

General Conditions of Insurance (GCI)

Health insurance

VIVA health plan (as per HIA/KVG)

Note:

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

1. Basis and principles

1.1 What is the VIVA health plan?

The Insurer offers the VIVA health plan in defined insurance regions. The current insurance regions recognised by the Insurer and their affiliated general practitioner practices or medical centres can be seen on the Insurer's website. The legal basis for the VIVA health plan consists of the applicable Health Insurance Act (HIA/KVG) and the Federal Act on General Aspects of Social Security Law (GSSLA/ATSG), as well as their implementing provisions and these General Conditions of Insurance (GCI).

The VIVA health plan is a form of statutory basic insurance and is operated in particular on the basis of art. 41 para. 4 and art. 62 of the Health Insurance Act (HIA/KVG). To identify the Insurer, please refer to your insurance policy.

1.2 On what principle is the VIVA health plan based?

The VIVA health plan is based on the principle of integrated care, which is characterised by holistic support, advice and medical care for the insured person. The chosen general practitioner practice or medical centre coordinates all medical treatments.

When entering into the VIVA health plan, the insured person agrees that all medical examinations and treatments shall be carried out by the chosen general practitioner practice or medical centre, which will also be in charge of making referrals to specialist physicians and other service providers.

1.3 How is integrated care organised in the VIVA health plan?

Healthcare organisation

The healthcare organisation is the group of medical service providers that ensures integrated, coordinated medical care for the insured persons (members of the healthcare organisation). The chosen healthcare organisation is indicated on the insurance policy.

General practitioner practice / medical centre (first point of contact)

When entering into the insurance contract, the insured person chooses a general practitioner practice or medical centre, which is affiliated with the respective healthcare organisation. The chosen general practitioner practice or medical centre is indicated on the insurance policy. Medical care is ensured by a general practitioner from the chosen general practitioner practice or medical centre. The chosen general practitioner practice or medical centre is hereinafter referred to as the 'coordinating service provider'.

Except in emergencies, for gynaecological examinations or treatment, or for dental treatment, the coordinating service

provider must always be consulted first before any outpatient or inpatient treatment.

1.4 What benefits does the VIVA health plan encompass?

The VIVA health plan encompasses the legally mandatory benefits pertaining to illness, accident, birth defects, pregnancy and maternity.

1.5 What applies in an emergency?

Emergency treatment is covered as part of the legally mandatory benefits, provided that the treatment is carried out by a physician or other service provider authorised by the HIA/KVG. An emergency is when the insured person urgently requires treatment for medically objective reasons and the coordinating service provider cannot be reached quickly enough for reasons of distance and/or time.

1.6 Can you suspend the accident cover?

The accident cover can be suspended if complete accident cover is in place in accordance with the Accident Insurance Act (AIA/UVG). The suspension is to be requested from the Insurer in writing. Insured persons must notify the Insurer of any changes in accident insurance cover within one month.

1.7 Can you arrange a freely selectable annual deductible?

In the VIVA health plan, it is possible to arrange a freely selectable annual deductible.

The selectable annual deductibles are offered in compliance with the provisions of the Ordinance on Health Insurance (HIO/KVV).

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

- a) Organ of publication**
Insured persons are informed about modifications of the conditions of insurance and provided with information of a general nature in the official newspaper of the Visana Group; such information 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 report all changes in personal circumstances that may affect the insurance situation (e.g. change of domicile or general practitioner) to the Insurer's organisational unit indicated on the insurance policy, within one month of such changes.
- d) Breaches of the duty to notify the Insurer**
Any disadvantages resulting from violation of the obligation to notify the Insurer shall be borne by the insured person.

2. Benefits

2.1 What is insured?

The services provided under the VIVA health plan are exclusively based on the Health Insurance Act (HIA/KVG).

2.2 Who provides the services?

In the VIVA health plan, outpatient treatment, care and advice are provided by the chosen coordinating service provider (restricted choice of physician).

2.3 What services are covered?

The VIVA health plan covers the costs of medication, analyses and therapeutic measures prescribed by the coordinating service provider, as long as this cover is envisaged in the HIA/KVG. Services from other service providers are covered similarly in emergencies, or if the coordinating service provider arranges referral to the other service provider.

2.4 Can other service providers be consulted?

External specialist physicians or other service providers can be consulted, upon referral by the coordinating service provider. The VIVA health plan covers the costs as per HIA/KVG.

2.5 What benefits are provided in the event of inpatient treatment?

In the event of inpatient treatment in a general ward at a listed hospital, the Insurer covers its share of the tariff that applies for a listed hospital in the insured person's canton of residence. If, for medical reasons, it is necessary to obtain treatment in a hospital that is not on the list of hospitals for the canton of residence, the Insurer covers its share of the tariff that applies for residents of the canton in which the institution providing the inpatient treatment is situated.

2.6 When is the consent of the coordinating service provider required?

Except in emergencies, admissions to acute-care hospitals must be arranged by the coordinating service provider, or with their consent.

2.7 What is not insured?

Outpatient or inpatient services used for reasons that do not constitute an emergency as per para. 1.5 and without a referral from the coordinating service provider shall be paid for by the insured person concerned.

2.8 When do you have to repay benefits received?

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

2.9 When does the entitlement to benefits begin?

The entitlement to benefits begins on the day that the insurance commences. The date of treatment is decisive with regard to the entitlement to benefits.

2.10 Where does the insurance apply?

The benefits are essentially provided for treatment in Switzerland.

2.11 What services are covered abroad?

During stays in EU member states, Iceland or Norway, the insured persons are entitled to necessary medical treatment, whereby the type of services and the likely duration of the stay are taken into consideration. During stays in any other foreign countries, there is only an entitlement to emergency treatment. An emergency is a situation in which insured persons need medical treatment during a temporary stay abroad and a journey back to Switzerland is not appropriate. Cases in which the insured persons go abroad for the purpose of this treatment are not emergencies.

After treatment has taken place abroad, the insured person is obliged to inform the coordinating service provider without delay and within 30 days at the latest. Within the framework of the law, the Insurer covers the costs of giving birth abroad, if this occurs in order to obtain citizenship abroad. The amount of any benefit is determined according to the Health Insurance Act (HIA/KVG).

2.12 What applies in cases of multiple insurance or benefits from third parties?

The insured person must notify the Insurer of any other insurances or third parties that are also obliged to pay benefits pertaining to an insured incident, and of any received benefits or indemnity. The Insurer is to be notified of any waivers of benefits before they are signed. Insured persons are obliged to notify the Insurer of any claims they may have against other insurance providers or liable third parties.

2.13 What is the relationship with other social insurances?

The relationship between the VIVA health plan and other social insurances is based on the relevant legal provisions.

2.14 Are claims against third parties transferred to the Insurer?

From the date of the insured incident, the Insurer is subrogated to the rights of the insured in all claims of the insured person against liable third parties to the extent of the statutory benefits.

2.15 How do you receive your compensation?

Insured persons are obliged to give the Insurer the details of a Swiss bank or PostFinance account as the address for payment. If these details are not provided, the payout costs shall be covered by the insured persons.

3. Premiums and out-of-pocket expenses

3.1 What premiums do you have to pay?

The VIVA health plan premium is based on the Insurer's insurance tariff, as approved by the supervisory authority. This is calculated according to age group and is lower than that of the ordinary basic insurance. Persons who are covered by military insurance for more than 60 days in succession are freed from the obligation to pay premiums as soon as this period of cover commences, as long as they notify the Insurer at least eight weeks in advance. If this notice period is not adhered to, the Insurer will stop charging premiums from the date of notification onwards, but no earlier than the start of military service.

3.2 What age groups apply?

The following age groups apply:

- I. Children aged 17 or under
- II. Insured persons aged from 18 to 24
- III. Insured persons aged 25 and above

Reallocation from age group I to II, or II to III, occurs at the end of the calendar year in which the age of 18 or 25 is reached, respectively.

3.3 How much of the costs do you have to pay?

The provisions in the Ordinance on Health Insurance (HIO/KVV) apply.

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 deductible and the retention fee are calculated on the basis of the date of treatment.

3.4 No out-of-pocket expenses for preventive services

The Insurer shall not require the insured to contribute to the costs of services described in section 3 of the Health Insurance

Benefits Ordinance (preventive health measures, art. 12a to 12e HIBO/KLV).

3.5 What happens in the event of delayed payment?

- a) Premiums / out-of-pocket expenses
If an insured person fails to pay premiums or out-of-pocket expenses despite being reminded to pay, they will be warned by the Insurer and a 30-day extension period shall be granted, in which payment is to occur. If the insured person fails to pay outstanding premiums, out-of-pocket expenses or default interest despite the warning, the Insurer shall initiate debt enforcement. At the same time, the Insurer informs the relevant cantonal office. Default interest of 5% must be paid on any premiums owing.
- b) Warnings
Warnings are issued in writing.
- c) Costs
The costs of the debt collection procedure and other expenses can be transferred to the insured person in default. In the event of a warning or debt collection, an administration fee can be charged.
- d) Change of insurer
The insured person in default cannot change insurer until they have paid the outstanding premiums, out-of-pocket expenses, default interest and debt collection costs in full.

3.6 What services are not covered?

Services that go beyond the statutory basic insurance are not covered. Voluntary top-up insurance covers such services.

3.7 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.

4. Admission

4.1 What are the terms of admission?

The group of persons obliged to take out insurance is as defined in the relevant legal provisions. Admission is only possible if no compulsory health insurance is simultaneously held elsewhere.

All insured persons residing in the VIVA health plan's insurance region can transfer from ordinary health insurance to the VIVA health plan at any time. The location of the person's domicile under civil law is decisive with regard to whether they reside in the insurance region.

5. Leaving the insurance

5.1 What notice periods apply?

Ordinary termination of the VIVA health plan can take place at the end of the calendar year, with three months' notice. The notice of termination must reach the Insurer no later than on the last working day before commencement of the three-month notice period. The extraordinary termination options as per art. 7 para. 2 to 4 HIA/KVG remain reserved.

5.2 What happens upon change of domicile?

- a) Moving out of a VIVA healthcare organisation's sphere of activity
If the insured person's domicile changes to a location outside the VIVA healthcare organisation's sphere of activity, the insured person is transferred to the Insurer's ordinary basic insurance at the start of the month that follows the change of domicile. The Insurer is to be notified at least

one month after departure from the healthcare organisation's sphere of activity.

- b) Moving into a VIVA healthcare organisation's sphere of activity
If the insured person's domicile changes to a location inside the sphere of activity of one of the Insurer's other VIVA healthcare organisations, the insured person has the right to continue their VIVA health plan within the new VIVA healthcare organisation. The Insurer must be notified of the departure from the previous VIVA healthcare organisation's sphere of activity and the continuation of insurance within the new VIVA healthcare organisation no later than one month after the change of domicile.

5.3 What happens if the coordinating service provider dissolves the contractual relationship?

If the coordinating service provider dissolves the contractual relationship with the healthcare organisation, insured persons registered with this service provider can choose to register with any other coordinating service provider or transfer to the Insurer's ordinary basic insurance within 30 days of receiving a corresponding written request from the Insurer. If the Insurer is not notified of any new coordinating service provider within the specified period, this automatically results in transfer to the Insurer's ordinary basic insurance at the start of the next month.

5.4 What happens if the contract between the Insurer and the healthcare organisation is dissolved?

If the contract between the Insurer and the healthcare organisation is dissolved, the health insurance under the VIVA health plan (as per HIA/KVG) is cancelled. This is automatically followed by transfer to the Insurer's ordinary basic insurance unless the insured person submits a request to the contrary.

5.5 What happens if it is no longer possible for the coordinating service provider to provide care?

If it is no longer possible for medical treatment to be provided by the coordinating service provider for reasons attributable to the insured person (e.g. if the insured person moves into a nursing home), the Insurer is entitled to transfer the insured person to the Insurer's ordinary basic insurance at the beginning of a calendar month, with 30 days' notice.

6. Data protection

6.1 How is personal data processed?

Personal data is mainly processed in order to provide the benefits of statutory health insurance, and to be able to support insured persons with regard to reliable insurance cover that meets their needs, in line with the principles of integrated care. 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.

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 What data is passed on?

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 apply to not only personal data such as names, dates of birth and insurance numbers, but also to 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. The Insurer and the healthcare organisation exchange data that is required for administrative purposes via a secure platform. The Insurer regularly sends lists to the healthcare organisation, which comprise the insured persons registered with each coordinating service provider, along with the associated insurance details pertaining to the individual insured customers, as well as an overview of the medical services that the insured persons registered with each of the respective healthcare organisation's coordinating service providers have used. The healthcare organisation regularly sends Visana an overview of the medical services that have not been provided or prescribed by the relevant coordinating service provider. In addition, the healthcare organisation regularly provides Visana with an overview of the insured persons who have not complied with the obligations described in para. 7.10 and 7.11.

7. Duties of the insured

7.1 How do you choose your coordinating service provider?

Insured persons choose their coordinating service provider from the list of VIVA health plan physicians. This provider can be changed at most once in a calendar year, at the beginning of a month, with one month's notice.

Insured persons are obliged to notify the previous coordinating service provider and the Insurer of this change. Insured persons shall release the previous coordinating service provider from the obligation to observe medical confidentiality, such that the latter can pass on treatment information and documents to the new coordinating service provider.

7.2 Consultation obligation and adherence to instructions

Insured persons (or a third person acting on their behalf) are obliged to follow the instructions given by physicians or other service providers and to take the cost-effectiveness of the treatment into account. They must consult the coordinating service provider before making any appointment for medical treatment. The coordinating service provider shall determine the appropriate treatment in consultation with the insured person. The instructions are binding for the insured person. The coordinating service provider shall determine the time frame and service provider for any further treatment. If the time frame is inadequate or if there is a change in the treatment plan, the insured person must obtain the consent of the coordinating service provider before resuming use of services. Failure to comply with these obligations shall result in penalties as per art. 8 of these General Conditions of Insurance.

7.3 What is the procedure in emergencies?

In an emergency, insured persons contact their coordinating service provider.

If the latter cannot be reached, the insured persons contact the provider's deputy, or the emergency organisation responsible for their place of residence or for the place where they are currently situated. In the event of emergency hospitalisation or treatment by an emergency physician, insured persons are obliged to inform their coordinating service provider at the earliest possible opportunity and to send them a report from the emergency physician.

7.4 What is the procedure in the event of inpatient treatment?

Insured persons are obliged to obtain the consent of the coordinating service provider before admission to acute-care hospitals (except in emergencies).

7.5 What are the obligations in the event of referrals to specialist physicians?

If insured persons are referred by their coordinating service provider to a specialist physician and the latter recommends that another physician or inpatient facility provide treatment or assessment, the insured persons are obliged to inform their coordinating service provider of this and to obtain their consent.

7.6 How should you proceed with regard to gynaecological treatment?

Gynaecological examinations and treatments can be carried out at the insured person's discretion. After the examination or treatment has taken place, the insured person is obliged to inform the coordinating service provider without delay and within 30 days at the latest.

7.7 Do you need authorisation for balneotherapy?

The legally mandatory benefits pertaining to balneotherapy shall only be paid if the coordinating service provider prescribed the therapy, or approved such a prescription.

7.8 What right to inspect does your coordinating service provider have?

Insured persons authorise their coordinating service provider and the healthcare organisation to inspect the necessary treatment and billing data pertaining to their medical care.

7.9 Obligation to obtain generics and biosimilars

The insured person undertakes to request a cost-effective medicament (generics/biosimilars or a comparatively cost-effective original preparation) from the medically prescribed group of active substances. Original preparations shall be replaced by generics/biosimilars if the latter are more cost-effective and the insured person is not dependent on the original preparation for medical reasons.

Generics

The 'New generics list with differentiated retention fee for originals and generics' maintained by the Federal Office of Public Health (FOPH/BAG) serves as a basis. The current list can be accessed on the FOPH/BAG website or the Insurer's website. If the insured person chooses a medicament on the FOPH/BAG generics list with a high retention fee (20%) for which a more cost-effective alternative is offered, the costs of the original medicament are not covered.

Biosimilars

Biosimilars are approved products that imitate the original biologics. If the insured person chooses an original medicament for which a more cost-effective alternative is offered, the costs of the original medicament are not covered. Information about the approved biosimilars, with trade name, active substance and indication of the original preparation, is to be requested

from the coordinating service provider. This rule does not apply to cases in which, for medical reasons, the insured person is dependent on the original preparation with a high retention fee. Corresponding evidence from the service provider must be made available for the benefits statement.

7.10 Disclosure of medical history and state of health
Upon admission to the VIVA health plan, the insured person undertakes to share existing medical documents with the chosen coordinating service provider, and to give the latter comprehensive and truthful information about their state of health.

7.11 Disease and chronic care management programmes

The insured person is obliged to undergo disease or chronic care management programmes if so instructed by the chosen coordinating service provider. The programmes and the service providers who run them shall be specified by the chosen coordinating service provider.

8. Penalties for breaching VIVA health plan obligations

8.1 What happens if insured persons do not meet their obligations?

Insured persons who fail to meet the obligations set out in para. 7.2 to 7.7 and para. 7.9 of these GCI can be penalised by the Insurer as follows, after prior written warning:

- After a second breach of obligation: 50% reduction of statutory benefits.
- After a third breach of obligation: Refusal to pay benefits. Amounts already paid for invoices will be reclaimed by the Insurer.
- After a fourth breach of obligation: Repeated rule-breaching conduct results in exclusion from the VIVA health plan. The exclusion is followed by transfer to the Insurer's ordinary health insurance and is carried out in the month that follows the penalised breach of obligation. After exclusion, readmission to an alternative insurance model offered by the Insurer is possible in the next calendar year at the earliest.

8.2 What happens if insured persons do not follow the coordinating service provider's instructions?

If the insured person does not follow instructions as per para. 7.10 or 7.11, they shall be excluded from the VIVA health plan after a reflection period of 30 days and reallocated to the ordinary health insurance.

9. Supplementary provisions

9.1 Legal options for insured persons

If an insured person disagrees with a decision made by the Insurer, they can, within a reasonable period of time, request that the Insurer issue a written ruling, including a rationale and instructions on rights of appeal.

An objection to a ruling can be lodged with the Insurer within 30 days. The Insurer shall examine this objection and issue a written decision on the objection, including a rationale and instructions on rights of appeal.

An appeal against the Insurer's decision on the objection can be lodged with the cantonal insurance court within 30 days. The court of jurisdiction is the insurance court in the canton of residence of the insured person or of the third party lodging the appeal. If the insured person or third party lodging the appeal is domiciled abroad, the insurance court in the canton in which their last Swiss domicile was located or in which their last Swiss employer is domiciled has jurisdiction; if neither of these locations can be determined, the insurance court in the canton where the implementing body is domiciled has jurisdiction (art. 58 para. 2 GSSLA/ATSG). An appeal may also be

lodged if, despite a request by the person concerned, the Insurer fails to issue a ruling or a decision on an objection. An appeal against the decision of a cantonal insurance court can be lodged with the Federal Supreme Court in accordance with the Federal Supreme Court Act (FSCA/BGG).

9.2 Who is liable in the event of incorrect treatment?

With regard to the professional correctness of medical treatments, liability resides with neither the Insurer nor the health-care organisation, but the service provider themselves.

10. Issue and entry into force

10.1 When do the GCI enter into force?

These General Conditions of Insurance (GCI) enter into force on 1/1/2024. They can be modified by the Insurer at any time.