General Conditions of Insurance (GCI)
Health Insurance
Med Call (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

1. General principles

1.1 What is the legal basis for the insurance?
Med Call insurance is another form of the obligatory insurance for medical treatment. Med Call insurance is based on the legal stipulations of the valid Federal Law on Health Insurance (FLHI/KVG), the Federal Law governing the General Part of Social Insurance Law (GPSIL/ATSG), the relevant administrative regulations, and the available 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 provide Med Call insurance?
The insurer provides Med Call insurance throughout the whole of Switzerland.

1.4 What is Med Call insurance?
Med Call insurance is a special form of the obligatory insurance for medical treatment with a limited choice of service providers offered pursuant to Art. 41 paragraph 4 FLHI in connection with Art. 62 FLHI and Arts. 99 to 101 of the Ordinance on the Health Insurance (OHI/KVV).

1.5 What is the basic principle underlying Med Call insurance?
Insured persons, or a third party acting on their behalf, contact a medical advisory center by telephone when they have a question about their health, in particular before making an initial appointment to consult a doctor. The medical consultation center does not provide any diagnostic or therapeutic services, but is restricted to issuing medical advice and recommendations for how to proceed next depending on the gravity and urgency of the health problem. The insured person is free to choose whether to heed the advice or not.

1.6 What is the scope of benefits of Med Call insurance?
Med Call insurance provides the obligatory benefits foreseen by the legislation for illness, accidents, congenital defects, pregnancy and maternity.

1.7 May accident cover be suspended?
Accident cover may be suspended if the insured person has appropriate cover in accordance with accident insurance legislation (FLAI/UVG). Written request for suspension of accident insurance has to be made to the insurer. Insured persons have to notify the insurer of all changes in accident insurance cover within one month.

1.8 May you choose the annual deductible you wish to pay?
Persons who take out Med Call insurance may choose an annual deductible from a number of options. The higher annual deductibles charged are offered in compliance with the conditions of the Ordinance on Health Insurance (OHI).

1.9 Where does the insurer conduct business?
The insurer conducts business throughout the whole of Switzerland.

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

a) 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.

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

c) 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.

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.

2. Benefits

2.1 What are you insured for?
The benefits provided by Med Call insurance are offered in explicit compliance with the provisions of the FLHI.

2.2 Which outpatient benefits are accepted by the insurance?
Costs for diagnosis, therapy, drugs and analyses carried out or prescribed by the doctor are accepted by Med Call insurance if the FLHI stipulates such should be paid by the insurer and if such measures meet the criteria of Article 32 of the FLHI concerning the effectiveness, suitability and economic efficiency of treatment.

2.3 What benefits are paid for stationary treatment?
If stationary treatment is provided in the general ward of a listed hospital, the insurer accepts its share of the costs at the prevailing tariff for listed hospitals at the insured person's canton of residence. If treatment is required for medical reasons in a hospital that is not on the hospital list of the canton of residence, the insurer accepts its share of the costs at the prevailing tariff

for individuals whose place of residence is in the canton where the stationary facility is located.

2.4 When do benefits have to be repaid?
Benefits which are wrongfully gained or paid in error must be repaid to the insurer.

2.5 When does entitlement to benefits begin?
Entitlement to benefits begins on the day the insurance commences. The date of treatment determines whether you are entitled to benefits.

2.6 Where is the insurance valid?
As a matter of principle benefits will be paid for treatment received in Switzerland.

2.7 What benefits will be provided for treatment abroad?
During stays in EU member states, Iceland or Norway insured persons are entitled to medically necessary treatment; in this respect the type of benefit and the length of stay envisaged will be taken into consideration. In all other countries insured persons are only entitled to emergency treatment. An emergency is deemed 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.
Med Call 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).

2.8 What applies in a situation with a number of insurers or liable third parties?
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 Insurer also has to be notified if benefits or settlements are received. The insurer has to be informed before you sign any agreement to waive payments or benefits.
Insured persons are obliged to provide information about any claims they may have against other bearers of insurance or liable third parties.

2.9 How is the relationship between the insurer and other social insurers regulated?
The relationship between Med Call insurance and other social insurance plans is regulated by the legislation.

2.10 Do insured persons have to subrogate claims on third parties 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 on third parties to the extent of the statutory benefits.

2.11 How do you receive refunds?
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.

3. Premiums and participation in costs

3.1 What premiums do you have to pay?
The premium for Med Call insurance is arranged in compliance with the insurer's premium tariffs; such have been approved by the supervisory authorities. These tariffs are calculated according to age group and are lower than those charged for regular basic insurance. 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.

3.2 What are the existing age groups?
The following age groups have been established:
I Children until completion of the 18th year of life
II Insureds aged from 19 to the end of the 25th year of life
III Insureds from the age of 26 upward
Transfer from age group I to II or from group II to III takes place at the end of the calendar year in which the insured attains the age of 18/25.

3.3 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.

3.4 What happens if you are in arrears with payments?

a) Premiums/participation in costs
If an insured person fails to pay premiums or shares of participation in costs when due, the insurer duns the insured and sets a time limit of 30 days for payment. If the 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.

b) Dunning notices
Dunning notices are sent in writing.

c) 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.

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. Admission

4.1 What are the conditions for admission to the insurance?
Med Call insurance can be taken out by all insured persons whose domicile under civil law is Switzerland. Transfer from the regular basic insurance to Med Call insurance is possible for

all persons insured with the Insurer domiciled in Switzerland; transfer takes place on the first of the month.

5. Leaving the insurance

5.1 What periods of notice apply?
Med Call insurance may be terminated in the regular manner at the end of a calendar year by giving written notice three months prior to the end of the year. Notice of termination must be received by the insurer at the latest on the last working day before the three-month period of notice begins. 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.

5.2 What happens if you change your domicile?
If the insured changes his place of domicile the insurer should be informed of the move within one month. Any prejudice resulting from willful violation of the obligation to notify must be borne by the insured.

5.3 What happens if the insurer ceases to offer Med Call insurance?
Insured persons will be informed at least two months in advance if the insurer intends to cease offering Med Call insurance in one or more cantons at the end of a calendar year. In the absence of notification to the contrary on the part of the insured person or notice to terminate the insurance, the insured person shall be automatically transferred to the insurer's regular basic insurance.

6. Duties of insureds

6.1 How do you proceed if you want to consult a doctor or be admitted to hospital?
Insured persons are obliged to contact the medical consultation center first before availing themselves of medical services or before entering a hospital for stationary treatment and in particular before making an initial appointment to consult a doctor.

6.2 Are there any exceptions to this rule?
The medical consultation center does not need to be contacted with respect to the following:

a) Optical aids in the cases stated in the aids and apparatus list (MiGeL)
b) Maternity treatment
c) Preventive gynecological check ups
d) Gynecological problems
e) Outpatient ophthalmic examinations
f) Dental treatment
g) Emergencies

6.3 What is an emergency and what has to be done in an emergency?
An emergency is deemed to exist if an individual, or a third party, assesses the condition of the insured person as life threatening or in need of immediate treatment and it is impossible or unreasonable to expect the insured person to inform the medical consultation center in advance. In such cases prior contact with the medical consultation center is not required. However, the medical consultation center should be informed about the emergency as soon as possible after it occurs.

6.4 What happens in the case of a stay abroad?
Insured persons who make use of medical services while abroad are not compelled to contact the medical consultation center.

7. Supplementary provisions

7.1 How is personal data processed?
Personal data is mainly processed in order to offer and provide contractual services, 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.
Personal data can be stored both physically and electronically. Such data is primarily stored in Switzerland. If data is transferred to a country that lacks adequate data protection, the Insurer shall take the necessary measures to nevertheless provide adequate 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.

7.2 What data is exchanged?
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.
In the context of Med Call insurance in particular, the Insurer obtains from the medical advice centre the personal data that it needs in order to perform the tasks assigned to it under the Federal Health Insurance Act. In particular, the insured person's insurance number, name, date of birth and gender, as well as the respective invoice number, invoiced amount and treatment period, along with the service provider's ZSR number and name, are transferred in order to enable the Insurer to carry out checks and breach management. The Insurer shall comply 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. The Insurer regularly transfers lists of persons insured under Med Call insurance, along with the insurance details of such persons, to the medical advice centre.

7.3 What can you do if you disagree with a decision made by the insurer?
Insured persons who are in disagreement with a decision taken by the insurer can request a formal ruling.

7.4 May an insured be excluded from Med Call insurance?

If the insured is repeatedly in breach of the regulations, the insurer is entitled to exclude the insured from Med Call insurance at the end of a calendar month; a one-month period of notice has to be observed. This results in the insured being transferred to the regular basic insurance offered by the insurer. After an insured person is excluded from Med Call insurance, readmittance is possible at the earliest at the beginning of the next calendar year.

8. Enactment and entry into force

8.1 When do the GCI take force?

The General Conditions of Insurance (GCI) take force on 1.1.2023. The insurer reserves the right to modify these conditions at any time.