VISANA

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 Berne 16
- sana24 Ltd, Weltpoststrasse 19, 3000 Berne 16
- vivacare Ltd, Weltpoststrasse 19, 3000 Berne 16

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 notifiedof 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 bimonthly, 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 notifiedof 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 issues 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. Data protection

6.1 Data protection and general obligation to maintain confidentiality

The Insurer's staff are obliged to maintain confidentiality as per art. 33 GSSLA/ATSG.

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 Data transfer to/from Medi24

a) In order to identify insured persons, the Insurer enables Medi24 to access insured persons' updated personal data (master data and insurance cover).

b) The Insurer provides Medi24 with an overview of all medical services that insured persons have used, so that Medi24 can check compliance with the specified course of treatment.

c) Medi24 provides the Insurer with the data necessary for determining benefits, such as the date of the call and the

time slot for the consultation with the specified service provider. Here, no medical or other particularly sensitive personal data as per the Data Protection Act is passed on.

d) Upon admission to Tel Doc, the insured person consents to this transfer of data that is required for administrative purposes.

7. Final provisions

7.1 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.

7.2 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

8. General provisions

8.1 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.

8.2 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.

9. Insurance relationship

9.1 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.

9.2 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.

9.3 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.

9.4 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.

10. Basic principles and scope of benefits

10.1 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.

10.2 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 opthalmic 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.

10.3 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.

11. Premiums

11.1 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.

11.2 Participation in costs

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

12. Duty to mitigate loss and to cooperate

12.1 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.

12.2 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.

13. Breach of the duty to mitigate loss and cooperate and penalties

13.1 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.

13.2 Further penalties

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

14. Miscellaneous

14.1 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.

14.2 Liability

Liability for all medical advice rests exclusively with Medi24.

15. Final provisions

15.1 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 1.1.2023. Such may be modified by the Insurer at any time.

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