured with the same insurer, the total annual participation in costs for the children will not exceed the maximum sum of CHF 950.–.

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.

4.6 What happens if you are in arrears with payments?

1. Premiums/participation in costs

If an insured person fails to pay premiums or shares of participation in costs when due, the insurer duns the in-

sured and sets a time limit of 30 days for payment. If an insured person fails to pay outstanding premiums, shares in participation in costs and interest on arrears despite having received the dunning letter, the insurer shall begin a debt collection procedure. Simultaneously the insurer notifies the responsible cantonal agency. Five percent (5%) interest is payable on premium arrears.

2. Dunning notices

Dunning notices are sent in writing.

3. Costs

The cost of the debt collection procedure and other expenses incurred may be charged to the account of the insured who is in arrears. If a dunning notice is sent or the debt collection procedure started, a charge can be made for the expenses incurred.

4. d) Change of insurer

Insured persons who have not yet paid in full all outstanding premiums, amounts due for participation in costs, interest on arrears and expenses incurred in debt collection may not change to another insurer.

4.7 Charges

There are many possible ways in which insured persons can pay their premiums and out-of-pocket expenses without incurring transaction charges. Any charges incurred when paying at a post office counter or at PostFinance's other physical access points can be passed on to the insured person by the Insurer.

5. Jurisdiction

5.1 When can you demand a formal ruling?

Insured persons who are in disagreement with a decision taken by the insurer can request a formal ruling.

5.2 When can you object to a ruling?

Insured persons may appeal against formal rulings within 30 days of receipt; appeals should be made directly to the insurer.

5.3 Which courts may you turn to in case of dispute?

Objections to rulings issued by the insurer can be lodged with the cantonal insurance tribunal at the domicile of the insured within 30 days of receipt of the ruling. 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 at the request of the individual concerned. Appeals against decisions made by the cantonal insurance tribunal may be made within 30 days to the Swiss Federal Court.

5.4 Which cases can be handled by arbitration?

The cantonal arbitration courts are responsible for disputes between service providers and insured persons or the insurers. If the fee is payable by the insured the insurer represents the insured at its own expense.

6. Miscellaneous conditions

6.1 How is personal data processed?

Personal data is mainly processed in order to supply services at the expense of the obligatory health insurance and to be able to advise and support insured persons with regard to reliable insurance cover that meets their needs. The Insurer also relies on the processing of personal data for customer acquisition within the scope of HIA/KVG, for meeting legal and regulatory requirements, for (further) development of its products and services, and for maintaining secure, efficient and profitable operations. Collection and benefit processing involve electronic data processing that can be classed as automated individual decision-making. Telephone conversations with our staff may be recorded to ensure proper provision of services and for training purposes.

To the extent necessary and legally required, the Insurer can disclose data (for processing) to third parties involved in fulfilment of the contract, in Switzerland and abroad (e.g. participating insurers, medical examiners, company physicians and authorities), in particular to companies in the Visana Group, as well as to co-insurers, pre-insurers, post-insurers and reinsurers. The Insurer can also specifically commission third parties to provide services for the benefit of insured persons (e.g. IT providers). The Insurer contractually obliges such third parties to maintain confidentiality and to continue to handle personal data in accordance with data protection requirements. This may include not only personal data such as names, dates of birth and insurance numbers, but also particularly sensitive personal data such as that pertaining to an individual's health. In such cases, the stricter legal requirements for the processing of particularly sensitive personal data shall be observed. Personal data can be stored both physically and electronically. Such data is primarily stored in Switzerland. The Insurer shall take the necessary measures to ensure that personal data is only transferred to countries that guarantee adequate data protection.

The Insurer shall ensure that the disclosed personal data is up to date, reliable and complete.

The Insurer obtains and uses personal data in accordance with the applicable data protection provisions, namely the Swiss Data Protection Act, and other legal requirements, in particular art. 84, 84a and 84b HIA/KVG.

Further information on the processing of personal data can be found online in the Insurer's privacy notice: www.visana.ch/datenschutz.

6.2 Who are required to maintain professional secrecy?

All employees of the Visana Group are subject to the obligation to maintain confidentiality in compliance with the Federal Law on the General Part of Social Insurance Law (GPSIL/ATSG).

6.3 May the insurer purchase re-insurance?

The insurer concludes re-insurance contracts provided this is in the interest of insured persons and to the extent stipulated in the ordinance on the health insurance.

6.4 When do the GCI take force?

The General Conditions of Insurance (GCI) take force on 1.1.2024. The insurer reserves the right to modify these conditions at any time.