

General Conditions of Insurance (GCI)

Health Insurance

Med Direct (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 principles

1.1 What is the legal basis for the insurance?

Med Direct insurance is a special form of the obligatory health insurance. Med Direct 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) 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 conducts its business throughout Switzerland.

1.4 Where does the insurer offer Med Direct insurance?

The premium regions where Med Direct is offered can be found in the document, "Med Direct Insurance Areas" on the Visana website, or you can inquire at the agency responsible for your insurance.

1.5 What is Med Direct insurance?

Med Direct insurance is a special form of the obligatory health insurance with a limited choice of service providers offered pursuant to Art. 41 paragraph 4 FLHI and in connection with Art. 62 FLHI and Art. 99 to 101 of the Ordinance on the Health Insurance (OHI/KVV).

1.6 What is the basic principle underlying Med Direct insurance?

Med Direct insurance is based on the family doctor principle in which basic medical care and medical consultations are provided by one doctor selected by the insured.

The insured chooses a family doctor and agrees to consult him for treatment and examinations at all times or to be referred to other doctors by the family doctor he has selected. Other than in emergencies and the cases cited in paragraph 6.5, the family doctor is consulted first in connection with every case involving outpatient or stationary treatment.

1.7 Who can be the family doctor?

Any doctor recognized by the insurer who is a licensed general practitioner, internist or pediatrician with a Swiss FMH qualification working in the field of social medicine, may serve as the family doctor. Further, the insurer may recognize other doctors with equivalent training as family doctors.

If the Insurer no longer recognises a doctor, it shall inform the insured person in writing at least one month in advance. The insured may then either designate another family doctor or transfer to the insurer's regular basic insurance. If the insured chooses to change insurer, the legal stipulations concerning giving notice have to be observed.

1.8 May you suspend accident cover?

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

1.9 May you choose the annual deductible you wish to pay?

Persons who take out Med Direct insurance may choose an annual deductible.

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

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

1. 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.
2. 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.

2. Benefits

2.1 What is insured?

The benefits provided under Med Direct insurance conform exclusively to the provisions of the FLHI.

2.2 Who provides outpatient services?

Under the Med Direct insurance plan the family doctor chosen by the insured provides outpatient treatment, medical care and advice.

2.3 Which outpatient benefits are accepted by the insurance?

Costs for diagnosis, therapy, drugs and analyses carried out or prescribed by the family doctor are accepted by Med Direct insurance if the FLHI stipulates such measures should be paid by the insurer.

2.4 May other service providers be consulted?

Specialists or other service providers may be consulted if insured persons are referred to them by the family doctor. Med Direct insurance accepts the costs stipulated in the FLHI. Costs for services provided by service providers other than the selected family doctor will also be accepted in emergencies. An emergency is said to exist if the insured person needs urgent medical treatment from a medical viewpoint and the family doctor cannot be reached in time, or cannot be reached because of the distance or time involved.

2.5 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. Other than in emergencies, individuals may not be referred to acute hospitals without the express approval of the family doctor.

2.6 Which medicinal drugs does the insurer pay for?

The insurer reimburses the costs for the most economical drugs available to treat specific medical conditions.

2.7 What is not insured?

If the insured person obtains outpatient or stationary treatment without first obtaining the approval of the family doctor the insured is liable for the costs arising unless the action was taken as a result of an emergency or for one of the exceptions cited in paragraph 6.5. Benefits in excess of those foreseen by the legislation on the basic insurance are not covered.

2.8 When do you have to repay benefits received?

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

2.9 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.

2.10 Where is the insurance valid?

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

2.11 Will benefits 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 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. Med Direct 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). The family doctor does not have to be contacted before insured persons avail themselves of services abroad.

2.12 What applies with respect to other 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 must be notified if benefits or settlements are received. The insurer must 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.

2.13 How is the relationship between the insurer and other social insurers regulated?

The relationship between Med Direct insurance and other social insurances is regulated in the legislation

2.14 Must insured persons 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.

2.15 How do you receive your 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 premiums for Med Direct insurance are arranged in compliance with the insurer's premium tariffs that have been approved by the supervisory authorities. These tariffs are calculated according to age group. 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 25
- III. Insureds older than 26

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 do you participate 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 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?

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 insured 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. 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.

3.5 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 conditions for admission to the insurance?

Med Direct insurance can be taken out by all insured persons whose private law domicile is in a canton in which the insurer offers Med Direct insurance.

Transfer from the regular basic insurance to Med Direct insurance is possible for all persons insured with the insurer domiciled in a canton where the insurer offers Med Direct insurance; transfer takes place on the first of any month.

5. Leaving the insurance

5.1 What periods of notice apply?

Under normal circumstances Med Direct insurance can be cancelled at the end of a calendar year while observing a three-month period of notice. Notice of termination must be received by the insurer at the latest on the last working day before the 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 Direct insurance?

Insured persons will be informed at least two months in advance if the insurer intends to dissolve Med Direct insurance 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 will be automatically transferred to the insurer's regular basic insurance.

5.4 What happens if care can no longer be provided by the family doctor?

If the family doctor can no longer provide medical treatment because of a change in the insured's circumstances (e.g. if an insured is admitted to a nursing home) the insurer is entitled to transfer the insured to the insurer's regular obligatory insurance; this takes place at the beginning of a calendar month and a one-month period of notice is observed.

6. Duties of insureds

6.1 How do you choose your family doctor?

Insured persons choose their family doctor from a number of doctors recognized by the insurer as family doctors. Insured persons can change family doctor at the beginning of any month, but at most once per calendar year. Insured persons are obliged to inform the insurer of such a change; a one-month period of notice must be observed.

6.2 How do you proceed if you need medical treatment?

Insureds are obliged to consult the family doctor at all times whether for treatment or examinations or for referral to other doctors (exceptions: c.f. paragraph 6.5).

If the family doctor cannot be reached they should consult his deputy or the emergency service at their place of residence or where they are at the time. If insureds are admitted to hospital in an emergency or receive treatment from an emergency doctor they are obliged to inform their family doctor as soon as possible.

6.3 How should you proceed if you need stationary treatment?

Insured persons are obliged to get the approval of their family doctor before being admitted to acute hospitals (except in emergencies). Insured persons are obliged to send the insurer written confirmation of the referral to hospital issued by their family doctor.

6.4 What should you do if you are referred to a specialist?

Insured persons are obliged to obtain the approval of their family doctor before consulting a specialist. If the family doctor refers insured persons to a specialist and the specialist recommends admission to a stationary facility for treatment or diagnosis, insured persons must inform their family doctor and get his approval (exceptions: c.f. paragraph 6.5). Insured persons are obliged to send the insurer written confirmation of the referral to hospital issued by their family doctor.

6.5 Which specialists can I consult without the express approval of the family doctor?

No approval is required in the following cases:

1. Optical aids in the cases cited in the Appliances and aids list (MiGel).
2. Maternity
3. Preventive gynecological check ups
4. Gynecological problems
5. Outpatient ophthalmic examinations
6. Dental treatment

6.6 Do you need approval for spa cures?

Obligatory benefits for spa cures are only paid if the cure has been prescribed or approved by the family doctor.

7. Additional terms of insurance

7.1 What can you do if you disagree with one of the insurer's decisions?

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

7.2 Penalties for breaching Med Direct obligations

Insured persons who fail to meet the obligations set out in art. 6.2 to 6.4 and 6.4 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 Med Direct insurance. 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.

7.3 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.

7.4 Confidentiality

All employees of the Visana Group are subject to the requirement to maintain confidentiality as stipulated in the GPSIL.

8. Enactment and entry into force

8.1 When do the GCI enter into 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.