General Conditions of Insurance (GCI)
Healthcare insurance
Combi 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

I General provisions

1. Basic principles of the insurance

Combi Care insurance is a form of compulsory healthcare insurance. The legal basis for Combi Care insurance consists of the current Federal Law on Health Insurance (FLHI/KVG) and the Federal Act on General Part of Social Insurance Law (GPSIL/ATSG), as well as their implementing provisions and these General Conditions of Contract (GCC).

2. Purpose and characteristics of Combi Care

The insurer covers the financial consequences of illness, maternity or accident.
When taking out the insurance, the insured person has to select a general practitioner who is recognised by the insurer.
In the event of health complaints, the insured person shall consult the selected general practitioner or the telemedical advice centre.
The circumstances outlined in art. 8 of these General Conditions of Contract are excluded from the obligation to engage in prior consultation.

3. Who is considered a general practitioner

A general practitioner is any FMH specialist in general internal medicine or paediatrics recognised by the insurer and authorised to practise in primary care. Other physicians with equivalent training who are recognised by the insurer are also considered general practitioners. If the insurer no longer recognises a physician, it shall inform the insured person in writing. The insured person can then either designate a different recognised general physician or transfer to the ordinary basic insurance.
The insured person is obliged to report any change of general practitioner immediately.

4. Admission

Combi Care can be taken out by all persons whose domicile under civil law (centre of vital interests) is in a canton in which the insurer offers Combi Care. All insured persons domiciled in a canton in which the insurer offers Combi Care can transfer from the ordinary basic insurance to Combi Care; if the same insurer stays the same, this is possible at any time, on the first day of a month.

II Benefits

5. Scope of benefits

Combi Care insurance encompasses the legally mandatory benefits pertaining to illness, accident, birth defects and maternity, provided that the specified course of treatment and the instructions (obligations) have been adhered to.
The circumstances outlined in art. 8 of these General Conditions of Contract are excluded from these obligations. Failure to comply with these instructions (obligations) shall result in penalties as per art. 10 of these General Conditions of Contract.

5.1 Outpatient benefits

Under Combi Care insurance, outpatient treatment, care and advice are generally provided by the selected general practitioner or the telemedical advice centre.
Combi Care insurance covers the costs of diagnostic and therapeutic measures, medication and analyses provided or prescribed by the general physician or telemedical advice centre, as long as this cover is envisaged in the FLHI/KVG.

5.2 Referrals

Specialist physicians or other service providers can be consulted upon referral by the general practitioner or telemedical advice centre. Referrals by the general practitioner to other service providers must always be reported to the telemedical advice centre.
Services provided by other service providers without a referral from the general practitioner or telemedical advice centre are only covered in emergency situations and in the exceptional cases specified in art. 8. An emergency is when the insured person urgently requires treatment for medical reasons and the general practitioner or telemedical advice centre cannot be reached quickly enough for reasons of distance and/or time.

5.3 Inpatient benefits

In the event of inpatient treatment in a general ward at a listed hospital, the insurer covers its share of the fee 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 fee that applies for residents of the canton in which the institution providing the inpatient treatment is situated. Except in emergency situations, admissions to acute-care hospitals must occur via the general practitioner or telemedical advice centre, or with their consent.

5.4 Benefits abroad

During stays in EU member states, Iceland or Norway, insured persons are entitled to necessary medical treatment, upon consideration of the type of services and the likely duration of the stay. During stays in any other foreign countries, there is only

an entitlement to emergency treatment. An emergency is a situation in which the insured person needs medical treatment during a temporary stay abroad and a journey back to Switzerland is not appropriate. Cases in which insured persons go abroad for the purpose of this treatment are not emergencies. Within the framework of the law, Combi Care insurance 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 Federal Law on Health Insurance (FLHI/KVG). There is no need to contact the general practitioner or telemedical advice centre before making use of services abroad.

6. Co-payment

If a number of children from the same family are insured with the same insurer, the total annual co-payment for the children will not exceed the maximum sum of CHF 950.
The deductible and the excess are calculated on the basis of the date of treatment.

III Obligations and rationale regarding claims

7. Consultation obligation and adherence to instructions

The 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 telemedical advice centre or their general practitioner before making any appointment for medical treatment. If the insured person is referred to a different physician, a hospital or a nursing home by the attending general physician, this must be reported to the telemedical advice centre.
The physicians shall determine the appropriate treatment in consultation with the insured person. The instructions are binding for the insured person. The general practitioner or telemedical advice centre 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 telemedical advice centre or general practitioner before resuming use of services.
Failure to comply with these obligations shall result in penalties as per art. 10 of these General Conditions of Contract.

8. Exceptions to the obligation to engage in prior consultation

In emergencies, prior contact with the telemedical advice centre or general practitioner is not required.
An emergency is when the insured person urgently requires treatment for medical reasons and the general practitioner or telemedical advice centre cannot be reached quickly enough for reasons of distance and/or time. The insured person is obliged to report emergency treatment to the telemedical advice centre at the first possible opportunity. If a follow-up treatment/check-up becomes necessary afterwards, this must be reported to the telemedical advice centre before the start of the follow-up treatment/check-up. With the latter's consent, the follow-up treatment/check-up can also be performed by the service provider who provided the emergency treatment. If the follow-up treatment/check-up is carried out by the selected general practitioner, it is not necessary to notify the telemedical advice centre.

For the following examinations and treatments, prior contact with the general practitioner or telemedical advice centre is not mandatory:

- Eye examinations and treatment
- Gynaecological examinations and treatment, as well as check-ups during and after pregnancy
- Services provided and arranged by paediatricians
- Dental treatment

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.

9.1 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 medicinal product on the FOPH/BAG generics list with a high retention fee, for which a more cost-effective alternative is offered, the costs of the original medicinal product are not covered.

9.2 Biosimilars

Biosimilars are approved products that imitate the original biologics. If the insured person chooses an original medicinal product or biosimilar with a high retention fee, for which a more cost-effective alternative is offered, the costs of the original medicinal product or biosimilar with high retention fee 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 general practitioner or telemedical advice centre. This rule does not apply to cases in which, for medical reasons, the insured person is dependent on the original preparation or biosimilar with a high retention fee. Corresponding evidence from the service provider must be made available for the benefits statement.

10. Penalties for breaching Combi Care obligations

Insured persons who fail to meet the obligations set out in art. 2, 5, 7 and 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 Combi 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.

11. Rationale regarding claims

The entitlement to outstanding benefits or contributions expires five years after the end of the month for which the benefit was due and five years after the end of the calendar year for which the contribution was due (art. 24 para. 1 GPSIL/ATSG).

Co-payment is governed by art. 6 of these General Conditions of Contract.

12. Transfer and pledging of benefits

The insured person may neither transfer nor pledge claims against the insurer without the insurer's consent. The right to transfer claims to service providers is reserved.

IV Start and end of the insurance

13. Start of the insurance

The insured person shall receive a policy as confirmation of the insurance cover. The insurance begins on the date stated in the policy. Admission to Combi Care is governed by the FLHI/KVG and the associated administrative provisions.

14. Changes made to the insurance by the insured person

Changing to a lower selectable deductible, to another form of insurance or to another health insurer is possible at the end of a calendar year, subject to the statutory notice periods.
Accident cover can be excluded at the request of the insured person if proof of accident insurance as per FLAI/UVG (the Federal Law on Accident Insurance (FLAI/UVG)) is provided (occupational and non-occupational accidents). This exclusion shall occur on the 1st day of the month following the request, at the earliest. Inclusion of accident cover occurs immediately after the end of the accident insurance as per FLAI/UVG. The insurer is to be notified of the discontinuation of accident insurance within 30 days.

15. Changes made to the insurance by the insurer

If medical treatment by the selected general practitioner or the telemedical advice centre is no longer possible, the insurer is entitled to transfer the insured person to the insurer's ordinary healthcare insurance at the beginning of the following calendar month, with 30 days' notice. Grounds for this include, in particular (this list is not exhaustive):

- The insured person staying abroad for longer than three months
- A stay in a nursing home, in the nursing ward of a retirement home or in a ward for chronically ill patients at an acute-care hospital
- A stay lasting more than three months in an acute-care hospital, a psychiatric clinic, a rehabilitation clinic or similar institution
- The insured person currently serving a prison sentence
- The insured person moving their domicile out of the insurer's service area
- The general practitioner withdrawing without naming a new selectable general practitioner

16. Leaving the insurance

Ordinary termination of Combi Care insurance 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. Upon notification of a new premium, the insured person can change insurance at the end of the month that precedes the new premium's applicability, with one month's notice.

17. Abolition of Combi Care by the insurer

If the insurer abolishes Combi Care insurance at the end of a calendar year, the insured persons will be notified at least two months in advance. This is automatically followed by transfer to the insurer's ordinary basic insurance unless the insured person submits a request to the contrary or a notice of termination.

V Premiums

18. Premium payment and due dates

Premiums are due for payment at the end of each preceding month (art. 90 OHI/KVV). Payments can be made annually, semi-annually, quarterly, bimonthly or monthly, whereby the insurance year commences on the 1st of January.
If the insurance is terminated early, any unused premium shall be refunded proportionately.
Premiums owing may not be offset by the insured person against outstanding benefits.

19. Delayed payment

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

20. 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.

VI Data protection

21. Data protection and general obligation to maintain confidentiality

All of the insurer's staff are legally obliged to maintain confidentiality as per GPSIL/ATSG. Data protection is governed by the FLHI/KVG and the GPSIL/ATSG.
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.

22. Data exchange

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 Combi Care, the Insurer obtains from the telemedical advice centre the personal data In the context of Combi Care, the Insurer obtains from the telemedical 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 Combi Care insurance, along with the insurance details of such persons, to the medical advice centre.

VII Administration of justice

23. 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 objection ruling, including a rationale and instructions on rights of appeal.
An appeal against the insurer's objection ruling 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 GPSIL/ATSG). An appeal may also be lodged if, despite a request by the person concerned, the insurer fails to issue a ruling or an objection ruling.
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).

VIII Miscellaneous

24. Payout of benefits

The 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.
If contracts make the insurer liable to pay fees to the service provider, it shall transfer its benefits to the service provider and charge the insured person for the co-payment (tiers payant system).
The insurer can offset insurance benefits owing, both against premiums owing and against outstanding co-payments, until a request to open debt enforcement proceedings is filed.

25. Duty to report

The insured person is obliged to immediately notify the insurer of all changes affecting the insurance relationship (name changes, change of domicile, change of general physician etc.). The insured person shall be liable for any losses incurred as a result of late notification.
The address stated on the policy is the address to which reports to the insurer or rationales regarding claims against the insurer are to be sent.

26. Modification of the conditions of contract

Changes to these General Conditions of Contract shall be published in the insurer's customer magazine and posted on its website.

27. Entry into force

These General Conditions of Contract enter into force on the 1st of January 2024. They are published on the health insurer's website. They can be modified by the insurer at any time.