SUPPLEMENTARY INSURANCE

GENERAL INSURANCE CONDITIONS (GIC) AND SUPPLEMENTARY CONDITIONS (SC) UNDER THE FEDERAL INSURANCE CONTRACT ACT (VVG).

Version of 2023, valid from 1 January 2023

BECAUSE HEALTH IS EVERYTHING SWICA

CUSTOMER INFORMATION

We wish to point out some contractual bases that are particularly important before you sign a contract.

Note this symbol in the following General Insurance Conditions and Supplementary Conditions: 

Please ask someone to explain the marked text passages before you sign the contract. We use the symbol to emphasise the following:

- Who is the insurance carrier?
- Who can take out insurance?
- What does the insurance cover and what does it exclude?
- What are the policyholder's obligations?
- When is an insured person entitled to benefits?
- How long is the contract term?
- What data are processed by whom and for what purpose?

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GENERAL INSURANCE CONDITIONS.

I. GENERAL INFORMATION

The insurance carrier for the supplementary insurances is SWICA Insurances Ltd, Römerstrasse 37, 8401 Winterthur, hereinafter referred to as "SWICA," unless stated otherwise in the Supplementary Conditions.

ART. 1 WHO CAN TAKE OUT INSURANCE AND WHO PROVIDES CUSTOMER CARE FOR THE POLICYHOLDERS*?

Only one person with legal place of residence in Switzerland can take out supplementary insurance with SWICA. Please contact SWICA if you require insurance advice or claim benefits from one of your policies. You will find the address of the customer service on the insurance policy.

ART. 2 WHAT BELONGS TO THE CONTRACT?

1. Your insurance contract – for both individual and group cover – comprises:
   a) Your insurance application,
   b) the policy,
   c) these General Insurance Conditions,
   d) the Supplementary Conditions (SC),
   e) any Special Agreements in effect.
2. Supplementary insurance is subject to the Federal Insurance Contract Act (VVG). In case of any contradiction between the GIC or SC and the mandatory provisions of the VVG, the latter take precedence. Dispositive provisions of the VVG apply only insofar as these GIC/SC do not include any deviating provisions.
3. These GIC/SC are based on the revised VVG of 19 June 2020 (in force as of 1 January 2022). They apply to all policyholders (including those who took out insurance before 1 January 2022), provided that these GIC/SC contain no contrary provisions.

II. SCOPE OF INSURANCE AND DEFINITION OF TERMS

ART. 3 WHAT IS INSURED?

The insurance covers the financial consequences of illness, accident and/or maternity as well as the cost of health-promoting and preventive measures in accordance with the Supplementary Conditions for supplementary insurance under the VVG.

In the case of self-therapy and treatment by family members, entitlement to benefits from SWICA applies only if SWICA has approved the costs in advance (in writing or in a form that permits text-based verification).

Please refer to Art. 7 below for information about SWICA's lists and directories of other benefits and service providers.

ART. 4 WHICH BENEFITS CAN BE INSURED?

a) The cost of treatment for illness, accident and maternity,
b) the cost of health-promoting and preventive measures,
c) daily benefits or,
d) lump-sum benefits on disability or death in accordance with the respective insurance conditions.

*To enhance readability, this document may in some instances use the masculine form, which applies to all gender-specific references.

ART. 5 DEFINITION OF TERMS AND APPLICATION OF THE GIC

Basic insurance is mandatory and provides the minimum cover for healthcare and accidents as laid out in the Federal Health Insurance Act. Supplementary insurance plans are individual add-ons to your mandatory health insurance and accident insurance that you can purchase to extend the scope of your cover.

All provisions of these GIC apply to supplementary insurance unless expressly stated otherwise. Unless expressly stated otherwise, all terms defined in the Federal Health Insurance Act (KVG) also apply to supplementary insurance within the meaning of this contract.

Supplementary insurance is essentially a form of indemnity insurance, unless stated otherwise in the relevant supplementary conditions.

In general, SWICA's supplementary insurance plans only cover additional services that are not covered under mandatory health and accident insurance. You will find further information about the benefits in the Supplementary Conditions for the respective insurance product.

ART. 6 ! WHICH TREATMENTS ARE COVERED?

SWICA covers the cost of treatment and of health-promoting and preventive measures, provided that such treatment and measures are efficacious, purposeful and cost-effective. You will find further provisions in the Supplementary Conditions of the respective supplementary insurance.

ART. 7 ! LISTS AND DIRECTORIES AND THEIR VALIDITY

The lists and directories of services and service providers mentioned in the respective Supplementary Conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

The extent to which SWICA covers services or indemnifies policyholders otherwise is determined on the basis of the lists and directories in effect at the time of the insured event.

ART. 8 ! WHEN DOES SWICA REFUSE OR REDUCE BENEFITS?

SWICA does not provide supplementary insurance in the following cases:

1. For the consequences of warlike events
   a) in Switzerland,
   b) abroad. However, if the policyholder suddenly finds himself faced with such an event in the country in which he is staying, insurance cover ends only 14 days after the first occurrence of this event;
2. For the consequences of civil unrest of any kind and the measures taken against it, unless the policyholder proves that he was not actively involved in causing or inciting such unrest;
3. In connection with service in a foreign army;
4. In connection with earthquakes or meteor strikes;
5. In connection with an actual or attempted felony or misdemeanour or as a consequence thereof;
6. As a consequence of participation in fights or brawls, unless the policyholder was injured by the disputants as a bystander or while assisting a defenceless person;
7. As a consequence of risks to which the policyholder exposes himself by provoking others;
8. For health damage resulting from the policyholder's exposure to extraordinary hazards (Art. 49 of the Accident Insurance Ordinance (UVV)) and hazardous activities (Art. 50 UVV); the statutory UVV provisions and the case law on social accident insurance lay out how extraordinary hazards and hazardous activities are to be assessed;
9. For health damage resulting from participation in motor vehicle races of any kind and during training for such races;
10. For illnesses or accidents resulting from ionising radiation or for damage from nuclear energy;
11. When the insured person or another person entitled to benefits intentionally causes an insured event;
12. For medical treatment as a result of misuse of medicines, drugs and alcohol. Abuse of addictive substances is expressly not considered an illness and therefore does not provide a basis for an obligation for SWICA to pay benefits.
13. For purely aesthetic, cosmetic surgery or similar procedures and the consequences of such treatment.

ART. 9 GROSS NEGLIGENCE

SWICA reduces its benefits if the insured event was caused through gross negligence; any supplementary conditions are reserved.

III. CONTRACT TERM AND TERMINATION

ART. 10 FROM WHEN IS THE INSURANCE VALID?

The contract is valid as soon as SWICA issues the policy or confirms acceptance of the application in writing or another form that permits text-based verification, but no earlier than on the agreed date. The consequences of an accident or illness are covered only if the accident happens or the first case of illness occurs after the insurance has come into effect.

ART. 11 ❗ FOR HOW LONG IS THE INSURANCE VALID?

Policyholders can claim benefits from SWICA for as long as the contract is in effect (subject to periodic benefit obligations within the meaning of Art. 35c VVG if the contract is suspended).

ART. 12 WHEN CAN THE INSURANCE BE CANCELLED?

1. ❗ Unless agreed otherwise, the contract term is at minimum one year, whereby the end of the insurance year always falls on 31 December. On expiry of the agreed period, the contract renews tacitly by one year at a time unless the policyholder terminates it within the specified period.
2. The policyholder can terminate the contract by giving three months' notice. For termination to be valid, notice must reach SWICA's reception area by 17:00 on the last workday before the three-month notice period ends (stamp date does not serve as reference date). The premiums are owed up to the next regular termination date. SWICA does not have this ordinary right of termination under the VVG.
3. After every case of illness or accident for which an indemnity is claimed. The policyholder can cancel the relevant part of the contract (in writing or in a form that permits text-based verification) no later than 14 days after having received the benefit payment. Cover ends when the notice reaches SWICA.
4. Supplementary insurance ends without notice also if the policyholder's usual place of stay is abroad for more than three months. Supplementary conditions or special agreements with SWICA are reserved.
5. The contract can also be terminated at any time for good cause (e.g. whenever circumstances arise that in good faith make it unreasonable for the person giving notice to continue it).
6. In all other situations, the insurance ends when the policyholder withdraws from the contract or dies.
7. Notice must always be given in writing or in a form that permits text-based verification.

ART. 13 WHAT HAPPENS AFTER THE INSURANCE ENDS?

a) Cover does not include the consequences of illnesses as well as of sequelae and relapses that occur after the insurance ends.

b) ❗ In principle, entitlement to benefits ends when the contract ends (subject to periodic benefit obligations within the meaning of Art. 35c VVG).

IV. PREMIUM PAYMENT

ART. 14 WHEN ARE PREMIUMS DUE?

1. The premiums must be paid in advance and usually monthly, but can also be paid every two, three, six, or twelve months by special agreement.
2. The premiums are due on the first day of each month of a payment period.
3. The premiums must be paid to SWICA in Swiss francs within one month from the agreed due date.

ART. 15 LATE PAYMENT

1. ❗ If the premium fails to reach SWICA within one month of the due date, SWICA will send a reminder demanding payment within 14 days of the reminder date. If the reminder is of no effect, the obligation to pay supplementary insurance benefits ends when the reminder period ends.
2. Suspended supplementary insurance cover can be reinstated in the original amount by paying the outstanding premiums and costs (interest on arrears, reminder fees, debt collection fees) within three months of the suspension, irrespective of the policyholder's health condition or after a renewed medical examination, even after the expiry of the aforementioned period. Cover is reinstated starting on the payment date.
3. SWICA can reclaim expenses incurred on account of defaulting policyholders, such as the cost of reminders, debt collection fees and interest on arrears, etc. and offset them against claims for compensation.

V. CHANGE IN PREMIUMS AND CONTRACT

ART. 16 CAN THE CONTRACTUAL RELATIONSHIP CHANGE?

If, after the insurance contract enters into force, the KVG is amended or the range of available services changes (e.g. due to new medical developments or therapy types that significantly affect the insurance relationship, an increase in the number of service providers, or the availability of new types of service providers), SWICA can adjust its Supplementary Conditions for its supplementary insurance. This also applies in the case of significant new findings in science and research. SWICA can also increase or reduce premiums in line with current cost trends. For this, SWICA must communicate the new contract terms no later than 30 days before the calendar year ends. The policyholder then has the right to terminate the part of the contract affected by the change to the end of the current insurance year. To be valid, notice of termination must be given in writing or in another form that permits text-based verification and reach SWICA's reception area by 17:00 on the last workday of the calendar year (stamp date does not serve as reference date). The absence of the policyholder's notice is deemed as tacit agreement to the contract change.

ART. 17 PREMIUM RATE MODELS

SWICA sets premiums annually as a rate. The rate of the selected product is decisive. The premium rate models are as follows, depending on the product:

1. Premium rate model based on age at the time of enrolment
   The premiums for products that are based on the age at the time of enrolment are calculated in accordance with the policyholder's age at that time. The age group and thus the rate remain the same throughout the insurance term.
2. Age-based premium model
   For products using an age-based premium model, the premium is adjusted regularly, at the beginning of a calendar year, to any changes in the policyholder's age group, which generally results in a premium increase. This provides the basis for the right of termination under Art. 16 above.
3. For policyholders who have included children or young people in the insurance at a special rate, the next higher rate category for the premium is calculated from the beginning of the insurance year when the child or young person reaches the age of 18 or the age of 25, which usually results in a premium increase – irrespective of the premium rate model. This provides the basis for the right of termination under Art. 16 above.

The age groups for the rate based on age at enrolment and for the rate based on age are generally 0–18, 19–25, 26–30, followed by 5-year age increments up the age group of 61+.

ART. 18 ! CHANGE OF PROFESSION, JOB OR PLACE OF RESIDENCE OF THE POLICYHOLDER

In the case of supplementary insurance, some benefit types are subject to premium scales based on the risk class and place of residence. If the policyholder changes his profession, job or place of residence and thus brings about a change in risk, SWICA can adjust the premium accordingly. A change in premium due to relocation does not result in the right of termination.

Customer Service (see insurance policy) must be notified of the change of profession, job or place of residence within 30 days. If this deadline is missed, SWICA can request payment of any missed premiums amounts from when the circumstances became known.

VI. OBLIGATIONS AND JUSTIFICATION OF CLAIMS

ART. 19 HOW DO YOU RECEIVE YOUR BENEFITS?

1. Cost of medical treatment
   SWICA pays the amount to your bank or postal account within 30 days of receiving all the relevant information, provided you proceed as follows:
   a) Cost of outpatient treatment
      All invoices and receipts must be sent to SWICA on an ongoing basis.
   b) Hospital costs
      If you have to go to hospital or a special clinic or medical spa, you must ask SWICA for a cover note at least 14 days before admission; in the case of an emergency, within 14 days after admission. SWICA decides on its obligation to pay benefits within 10 days after it receives the complete request. The benefits obligation becomes effective once SWICA has issued a cover note in writing or in another form that permits text-based verification. The invoices must be submitted to SWICA within one year.

   If you also have other insurance for hospital or outpatient treatment costs (supplementary insurance, mandatory accident insurance or another health insurer), you must submit to SWICA the statements of these insurers (e.g. health insurer, SUVA, etc.) in addition to the documents already mentioned.
2. Lump-sum benefits must be claimed in accordance with the Supplementary Conditions.
3. Payments in accordance with 1.) and 2.) must be made in Swiss francs to a Swiss or Liechtenstein bank or postal account.
4. Right to information
   SWICA has the right to request documents and information, in particular medical information. The policyholder hereby grants SWICA the right to obtain relevant documents and information directly and to instruct a doctor or therapist of its choice to review the basis of an insurance claim. Furthermore, the policyholder must truthfully provide all information about the current case in question as well as about any prior illnesses and accidents. The policyholder must release all doctors/therapists, officials, insurers and attorneys that have treated, advised or insured him from all non-disclosure obligations towards SWICA. In the case of underage policyholders, the person with custody or the policyholders must ensure that the obligations are met.

ART. 20 CONSEQUENCES OF CONDUCT IN BREACH OF CONTRACT

SWICA has or right to reduce or refuse its benefits if the General Insurance Conditions and the Supplementary Conditions are violated – unless such violations were not of a culpable nature and are proven to have had no influence on the consequences of the illness or accident and on how they were determined. Entitlement to benefits applies only if SWICA receives all the requisite documents within four weeks after it has issued its written reminder.

VII. MISCELLANEOUS

ART. 21 PLACE OF PERFORMANCE, APPLICABLE LAW, PLACE OF JURISDICTION

1. Obligations arising from this contract must be met in Switzerland and in Swiss currency.
2. Insurance under these GIC/SC and in accordance with the VVG is subject solely to Swiss substantive law to the exclusion of the Vienna Sales Convention, private international law, and other conflict-of-law rules.
3. In the case of disputes arising from the supplementary insurances, the eligible claimant can choose either SWICA's Head Office in Switzerland or his Swiss place of residence as the place of jurisdiction. If the policyholder or eligible claimant lives abroad, the exclusive place of jurisdiction is Winterthur.

ART. 22 RIGHT OF REVOCATION

1. The applicant can revoke the application to SWICA to conclude the contract or the declaration of acceptance of the contract in writing or another form that permits text-based verification (in accordance with the contact details on the insurance policy).
2. The revocation period is 14 days and begins as soon as the policyholder has applied for or accepted the contract.
3. The deadline is met if the policyholder notifies SWICA of his revocation on the last day of the revocation period or delivers his declaration of revocation to the post office.
4. Revocation voids the application to conclude the contract or the policyholder's declaration of acceptance from the start. Any benefits that have been received must be refunded.
5. The policyholder does not owe SWICA any further amounts. Where equitable to do so, the policyholder must reimburse SWICA in part or in full for the cost of any special inquiries that SWICA undertakes in good faith with a view to concluding the contract.

ART. 23 ! EXCLUSION OF COVER/REJECTION

Illnesses and consequences of an accident which exist or existed at the time of acceptance can be excluded from the requested supplementary insurance by means of an exclusion clause. The exclusion clause can be applied retrospectively if information about illnesses and accidents was withheld at the time of acceptance. SWICA can refuse to enter into a supplementary insurance contract without giving the reasons. There is no entitlement to benefits for illnesses and accident consequences that are subject to an exclusion clause. The same applies in the case of benefits for illnesses and accidents about which information was withheld at the time of enrolment. SWICA can demand a medical examination whenever new insurance is purchased or cover is increased. The signature on the application authorises SWICA to obtain the information it needs from authorities, doctors and third parties.

If significant points that the person subject to the disclosure obligation knew or should have known are falsified or omitted when purchasing contract, SWICA can terminate the contract in writing or another form that permits text-based verification within four weeks of becoming aware of this breach of disclosure obligation and reclaim, to the extent permitted by law, all benefits relating to the breach from when the contract began. The contract ends as soon as notice of termination reaches the policyholder.

ART. 24 TRANSFER FROM GROUP INSURANCE TO INDIVIDUAL INSURANCE

1. Anyone who withdraws from SWICA's group insurance contract (the framework agreement is also subsumed under this term) or no longer fulfils the conditions making him eligible to be a member of the group contract must notify SWICA in writing or in another form that permits text-based verification within 30 days. However, this person has the right to transfer to SWICA's individual insurance within three months. The right of transfer to individual insurance also applies when the group insurance contract ends.
2. The person transferring to individual insurance has the same cover as he had in the group contract. The group policyholder must make the insured persons aware of the right to transfer on withdrawal from the group contract. Benefits from the group insurance contract are carried over to those from individual insurance.
3. The premium is based on the current premium rate of the individual insurance at the time of transfer. The transfer age from group insurance to individual insurance is the same as the age when the person joined the medical expenses contract.

ART. 25 WHAT HAPPENS IN CONNECTION WITH A CURRENT LIABLE THIRD PARTY OR THIRD-PARTY SERVICE PROVIDERS?

1. SWICA does not grant any insurance cover if any third parties are liable. SWICA is obliged to pay benefits only to the extent that a third party cannot fully or partially be held liable. If the third party has a partial obligation to pay benefits, SWICA adjusts its benefits so that the policyholder is not overcompensated.
2. SWICA adjusts its compensation in line with amounts paid from accident insurance (UVG), health insurance (KVG), federal disability insurance (IV) or federal military insurance (MV). If several insurers under the VVG are liable for the same costs or there are other third parties that would be liable for such costs in the absence of cover from SWICA, the costs are paid only once in total. In cases where multiple policies are in effect, each insurer is liable for claims in line with its share of the total sums insured.
3. SWICA is not obliged to cover the benefits that a third party disputes.
4. SWICA pays voluntary advance benefits only if the policyholder transfers his rights against third parties to SWICA. SWICA can grant the policyholder legal protection when asserting his rights against a third party.
5. SWICA cannot be held liable if the policyholder settles with a third party without first obtaining SWICA's consent.
6. SWICA is under no obligation to pay benefits if the policyholder fails to claim benefits from a third party in good time or makes no effort to collect them.
7. The policyholder must inform SWICA about the nature and amount of all third-party benefits. If such information is omitted, SWICA can refuse or reduce its benefits.

ART. 26 OFFSETTING AND RECLAIMING

The policyholder must return upon written request any benefits that SWICA paid by mistake. The right of offset amounts in favour of SWICA applies in this connection.

ART. 27 PROHIBITION OF ASSIGNMENT AND PLEDGING

Claims against SWICA may be neither assigned nor pledged.

ART. 28 JOINT APPLICATION (FAMILY CONSTELLATION)

1. In the case of a joint application for cover for several persons who form a family constellation (e.g. husband and wife, incl. children/cohabiting partner/grandparents and grandchildren; the persons of this family constellation are listed in the family policy), the main applicant (authorised representative who submits the application, incl. health declaration for himself and those he represents (co-applicants) and through whom all communication concerning the insurance application is handled) can represent and obligate the other adult co-applicants (for underage children, the legal representative submits the application) who are capable of judgement. The representative must obtain proper authorisation from the person being represented, i.e. the principal. If a person acts without proper authorisation, SWICA can hold this individual liable for any loss arising from the termination of the insurance contract due to one principal or several principals failing to have approved this contract.
2. A joint application also means that all documents (e.g. enrolment decisions, invoices for premiums and co-payments, benefit statements, insurance policies, insurance cards, tax statements, correspondence on benefit refunds and insurance cover, etc.) are administered as a family policy (payment facility for the family) within the context of the insurance relationship and that the person defined in the application as the "contact person for the contract" (this does not have to be the main applicant) is assigned the tasks defined in the authorisation (power of attorney).
3. The power of attorney for the contact person for the contract includes the following functions: As the person making the payments, the contact person for the contract must ensure that all premiums and co-payments (of all policyholders of the family policy jointly) are paid. In addition, he is the recipient of the benefit payments. SWICA will send or forward all correspondence and information contained therein, including particularly sensitive personal information such as health data, to this designated contact. This applies to all correspondence, including administrative orders, legally binding notifications and time-sensitive decisions. SWICA rejects all liability for consequences arising if the contact person for the contract discloses such information to other parties or if a delay results from the contact person for the contract failing to pass information on to the policyholder in time.
4. The power of attorney granted to the contact person for the contract can be revoked in writing at any time. The contact person for the contract must obtain proper authorisation from the principal or principals for the actions and tasks to be undertaken.
5. SWICA assumes that a jointly submitted application has been prepared with the knowledge of the represented co-applicants and that the health declarations have been filled in together with the co-applicants or with their knowledge. Any false declarations by the main applicant can result in the same type of breach of disclosure obligation as when the co-applicant completes the application by himself. The policyholder himself is always the contracting party that owes the premium, the eligible claimant under the insurance contract, and the party that assumes all the associated rights and obligations.
6. By submitting the insurance application, the applicants (main or co-applicants), irrespective of whether it comprises a joint application, confirm that they have read, understood and accepted these GIC and the respective Supplementary Conditions as well as any additional or special conditions and the Privacy Statement (cf. Art. 29). Furthermore, submission of the insurance application assumes that the co-applicants whom the main applicant represents have given their consent.
7. However, the principals have the right to revoke the authorisation they have granted at any time. On the other hand, any falsely declared information that could result in a breach of disclosure obligation remains in effect.
8. The rules laid out in this Art. 28 apply only to contracts concluded after 1 January 2022. For contracts concluded before 1 January 2022, the current rules apply.

VIII. DATA PROCESSING

ART. 29 DATA PROCESSING BY SWICA

1. SWICA obtains and uses policyholders' personal data in accordance with the Data Protection Act and its ordinances, social and private insurance law and its data protection provisions (Data Privacy Statement).
2. In particular, processing involves master and contract data (such as first name, surname, address, postcode, date of birth, email address, phone number [mobile and fixed line], bank details, marital status, number of children, data on authorised representatives, financial information on income), health data (diagnoses, symptoms, medication, operations carried out, etc.), data on treatment and its course, the cost of services, data on personal and interpersonal circumstances, personality profiles, data from other insurers and service providers, and data relating to debt collection and bankruptcy law.
3. The data is processed for purposes for which the policyholder has given his consent while applying for and purchasing the insurance, for purposes relevant for the GIC and SC, or for purposes for which SWICA is authorised under the Data Protection Act and under social and private insurance law.
4. In particular, SWICA processes data during the application phase (consultation, request, review, purchase, etc.) for contract purchases and while managing the contract (administering benefits, providing information and customer care, managing the customer journey and integrated care, handling product offers, marketing, etc.) for the duration of the insurance relationship. Furthermore, SWICA uses mathematical methods to evaluate such data for statistical purposes, to develop and improve the quality and utility of its services and products for current, former and prospective policyholders, and to inform its policyholders accordingly. SWICA also reserves the right to investigate suspected cases of insurance fraud if there are substantiated reasons for doing so. SWICA can create personality profiles in connection with these processing steps.
5. SWICA stores personal data electronically or in paper form and processes it to deliver the contractual services and to advise policyholders and provide them with reliable cover that meets their needs.
6. SWICA can commission third parties (other insurers involved, medical examiners, authorities, lawyers and external experts, data centres, etc.) to provide services for the benefit of the policyholder and pass on personal data to third parties to carry out such tasks. SWICA contractually obliges its third parties to maintain confidentiality and secrecy and to comply with the Data Protection Act. Data may also be disclosed for the purpose of detecting or preventing insurance fraud.
7. The insurance card that SWICA issues to policyholders serves as proof vis-à-vis other service providers that cover is in effect. In the case of purchase of a KVG-compliant insurance product, the card is issued in accordance with KVG provisions, includes information in accordance with EU standards, and serves as proof that the holder is covered during stays in an EU country. For purchases of VVG-compliant insurance, the information can also include details about the scope of cover, incl. supplementary cover.
8. SWICA's Data Privacy Statement has more information about data processing. The Data Privacy Statement is valid for the duration of the contractual relationship between SWICA and the policyholder. The Data Privacy Statement informs about the data categories being processed, the data processing procedures and purposes, the basis for data processing, the rights of insured persons with regard to data processing at SWICA, and the duration of data processing and data retention periods.

IX. FINAL PROVISIONS

ART. 30 MESSAGES AND NOTIFICATIONS

1. The policyholder must address all messages and notifications to SWICA. The contact details are included in the policy. The insurance carrier considers all such messages and notifications to have been addressed to itself.
2. The policyholder must notify SWICA immediately of any changes in his personal circumstances affecting the insurance relationship (e.g. change of legal representative/premium payer, change of residence, change of gender, etc.) in writing or in another form that permits text-based verification.
3. All notifications and messages from SWICA or the insurance carrier are deemed legally valid when sent to the most recent address in Switzerland or specified electronic contact that the policyholder provides.

ART. 31 LIMITATION PERIOD

Claims under the insurance contract become time-barred five years after the circumstances occurred on which the benefits obligation is based.

Contracts concluded before 1 January 2022 that cover amounts the policyholder owes are subject to a two-year limitation period.

COMPLETA TOP AND COMPLETA PRAEVENTA SUPPLEMENTARY INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 PURPOSE

1. SWICA pays further benefits from COMPLETA TOP (basic module) and COMPLETA PRAEVENTA supplementary insurance (add-on module) for outpatient and inpatient treatment in addition to the benefits from mandatory (KVG) healthcare insurance.
2. The COMPLETA PRAEVENTA supplementary module can be purchased as an add-on to the COMPLETA TOP basic module.
3. ❗ The add-on module cannot be purchased by itself but only together with COMPLETA TOP. Termination of the COMPLETA TOP insurance contract results in automatic and simultaneous termination of the COMPLETA PRAEVENTA contract.

ART. 2 POLICYHOLDER

Anyone whose legal place of residence is in Switzerland can apply for this supplementary insurance. If the policyholder moves his place of residence abroad, the contract for COMPLETA TOP and COMPLETA PRAEVENTA cover ends on the date when the foreign residence status comes into effect.

II. SCOPE OF INSURANCE

ART. 3 SCOPE OF INSURANCE

1. ❗ SWICA covers the cost of treatment and of preventive and health-promoting measures, provided that such treatment and measures are efficacious, purposeful and cost-effective.
2. The scope of the insurance is based on these conditions and the policy.
3. Co-payments from other social insurances are not covered.

III. COMPLETA TOP BENEFITS IN SWITZERLAND

ART. 4 COMPLEMENTARY MEDICINE

1. Cover includes the cost of SWICA-recognised complementary medical methods if a SWICA-recognised doctor or therapist administers the treatment.
2. SWICA keeps a list of recognised methods and a directory of recognised doctors and therapists.
3. In the absence of a recognised rate, SWICA pays an hourly rate of 80 francs.

ART. 5 MEDICINES

1. SWICA covers the medically necessary medication a doctor prescribes that is not included in the negative list.
2. SWICA covers the cost of homoeopathic, phytotherapeutic and anthroposophic preparations that a doctor or therapist in accordance with Art. 4 who specialises in the respective type of therapy prescribes or dispenses.
3. Preparations and medicines are reimbursed at the retail price. If the preparations or medicines are self-produced, SWICA reimburses the production costs with a surcharge of max. 30%.
4. Medicines are defined as preparations that are registered with Swissmedic. However, cover does not include active ingredients and preparations that are used for preventing illnesses, are cosmetics, are used for sexual stimulation, contribute towards weight reduction, as well as active ingredients and preparations that are subject to the provisions of the Swiss Food Ordinance (not registered with Swissmedic). Similarly, products that manufacturers remove voluntarily from the special medicines list under the KVG are not covered. SWICA's COMPLETA TOP plan also does not cover products beyond the extent to which they are partially covered under mandatory health insurance or for uses that lie outside of their defined scope of application.

ART. 6 PSYCHOTHERAPY WITH INDEPENDENT PSYCHOTHERAPISTS

SWICA pays 90% of the cost of medically prescribed treatment of mental illnesses that an independent psychotherapist administers – max. 60 sessions per calendar year at 50 francs per session. The psychotherapist must have a specialist qualification recognised by the federal or cantonal authorities or be a member of the Association of Swiss Psychotherapists (ASP).

ARTICLE 7 MATERNITY/BREASTFEEDING ALLOWANCE

SWICA pays a breastfeeding allowance of 200 francs if the policyholder breastfeeds fully or partially for at least ten weeks. In the case of multiple births, the amount applies per child. Confirmation from the doctor or midwife is required.

ART. 8 MEDICAL SPA TREATMENT

1. For medically necessary spa treatment that a doctor prescribes, SWICA approved in advance and a recognised Swiss spa administers – or in special cases, a spa abroad administers on request and with SWICA's prior approval, SWICA contributes a maximum of 30 francs per spa day towards the cost of accommodation and treatment for a maximum of 30 days per calendar year.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 9 CONVALESCENCE TREATMENT

1. For medically prescribed and justified convalescent cures that SWICA has approved in advance and a spa on SWICA's list administers, SWICA contributes up to 20 francs per spa day towards the cost of the stay for a maximum of 30 days per calendar year.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 10 HOME HELP

1. SWICA pays 50% of the verified cost of necessary home help in the policyholder's household, at maximum 30 francs per day for not more than 60 days per calendar year.
2. The need for home help must be verified in a medical certificate.
3. The contributions are paid also to family members or relatives who can prove a loss of earnings as a result of the help they provide.

ART. 11 LENSES AND FRAMES; CONTACT LENSES

1. SWICA covers 90% of the cost, up to 200 francs, of medically indicated lenses and frames and for contact lenses every three calendar years.
2. This amount is paid only if no benefits for visual aids have been received from mandatory healthcare insurance in the last three calendar years.

ART. 12 AIDS

SWICA covers 90% of the cost, up to 200 francs, for SWICA-recognised aids (excluding dentures and visual aids) not covered under a statutory mandatory plan per calendar year. SWICA keeps a list of the aids it recognises.

ART. 13 COST OF DENTAL TREATMENT

SWICA pays 50% of the cost, up to 100 francs per calendar year, of dental treatment that is not covered under a statutory mandatory plan.

ART. 14 ORTHODONTIC TREATMENT

1. SWICA pays 50% of the costs based on the UVG rate, up to 10,000 francs, for orthodontic procedures in children and young people up to the age of 25 per calendar year.
2. For inpatient treatment, SWICA pays 50% of the costs, up to 10,000 francs, based on the rate for the general ward of the nearest public treatment facility in the policyholder's canton of residence per calendar year.

ART. 15 ORTHODONTIC SURGERY

1. For orthodontic surgery, SWICA pays 50% of the costs, up to 10,000 francs, based on the reference rate of the policyholder's canton of residence per calendar year.
2. For outpatient treatment, SWICA pays 50% of the costs, up to 10,000 francs, based on the rate that applies under the KVG per calendar year.

ART. 16 EMERGENCY/TRANSFER TRANSPORTS; SEARCH/RESCUE OPERATIONS IN SWITZERLAND

1. Supplementing basic insurance, SWICA covers up to 90%, at maximum 20,000 francs in total, of the cost of emergency transports or medically necessary transfers to the nearest doctor or hospital based on the usual rates per calendar year.
2. SWICA covers up to 20,000 francs for search and/or rescue operations for the policyholder per calendar year.

IV. COMPLETA TOP BENEFITS ABROAD

ART. 17 BENEFITS ABROAD

1. SWICA issues cover notes and covers the cost of medically necessary treatment of Swiss residents who stay abroad temporarily and are not covered by another insurance. The insurance covers all treatments recognised under mandatory health insurance in Switzerland.
2. SWICA covers the cost of outpatient and inpatient treatment in emergencies (private hospital category for the first three months of travel) supplementary to mandatory health insurance.
3. SWICA does not reimburse the cost of a policyholder who goes abroad for treatment without SWICA's prior consent.

ART. 18 PERSONAL ASSISTANCE

SWICA also pays the following benefits if a policyholder falls ill, has an accident, or experiences a medically certified, unexpected aggravation of a chronic condition while abroad:

1. Search/recovery operations and emergency transport and transfer abroad as deemed necessary by a doctor that the SWICA emergency call centre appoints, up to 50,000 francs in total per calendar year.
2. Repatriation to Switzerland or to hospital as deemed necessary by a doctor that SWICA or its emergency call centre appoints.
3. If a hospital stay abroad lasts longer than seven days, the cost of a visit by a person very close to the person insured with SWICA is covered as follows: the verified cost of the round-trip plane ticket in economy class, plus the verified cost of accommodations and meals, up to 200 francs per day and up to 1,000 francs in total.

ART. 19 CONDUCT IN THE EVENT OF A CLAIM

1. In principle, the benefits as laid out in Art. 17 (with the exception of cost cover for outpatient treatment) and Art. 18 require the involvement of the SWICA emergency call centre. Benefits are not paid if SWICA's emergency call centre has not approved them and made arrangements.
2. In principle, the policyholder can arrange for outpatient treatment himself. However, if medical outpatient measures, such as diagnostics, treatment, care and medication, exceed 25,000 francs in total per calendar year, the policyholder must first obtain a cover note from SWICA. In the absence thereof, there is no entitlement to benefits from this insurance.
3. For hospital stays, the policyholder must request a cover note from SWICA's emergency call centre before the treatment or admission to hospital. In the case of emergencies, a five-day notification period applies from when treatment begins. The doctors at the emergency call centre decide on the basis of medical findings whether SWICA will issue a cover note and whether the insured person should be transferred to another hospital or repatriated to a suitable hospital near the policyholder's place of residence in Switzerland.
4. ❗ The policyholder must send SWICA all original invoices together with the necessary medical information, or use an electronic delivery channel that SWICA provides. If the documents are insufficient, incomprehensible or include an abusive rate, SWICA can reduce or refuse benefits.
5. The policyholder is obliged to do his utmost to minimise the damage and clarify the events.

V. COMPLETA PRAEVENTA BENEFITS

ART. 20 PURPOSE

If a COMPLETA PRAEVENTA plan is in effect as a supplement, SWICA covers the following preventive measures:

ART. 21 VACCINATIONS, TRAVEL VACCINATIONS

SWICA covers 90% of the costs, up to 200 francs, for medically recommended vaccinations that are not covered under a statutory mandatory plan per calendar year.

ART. 22 HEALTH PROMOTION AND PREVENTIVE HEALTHCARE

1. SWICA pays 50% of the costs, up to 500 francs, of health-promoting measures and preventive healthcare based a separate list per calendar year.
2. For medical checkups and gynaecological preventive exams not covered under a statutory mandatory plan and that serve to detect illnesses at an early stage, SWICA uses a separate list and covers 90% of the cost, up to 500 francs, within three calendar years.

VI. CO-PAYMENT

ART. 23 ❗ CO-PAYMENT

1. Adult policyholders can choose between no excess and an excess of 600 francs when claiming benefits as defined in Art. 4 Complementary medicine, Art. 5 Medicines and Art. 17 Benefits abroad of these General Insurance Conditions. No excess is applied for children below the age of 18. The policyholder is automatically enrolled in the option with no excess from the beginning of the insurance year after they reach the age of 18.
2. All policyholders pay a deductible of 10%. Any co-payment (excess and deductible) already paid under mandatory healthcare insurance will be taken into account.
3. Adult policyholders can request to change from an excess of 600 francs to no excess or vice versa at the beginning of a calendar year, subject to a three-month adjustment period. Reduction of the excess requires a medical examination and may be refused, whereas no medical exam is required if the policyholder wishes to increase the excess.
4. The percentage of the co-payment is applied on top of any other supplementary insurance cover and is calculated separately for each SWICA insurance product.

VII. GENERAL PROVISIONS

ART. 24 LISTS AND DIRECTORIES

The lists and directories mentioned in these insurance conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

ART. 25 PREMIUM RATE MODEL

The products are based on a rate based on age at enrolment.

SUPPLEMENTA
SUPPLEMENTARY INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 PURPOSE
SWICA covers costs from SUPPLEMENTA supplementary insurance that are not or only partially covered under statutory healthcare insurance and another supplementary plans from SWICA.

ART. 2 POLICYHOLDER
Any Swiss legal resident can apply for SUPPLEMENTA supplementary insurance. A COMPLETA TOP supplementary plan from SWICA must be in effect before a SUPPLEMENTA plan can be purchased.
Termination of the COMPLETA TOP insurance contract results in automatic and simultaneous termination of the SUPPLEMENTA contract.

II. SCOPE OF INSURANCE

ART. 3 SCOPE OF INSURANCE
1. The scope of the insurance is based on these conditions and the policy.
2. Co-payments from other social insurances are not covered.

III. BENEFITS

ART. 4 LENSES AND FRAMES; CONTACT LENSES
SWICA covers 90% of the cost, up to 300 francs, of medically indicated lenses and frames and for contact lenses every three calendar years.

ART. 5 AIDS
SWICA covers 90% of the cost, up to 500 francs, for SWICA-recognised aids (excluding dentures and visual aids) not covered under a statutory mandatory plan per calendar year. SWICA keeps a list of the aids it recognises.

ART. 6 EMERGENCY TRANSPORT AND TRANSFERS
SWICA covers up to 90%, at maximum 20,000 francs in total, of the cost of emergency transports or medically necessary transfers to the nearest doctor or hospital based on the usual rates per calendar year.

IV. GENERAL PROVISIONS

ART. 7 COORDINATION WITH OTHER INSURANCE PLANS
The percentage of the co-payment is applied in addition to other supplementary insurance cover and calculated separately for each SWICA insurance product.

ART. 8 LISTS AND DIRECTORIES
The lists and directories mentioned in these insurance conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

ART. 9 PREMIUM RATE MODEL
This product uses a rate based on age at enrolment.

OPTIMA
SUPPLEMENTARY INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 PURPOSE
SWICA pays further benefits from OPTIMA outpatient insurance for private persons, supplementary to mandatory healthcare insurance and its COMPLETA TOP and COMPLETA PRAEVENTA supplementary insurance.

ART. 2 POLICYHOLDER
Any Swiss legal resident can apply for OPTIMA outpatient insurance for private persons.

II. SCOPE OF INSURANCE

ART. 3 SCOPE OF INSURANCE
The scope of the insurance is based on these insurance conditions and the policy. SWICA covers the cost of treatment and of health-promoting and preventive measures, provided that such treatment and measures are efficacious, purposeful and cost-effective.

III. BENEFITS

ART. 4 ❗ OUTPATIENT TREATMENT
SWICA covers the fees of medical persons worldwide. If the policyholder has purchased mandatory health insurance with limited choice, these provisions also apply to this supplementary insurance.

ART. 5 COMPLEMENTARY MEDICINE
1. Cover includes the cost of SWICA-recognised complementary medical methods if a SWICA-recognised doctor or therapist administers the treatment.
2. SWICA keeps a list of recognised methods and a directory of recognised doctors and therapists.

ART. 6 PSYCHOTHERAPY WITH INDEPENDENT PSYCHOTHERAPISTS
SWICA contributes to the cost of medically prescribed treatment of mental illnesses that an independent psychotherapist administers – max. 60 sessions per calendar year at 25 francs per session. The psychotherapist must have a specialist qualification recognised by the federal or cantonal authorities or be a member of the Association of Swiss Psychotherapists (ASP).

ART. 7 MATERNITY
In the case of outpatient births, SWICA covers all medical expenses and the services of the midwife.

ART. 8 VACCINATIONS, TRAVEL VACCINATIONS
SWICA covers 90% of the cost of medically recommended vaccinations.

ART. 9 HEALTH PROMOTION AND PREVENTIVE HEALTHCARE
1. SWICA covers 90% of the cost, up to 300 francs, of health-promoting measures and preventive healthcare based a separate list per calendar year.
2. For medical checkups and gynaecological preventive exams not covered under a statutory mandatory plan and that serve to detect illnesses at an early stage, SWICA uses a separate list and pays 90% of the cost with no limit of the amount.

ART. 10 MEDICAL SPA TREATMENT
1. SWICA contributes up to 30 francs per spa day for a maximum of 30 days towards the cost of treatment and stays at a spa that a doctor prescribed and that SWICA approved in advance per calendar year.
2. Prerequisite for the spa contributions is that the policyholder has a medical exam on admission to and discharge from the facility and receives intensive balneological and physiotherapeutic treatment.
3. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 11 CONVALESCENCE TREATMENT

1. For medically prescribed and justified convalescent cures that SWICA has approved in advance and a spa on SWICA's list administers, SWICA contributes up to 30 francs per spa day towards the cost of the stay for a maximum of 30 days per calendar year.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 12 LENSES AND FRAMES; CONTACT LENSES

SWICA covers 90% of the cost, up to 300 francs, of medically indicated lenses and frames and for contact lenses every three calendar years.

ART. 13 AIDS

SWICA covers 90% of the cost, up to 300 francs, for SWICA-recognised aids (excluding dentures and visual aids) not covered under a statutory mandatory plan per calendar year. SWICA keeps a list of the aids it recognises.

ART. 14 EMERGENCY TRANSPORT AND TRANSFERS

SWICA covers up to 90%, at maximum 20,000 francs in total, of the cost of emergency transports or medically necessary transfers to the nearest doctor or hospital based on the usual rates per calendar year.

IV. CO-PAYMENT

ART. 15 ❗ CO-PAYMENT

The benefits laid out in Art. 4 and Art. 5 of these insurance conditions are subject to co-payments based on the selected annual excess that applies to mandatory healthcare insurance. Co-payments (excess and deductible) that were already paid under mandatory healthcare insurance are offset.

V. GENERAL PROVISIONS

ART. 16 ❗ COORDINATION WITH OTHER INSURANCE PLANS

1. The benefits laid out in these insurance conditions are paid in addition to benefits from mandatory healthcare insurance and other supplementary insurances with SWICA that may be in effect.
2. The percentage of the co-payment is applied in addition to other supplementary insurance cover and calculated separately for each SWICA insurance product.

ART. 17 LISTS AND DIRECTORIES

The lists and directories mentioned in these insurance conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

ART. 18 PREMIUM RATE MODEL

The product uses a rate based on age at enrolment.

HOSPITA
HOSPITALISATION INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 PURPOSE

Under HOSPITA hospitalisation insurance, SWICA covers supplementary benefits for inpatient hospital treatment as well as outpatient surgical procedures and interventions, in addition to benefits from the mandatory healthcare insurance.

SWICA maintains a hospital register that lists all the hospitals it recognises by insurance category (see Art. 3). For hospitals without a rate agreement with SWICA, the maximum rate[1] that SWICA specifies applies. The extent of participation is reviewed during the request for a cover note.

The hospital directory mentioned in these insurance conditions is available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

In addition, this supplementary insurance covers further benefits in accordance with the selected insurance category.

ART. 2 POLICYHOLDER

Any Swiss legal resident can apply for this insurance.

II. SCOPE OF INSURANCE

ART. 3 CHOICE OF INSURANCE CATEGORY

SWICA covers the costs of services if they are efficacious, purposeful and cost-effective.

The choice of insurance category includes:

Category 1 HOSPITA GENERAL: General ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein. This category can be concluded with a guarantee that offers increased insurance in the semi-private or private hospital ward without a medical examination.

Category 2 HOSPITA SEMI-PRIVATE: Semi-private ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein (list hospitals and contract hospitals) with a rate agreement. At hospitals without a rate agreement with SWICA, the maximum rate that SWICA specifies (recognised rate) applies.

Category 3 HOSPITA SEMI-PRIVATE LIST: Semi-private ward in hospitals in Switzerland and the Principality of Liechtenstein as indicated in SWICA's hospital directory.

Category 4 HOSPITA PRIVATE: Private ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein (list hospitals and contract hospitals) with a rate agreement. At hospitals without a rate agreement with SWICA, the maximum rate that SWICA specifies (standard private rate) applies.

Category 5 HOSPITA PRIVATE LIST: Private ward in hospitals in Switzerland and the Principality of Liechtenstein as indicated in SWICA's hospital directory.

[1] The maximum rate is calculated based on the averages of the rate agreements between SWICA and comparable hospitals or the most recent rate with the hospital in question, whereby the lower of the two rates is used. The maximum rate is calculated separately for each hospital category.

Category 6 HOSPITA PRIVATE WORLDWIDE: Private ward in all public and private hospitals worldwide. In the absence of a contractual agreement, the maximum rate (standard rate for private patients) applies in Switzerland and the Principality of Liechtenstein.

Category 7 HOSPITA COMFORTA – two-bed room in all SWICA-recognised hospitals in Switzerland as indicated in SWICA's hospital directory.

Category 8 HOSPITA COMFORTA – one-bed room in all SWICA-recognised hospitals in Switzerland as indicated in SWICA's hospital directory.

ART. 4 GUARANTEE FOR CATEGORY CHANGE

1. Taking out a HOSPITA GENERAL plan, incl. guarantee for category change (= HOSPITA PLUS) makes it possible to change to a HOSPITA SEMI-PRIVATE or HOSPITA PRIVATE plan without a medical examination.
2. The guarantee for category change can be concluded as one of the two options below:
   a) Change from HOSPITA GENERAL to HOSPITA SEMI-PRIVATE (choice of category 2 or 3)
   b) Change from HOSPITA GENERAL to HOSPITA PRIVATE (choice of category 4 or 5)
3. A HOSPITA PLUS plan can be taken out until the end of the calendar year in which the person reaches the age of 18.
4. Including the HOSPITA PLUS guarantee for category change with HOSPITA GENERAL is possible after a positive result of medical examination.
5. The change to the higher category is possible until the end of the calendar year in which the person reaches the age of 40. The change guarantee expires unless it is used by this date.
6. A change is possible on the following first calendar day of a month or by agreement.
7. ! A twelve-month qualifying period applies to all benefits after the change to the insured higher category. During this period, treatment in the general ward is covered.

ART. 5 ! CO-PAYMENT OPTIONS

1. For categories 1–6, the policyholder can select special co-payment models with an excess amount per calendar year:
   - 1,000 francs
   - 2,000 francs
   - 5,000 francs
2. Persons covered under HOSPITA SEMI-PRIVATE (categories 2 and 3) can also choose co-payment models with a 300 francs deductible per hospital day, up to 6,000 francs per calendar year.
3. Insured persons with HOSPITA PRIVATE cover (categories 4 and 5) can also choose co-payment models with a 300 francs deductible per day in hospital up to 6,000 francs per calendar year for treatment in a semi-private ward and 400 francs per day in hospital up to 8,000 francs per calendar year for treatment in a private ward.
4. The premium is reduced in accordance with the selected co-payment model. Co-payments (excess and deductible) already paid for basic insurance or another SWICA supplementary insurance are factored into the calculation of the maximum annual co-payment of this supplementary insurance.
5. Requests to change to a lower co-payment are possible at the beginning of a calendar year, subject to a three-month adjustment period. For persons who undergo a medical examination, SWICA can agree to reduce the co-payment, exclude illnesses and the consequences of accidents that exist at the time of the co-payment reduction request, or reject the request.
6. In the case of maternity, a 360-day qualifying period applies when changing to a lower co-payment amount.
7. The medical examination for reducing the co-payment also applies simultaneously when reducing the insurance category. Exception: In the case of reduction to HOSPITA GENERAL (option without guarantee for category change), a medical examination is not required for reducing the co-payment.
8. The same terms apply to suspending co-payments as to reducing them.

ART. 6 SECOND MEDICAL OPINION

With insurance categories 3 and 5, the policyholder can ask SWICA for a second medical opinion before agreeing to a recommended surgical procedure.

III. BENEFITS

ART. 7 ENTITLEMENT TO BENEFITS IN CASE OF ILLNESS (INPATIENT HOSPITAL TREATMENT)

1. SWICA covers the stay and treatment costs during hospital stays in accordance with the selected insurance category.
2. SWICA covers the stay and treatment costs in the general ward (Category 1) of its recognised hospitals (as indicated in SWICA's hospital directory). Cover includes only benefits for inpatient treatment in other cantons, i.e. the portion exceeding the reference rate of the canton of residence for which mandatory (OKP) cover applies – unless such mandatory benefits are paid for a medically valid reason.
3. Benefit entitlement in categories 2 and 4 is contingent on a rate agreement being in effect between SWICA and the service provider to whom this benefit applies. These contractual rates cover the full cost of the services provided (as indicated in SWICA's directory of hospitals). In the absence of a contract with SWICA, cover is based on the maximum rate that SWICA defined or in accordance with Art. 9 for categories 2 and 3. If the service provider claims amounts that are higher than SWICA's recognised maximum rate, the policyholder must pay the difference between that rate and the amount on the service provider's invoice.
4. Categories 3 and 5 include benefits for the hospitals indicated in SWICA's hospital directory. Hospitals that do not have a contract with SWICA are not included in SWICA's hospital directory, and SWICA does not cover the costs of their services.
5. In category 6, the full hospital costs abroad are covered. In the absence of a contract with a hospital in Switzerland or the Principality of Liechtenstein, SWICA's maximum rate applies. If the service provider claims amounts that are higher than SWICA's recognised maximum rate (standard rate for private patients), the policyholder covers the difference between that rate and the amount on the service provider's invoice.
6. In the case of COMFORTA category 7 (two-bed room) and category 8 (one-bed room), the cost of accommodation and meals is covered based on SWICA's contract with these hospitals. The insurance does not cover doctor's fees and the cost of treatment and diagnoses.
   Hospitals that do not have a contract with SWICA are not included in SWICA's hospital directory, and SWICA does not cover the costs of their services.
7. Supplementary insurance does not cover additional costs incurred through treatment in other cantons for medical reasons.
8. For bone marrow and organ transplants, benefits are based on SWICA's recognised rate.

ART. 8 BENEFIT PERIOD

Unless stated otherwise in these insurance conditions, the HOSPITA plan provides benefits for an unlimited term.

ART. 9 CHOICE OF ANOTHER HOSPITAL WARD/ TREATMENT ABROAD

1. Choice of another hospital ward
   If a higher hospital category is chosen that differs from the insurance that was purchased, costs are paid supplementary to benefits from mandatory healthcare insurance.
   The following maximum amounts apply:

Category 1	up to 50 francs per day towards room and board and up to 5,000 francs per calendar year towards the cost of treatment
Categories 2 + 3	up to 100 francs per day towards room and board and up to 10,000 francs per calendar year towards the cost of treatment
Category 7	up to 100 francs per day towards room and board

   Any co-payments by the policyholder are deducted from the amounts mentioned above.
2. Hospital treatment abroad
   In the case of hospital stays abroad, the insurance covers the following benefits for inpatient treatment and outpatient treatment in accordance with Art. 10 no. 2, supplementary to mandatory healthcare insurance:

Category 1	up to 50 francs per day towards room and board and up to 5,000 francs per calendar year towards the cost of treatment
Categories 2 + 3	up to 100 francs per day towards room and board and up to 10,000 francs per calendar year towards the cost of treatment
Categories 4 + 5	up to 150 francs per day towards room and board and up to 30,000 francs per calendar year towards the cost of treatment
Category 6	full cost cover
Category 7	up to 100 francs per day towards room and board
Category 8	up to 150 francs per day towards room and board

   Any co-payments by the policyholder are deducted from the amounts mentioned above.

3. Co-payment
   If a privately or semi-privately insured person with a co-payment option under Art. 5 no. 2 and no. 3 chooses treatment in a general ward, the supplementary insurance deductible for treatment in the general ward ceases to apply. If a privately insured person with a co-payment option under Art. 5 no. 3 chooses treatment in the semi-private ward, the deductible is reduced to 300 francs per day, max. 6,000 francs per year.
4. Maximum benefit
   The amounts under Art. 9 nos. 1 and 2 cannot be cumulated and are the maximum per category for all benefit payments.

ART. 10 OUTPATIENT MEDICAL CENTRES (HOSPITALS, DAY CLINICS OR OUTPATIENT CLINICS WITH CORRESPONDING FACILITIES)

1. Benefit entitlement is contingent on a rate contract being in effect between SWICA and the service provider to whom this benefit applies. SWICA keeps a directory of the service providers it recognises.
2. SWICA keeps a list of procedures for which it covers the additional accommodation, treatment and ancillary costs that exceed amounts covered by mandatory health insurance.
3. Insured person are not subject to co-payments for the costs that exceed statutory mandatory benefits.

ART. 11 SPECIAL CLINICS AND PSYCHIATRIC CLINICS

1. SWICA contributes as follows towards stays in psychiatric clinics or special wards for mentally ill patients in its recognised hospitals and in special clinics, rehabilitation centres, multi-purpose sanatoria, climate control wards, sleep clinics and sleep wards from its cover in categories 2 to 5, in addition to the health-care insurance:

Day 1–180	Cover based on the insured hospital ward	
from day 181	Category 2 + 3	80 francs per day
	Category 4 + 5	150 francs per day

   In HOSPITA Category 6, no cost limit applies.
   In HOSPITA Categories 1, 7 + 8, no benefits are paid.
2. These benefits are paid for max. 720 days within 900 consecutive days.

ART. 12 MATERNITY

1. SWICA pays the same benefits for maternity as for illness. In addition, SWICA reimburses from the mother's insurance also the costs of the healthy child's stay and treatment following confinement, provided that the child is insured with SWICA and was in hospital together with the mother.
2. Entitlement to benefits for maternity starts 360 days after the insurance begins.

ART. 13 MEDICAL SPA TREATMENT

1. In the case of spa treatments that are medically prescribed, SWICA-approved in advance, and administered in a recognised health spa in Switzerland or in special cases – upon request and with SWICA's prior approval – abroad, SWICA contributes as follows to the cost of the stay and the treatment for up to 30 days per calendar year:

Category 1	30 francs per day
Categories 2 + 3	60 francs per day
Categories 4 + 5	80 francs per day
Category 6	100 francs per day

   No benefits are paid from Categories 7 + 8.
2. Prerequisite for the spa contributions is that the policyholder has a medical exam on admission to and discharge from the facility and receives intensive balneological and physiotherapeutic treatment.
3. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 14 CONVALESCENCE STAYS

1. For medically prescribed and justified convalescent stays that SWICA has approved in advance and a spa on SWICA's list administers, SWICA contributes as follows towards the cost of the stay for max. 30 days per calendar year:

Category 1	15 francs per day
Categories 2 + 3	30 francs per day
Categories 4 + 5	40 francs per day
Category 6	50 francs per day

   No additional benefits are paid from Categories 7 + 8.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 15 HOME NURSING CARE

1. SWICA contributes as follows towards the verified cost of care at the policyholder's own home:
   Category 1 30 francs per day
   Categories 2 + 3 60 francs per day
   Categories 4 + 5 80 francs per day
   Category 6 100 francs per day
   No benefits are paid from categories 7 + 8.
2. The policyholder's need for care must be verified in a medical certificate.
3. The contributions are also paid to family members or relatives if the help they provide results in a verifiable loss of earnings.
4. These benefits are paid for max. 720 days within 900 consecutive days.

ART. 16 HOME HELP

1. SWICA pays the following contributions towards the verified cost of necessary home help in the policyholder's own household for max. 60 days per calendar year:
   Category 1 15 francs per day
   Categories 2 + 3 30 francs per day
   Categories 4 + 5 40 francs per day
   Category 6 50 francs per day
   No benefits are paid from categories 7 + 8.
2. The need for home help must be verified in a medical certificate.
3. The contributions are also paid to family members or relatives if the help they provide results in a verifiable loss of earnings.

ART. 17 ORTHODONTIC SURGERY

1. For orthodontic surgery, SWICA assumes the cost that are not covered, up to 10,000 francs, based on the reference rate of the policyholder's canton of residence per calendar year.
2. For outpatient treatment, SWICA pays 50% of the costs, up to 10,000 francs, based on the rate that applies under the KVG per calendar year.
3. No benefits are paid from Categories 7 + 8.

ART. 18 EMERGENCY TRANSPORTS AND TRANSFERS

SWICA covers up to 90% of the effective total cost (other benefit contributions are offset) of emergency transport or medically necessary transfers to the nearest doctor or hospital as follows:

Category 1 5,000 francs per calendar year
Categories 2–6 unlimited
No benefits are paid from categories 7 + 8.

ART. 19 COST OF REPATRIATION AND OF SEARCH/RESCUE OPERATIONS

1. SWICA covers 90% of the repatriation cost from abroad to Switzerland and contributes as follows towards the search and rescue costs of a policyholder per event:
   Category 1 5,000 francs
   Categories 2–6 20,000 francs
   No additional benefits are paid from Categories 7 + 8.
2. Benefits are paid only if SWICA's emergency call centre was involved in the arrangements.
3. SWICA can reduce or refuse benefits if such operations are conducted without its authorisation.

IV. LISTS AND DIRECTORIES

ART. 20 LISTS AND DIRECTORIES

The lists and directories mentioned in these insurance conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

V. PREMIUMS

ART. 21 CHOICE OF PREMIUM MODEL

SWICA sets premiums annually as a rate. The rate for the selected premium model is definitive. Policyholders of HOSPITA supplementary insurance can choose between the following models:

1. Premium rate model based on age at the time of enrolment
   If the policyholder chooses the rate model based on age at the time of enrolment, his age at that time serves as basis for calculating the premium.
2. Age-based premium model
   If the policyholder chooses the age-based premium model, the premium is adjusted regularly at the beginning of each calendar year whenever the age group changes.
3. For policyholders included in the insurance at a special rate for children or young people, the next higher premium rate is calculated from the beginning of the insurance year following the year in which this person reaches the age of 18 or 25. Policyholders are assigned automatically to the age-based rate unless they expressly request the rate based on age at enrolment.

4. Policyholders can change from the age-based rate to the rate based on age at enrolment at the beginning of the next calendar year until they reach the age of 50, irrespective of their state of health and by keeping their current insurance cover. In this case, the time during which they have been insured so far is taken into account. Policyholders are automatically reassigned according to these rules when they reach the age of 50.
5. Policyholders can, in writing, waive the automatic reallocation from the age-based rate to the rate based on age at enrolment until they reach the age of 50 and request to continue the age-based rate. Policyholders who forgo this change can no longer apply the time of the current insurance period.

VI. GENERAL PROVISIONS

ART. 22 COORDINATION WITH OTHER INSURANCE PLANS

1. The benefits provided under these insurance conditions are paid only in addition to those from mandatory healthcare insurance and from COMPLETA TOP with SWICA.
2. The percentage of the co-payment is applied in addition to other supplementary insurance cover and calculated separately for each SWICA insurance product.

DENTA
DENTAL TREATMENT INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 PURPOSE
SWICA covers the cost of dental treatment, dental prostheses and preventive care from its DENTA insurance.

ART. 2 POLICYHOLDER
1. Any Swiss legal resident can apply for this insurance.
2. A dentist must fill in SWICA's admission form. The applicant bears the costs of the dental examination.

II. SCOPE OF INSURANCE

ART. 3 SCOPE OF INSURANCE
DENTA insurance can include the following options:
- **Benefit Category 1:** 50% of the dentist's fee, max. 500 francs within a calendar year
- **Benefit Category 2:** 50% of the dentist's fee, max. 1,000 francs within a calendar year
- **Benefit Category 3:** 75% of the dentist's fee, max. 1,500 francs within a calendar year
- **Benefit Category 4:** 75% of the dentist's fee, max. 2,000 francs within a calendar year

The percentage of the co-payment is applied in addition to other supplementary insurance cover and calculated separately for each SWICA insurance product.

III. BENEFITS

ART. 4 ! BENEFITS
1. SWICA covers dental treatment by a qualified dentist based on the choice of insurance option.
2. Policyholders below the age of 25 are eligible for double the amounts for orthodontic treatment.
3. The insurance does not cover dental care products.
4. SWICA does not cover the consequences of accidents that occurred before the insurance begins.
5. If the insurance starts during the calendar year, entitlement to benefits (insured maximum rate) is prorated to the number of insured months.

ART. 5 DEFINITIVE RATE
SWICA covers dental treatment that is administered in a cost-effective manner. The policyholder must pay the dentist's fee.

ART. 6 BENEFIT EXCLUSION
The insurance does not cover the cost of replacing teeth that were missing when the plan came into effect.

IV. GENERAL PROVISIONS

ART. 7 SUPPLEMENTARY BENEFITS
Benefits under these conditions are paid in addition to the benefits from healthcare insurance and other supplementary insurances from SWICA that may be in effect.

ART. 8 PREMIUM RATE MODEL
The product uses a rate based on age at enrolment.

INFORTUNA
ACCIDENT INSURANCE.

GENERAL INSURANCE CONDITIONS (GIC)

INSURANCE MANAGEMENT

SWICA Healthcare Insurance Ltd, Römerstrasse 38, 8401 Winterthur, hereinafter referred to as "SWICA."

INSURANCE CARRIER

SWICA Insurances Ltd, Römerstrasse 37,
8401 Winterthur, hereinafter referred to as "Insurer."

I. SCOPE OF APPLICATION

ART. 1 PURPOSE

These Supplementary Conditions (SC) govern individual accident insurance supplementary to healthcare insurance (KVG), accident insurance (UVG), military insurance (MVG), and disability insurance (IVG). The General Insurance Conditions (GIC) are an integral part insofar as they do not contradict these Supplementary Conditions (SC).

II. CHOICE OF INSURANCE OPTION

ART. 2 INSURANCE OPTIONS

The policyholder can choose from the following insurance options:

- Lump-sum benefits on accident death
- Lump-sum benefits on accident disability
- Medical expenses insurance supplementary to health insurance (KVG), accident insurance (UVG), military insurance (MVG), or disability insurance (IVG)

III. PURCHASE OF THE INSURANCE

ART. 3 PURCHASE

Purchasing accident insurance is possible up to the AHV retirement age. Increasing the amount of insurance is the same as purchasing new insurance.

IV. LUMP SUM IN THE EVENT OF ACCIDENT DEATH OR ACCIDENT DISABILITY (ADI)

ART. 4 SUMS INSURED

1. INFORTUNA accident cover constitutes fixed-sum insurance – except for medical expenses cover, which constitutes indemnity insurance. The sums insured as shown on the policy apply.
2. The following maximum sums insured apply after the age of 70:
   - On death: 50,000 francs
   - On disability: 100,000 francs

   Policies currently in effect will be adjusted accordingly after the person reaches this age.
3. For policyholders above the age of 70 at the time of the accident, the progression in disability insurance does not apply.
4. The lump-sum death benefit for children up to the age of 30 months is limited to 2,500 francs; up to the age of 12, it is limited to 20,000 francs.
5. The Insurer's maximum guarantee for one and the same person from all accident insurance policies in effect with this Insurer jointly, insofar as they cover flight risk without special premiums, is limited to 500,000 francs in the event of death and to 1,000,000 francs in the event of full disability (with a corresponding reduction in the event of partial disability).

ART. 5 DEATH

1. If the accident is proven to have led to the policyholder's death immediately or within five years from the accident date, the Insurer pays the sum insured in the event of death to the surviving dependants named below, whose entitlement applies in the following order and scope:
   a) The full lump sum on death to the surviving spouse – in the absence thereof, to the children – in the absence thereof, to the parents – in the absence thereof, to the legal heirs to the exclusion of the community. Spouses and children from a marriage entered into only after the accident are not entitled to a claim.
   b) The policyholder can appoint or exclude beneficiaries by notifying SWICA in writing, in amendment of these rules. A statement to this effect can be revoked or amended at any time by notifying SWICA in writing.
   c) In the absence of eligible claimants as laid out in letters a and b, the Insurer covers the funeral costs, up to 10% of the death lump sum.
2. Disability lump sums paid out as defined in Art. 6 are factored into the death lump sum.

ART. 6 DISABILITY

1. If it can be assumed that the accident will lead to the insured person's permanent disability within five years from the accident date, the Insurer pays the agreed sum insured, i.e. the full sum insured in the case of full disability or the partial sum insured adjusted to the partial disability as the case may be.
2. Full disability is defined as the loss or inability to use both arms or hands, both legs or feet, the simultaneous loss of an arm or a hand and of a leg or a foot, total paralysis, and total blindness.
3. In case of partial disability, the insurance covers the part of the sum insured for total disability corresponding to the degree of the disability. The decision is based on the following percentages.

Loss of:	**Degree of disability:**
› Upper arm	70%
› Forearm	65%
› Hand	60%
› Thumb with metacarpal joint	25%
› Thumb but not the metacarpal joint	22%
› Foremost joint of the thumb	10%
› Index finger	15%
› Middle finger	10%
› Ring finger	9%
› Little finger	7%
› One leg at the thigh	60%
› One leg at the lower part	50%
› One foot	45%
› One large toe	8%
› Other toes each	3%
› Vision in one eye	30%
› Vision in one eye if the other eye is blind	50%
› Hearing in both ears	60%
› Hearing in one ear	15%
› Hearing in one ear if the hearing in the other ear was already completely lost before the insured event occurred	30%
› Kidney	20%
› Sense of smell	10%
› Sense of taste	10%
› Very painful functional restriction of the spine	50%

In the event of a partial loss or incapacity for use, a correspondingly lower degree of disability applies. In cases not listed above, the disability level is determined through a medical assessment using the rates for impairment in Annex 3 to the Accident Insurance Ordinance (UVV).

4. In case of simultaneous loss or incapacity for use of several body parts due to the same accident, the disability level is usually calculated by adding up the percentages. The disability level can never exceed 100%. In case of loss of all fingers of a hand, the insurance covers at most the disability lump sum for the loss of that hand.

5. If parts of the body were already completely or partially lost or disabled before the accident, the previous disability level as determined by the above principles is deducted when determining the new disability level.
6. Endowment insurance for disability uses progressive sums insured (exception Art. 4, para. 4): progression 350%. Compensation for a disability of more than 25% increases as follows.

from %	to %	from %	to %	from %	to %
› 26	28	› 51	105	› 76	230
› 27	31	› 52	110	› 77	235
› 28	34	› 53	115	› 78	240
› 29	37	› 54	120	› 79	245
› 30	40	› 55	125	› 80	250
› 31	43	› 56	130	› 81	255
› 32	46	› 57	135	› 82	260
› 33	49	› 58	140	› 83	265
› 34	52	› 59	145	› 84	270
› 35	55	› 60	150	› 85	275
› 36	58	› 61	155	› 86	280
› 37	61	› 62	160	› 87	285
› 38	64	› 63	165	› 88	290
› 39	67	› 64	170	› 89	295
› 40	70	› 65	175	› 90	300
› 41	73	› 66	180	› 91	305
› 42	76	› 67	185	› 92	310
› 43	79	› 68	190	› 93	315
› 44	82	› 69	195	› 94	320
› 45	85	› 70	200	› 95	325
› 46	88	› 71	205	› 96	330
› 47	91	› 72	210	› 97	335
› 48	94	› 73	215	› 98	340
› 49	97	› 74	220	› 99	345
› 50	100	› 75	225	› 100	350

7. Entitlement to disability benefits applies to the policyholder.
8. The Insurer covers the reasonable cost, up to 10% of the insured disability lump sum, of retraining the person if such a measure proves necessary as a result of an accident for which the Insurer has paid benefits.

V. MEDICAL EXPENSES

ART. 7 BENEFITS

The insurance covers healthcare benefits and cost reimbursements not included in mandatory healthcare insurance (KVG), accident insurance (UVG), military insurance (MVG) or disability insurance (IVG), namely:

a) Medical measures that a doctor, dentist or chiropractor with a federal or non-Swiss qualification of equal value administers or orders.
b) In case of hospitalisation, SWICA covers the cost of the private hospital ward based on the contractual rate that SWICA recognises. In the absence of a contract with a hospital in Switzerland or the Principality of Liechtenstein, SWICA's maximum rate applies. If the service provider claims amounts that are higher than SWICA's recognised maximum rate (standard rate for private patients), the policyholder covers the difference between that rate and the amount on the service provider's invoice.
c) Cover includes the cost of SWICA-recognised complementary medical methods if a SWICA-recognised doctor or therapist administers the treatment. SWICA keeps a list of recognised methods and a directory of recognised doctors and therapists.
d) The cost of medically prescribed treatment of mental illnesses that an independent psychotherapist administers. The psychotherapist must have a qualification that is recognised federally or be a member of the Association of Swiss Psychotherapists (ASP).
e) Medically prescribed home care by qualified nursing staff. The same applies to caregivers working for home-help and healthcare providers, as well as to housekeepers (excluding family members).
f) Cost of rehabilitation and medical spa treatment.
g) Medical treatment abroad.
h) Reasonable versions of aids that compensate for physical impairment or functional deficiencies.
i) Damage to objects that replace a body part or function; cover for glasses, hearing aids and dentures applies only in connection with a physical injury that requires treatment.
j) Medically necessary travel and transport; necessary rescue operations and the transport of a decedent. Operations to rescue the policyholder are limited to 20,000 francs.

ART. 8 HOSPITALS AND HEALTH SPAS

1. Hospitals are deemed to be institutions or departments thereof that treat inpatients for illnesses or the consequences of accidents, are under permanent management by medical experts, have the necessary professionally trained nursing staff, and have appropriate medical facilities.
2. Health spas are deemed to be institutions that provide follow-up treatment or rehabilitation, are under management by medical experts, have staff with the necessary specialist qualifications, and have appropriate facilities.

ART. 9 CO-PAYMENT

Cover does not include deductibles, excess amounts and fees charged by health and mandatory accident insurers.

VI. GENERAL PROVISIONS

ART. 10 INSURED ACCIDENTS

1. The insurance covers all occupational and non-occupational accidents that occur during the contract term.
2. An accident is defined as any sudden, unintentional and damaging effect on the human body by an extraordinary external factor resulting in the impairment of physical or mental health, or in death.
3. The following conclusively listed bodily injuries are deemed equivalent to accidents – even in the absence of unusual external factors, unless illness or degeneration is the unequivocal cause:
   a) Fractured bones;
   b) Dislocated joints;
   c) Torn meniscus;
   d) Torn muscles;
   e) Pulled muscles;
   f) Torn tendons;
   g) Injured ligaments;
   h) Injured ear drums.

ART. 11 EXCLUSIONS AND BENEFIT REDUCTIONS

1. The insurance does not cover accidents in accordance with Art. 8 of SWICA's General Insurance Conditions under the VVG.
2. SWICA or the Insurer hereby waives its statutory right to reduce benefits if the accident is caused through gross negligence.

ART. 12 CONVERGENCE OF ACCIDENT CONSEQUENCES WITH DISEASES, AILMENTS AND THE CONSEQUENCES OF PRIOR ACCIDENTS

Insurance benefits are reduced commensurately if the consequences of an accident are significantly aggravated by pre-existing conditions, disabilities, or prior accident consequences that were apparent already before the new accident occurred. This restriction does not apply to treatment costs. The insurance continues to cover the cost of medical treatment until the accident is proven to be no longer the cause of impaired health.

ART. 13 TERRITORIAL SCOPE

The insurance is valid worldwide.

ART. 14 CLAIM NOTIFICATION

1. Claims must be filed immediately, at the latest within 30 days from when the damage became known.
2. If a claim is culpably notified late or not at all, benefits can be reduced by the amount that would apply if the claim had been reported in good time.
3. The policyholder must address all notifications and messages to SWICA. The contact details are included in the policy.

ART. 15 LISTS

The lists and directories mentioned in these insurance conditions are available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

ART. 16 PREMIUM RATE MODEL

This product uses an age-based rate.

SALARIA
DAILY BENEFITS INSURANCE UNDER THE VVG.

I. GENERAL CONTRACTUAL BASES

ART. 1 WHAT ARE THE BASES OF THIS CONTRACT?

This contract is based on the following:

1. These General Insurance Conditions, Supplementary Conditions that may apply, the provisions in the policy and addenda that may apply;
2. The Federal Insurance Contract Act of 2 April 1908 for matters not covered under para. 1 above. If the following provisions conflict with the binding provisions of the VVG, the latter take precedence;
3. All written contractual agreements between SWICA and the policyholder.

II. SCOPE OF INSURANCE COVER

ART. 2 ! WHAT DOES THE INSURANCE COVER CONSIST OF?

1. SWICA grants insurance cover against the financial consequences of disease and childbirth as part of the agreed benefits. It pays policyholders for verified loss of earnings and income up to the maximum of the insured daily benefits.
2. For housewives and househusbands, proof of loss of earnings and income up to the insured amount of 40 francs is not a prerequisite for SWICA's obligation to pay benefits.
3. Daily sickness benefits insurance comprises indemnity insurance.

ART. 3 HOW IS ILLNESS DEFINED?

An illness is defined as any impairment of physical or mental health that is not the consequence of an accident, that requires a medical examination or treatment, or that leads to incapacity for work.

ART. 4 WHO IS INSURED?

All persons between the ages of 15 and 65 with place of residence in Switzerland or the Principality of Liechtenstein can take out daily benefits insurance in connection with their gainful employment.

ART. 5 WHERE DOES THE INSURANCE APPLY?

1. The insurance is valid only in Switzerland and the Principality of Liechtenstein.
2. Policyholders who fall ill abroad can claim benefits for ten days. This does not apply to hospital stays that are necessary for medical reasons.
3. Policyholders who are incapacitated for work but go abroad without SWICA's prior consent are no longer entitled to benefits during the stay abroad.
4. For cross-border commuters, the restrictions under paras. 1–3 apply only if they stay outside of the border area.

ART. 6 WHAT HAPPENS IN THE CASE OF ILLNESS DUE TO GROSS NEGLIGENCE?

SWICA waives its statutory right to reduce benefits if the policyholder caused the illness through gross negligence.

ART. 7 ! IN WHAT CASES IS THERE NO INSURANCE COVER?

Benefit entitlement does not apply in the case of:

a) Illnesses that are covered under statutory accident insurance (UVG).
b) Health impairment through exposure to ionising radiation; damage from nuclear energy. However, health impairments through medically prescribed radiation treatment due to an insured illness are insured.
c) Illnesses resulting from warlike incidents or acts of terrorism. If the policyholder suddenly finds himself faced with such an event outside of Switzerland, insurance cover ends only 14 days after the first occurrence of this event.

III. INSURANCE BENEFITS

ART. 8 ❗ WHEN DOES ENTITLEMENT TO DAILY BENEFITS APPLY?

1. If a doctor finds that the policyholder is fully incapacitated for work, SWICA pays the insured daily benefits up to the verified amount in lost earnings.
2. In the case of partial incapacity for work of at least 25%, daily benefits are prorated to the corresponding level.
3. After each birth, the obligation to pay benefits is suspended for eight weeks. Cover for birth benefits is reserved.

ART. 9 HOW IS INCAPACITY FOR WORK DEFINED?

Incapacity for work is defined as the full or partial inability to do work that can be reasonably expected of the person in connection with his job or area of responsibility at the time owing to impaired physical or mental health. After three months of incapacity for work, a reasonable activity in another occupation or area of activity must also be considered.

ART. 10 ❗ HOW IS THE WAITING PERIOD CALCULATED AND WHAT COUNTS AS A RELAPSE?

1. The waiting period starts on the first day of medically determined incapacity for work of at least 25%, but no earlier than three days before the first medical treatment. The waiting period applies in every new case of illness. Days of partial incapacity for work of at least 25% count as whole days when calculating the waiting period.
2. With respect to waiting periods and benefit terms, a new case of illness counts as:
   - The recurrence of an illness (relapse) due to which the policyholder was not incapacitated for work for twelve months previously;
   - a new illness that sets in when the policyholder has fully resumed work for at least two months after having been incapacitated.

ART. 11 ❗ FOR HOW LONG ARE DAILY BENEFITS PAID?

1. Daily benefits are paid for 720 days during a period of 900 consecutive days, including a possible waiting period. Daily benefits already received are carried over on transfer from group to individual daily benefits insurance.
2. Days of partial incapacity for work of at least 25% count as whole days when calculating the waiting period.
3. If an additional illness sets in during a current case of illness, the days of the initial case that are eligible for benefits are factored into the benefit term.
4. Starting at AHV retirement age, daily benefits are paid for a maximum of 180 days for all current and future insured events, but not past the age of 70. In cases of incapacity for work at AHV retirement age, entitlement to benefits ends unless the policyholder proves that the employment relationship would have continued if incapacity had not set in.
5. The benefits obligation ends when insurance cover ends (subject to periodic benefit obligations within the meaning of Art. 35c VVG if the contract is suspended).

ART. 12 WHEN DOES ENTITLEMENT TO BIRTH BENEFITS APPLY?

1. Childbirth benefits that are included in the insurance are paid for every birth for 56 days. Any agreed waiting period is not counted towards the benefit period.
2. If the birth benefit insurance for the mother has been in place for less than 270 calendar days at the time of birth, no birth benefit will be paid.
3. Childbirth benefits from statutory social insurance are offset against SWICA's benefits from birth benefit insurance. SWICA's obligation to pay daily sickness benefits rests for as long as the policyholder receives benefits from SWICA's birth benefit insurance or from a statutory social insurer.
4. The birth benefit is not factored into the benefit period defined in Art. 11, para. 1.

ART. 13 UNEMPLOYMENT

1. If the policyholder is unemployed in accordance with Art. 10 of the Unemployment Insurance Act (AVIG), SWICA pays benefits up to the level of lost unemployment benefits as follows:
   a) Half the daily benefits in case of incapacity for work of more than 25%;
   b) the full daily benefits amount in case of incapacity for work of more than 50%.
2. Unemployed policyholders can, without proviso, convert their current daily benefits insurance into one with the same amount, an adjusted premium, and a 30-day waiting period.

IV. BEGINNING AND TERM OF INSURANCE COVER

ART. 14 BEGINNING OF INSURANCE

The insurance begins as soon as SWICA issues the certificate of insurance or declares its acceptance of the application, but not before the date agreed on and stipulated in the certificate of insurance.

ART. 15 RIGHT OF REVOCATION

1. The applicant can revoke the application to SWICA to conclude the contract or the declaration of acceptance of the contract in writing or another form that permits text-based verification (in accordance with the contact details on the insurance policy).
2. The revocation period is 14 days and begins as soon as the policyholder has applied for or accepted the contract.
3. The deadline is met if the policyholder notifies SWICA of his revocation on the last day of the revocation period or delivers his declaration of revocation to the post office. The right of revocation does not apply to group personal insurances, provisional cover notes, and agreements with a term of less than one month.
4. Revocation voids the application to conclude the contract or the policyholder's declaration of acceptance from the start. Any benefits that have been received must be refunded.

ART. 16 ! EXCLUSION OF COVER/REJECTION

1. Illnesses that exist or existed at the time of acceptance can be excluded (exclusion of cover). If information about illnesses was withheld at the time of acceptance, the exclusion can be applied retrospectively. SWICA can refuse to enter into a contract without giving the reasons.
2. There is no entitlement to benefits for illnesses that are subject to an exclusion clause. The same applies if information about illnesses was withheld at the time of acceptance.
3. SWICA can demand a medical examination whenever new insurance is purchased or cover is increased. The signature on the application authorises SWICA to obtain the information it needs from authorities, doctors and third parties.
4. If significant points that the person subject to the disclosure obligation knew or should have known are falsified or omitted in the application, SWICA can terminate the contract in writing or another form that permits text-based verification within four weeks of becoming aware of the breach and reclaim, to the extent permitted by law, all benefits relating to the breach from when the contract began. The contract ends as soon as notice of termination reaches the policyholder.
5. In the case of increased insurance, the same provisions apply as for new enrolments.

ART. 17 WHEN CAN THE INSURANCE BE ADJUSTED?

Insurance cover can be reduced at the end of a month. A reduction of the insured daily benefits amount while benefits are being paid is possible only by mutual agreement.

ART. 18 ! WHEN DOES THE INSURANCE END?

1. The policyholder can give ordinary notice of termination on the daily benefits insurance to the end of a calendar year. In this case, a three-month notice period applies. For termination to be valid, notice must reach SWICA's reception area by 17:00 on the last workday before the three-month notice period ends (stamp date does not serve as reference date). SWICA does not have this ordinary right of termination under the VVG.
2. The policyholder can terminate the daily benefits insurance following a period of incapacity for work for which SWICA pays benefits. The policyholder can terminate the relevant part of the contract no later than 14 days after having received the benefit payment. Cover ends 14 days after the notice reaches SWICA. SWICA does not have this ordinary right of termination under the VVG.

3. Supplementary insurance ends without notice also if the policyholder's usual place of stay is abroad for more than three months. Cross-border commuters can remain insured as long as they receive unemployment benefits and suffer a verifiable loss of earnings due to incapacity for work.
4. In addition, daily benefits insurance ends
   a) when unemployment insurance benefits end;
   b) when the person reaches the statutory (AHV) retirement age. However, this does not apply if the person continues to work in a permanent job and is fully fit for work, in which case an illness results in a verifiable loss of earnings. Daily benefits insurance ends definitively if such a policyholder has received benefits for 180 days after reaching AHV retirement age;
   c) on death;
   d) when the right to such benefits no longer applies.

ART. 19 WHAT HAPPENS AFTER THE INSURANCE ENDS?

1. Cover does not include the consequences of illnesses as well as of sequelae and relapses that occur after the insurance ends.
2. ❗ In principle, entitlement to benefits ends when the contract ends (subject to periodic benefit obligations within the meaning of Art. 35c VVG).

V. OBLIGATIONS IN A CASE OF AN ILLNESS

ART. 20 NOTIFICATION PERIOD OF AN ILLNESS (NOTICE OF CLAIM)

1. Claims for daily benefits must be submitted within five days from when the waiting period ends. If a waiting period of more than 30 days has been agreed, notification must be submitted at the latest 30 days after the onset of incapacity for work or occupational disability. A medical certificate must be submitted with the claim. The policyholder bears the costs incurred.
2. The benefit can be reduced by the amount in which it would be lower if notification had been sent in good time or if notification is culpably delayed or omitted altogether – unless it is proven, based on circumstances, that the omission or delay of such notification was neither party's fault or the policyholder proves that the delayed or omitted notification had no influence on the event in question and the benefit amount that SWICA owes.
3. If the illness lasts for longer than one month, SWICA requires a monthly report on the level and duration of the incapacity for work. In this case, SWICA pays daily benefits on a monthly basis.

ART. 21 POLICYHOLDER'S OBLIGATIONS

The policyholder must do his utmost to assist with clarifying the illness and its consequences. Under the obligation to minimise damage, the policyholder must refrain from any activity that is incompatible with his incapacity for work or eligibility for daily benefits and that jeopardises or delays recovery. The doctors who treat or have treated the policyholder must be released from their non-disclosure obligations towards SWICA.

ART. 22 INVOLVEMENT OF A LICENSED DOCTOR

1. After the onset of the illness, the policyholder must consult a licensed doctor as soon as possible and seek appropriate specialist treatment. The policyholder must follow the orders of the doctor and nursing staff.
2. SWICA can demand an examination by a doctor it appoints. In this case, SWICA covers the travel expenses for the most economical means of public transport and other expenses in accordance with the guidelines of the Swiss National Accident Insurance Fund (SUVA).
3. SWICA has the right to visit patients and request additional documents and information, in particular medical certificates.
4. A policyholder's benefits can be temporarily or permanently reduced or refused if he quits or resist reasonable treatment or integration into gainful employment promising a significant improvement in earning capacity or a new earning opportunity, or if he does not contribute of his own accord what can reasonably be expected of him.

ART. 23 OBLIGATION TO MINIMISE DAMAGE

1. Policyholders who are unable to work in their usual occupation must look for another line of work within three months or register with the disability or unemployment insurance.
2. If the residual capacity for work is unused, daily benefits are calculated by taking into account the policyholder's duty to minimise loss.
3. If the policyholder fails to register with the unemployment or disability insurance, SWICA has the right to discontinue its daily benefits. Possible benefits that are due are calculated based on the assumed amounts due from these insurances.

ART. 24 WHAT IF THE POLICYHOLDER CAN ALSO CLAIM BENEFITS FROM THIRD PARTIES?

1. If the policyholder is also entitled to benefits from public or private insurer or if a liable third party has paid such benefits, SWICA supplements the amount paid so far up to the insured daily benefits that are due.
2. If the decision on a disability (IV) pension is still pending, SWICA can voluntarily advance the insured daily benefits. In this case, SWICA will reclaim any excess benefits paid from the beginning of the entitlement period. The advance payment, if any, is made expressly on condition that the amounts are offset against Federal Disability Insurance (IV) benefits. The offset amount is prorated based on the disability (IV) pension granted for the same period and applied without the policyholder's additional authorisation.
3. SWICA pays daily benefits, as part of its voluntary advance on behalf of a liable third party, to cover lost earnings only if the eligible claimant's or policyholder's claims have been assigned to it by means of a written statement.
4. In the case of multiple policies with concessioned companies covering lost earnings, the insured loss of earnings from this contract are prorated to the benefits amount that all insurers jointly have guaranteed.
5. SWICA's benefit obligation ends if the policyholder settles with a third party without first obtaining SWICA's consent.
6. SWICA is under no obligation to pay benefits if the policyholder fails to claim benefits from a third party in good time or makes no effort to collect them.
7. The policyholder must inform SWICA immediately about the nature and amounts of any third-party benefits.

ART. 25 CONSEQUENCES OF FAILING TO MEET OBLIGATIONS IN CASE OF AN ILLNESS

If the obligations laid out in Art. 20–24 are ignored, SWICA can reduce or refuse its benefits, unless there is proof that the failure to meet such obligations was not negligent and had no influence on the diagnosis and consequences of the illness.

VI. PREMIUM

ART. 26 WHEN ARE PREMIUMS DUE?

Premiums must be paid in Swiss francs on the first day of the month of each payment period.

ART. 27 LATE PAYMENT

1. If the premium fails to reach SWICA within one month of the due date, SWICA will send a reminder requesting that payment be made within 14 days of the reminder date. If the reminder is of no effect, the obligation to pay benefits is suspended as of the end of the reminder period.
2. SWICA can reclaim expenses incurred on account of defaulting policyholders, such as the cost of reminders, debt collection fees and interest on arrears, etc. and offset them against claims for compensation.

VII. ADDITIONAL PROVISIONS

ART. 28 ACCIDENT INSURANCE

1. If cover for daily accident benefits has been agreed, SWICA also covers the financial consequences of accidents, accident-like bodily injuries and occupational illnesses, in addition to Art. 2 of these GIC.
2. The insurance covers occupational accidents, accident-like bodily injuries, occupational illnesses and non-occupational accidents that occur or are caused during the supplementary insurance contract term. The definitions of accidents, accident-like bodily injuries and occupational diseases as used in the context of statutory accident insurance (UVG) apply.
3. If the policyholder caused the accident while committing a misdemeanour or crime, the insured daily benefits are reduced in accordance with UVG practice.
4. There is no entitlement to insured benefits for accidents that:
   a) The policyholder caused intentionally;
   b) result from earthquakes in Switzerland or the Principality of Liechtenstein;
   c) result from warlike events in Switzerland and the Principality of Liechtenstein;
   d) result from warlike events abroad. However, if the policyholder suddenly finds himself faced with such an event in the country in which he is staying, insurance cover remains in effect for 14 days from the start of the war;
   e) occur while the person serves in a foreign military;
   f) result because the policyholder commits or attempts to commit a crime;

g) result from unrest of any kind and measures taken against it, unless the policyholder proves not having been an active perpetrator and not contributing to its incitement;
h) result from participation in motor vehicle races or rallies, including training runs;
i) result in impaired health due to ionising radiation or the effects of nuclear energy. The insurance does, however, cover damage to health caused by medically prescribed radiotherapy administered because of an insured accident. The insurance also covers damage to health as a result of exposure to radiation in connection with an occupational activity, provided that such damage would give rise to a benefit obligation under the UVG.

5. In all other respects, the provisions of this GIC and the contract apply by extension.

ART. 29 PLACE OF PERFORMANCE AND PLACE OF JURISDICTION

1. Obligations arising from this contract must be met in Switzerland and in Swiss currency. The policyholder must provide SWICA with a Swiss bank or postal account as the payment address.
2. The policyholder can choose the ordinary place of jurisdiction or the place of residence in Switzerland or the Principality of Liechtenstein.

ART. 30 TAX AT SOURCE

For policyholders who are subject to tax at source, the tax is deducted from the benefits.

ART. 31 OFFSETTING AND RECLAIMING

The policyholder must refund upon written request any daily benefits that were paid by mistake. SWICA has the right to offset such payments. The policyholder has no offsetting rights.

ART. 32 PROHIBITION OF ASSIGNMENT AND PLEDGING

Claims against SWICA can be neither assigned nor pledged. SWICA accepts no assignments or pledges of such claims.

ART. 33 TO WHOM SHOULD MESSAGES AND NOTIFICATIONS BE ADDRESSED?

1. All messages and notifications (including claims) from the policyholder, insured person or eligible claimant must be addressed to SWICA. The contact details are included in the policy.
2. All messages and notifications (including claims) from SWICA or the insurer are sent in a legally valid manner to the address in Switzerland or the electronic contact that the policyholder, insured person or eligible claimant provided.
3. The policyholder must notify SWICA immediately of any changes in his personal circumstances affecting the insurance relationship (e.g. change of legal representative/premium payer, change of residence, change of gender, etc.) in writing or in another form that permits text-based verification.

ART. 34 PREMIUM RATE MODEL

This product uses a rate based on age at enrolment.

GLOSSARY.

This glossary defines certain terms used in the General Insurance Conditions (GIC) and Supplementary Conditions (SC) in accordance with the VVG and is meant as an aid. It does not form an integral part of the GIC or SC.

Accident
An accident is defined as any damaging, sudden and involuntary injury caused to the human body by an extraordinary external factor, resulting in the impairment of physical or mental health, or death.

Basic insurance
Basic insurance (also called mandatory healthcare insurance (OKP)) covers basic health services and is mandatory for all residents in Switzerland.

Breach of disclosure obligation
The disclosure obligation is deemed to have been breached if health questions were not answered truthfully or fully when the supplementary insurance contract was concluded. In other words, the breach refers to the omission of information relevant for assessing the risk that the policyholder had or should have had.

Co-payment
When policyholders request medical services (such as a doctor's appointment, medication, therapy), they must cover a part of the costs themselves. This part of the cost is referred to as the co-payment, which consists of the excess, i.e. a fixed amount in contribution the policyholder pays per calendar year towards the treatment costs, and/or a deductible, i.e. a percentage the policyholder pays toward the treatment costs or a fixed amount per hospital day.

Complementary medicine
Complementary medicine includes all forms of therapy that do not fall under conventional medicine. SWICA keeps a directory of its recognised therapists. Policyholders can obtain extracts from SWICA Customer Service at any time based on their individual wishes (e.g. therapists in a specific field and in a specific region). The directory is available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Service for extracts thereof at any time.

Contract hospitals
Contract hospitals are hospitals that do not have a cantonal service mandate but a contract with SWICA that governs their rates.

Conventional treatment
Medical practice as taught at universities. Conventional medicine uses only medicines and treatment methods with proven efficacy. It encompasses much of the knowledge and experience on which medicine in the Western world is based.

Cover note
The health insurer's consent to pay for a planned treatment. Before a hospital stay, it is important to obtain a cover note from Customer Service.

Deductible
In basic insurance, the deductible is the policyholder's contribution as a percentage toward the costs of medical treatment and medication. On issue of these GIC/SC, the deductible is generally 10% of the amount due after the excess has been applied. It also has an upper limit (children pay a maximum deductible of 350 francs per year, adults a maximum of 700 francs per year).
The deductible in supplementary insurance is the percent the policyholder pays towards the treatment costs, or it can be a fixed amount the policyholder pays per hospital day.
Please see "Co-payment" for more information.

Emergency
Emergencies are situations in which medical treatment must be administered immediately.

Exclusion
An existing condition the policyholder suffers from is excluded from one type or several types of insurance for a defined or undefined period.

Excess
The excess is a fixed amount the policyholder pays per calendar year as a contribution towards the cost of treatment.

Federal Accident Insurance Act (UVG)
Federal Act of 20 March 1981 on Accident Insurance, in effect since 1 January 1984.

Federal Insurance Contract Act (VVG)
Federal Insurance Contract Act of 2 April 1908, in effect since 1 January 1910.

Framework agreement
A framework agreement enables a contracting party to apply certain conditions to group members who have a defined legal connection (e.g. employment relationship, association membership or the like) to the contracting party, whereby the conditions come into effect when the members meet the prerequisites laid out in the framework agreement.

Group insurance contract
An insurance contract that one person or organisation – the policyholder – concludes to cover a group of others, who then are not policyholders but the insured persons.

Health Insurance Act (KVG)
Federal Act of 18 March 1994 on Health Insurance, in force since 1 January 1996.

Illness
An illness is defined as any impairment of physical or mental health that is not the consequence of an accident, that requires a medical examination or treatment or that leads to incapacity for work.

In-patient treatment
Inpatient treatment is defined as treatment involving a hospital stay of at least 24 hours or one night.

Insurance year
The insurance year is the same as the calendar year.

List hospitals
List hospitals are hospitals that have received a service mandate from the cantons on the basis of the KVG.

List of pharmaceutical preparations with special uses (LPPV)
List of medicines that health insurers cover neither from mandatory health care insurance nor from supplementary insurances under the VVG.

Lists and directories
Policyholders can access all lists and directories mentioned in the General Insurance Conditions that are relevant for calculating benefit amounts at any time on SWICA's website. Policyholders can obtain extracts from SWICA Customer Service at any time based on their individual wishes (e.g. therapists in a specific field and in a specific region). The lists and directories are available digitally, updated continuously and accessible at any time.
The extent to which SWICA covers services or indemnifies policyholders otherwise is determined on the basis of the lists and directories in effect at the time of the insured event.

Notice period/adjustment period
For termination to be valid, notice must reach SWICA's reception area no later than 17:00 on the last workday before the notice period ends (stamp date does not serve as reference date). The notice must be given in writing or in another form that permits text-based verification.

Maternity
Maternity refers to pregnancy and confinement as well as the mother's subsequent convalescence.

Maximum rates
The maximum rate is calculated based on the averages of the rate agreements between SWICA and comparable hospitals or the most recent rate with the hospital in question, whereby the lower of the two rates is used. The maximum rate is calculated separately for each hospital category.

Negative list
The negative list includes the preparation categories that SWICA does not cover. This includes: The LPPV (list of pharmaceutical preparations with special uses), medicines not registered with Swissmedic, food supplements, among other things.

Orthodontic surgery
Orthodontic surgery includes interventions following completion of body and jaw growth to correct severe malpositioning or misalignment of the upper and lower jaws that cannot be corrected with simple measures.
Orthodontic surgery does not include necessary implants and sinus lifts (thickening the bony floor of the maxillary sinus) because such procedures are closer to fitting a replacement tooth, which falls under dental treatment.

Policyholder
The policyholder is the person who has entered into an insurance contract with SWICA.

Premium
The premium is the amount the policyholder pays for the cover that the insurer provides. Differences in costs make it possible to offer different premium categories. Premiums are charged in advance.

Relapse
The recurrence of a disease.

Service provider
Service providers under the Health Insurance Act include doctors, pharmacists, chiropractors, midwives and persons who render services for or on behalf of doctors, laboratories, hospitals, nursing homes, and spas that meet the prerequisite statutory conditions.

Special medicines list (SL)
After Swissmedic has authorised a new medicinal product, a company can request to have this product included in the federal special medicines list. The SL is a positive list: health insurers must cover the cost of these medicines when doctors prescribe them for treating the associated condition as laid out in the SL.

Supplementary insurance
Supplementary insurance is voluntary and can be purchased in addition to mandatory health insurance (basic insurance). It can be purchased to cover individual needs. However, insurance companies can reject insurance applications or accept them only with an exclusion clause.

SWICA-recognised hospitals
SWICA-recognised hospitals are list hospitals and contract hospitals with which SWICA has a contract concerning rates.

Swissmedic
Medicines can be sold in Switzerland only once their safety, efficacy and quality have been adequately documented and tested. Swissmedic, the Swiss Agency for Therapeutic Products, is responsible for authorising medicines.

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