

General Conditions of Insurance (GCI)

Health Insurance

Managed Care (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 Managed Care insurance?

The insurer offers Managed Care insurance in specifically defined insurance regions (Managed Care networks). Managed Care insurance is based on the current provisions of the 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 General Conditions of Insurance (GCI).

Managed Care insurance is a form of the basic insurance required by law and is based on the provisions of Article 41 paragraph 4 and Article 62 of the Federal Law on Health Insurance (FLHI). The name of the insurer can be found on your insurance policy.

1.2 What is the underlying principle of the Managed Care insurance?

Managed Care insurance is based on the gatekeeper principle and provides insured persons with comprehensive support, advice and medical care. The gatekeeper (Managed Care doctor) coordinates all the patient's medical treatment.

On taking out Managed Care insurance, insured persons agree to consult the Managed Care doctor they have selected for all medical examinations and treatment and/or for referral to specialists and other service providers.

1.3 How is a Managed Care network organized?

The doctors in the Managed Care network have a contractual relationship with the Insurer, either via the network of doctors or via a separate operating company.

1.4 Who is your Managed Care doctor?

The insured person chooses their Managed Care doctor from the list of Managed Care doctors. The Managed Care doctor has to be consulted first if any outpatient or inpatient treatment is required, with the following exceptions: emergencies, outpatient ophthalmological examinations, preventative gynaecological examinations and check-ups, obstetric care, and dental treatment.

1.5 What benefits does Managed Care insurance provide?

Managed Care insurance provides the mandatory benefits foreseen by the legislation for illness, accidents, congenital defects, pregnancy and maternity.

1.6 What conditions apply in emergencies?

Emergency treatment is covered within the scope of the mandatory benefits foreseen in the legislation provided the treatment is given by a doctor or a service provider authorized to provide services under the provisions of the FLHI. An emergency is a situation where the insured person needs urgent medical treatment from an objective medical viewpoint and the Managed Care doctor cannot be reached in time or is unavailable because of the distance or time involved.

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?

The Managed Care plan offers you the option of contracting for an annual deductible. The higher annual deductibles charged are offered in compliance with the conditions of the Ordinance on Health Insurance (OHI/KVV).

1.9 How does the insurer communicate with insured persons? 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 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 or insurance certificate, 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 are you insured for?

The benefits provided by Managed Care insurance are offered in explicit compliance with the provisions of the FLHI.

2.2 Who provides medical services?

Under the Managed Care plan, the Managed Care doctor of your choice is responsible for outpatient treatment, medical care and consultation (restricted choice of physician).

2.3 Which services are accepted under the insurance?

Managed Care insurance accepts the costs for medicinal drugs, analyses and therapeutic measures prescribed by the Managed Care doctor if the FLHI stipulates such measures should be paid by the insurer. Services provided by doctors who are not members of a Managed Care network will be accepted analogously provided such are necessary in an emergency or if the insured is referred to another service provider by the Managed Care doctor.

2.4 May other service providers be consulted?

Specialists or other service providers may be consulted on referral by the Managed Care doctor. Managed Care insurance accepts the costs stipulated in the FLHI.

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 in 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 resident in the canton where the stationary facility is located.

2.6 When is the approval of the Managed Care doctor necessary?

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

2.7 What is not insured?

Costs incurred for outpatient or hospital services other than in cases of accident (in compliance with paragraph 1.6) without prior referral by the Managed Care doctor are borne by the insured person.

2.8 When do benefits have to be repaid?

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 What benefits will be provided for treatment abroad?

During stays in EU member states, Iceland or Norway, insureds are entitled to medically necessary treatment; in this respect the type of benefit and the length of stay envisaged will be taken into consideration. In all other countries insureds 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.

After having received treatment abroad, the insured person is obliged to inform the Managed Care doctor without delay.

The Managed Care 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).

2.12 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 insured also has to inform the Insurer if benefits are received. The insurer has to be informed before any agreement to waive payments or benefits is signed. Insured persons are obliged to provide information about any claims they may have against other bearers of insurance or liable third parties.

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

The relationship between the Managed Care insurance and other social insurances is regulated in the legislation.

2.14 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.

2.15 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 premiums for Managed Care insurance are arranged in compliance with the insurer's premium tariffs, which have been approved by the supervisory authorities. This tariff is calculated according to age group and is lower than that 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 completes his 18th or 25th year of life.

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?

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 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.

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 What benefits does the insurance not cover?

Benefits in excess of those foreseen by the legislation on the basic insurance are not covered.

A non-mandatory supplementary insurance is required to cover such benefits.

3.6 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?

All persons insured with the Insurer domiciled in an area where the Insurer offers Managed Care insurance may transfer from the regular basic insurance to Managed Care insurance; the transfer can take place at any time. The civil law domicile determines whether persons live in an area where Managed Care insurance is offered.

5. Leaving the insurance

5.1 What periods of notice apply?

Managed Care insurance may be terminated in the regular manner 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. The right to terminate the insurance under extraordinary circumstances pursuant to Article 7 paragraphs 2 to 4 FLHI remains reserved.

5.2 What happens if you change your domicile?

1. Moving out of a Managed Care region

If the new domicile is in a location where there is no Managed Care network, insured persons with Managed Care insurance are transferred to the regular basic insurance provided by the insurer; the transfer takes place at the beginning of the month following relocation. The insured person has to notify the insurer within one month of moving if he relocates to an area not served by the Managed Care network.

2. Moving to a Managed Care region

If insured persons relocate to an area in which the insurer operates a further Managed Care network, they are entitled to continue their Managed Care insurance within the new Managed Care network. The insurer should be notified within one month of the event if the insured moves out of the area served by the Managed Care network or if his insurance is continued by a new Managed Care network.

5.3 What happens if the Managed Care doctor dissolves the contract?

If the selected Managed Care doctor dissolves the contractual relationship with the network of doctors or with the Managed Care operating company, insured persons registered with this doctor can choose to register with any other Managed Care doctor or transfer to the ordinary basic insurance offered by the Insurer within 30 days of receiving a written request to do so by the Insurer. If the insurer is not notified of a new Managed Care doctor within the period stipulated, the insured person will be transferred automatically to the regular basic insurance offered by the insurer at the beginning of the following month.

5.4 What happens if the contract between the insurer and all the doctors in a Managed Care network is dissolved?

If the contract between the insurer and the company operating the Managed Care service or, respectively, all doctors in a Managed Care network, is dissolved, the Managed Care insurance (FLHI) ceases to exist. In the absence of notification to the contrary on the part of the insured person, the insured person shall be transferred to the insurer's regular basic insurance.

5.5 What happens if the Managed Care doctor can no longer provide care?

If the Managed Care doctor can no longer provide medical treatment because of a change in the insured person's circumstances (e.g. if an insured is admitted to a nursing home), the insurer is entitled to transfer the insured person to the insurer's regular basic insurance; the transfer takes place at the beginning of a calendar month and a 30 day period of notice is observed.

6. Data protection

6.1 How is personal data processed?

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

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 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.

The Insurer and the Managed Care operating companies or networks of doctors exchange data that is required for administrative purposes via a secure platform. The Insurer regularly sends lists of the insured persons registered with a Managed Care doctor, along with the associated insurance details pertaining to the individual customers insured under this model, as well as an overview of the medical services that the insured persons registered with a Managed Care doctor have used, to the operating company or network of doctors.

The operating company or network of doctors regularly sends Visana an overview of the medical services that have not been provided or prescribed by a Managed Care doctor.

7. Duties of Managed Care insureds

7.1 How do you choose your Managed Care doctor?

Persons insured under Managed Care insurance select their Managed Care doctor from the specific list of Managed Care doctors.

The insured person may change doctor once at most within a calendar year; the change takes place at the beginning of a month and a period of notice of one month has to be observed. Persons insured under the Managed Care insurance are obliged to inform both the previous Managed Care doctor and the insurer about the change. They release the Managed Care doctor from the obligation to maintain patient confidentiality and authorize him to give information about treatment given and to pass on the patient's records to the new Managed Care doctor.

7.2 How do you proceed in an emergency?

In emergencies persons insured under the Managed Care insurance have to contact their Managed Care doctor. If the doctor cannot be reached, they have to consult his deputy or the emergency service at their place of residence or wherever they are at the time. If persons insured under the Managed Care insurance are hospitalized in an emergency or if they receive treatment by an emergency doctor, they are obliged to inform their Managed Care doctor as soon as possible and to pass on the emergency doctor's report to him.

7.3 How should you proceed if you need stationary treatment?

Persons insured under the Managed Care insurance are obliged to get the approval of their Managed Care doctor before being admitted to acute hospitals (except in emergencies).

7.4 What duties do you have if you are referred to a specialist?

If persons insured under the Managed Care insurance are referred to a specialist by a Managed Care doctor and the specialist recommends that the insured consult a further doctor or be admitted to a stationary facility for treatment or diagnosis, Managed Care insureds are obliged to inform their Managed Care doctor and get his approval.

7.5 How should you proceed with regard to gynaecological treatment?

Preventative gynaecological examinations and check-ups, as well as obstetric care, can be carried out by the gynaecological or obstetric specialist of your choice in your canton of residence. For all other gynaecological treatment, approval must be obtained in advance from the Managed Care doctor.

7.6 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 Managed Care doctor.

7.7 What right to information does your Managed Care doctor have?

Persons insured under the Managed Care insurance consent to the condition whereby the Managed Care doctor and the Managed Care operating company have access to the necessary data on treatment and invoicing concerning the insured person's medical treatment.

7.8 Penalties for breaching Managed Care obligations

Insured persons who fail to meet the obligations set out in art. 7.1 to 7.6 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 Managed Care 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.

8. Supplementary provisions

8.1 Who is responsible for issuing formal decisions and decisions on appeals?

Formal rulings and decisions on appeals are issued by the insurer.

8.2 Who is liable in cases of incorrect or inadequate medical treatment?

Neither the insurer nor the Managed Care company can be held liable for incorrect or inadequate medical treatment; the service provider is solely liable.

9. Enactment and entry into force

9.1 When do the GCI take force?

The General Conditions of Insurance (GCI) take force on 1.1.2024.

The insurer reserves the right to modify these conditions at any time.