General Conditions of Insurance (GCI)
Voluntary daily allowance insurance as per HIA/KVG

Note:
- To make this document easy to read, we use gender-neutral language or address you directly as "you".

The conditions of insurance are valid for the following insurers:
- Visana Ltd, Weltpoststrasse 19, 3000 Berne 16
- sana24 Ltd, Weltpoststrasse 19, 3000 Berne 16

1. Basic principles

1.1 What legal principles apply?
The legal basis underlying voluntary daily allowance insurance comprises the General Conditions of Insurance (GCI), the current Federal Act on Health Insurance (HIA/KVG) and the Federal Act on General Aspects of Social Security Law (GSSLA/ATSG), as well as their implementing provisions.

1.2 Who is your insurer?
To identify the insurer, please refer to your insurance policy.

1.3 Where does the insurer operate?
The insurer provides daily allowance insurance cover across the whole of Switzerland.

1.4 Is collective insurance available?
Collective insurance is not available.

2. Insurance relationship

2.1 Who is insured?
The insurer will provide cover for natural persons from the age of 15 up to their 65th birthday who are resident or gainfully employed in the territory within which the insurer operates.
The insurance will lapse on the first day of the month following the insured person's 65th birthday.

2.2 What are the terms of admission?
Each individual must personally sign a written insurance application containing complete and truthful information regarding their personal details, state of health, existing insurance and receipt of benefits.
The application can be revoked seven days after signature by means of a registered letter addressed to the insurer's head office. All rights and obligations of both parties lapse retroactively upon dispatch of the declaration of revocation. Where an individual lacks the capacity to act, their statutory representative must sign on their behalf.
The insurer can order a pre-admission medical examination and request medical certificates. By submitting their insurance application, the person requesting insurance authorises the physicians, hospitals and medical auxiliaries they have consulted to provide the insurer or its medical examiners with the information required to assess their insurance application.

2.3 Will the insurer conduct a risk assessment?
The insurer will conduct a risk assessment on the basis of the insurance application. Furthermore, a risk assessment will be conducted if the insurance is changed or if any illnesses and consequences of accidents are discovered that were knowingly not disclosed when the application was made.

2.4 Could insurance provisos be applied?
Illnesses/consequences of accidents that exist on admission or which experience shows could lead to a relapse will be subject to an insurance proviso. Provisos lapse after five years. During this five-year period, insured persons can provide evidence that the proviso is no longer justified.
Provisos imposed by a previous insurer will be continued in cases where the new insurer cannot apply new provisos (vested benefits).

2.5 When can you make changes to your insurance?
You can change your insurance at any time. You will then be subject to the same conditions as a new policy.

2.6 What age groups apply?
The age groups are shown in the tariff.

2.7 When does the insurance start?
The insurance begins at the earliest on the day the insurance application is signed. Retroactive commencement of insurance is not possible. If the insurance does not start on the day the application is signed, it will start on the first day of the following month.

2.8 When does the insurance end?
In the following situations, the insurance ends:

a) Written notice of termination
Insurance can be terminated with effect from the end of any calendar half-year by providing three months' notice. Termination is only valid if the insurer has received notice on time, i.e. no later than the last working day before commencement of the three-month notice period.
b) b) On the death of the insured person
c) On ceasing to reside or pursue gainful employment in the area in which the insurer provides cover
d) When the insurer's obligation to provide benefits lapses
e) On reaching the maximum age
f) Exclusion

Insured persons may be excluded from insurance for compelling reasons. Insurance fraud and serious breach of obligations towards the insurer constitute compelling reasons. Exclusion will be made in the legally valid form of a formal decision.

2.9 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 organ of publication of the Visana Group; such information is binding. One copy of the organ of publication 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 relationship (e.g. change of domicile) to the insurer within one month of such changes.

d) Breaches of the duty to notify the insurer
Any disadvantages resulting from a breach of the duty to notify the insurer will be borne by the insured person.

2.10 From whom can you obtain advice?
The responsible organisational units will be happy to answer questions and provide advice.

3. Benefits

3.1 What is insured?
The following options are available for daily allowance insurance:
- Illness (including maternity)
- Illness (including maternity) and accident

3.2 What is the scope of benefits?
A daily allowance of CHF 5 to CHF 30 can be insured in increments of CHF 1. The minimum waiting period is three days.
The following additional waiting periods are possible: 14, 21, 30, 60, 90, 120, 150, 180, 270 and 360 days.
The minimum daily allowance is:
CHF 5 with a waiting period of 3, 14, 21 and 30 days
CHF 10 with a waiting period of 60 days
CHF 15 with a waiting period of 90 and 120 days
CHF 20 with a waiting period of 150 or more days. The maximum daily allowance for all waiting periods together is CHF 30. However, benefits may be reduced on the grounds of overcompensation if the daily allowance exceeds the loss of earnings experienced by the insured person for the entire duration of the insured period of incapacity to work and if no evidence of additional outlay is provided. A total of three waiting period options can be chosen.

3.3 How is the waiting period calculated?
The waiting period normally starts from zero with each new case. Where the case is still the same, however, the days during which the insured person was previously incapacitated will count towards the waiting period provided the interruption has not exceeded three months. The insurer may authorise exceptions in cases of hardship.

3.4 What entitlement to benefits do you have?
The physician or chiropractor of persons insured for daily allowances must attest to their incapacity to work.
The insured person is entitled to daily allowance payments if their incapacity to work is at least 50%. Benefits are calculated according to the degree of incapacity to work. Full benefits will be paid from an incapacity to work of 75% or more.

3.5 How are vested benefits dealt with?
In cases involving vested benefits, the daily allowances provided by the previous insurance will count towards the period of eligibility.

3.6 When does entitlement to benefits begin?
Entitlement to benefits begins at the earliest on the day insurance starts.

3.7 How long is the period of eligibility?
A daily allowance will be paid for one or more events (illnesses/accidents) until such time as the insured person has received benefits for 720 days in the 900-day period determined by counting back from the current calendar date.
In the event of partial incapacity to work, a correspondingly reduced daily allowance will be paid for the same period. Insurance cover for the remaining capacity to work is unaffected.
If daily allowance benefits are reduced due to overcompensation, the insured person is entitled to the equivalent of 720 daily allowances. This entitlement is determined by the degree of incapacity to work.
The insured person may not delay the end of the indemnity period by waiving their right to daily allowance benefits before the end of the medically attested incapacity to work.

3.8 What benefits are paid for maternity?
A daily allowance for maternity will be paid if the insured person has been insured for at least 270 days prior to the birth without an interruption of more than three months. If the childbirth occurs during the waiting period, the insured benefits are only paid if the expected date of birth, calculated and certified by a physician, complies with the waiting period. The foregoing is without prejudice to vested benefit provisions (Art. 70 HIA/KVG, “Change of insurer”).
If the conditions are fulfilled, the insurer will pay the insured daily allowance for a period of 16 weeks, taking account of the waiting period. Of these 16 weeks, at least eight must be after childbirth. Within this framework, the insured person is free to choose how to divide the period of eligibility between the time before and after childbirth. The maternity benefits are not offset against the period of eligibility pertaining to the daily allowance insurance taken out.

3.9 What is the entitlement in the event of unemployment?
The daily allowance entitlement for unemployment is that stipulated by law (Art. 73 HIA/KVG).

3.10 How do you claim benefits?
The insurer must be notified of illnesses and accidents within one week of the waiting period expiring.
If notification is given after the reporting period has ended, benefits will only be due from the date of notification. If notification was delayed for compelling, valid reasons, the insurer will recognise the commencement of benefits up to a maximum of six months before the date of notification.
Any insured person with an illness who is initially still able to work but whose incapacity to work reaches at least 50% as the illness progresses and/or as the result of an accident must immediately notify the insurer of their incapacity to work.
The insurer must be given all details needed to provide the benefits, particularly the reason for treatment (diagnosis) and appointments with physicians (calendar). Failure to provide this information or refusal to consent to measures requested by the insurer may result in benefits being refused.
Insured persons are obliged to assist the insurer’s medical examiner in assessing their entitlement to benefits and to release the physicians treating them from their obligation to observe medical confidentiality.

3.11 Where does the insurance apply?
Benefits will be paid for incapacity to work in Switzerland and the EU/EFTA states. Daily allowances will only be paid to insured persons in a country that does not belong to the EU or EFTA if they have to be admitted to hospital on medical grounds and only for as long as they are unable to return to their country of residence.

3.12 When will benefits be reduced or refused?
If the insured person brought about or exacerbated the insured event deliberately or while deliberately committing a felony or misdemeanour, benefits may be temporarily or permanently reduced or, in serious cases, refused.
If an insured person withdraws from or opposes a reasonable course of treatment that promises to significantly improve their health, or if they do not, of their own volition, make such contributions to the improvement of their own health as might

reasonably be expected, their benefits may be temporarily or permanently reduced or refused. The insurer will send the insured person advance written warning and make them aware of these legal consequences.

3.13 How do you receive your compensation?
Payment will be made, in Swiss francs only, after your entitlement to benefits has been reviewed. Insured persons are obliged to give the insurer the details of a Swiss bank or postal account as the address for payment. If these details are not provided, the payout costs will be covered by the insured persons.

3.14 Can you transfer or pledge claims against the insurer?
Claims against the insurer may not be transferred without its consent.

3.15 What is the relationship with other insurances and third-party benefits (recourse)?
a) Duty of disclosure and notification
The insurer must be notified of any other insurance providers or third parties that are also obliged to pay benefits pertaining to an insured incident. Any received benefits must also be reported. The insurer is to be notified of any indemnity before it is received and 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. Any breach of this duty of disclosure and notification will result in the insured person losing their entitlement to benefits. Benefits paid by mistake must be repaid.

b) Coordination of benefits
The relationship between social health insurance and other social insurances is based on the relevant legal provisions.

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

3.16 When do you have to repay benefits received?
Benefits that are wrongfully gained or paid in error must be repaid to the insurer. The insurer has the right to offset claims for repayment against the insured person's claims.

3.17 When does entitlement to benefits lapse?
Entitlement to outstanding benefits lapses five years after the end of the month for which the benefit was due.

4. Premiums and out-of-pocket expenses

4.1 What premiums do you have to pay?
The premium applicable to you, which has to be paid for at least one month in advance, can be found in your policy document. In the month of admission, premiums are due from the actual date on which insurance commences. If the insured person leaves or dies, no premium will be due for the period after the actual date of leaving or date of death.

4.2 What payment periods apply?
Premiums are paid monthly, bimonthly, quarterly, semi-annually or annually. The corresponding payment dates can be found in the premium invoice. The insurer grants discounts for semi-annual or annual payments. The associated conditions are set by the insurer.

4.3 How much is the premium?
Premiums are based on the tariffs approved by the supervisory authority. Premiums are graded according to age group and waiting period.

4.4 What happens in the event of delayed payment?
a) Premiums
The insurer will issue a reminder for premiums that are not paid on time. If the insured person is in arrears by more than 90 days from the date on which the payment deadline expired, entitlement to benefits will cease until all arrears have been paid in full.

b) Reminders
Reminders are issued in writing. Presentation of a COD will be treated in the same way.

c) Default interest
The insurer has the right to demand default interest of 5% on any premiums owing.

d) Costs
The insured person in default will be liable for expenses as well as reminder and debt enforcement costs.

e) Offsetting
Outstanding premiums can be offset against insured persons' claims.

5. Administration of justice

5.1 When can you ask for a formal decision?
Insured persons who disagree with a decision made by the insurer can demand an appealable formal decision.

5.2 When is it possible to lodge an objection?
Objections against a formal decision can be lodged with the insurer within 30 days of opening.

5.3 What legal redress do you have?
An appeal against the insurer's decisions on objections can be lodged with the Cantonal Insurance Court within 30 days. The court responsible is the insurance court of the canton in which the insured person or third-party plaintiff is resident at the time of the appeal. An appeal may also be made to the Cantonal Insurance Court if, despite the request of the person concerned, the insurer fails to issue a formal decision or a decision on an objection. Decisions by the Cantonal Insurance Courts may be appealed before the Federal Supreme Court within 30 days.

6. Miscellaneous provisions

6.1 Who is obliged to maintain confidentiality?
All staff of the Visana Group are obliged to maintain confidentiality as per GSSLA/ATSG.

6.2 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.
To the extent necessary and required by law, 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 reinsur-

ers. 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 sensitive personal data such as that pertaining to an individual's health. In such cases, the stricter legal requirements governing the processing of sensitive personal data will be observed.
Personal data can be stored both physically and electronically. Such data is primarily stored in Switzerland. The insurer will take the necessary measures to ensure that personal data is only transferred to countries that guarantee adequate data protection.
The insurer will 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.

6.3 Is it possible to take out reinsurance?
The insurer will conclude reinsurance contracts where this is in the insured persons' interests.

6.4 When do these GCI enter into force?
These General Conditions of Insurance (GCI) enter into force on 1 January 2023.
The insurer may modify them at any time.