SUPPLEMENTARY INSURANCE

GENERAL INSURANCE CONDITIONS (GIC) AND SUPPLEMENTARY INSURANCE CONDITIONS (SIC) UNDER THE VVG.

Version 2013

BECAUSE HEALTH IS EVERYTHING SWICA

Customer information

Before the conclusion of an agreement, we are required by law to provide a comprehensible and transparent indication of some important contractual changes.

In the following General Insurance Conditions and Supplementary Insurance Conditions, look out for this symbol:

Before concluding an agreement, have the relevant marked text passages explained to you. The symbol draws attention in particular to the following points:

- Who is the insurer?
- Who is insured?
- What is insured and what is not covered by the insurance?
- What obligations does the insured person have?
- When is an insured person entitled to benefits?
- How are the benefits calculated?
- How is the premium calculated?
- How long does the agreement run?
- What data are processed by whom and for what purpose?

Contents

I General

Insurer in the case of supplementary insurance schemes, unless otherwise mentioned, is SWICA Healthcare Insurance Ltd, Römerstrasse 38, 8401 Winterthur, hereinafter referred to as SWICA.

In the case of the supplementary plan INFORTUNA, the health insurer is SWICA Insurances Ltd, Römerstrasse 38, 8401 Winterthur.

Article 1 Who is responsible for the support of insured persons?
If you need insurance advice or want to claim benefits under your insurance plan, please contact SWICA. You will find the address of the customer service responsible for you on your insurance policy.

Article 2 What are the various elements of the contract?
1. The insurance contract – both for individuals and for those covered under a group contract – is made up as follows:
   a) your application for insurance,
   b) the insurance certificate (policy),
   c) these General Insurance Conditions,
   d) the Supplementary Insurance Conditions,
   e) any Special Agreements.
2. For supplementary insurance plans, the Insurance Contract Act (VVG) applies.

II Scope of the insurance and definition of terms

Article 3 What is insured?
Insurance can be taken out against the financial consequences of illness, accident and/or maternity as defined in the additional conditions for supplementary insurance plans in accordance with the VVG.

Article 4 How can you insure yourself?
The following types of benefit can be insured:
a) The cost of care in the case of illness, accident and maternity as defined in the supplementary insurance plans for this line of insurance,
b) Daily benefits as defined in the General Insurance Conditions for this line of insurance,
c) Lump-sum payments in the event of disability or death as defined in the Supplementary Insurance Conditions.

Article 5 Definition of terms and application of the General Insurance Conditions
The basic insurance is the compulsory health and accident insurance required as minimum cover under the Health Insurance Act. Supplementary insurance plans are the individual supplements which you may agree on in addition to the basic insurance.
All the provisions of these General Insurance Conditions apply for supplementary insurance plans, unless otherwise stipulated. Unless expressly stipulated otherwise, all definitions of terms in this contract that are used in the context of the KVG also apply to supplementary insurance.

Article 6 What treatment costs are covered?
SWICA covers the costs of therapeutic or preventive measures if they are effective, expedient and economical. You will find further provisions in the Supplementary Insurance Conditions of any supplementary insurance agreement which you have concluded.

Article 7 Lists and directories and their validity
The lists and directories of service providers mentioned in the Supplementary Insurance Conditions for supplementary insurance plans will be placed at the disposal of the insured person at any time. The lists and directories current at the time of a claim for goods or services covered by SWICA are consulted for the assessment of any such claim for benefit.

Article 8 When does SWICA refuse or reduce benefits?
In the following cases, SWICA does not provide benefits from the supplementary insurance plans:
1. For consequences of the events of war
   – in Switzerland,
   – abroad. However, if such events take the insured person by surprise while in a country which he or she is visiting at the time, the insurance cover does not cease until 14 days after their first occurrence;
2. For consequences of unrest of any kind and measures taken to combat the situation, unless the insured person can show that he or she was not involved on the side of the agitators either actively or by incitement;
3. In association with military service with a foreign army;
4. In the event of earthquake or impact of a meteorite;
5. When occurring in the context of criminal acts the insured person commits or attempts to commit;
6. As a consequence of involvement in fights or brawls, unless the insured person was injured by the belligerent parties either as an uninvolved person or as a result of going to the aid of a defenceless person;
7. As a consequence of risks to which the insured person is exposed through the provocation of others;
8. In cases of damage to health attributable to an act of daring. Acts of daring are activities in which the insured person exposes himself or herself to a particularly high level of risk without taking or being able to take precautions that would reduce the risk to a reasonable level;
9. In the case of participation in races or training of any kind with motorcycles;
10. In the case of illnesses or accidents resulting from ionising radiation;
11. In the case of the insured event being deliberately brought about by the insured person or another person entitled to benefits;
12. For treatments resulting from the misuse of medicines, drugs and alcohol. The misuse of these addictive substances is expressly deemed not to be an illness and thus does not fall under the obligations of SWICA to pay benefits.

Article 9 Gross negligence
SWICA reduces the benefits if the insured event was caused through gross negligence; supplementary provisions are reserved.

III Contract term and termination

Article 10 When does the insurance come into effect?
The contract becomes effective as soon as SWICA issues the insurance policy or declares acceptance of the application in writing, but not earlier than on the date agreed. Consequences of accidents and illnesses are only covered if the accidents or illnesses occur after the start of the insurance period.

Article 11 How long does the insurance apply?
You are entitled to claim benefits from SWICA for as long as the contract is not terminated, subject to Art. 15 of these Conditions.

Article 12 When can the insurance agreement be terminated?

1. ! Unless otherwise agreed, a minimum contract term of one year applies, the end of the insurance year always falling on 31 December. After the agreed term ends, the contract is tacitly extended by a year, unless the insured person has given due notice of termination.
2. You may terminate the agreement at the end of a calendar year. Notice of three months must be observed.
3. After any case of illness or accident for which SWICA pays a benefit. Not later than 14 days after receipt of the benefit, the policyholder may terminate this part of the agreement. Cover ceases when SWICA receives notification. SWICA also waives its right to notice on expiry of the agreement.
4. SWICA waives its right to cancel the agreement for supplementary insurance after the occurrence of an insured event, except in cases of attempted or committed insurance fraud. In these cases, SWICA may terminate the agreement within 14 days after becoming aware of the fact.
5. Even without notice of termination, supplementary insurance automatically ceases after the insured person has had his or her normal place of residence abroad for three months, unless otherwise stipulated in supplementary conditions or special agreements with SWICA.
6. Otherwise the insurance ceases with the death, withdrawal or exclusion of the insured person or termination of the insurance contract.
7. The written notice of termination is deemed to be given in time if it is received by SWICA not later than the last day before the start of the three-month period of notice.

Article 13 What happens after the insurance is cancelled?

a) Consequences of illnesses and accidents, including delayed effects and relapses, which occur after the insurance cover has ceased are not insured.
b) ! Entitlement to benefits ends in every case with the termination of the agreement.

IV Payment of premiums

Article 14 When are premiums due?

1. As a rule, premiums are payable annually in advance, but subject to a special agreement may also be paid every six, three or two months at an extra charge.
2. The premiums fall due, depending on the agreed mode of payment, in each case on the first day of the month of the given payment period.
3. The premiums must be paid to SWICA in Swiss francs within one month of the agreed due date.

Article 15 Late payment

1. ! If the premium is not paid to SWICA within one month of the due date, SWICA will issue a reminder to pay within 14 days of the date on which the reminder is sent. If the reminder fails to elicit payment, the obligation to pay benefits as defined in the supplementary insurance plans is suspended with effect from expiry of the period of notice onwards. Furthermore, Article 13 applies by extension.
2. Suspended supplementary cover may be restored at its original level upon payment of the outstanding premiums and costs (default charges, reminder fees, expenses for enforcement proceedings), without regard to the condition of health of the insured person within three months of its suspension, and also after this period has elapsed if evidence is furnished of a satisfactory condition of health. The insurance cover becomes effective again from the time of payment.
3. SWICA is entitled to compensation for any expenses and costs for reminders, enforcement proceedings and default charges etc. caused by insured persons in default.

V Premium changes and modifications to the agreement

Article 16 Can changes be made in the contractual relationship?

If, after conclusion of the insurance agreement, changes occur in the context of the social healthcare insurance or in the relationship between SWICA and healthcare providers, SWICA may adjust the additional conditions in its supplementary insurance plans. This likewise applies in the case of substantial new knowledge arising from science and research. SWICA may also increase or reduce premiums depending on cost developments. To this end, SWICA shall announce the new contractual conditions not later than 30 days before the end of the calendar year. Hereupon, the policyholder has the right to terminate the agreement in respect of the part affected by the change with effect from the end of the current calendar year. For the written notice to be effective, it must be received by SWICA not later than the last day of the calendar year. If the policyholder fails to give notice, this shall be interpreted as tacit consent to the change in the agreement.

Article 17 Insurance of children and adolescents

For insured persons who have been admitted to the insurance plan before the age of 18 or before the age of 25 at a special rate for children or adolescents, respectively, the next rate up is calculated for the premium to be paid from the beginning of the policy year following attainment of the age of 18 or 25. This gives rise to an extraordinary right to notice of termination according to Article 16.

Article 18 Insurance according to age-related rates

If an insured person chooses the model in the supplementary insurance by which the premium is calculated according to age, the premiums are regularly adjusted to the age of the insured person. This gives rise to an extraordinary right to notice of termination according to Article 16. Up to the age of 50 years, the insured person has the option of changing to the model by which the premium is calculated according to the age on entry, without regard to the condition of health, within the same framework of the previous insurance coverage and counting the insurance period when the premium was calculated according to actual age, with effect from the start of the next calendar year.

Article 19 ! Change of profession, job or place of residence of the insured person

In the case of supplementary insurance plans, premium scales based on risk category and place of residence apply for certain types of benefit. If the insured person changes profession, job, or place of residence, with the result that the risk category changes, SWICA may adjust the premium accordingly. If there is a change in the premium region as a result of the insured person relocating, there is no right of termination. The customer service responsible must be notified of the change of profession, job or place of residence within 30 days. If notification is not given within this period, SWICA may request back-payment of any shortfall in premiums when the new circumstances become known.

VI Obligations and proof of claim

Article 20 How do you receive your benefits?

1. Costs of care
   SWICA pays the balance due to you into your bank or postal account within 30 days of receipt of all the relevant information, if you proceed as follows:
   a) Costs in the case of outpatient care:
      SWICA must be sent all invoices and receipts continually within one month of their being issued.
   b) Hospital costs:
      If you are referred to hospital, another institution of care, or a health spa, SWICA must be notified not later than 14 days before admission, in the case of emergencies not later than 14 days after admission. SWICA issues authorisation within 10 days for the costs to be settled. The invoices are to be submit-

ted to SWICA within one year. If you have other insurance for hospital costs or costs for outpatient care (supplementary insurance plans, compulsory accident insurance or another health insurance), the invoices of the relevant insurer (e.g. health insurance company, SUVA, etc.), except for the documents already mentioned, must be submitted to SWICA.

2. Lump-sum payments are claimed according to the Supplementary Insurance Conditions.
3. Payments as defined under 1. and 2. are transferred to a Swiss bank account in Swiss francs.
4. Right of information
   SWICA is entitled to demand receipts and information, in particular doctors' certificates. The insured person shall grant SWICA the right to demand relevant receipts and information directly and to order the examination of insurance claims by a doctor designated by SWICA. The insured person must moreover give true information regarding the current case as well as previous illnesses and accidents. The insured person releases all doctors and official departments as well as insurers and lawyers who have treated, counselled or insured him or her from any obligation of secrecy towards SWICA. In the case of minors insured with SWICA, those with parental authority or the policyholders shall ensure that the obligations are met.

Article 21 Consequences in the case of a breach of contract
If the General Insurance Conditions and Supplementary Insurance Conditions are violated, SWICA can reduce or refuse its benefits, unless it is proven that the act in question was not culpable and had no influence on the consequences and findings of the illness or accident. The insurance claim lapses unless all the requisite documents are submitted within four weeks of a written reminder by SWICA.

Article 22 ! Processing of personal data by SWICA
1. SWICA obtains and uses personal information of insured persons in compliance with the Federal Data Protection Act and its ordinances as well as social security laws.
2. On the establishment of an insurance contract (consultation, application for insurance, conclusion of agreement) and during the period of this contract, SWICA obtains knowledge of personal information about the contracting parties or insured persons. In particular, SWICA obtains information about insured persons' state of health and relevant treatments which is especially worthy of protection.
3. SWICA stores personal information in electronic form or as hard copy, and processes it in order to provide the contractually agreed services and to enable it to advise and support insured persons with regard to reliable insurance cover that meets their needs.
4. Furthermore, SWICA may analyse data using mathematical and statistical methods in order to further develop and improve the quality and benefits of its services and products, based on the information obtained, for existing, former and potential new customers and to inform them about these improvements.
5. SWICA may commission third parties to provide services to customers and forward personal data for the fulfilment of this task to these third parties (e.g. other insurers involved, independent examining doctors, authorities, lawyers and external experts, computer centres). In this case, SWICA commits the third parties to observe confidentiality and compliance with data protection standards. Data may also be forwarded for the purpose of exposing or preventing insurance fraud.
6. The personal data are only processed and kept in a database or as hard copy as long as it is mandatory by virtue of legal or contractual requirements. Afterwards, the personal data are deleted.
7. SWICA provides insured person with an insurance card. This serves as identification of the concluded insurance agreements for healthcare providers. The card is created according the legal requirements of the KVG and also contains information consistent with EU standards as proof of insurance cover during stays in EU countries. It also contains further details on the scope of the insurance cover incl. supplementary insurance plans.

VII Miscellaneous

Article 23 Place of performance and legal venue
1. The obligations arising from this agreement shall be met in Switzerland and in Swiss currency.
2. In the event of disputes arising from supplementary insurance plans, the person entitled to benefits may choose between the domicile of SWICA or his or her place of residence in Switzerland as the legal venue. If the policyholder or the person entitled to benefit lives abroad, Winterthur shall be the exclusive venue.

Article 24 Right of withdrawal
Within the first seven days after the signing of the application, the applicant has the right to withdraw his or her application. The withdrawal must be sent by registered letter to SWICA Healthcare Organisation, Head Office, P.O. Box, 8401 Winterthur.
With the sending of a declaration of withdrawal, any existing provisional insurance cover as well as the definitive cover also cease retrospectively.

Article 25 ! Exclusion/refusal of cover
Diseases and consequences of any accident which exist or existed at the time of acceptance may be excluded from the requested supplementary insurance by means of a special exclusion clause. If information about illnesses and accidents was withheld at the time of acceptance, the exclusion clause may be applied retrospectively. In the context of the supplementary insurance, SWICA may refuse to conclude an agreement without giving any reasons.
There is no entitlement to benefits for illnesses and consequences of accidents subject to any such exclusion clause. This also applies to information about illnesses and accidents that was withheld at the time of acceptance. In the case of any new or increased insurance cover, SWICA may demand a medical examination. By virtue of the signature on the application, SWICA is empowered to make the necessary enquiries of official departments, doctors and third parties.
If the person under obligation to provide information withholds or incorrectly discloses substantial details which he or she knew or must have known when the agreement is concluded, SWICA may give written notice of termination of the contract within four weeks after becoming aware of this non-disclosure and may demand the repayment of all benefits relating to the breach of obligation since the start of the agreement. The contract ends as soon as the insured person receives the notice of termination.

Article 26 Transfer from group to individual insurance
1. Anyone who leaves a group insurance contract with SWICA has the right to transfer to an individual insurance agreement within three months. The right of transfer to individual insurance also applies if the group insurance contract ends.
2. The person transferring to the individual insurance shall be covered to the same extent as before in the group insurance contract. The insured persons shall be informed of their right of transfer by the group policyholder at the time of withdrawing from the group insurance contract. Benefits from the group insurance contract are applied to those from individual insurance.
3. The premium of the individual insurance in effect at the time of transfer shall apply. The age at transfer from group to individual insurance is identical with the age when joining the medical expenses insurance contract.

Article 27 What happens in the case of a liable third party or a third-party service provider?

1. If a third party is liable, SWICA does not provide insurance cover. The obligations of SWICA are confined to the extent to which there is only partial or no third-party liability. In the case of a partial obligation on the part of the third party, SWICA shall pay benefits to the extent that no overcompensation accrues for the insured person.
2. Should several insurances exist for the same costs or should other contact partners exist who would be under obligation to pay benefits if there were no insurance with SWICA, the costs shall be reimbursed only once. The entitlement to reimbursement of such costs applies only to the extent of the relation in which the costs covered by SWICA stand to the total sum of benefits of all insurers.
3. Should a third party dispute his or her liability, SWICA is not under obligation to pay any benefits.
4. Voluntary prior benefits shall only be paid by SWICA if the insured person assigns his or her rights in respect of third parties to SWICA. SWICA may grant the insured person legal protection in the assertion of his or her rights in respect of third parties.
5. If the insured person comes to an arrangement with a third party without the prior consent of SWICA, the obligations of SWICA shall no longer apply.
6. SWICA is not under obligation to pay benefits if the insured person does not assert his or her claim over a third party in good time or makes no attempt to obtain compensation.
7. The insured person shall notify SWICA of the nature and extent of all third-party benefits. If he or she omits to do so, SWICA may reduce or refuse the payment of benefits.

Article 28 Offsetting and reclaiming of payments

Benefits paid out in error by SWICA shall be reimbursed by the insured person on request in writing. In this case, SWICA has the right to offset such payments in error.

Article 29 Prohibition of assignment and pledges

Claims against SWICA must neither be assigned nor pledged.

VIII Final provisions

Article 30 Notifications

1. All notifications by insured persons or persons entitled to benefits must be addressed to SWICA. The addresses can be found on the insurance ID card. The insurer recognises all such notifications and notices as being addressed to the insurer himself.
2. All notifications with legal force from SWICA or the insurer are sent to the address in Switzerland last given by the insured person or the person entitled to benefit.

COMPLETA TOP and COMPLETA PRAEVENTA supplementary insurance

I General Scope

Article 1 Purpose

1. SWICA pays additional benefits for outpatient and inpatient care on top of those stipulated under compulsory health insurance (KVG) out of its COMPLETA TOP (basic module) and COMPLETA PRAEVENTA (extra module) supplementary insurance plans.
2. The COMPLETA TOP module can be extended by the COMPLETA PRAEVENTA supplementary module.
3. ! The supplementary module cannot be used alone, but only in conjunction with COMPLETA TOP. If COMPLETA TOP ceases to apply, then COMPLETA PRAEVENTA also automatically ceases to apply at the same time.
4. If the insured person takes up residence abroad, both products likewise cease to apply.

Article 2 Insured persons

Anyone may apply for this supplementary insurance, provided this person's legal place of residence is in Switzerland and he or she has not yet reached the age of 60.

II Scope of insurance

Article 3 Scope of insurance

1. ! SWICA pays the cost of treatment or preventive healthcare, if it is effective, expedient and economical.
2. The scope of the insurance is defined according to these conditions and the policy.
3. The co-payment percentage of the insured person is separately calculated in each SWICA insurance line, the basis in each case being the aggregate costs.
4. Any excess (the amount payable by the insured person) which is imposed by other social healthcare providers is not covered by this insurance.

III COMPLETA TOP benefits in Switzerland

Article 4 Complementary medicine

1. Cover includes the cost of SWICA-recognised natural treatments involving a complementary medical practice if administered by a SWICA-recognised doctor. It also includes the cost of treatment by a SWICA-recognised naturopath or a SWICA-recognised paraprofessional in the field of complementary medicine.

2. SWICA keeps a list of recognised healing methods and a directory of the recognised therapists. The list and the directory are adjusted regularly, and the insured person can inspect them or request extracts thereof.
3. If there are no recognised rates, SWICA bases the calculation of benefits on a rate of 80 francs per hour.

Article 5 Medicines
1. SWICA covers the medically necessary medication, as prescribed by a doctor, that is not included in the negative list.
2. SWICA pays the cost of homoeopathic, phytotherapeutic and anthroposophical preparations which are prescribed or dispensed by a therapist as per Article 4 and which do not appear on the negative list.
3. Compensation for preparations and medicines is paid at the retail price. If the preparations or medicines are prepared by the therapists themselves, SWICA reimburses the cost of preparation plus benefits of not more than 30 %.
4. Medicines are deemed to be preparations approved by Swissmedic. Reimbursement is not paid, however, for active substances or preparations which may be advertised to the general public, are designed for the prevention of diseases, are cosmetics, are intended for sexual stimulation or for weight reduction, as well as preparations and active substances which fall under the provisions of the ordinance governing foodstuffs (not registered with Swissmedic). Products which the manufacturer voluntarily takes off the list of specialities as defined by the KVG or which compulsory healthcare insurance covers only for restricted uses or only partially are likewise not paid for out of COMPLETA TOP outside these restrictions.

Article 6 Psychotherapy with psychotherapists in private practice
SWICA shall pay 90 % of the costs of medically prescribed psychotherapy which is intended for the treatment of a psychiatric disorder and is provided by a psychotherapist in private practice in a maximum of 60 sessions per calendar year at a rate of 50 francs per session. The psychotherapist must have a specialist qualification recognised by the federal or cantonal authorities or be a member of the Swiss Psychotherapists' Association (SPV).

Article 7 Maternity/breastfeeding
SWICA shall pay 200 francs to insured mothers who wholly or partly breastfeed their infants for at least 10 weeks.

Article 8 Spa treatments
1. In the case of spa treatments which are medically indicated, prescribed by a doctor and approved by SWICA beforehand, SWICA shall pay a contribution towards the stay and the treatment amounting to not more than 30 francs per treatment day for not more than 30 days per calendar year. The treatment must be provided in a recognised Swiss spa or in special cases, upon request and after approval by SWICA, may take place abroad.
2. The prescription for spa treatment shall be submitted to SWICA not less than 14 days before entering the spa.

Article 9 Convalescence treatment
1. In the case of convalescence treatments which are medically indicated, prescribed by a doctor, approved by SWICA beforehand, and provided in a health spa which appears in the SWICA list, SWICA shall pay a contribution towards the convalescence stay amounting to not more than 20 francs per treatment day for not more than 30 days per calendar year.
2. The prescription for convalescence shall be submitted to SWICA not less than 14 days before entering the spa.

Article 10 Home help
1. SWICA shall pay 50 % of the documented costs for home help which is necessary for work in the insured person's household, amounting to not more than 30 francs per day for not more than 60 days per calendar year.
2. The need for home help must be shown by a doctor's certificate.
3. The contributions shall also be paid to family members or relatives, if loss of earnings can be shown to have occurred as a result of the help provided.

Article 11 Lenses and frames for glasses, contact lenses
1. SWICA shall pay 90 % of the costs for medically indicated lenses and frames for glasses and for contact lenses, amounting to not more than 200 francs every three calendar years.
2. A precondition for this benefit is that no benefits for visual aids have been paid out of the compulsory healthcare insurance in the last three calendar years.

Article 12 Aids
SWICA shall pay 90 % of the costs for medically prescribed aids which compensate for functional deficits or serve as replacements for body parts (exceptions are dental prostheses and aids to vision) and which do not fall under compulsory legal obligations, amounting to not more than 200 francs per calendar year.

Article 13 Costs for dental treatment
SWICA shall pay 50 % of the costs, amounting to not more than 100 francs per calendar year for dental treatment which does not fall under compulsory legal obligations.

Article 14 Orthodontic treatment
1. For orthodontic treatment in children and adolescents up to the age of 25, SWICA shall pay 50 % of the costs according to the rates laid down in the accident insurance law (UVG), at the rate factor currently applicable for health insurance schemes, amounting to not more than 10 000 francs per calendar year.
2. In the case of inpatient treatment, SWICA shall pay 50 % of the costs according to the rates of the general ward of the clinic closest to the insured person's place of residence in the canton of residence, amounting to not more than 10 000 francs.

Article 15 Orthodontic surgery
1. For orthodontic surgery SWICA shall pay 50 % of the costs according to the rates of the general ward of the clinic closest to the insured person's place of residence in the canton of residence, amounting to not more than 10 000 francs.
2. In the case of outpatient care, SWICA shall pay 50 % of the costs according to the rates laid down in the accident insurance law (UVG), amounting to not more than 10 000 francs.

Article 16 Emergency transports, transfers and rescue operations in Switzerland
1. Supplementary to the basic insurance SWICA shall pay altogether not more than 90 % of the costs for emergency or medically indicated transport to the nearest doctor or hospital within Switzerland according to the standard rates, up to 20 000 francs per calendar year.
2. SWICA shall pay up to a maximum of 20 000 francs per calendar year in respect of operations to search for and/or rescue the insured person.

IV COMPLETA TOP benefits abroad

Article 17 Benefits abroad

1. SWICA shall issue authorisation for cost settlement and pay the costs incurred for medically indicated treatments during a stay abroad by a person who is resident in Switzerland and not covered by any other insurance. The insurance covers all treatments which are recognised by compulsory healthcare insurance in Switzerland.
2. If an insured person travels abroad for treatment without the consent of SWICA, the costs shall not be reimbursed.

Article 18 Personal assistance

If while abroad an insured person falls ill, or suffers an accident, or if a medically confirmed and unexpected worsening of a chronic disorder occurs, SWICA shall also pay the following benefits:

1. Rescue/search operations and emergency transport abroad, if the doctor commissioned by the SWICA emergency call centre considers this necessary, up to a total of 50 000 francs per calendar year.
2. Transport back to Switzerland or to hospital if the doctor commissioned by the SWICA emergency call centre considers this necessary.
3. If a hospital stay abroad lasts longer than 7 days, the costs for a visit by a person in a very close relationship to the person insured with SWICA shall be paid as follows: The documented costs for the journey there and back, but not more than the cost for a flight in Economy Class, and in addition the documented costs for board and accommodation, but not more than 200 francs per day and in total not more than 1 000 francs.

Article 19 Conduct in the event of a claim

1. In principle, the benefits defined in Article 17 (with the exception of the costs borne for outpatient care) and Article 18 are subject to the SWICA emergency call centre being contacted. The benefits shall not be paid if they are not approved and organised by the SWICA emergency call centre.
2. The insured person may in principle make his or her own arrangements for outpatient care. However, if the total cost of medical outpatient healthcare such as diagnosis, treatment, nursing care and medicines exceeds 25 000 francs per calendar year, the insured person must request an authorisation for the settlement of costs to be issued by SWICA. If this authorisation is not provided, no benefit can be claimed from this insurance.
3. For hospital stays, the insured person must request an authorisation for the settlement of costs from the SWICA emergency call centre before the start of treatment or before admission to hospital. In emergencies, a 5-day period of notice is applicable from the start of treatment. Based on the medical findings, the doctors from the emergency call centre decide on the authorisation for the settlement of costs by SWICA and on a possible transfer to another hospital or a return to a suitable hospital in Switzerland close to the place of residence of the insured person.
4. ! The insured person shall submit to SWICA all bills in the original and in detail, showing the necessary medical details. If the documents are insufficient or incomprehensible or if the rates applied are improper, SWICA may reduce the benefits or refuse payment.
5. The insured person shall do everything in his or her power that will minimise the loss and can contribute to its investigation.

V COMPLETA PRAEVENTA benefits

Article 20 Purpose

Under the additional COMPLETA PRAEVENTA insurance, SWICA shall pay for the following preventive measures carried out in Switzerland.

Article 21 Vaccinations

SWICA shall pay up to a maximum of 200 francs per calendar year for voluntary medically recommended vaccinations.

Article 22 Health promotion and preventive healthcare

1. SWICA shall pay 50 % of the costs up to a maximum of 500 francs per calendar year for measures relating to health promotion and preventive healthcare, according to a separate list.
2. For medical and gynaecological check-ups which do not fall under the legal compulsory obligations and are aimed at early detection of disease, SWICA shall pay 90 % of the costs according to health insurance rates, up to a maximum of 500 francs within three calendar years.

VI Co-payment

Article 23 ! Co-payment

For the benefits defined in the conditions under Article 4 Complementary medicine, Article 5 Medicines, and Article 17 Benefits abroad, an excess of 600 francs shall be charged for adult insured persons and a co-payment of 10 % for all insured persons. Any co-payment (annual franchise and excess) already paid under compulsory healthcare insurance is applied towards the excess.

VII General provisions

Article 24 Lists and directories

The lists and directories mentioned in these conditions shall be placed at the disposal of the insured person at any time.

Article 25 Applicable law

Supplementing these provisions, the General Insurance Conditions of SWICA and the conditions of other supplementary insurers apply.

SUPPLEMENTA supplementary insurance

I General scope

Article 1 Purpose
Under the SUPPLEMENTA plan, SWICA pays the costs which are only partly borne, if at all, by the compulsory healthcare insurance and another supplementary healthcare insurance plan of SWICA.

Article 2 Insurable persons
Anyone who has not yet reached the age of 60 may apply for SUPPLEMENTA insurance. Acceptance is conditional upon the applicant being insured with SWICA under a supplementary COMPLETA TOP plan.

II Scope of insurance

Article 3 Scope of insurance
1. The scope of the insurance is defined according to these conditions and the policy.
2. Any excess (the amount payable by the insured person) which is imposed by other social healthcare insurers is not covered by this insurance.

III Benefits

Article 4 Lenses and frames for glasses, contact lenses
SWICA shall pay 90 % of the costs for medically indicated lenses and frames for glasses and contact lenses, amounting to not more than 300 francs every three calendar years.

Article 5 Aids
SWICA shall pay 90 % of the costs for medically prescribed aids which compensate for functional deficits or serve as replacements for body parts (exceptions are dental prostheses) and which do not fall under compulsory legal obligations, according to the list of the Swiss Association of Orthopaedic Technicians (SVOT), amounting to not more than 500 francs per calendar year.

Article 6 Emergency transports and transfers
SWICA shall pay not more than 90 % of the costs of emergency or medically indicated transport to the nearest doctor or hospital within Switzerland according to the standard rates, up to 20 000 francs per calendar year.

IV General provisions

Article 7 Coordination with other insurance companies
The co-payment percentage of the insured person is calculated separately in every SWICA insurance line, the basis in each case being the aggregate costs.

Article 8 Applicable law
Supplementing these provisions, the General Insurance Conditions of SWICA and the conditions of other supplementary insurers apply.

OPTIMA supplementary insurance

I General scope

Article 1 Purpose
Under the OPTIMA insurance plan for outpatient private care, SWICA pays additional benefits supplementary to the compulsory healthcare insurance of SWICA and the supplementary plans COMPLETA TOP and COMPLETA PRAEVENTA.

Article 2 Insurable persons
Anyone who has not yet reached the age of 60 may apply to join the OPTIMA plan for private outpatient care.

II Scope of insurance

Article 3 Scope of insurance
The scope of the insurance is defined according to these conditions and the policy. SWICA shall bear the costs of therapeutic or preventive care if it is effective, expedient and economical.

III Benefits

Article 4 ! Outpatient treatment
SWICA shall pay the fees of health professionals worldwide. If the insured person has opted for healthcare insurance with limited choice, these regulations also apply for this supplementary insurance plan.

Article 5 Complementary medicine
1. The costs of naturopathic treatment carried out according to therapeutic methods of complementary medicine are covered by SWICA, provided the treatment is administered by a SWICA-recognised doctor, a SWICA-recognised naturopath or a person recognised by SWICA as practising complementary medicine.
2. SWICA keeps a list of recognised healing methods and a directory of the recognised therapists. The list and the directory are adjusted regularly, and insured persons can inspect them or request extracts thereof.

Article 6 Psychotherapy with psychotherapists in private practice
SWICA shall pay a contribution towards the cost of medically prescribed psychotherapy which is intended for the treatment of a psychiatric disorder and is provided by a psychotherapist in private practice in a maximum of 60 sessions per calendar year at a rate of 25 francs per session. The psychotherapist must have a specialist qualification recognised by the federal or cantonal authorities or be a member of the Swiss Psychotherapists' Association (SPV).

Article 7 Maternity
In the case of deliveries in an outpatient setting, SWICA shall pay all costs arising for medical care and the services of the midwife.

Article 8 Vaccinations, travel vaccinations
SWICA covers 90 percent of the costs of medically recommended vaccinations that do not fall under statutory mandatory benefits.

Article 9 Health promotion and preventive healthcare

1. SWICA shall pay 90 % of the costs for preventive measures, as defined in a separate list, amounting to not more than 300 francs per calendar year.
2. For medical and gynaecological check-ups, SWICA shall pay 90 % of the costs without any limit on the sum.

Article 10 Spa treatments

1. In the case of spa treatments which are medically prescribed and approved by SWICA beforehand, SWICA shall pay a contribution towards the stay and the treatment amounting to not more than 30 francs per treatment day for not more than 30 days per calendar year.
2. The payment of contributions to the spa treatment is conditional upon the insured person submitting to a medical examination on admission and discharge and undergoing intensive balneological and physiotherapeutic treatments.
3. The prescription for spa treatment shall be submitted to SWICA not less than 14 days before entering the spa.

Article 11 Convalescence treatment

1. In the case of convalescence treatments which are medically indicated and approved by SWICA beforehand and provided in a health spa which appears in the SWICA list, SWICA shall pay a contribution towards the convalescence stay amounting to not more than 30 francs per treatment day for not more than 30 days per calendar year.
2. The prescription for convalescence shall be submitted to SWICA not less than 14 days before entering the spa.

Article 12 Lenses and frames for glasses, contact lenses

SWICA shall pay 90 % of the costs for medically indicated lenses and frames for glasses and for contact lenses, amounting to not more than 300 francs every three calendar years.

Article 13 Aids

SWICA shall pay 90 % of the costs for medically prescribed aids which compensate for functional deficits or serve as replacements for body parts (exceptions are dental prostheses and aids to vision) and which do not fall under compulsory legal obligations, according to the list of the Swiss Association of Orthopaedic Technicians (SVOT), amounting to not more than 300 francs per calendar year.

Article 14 Emergency transports and transfers

SWICA shall pay not more than 90 % of the costs for emergency or medically indicated transport to the nearest doctor or hospital within Switzerland according to the standard rates, up to 20 000 francs per calendar year.

IV Co-payment

Article 15 ! Co-payment

For the benefits defined in Articles 4 and 5 of these conditions, a co-payment shall be charged at the level of the annual excess chosen in the compulsory healthcare insurance. Any co-payment (excess and deductible) already paid under compulsory healthcare insurance is taken into account.

V General provisions

Article 16 ! Coordination with other insurance companies

1. The benefits set out in these conditions shall be paid in addition to the benefits from the basic compulsory healthcare insurance and any further supplementary insurances with SWICA. If the basic insurance is provided by another company, then no benefits shall be paid from OPTIMA for costs which would be reimbursed from the STANDARD and COMPLETA TOP and COMPLETA PRAEVENTA plans if this cover were provided by SWICA.
2. The co-payment percentage of the insured person is calculated separately in every SWICA insurance line, the basis in each case being the aggregate costs.

Article 17 Lists and directories

The lists and directories mentioned in these conditions shall be placed at the disposal of the insured person at any time.

Article 18 Applicable law

Supplementing these provisions, the General Insurance Conditions of SWICA and the conditions of other supplementary insurers apply.

HOSPITA hospitalisation insurance

I General scope

Article 1 ! Purpose

Under the HOSPITA hospitalisation insurance plan, which is supplementary to compulsory healthcare insurance, SWICA shall, in the case of inpatient treatment in acute hospitals, pay the costs of the stay, the treatment and ancillary costs which are not covered under compulsory insurance. Depending on the level of insurance selected, further benefits will also be paid from this supplementary plan.

Article 2 Insurable persons

Anyone who has not yet reached the age of 60 may apply to join this insurance plan.

II Scope of insurance

Article 3 Choice of insurance levels

SWICA shall bear the costs of hospital care if it is effective, expedient and economical.

The insurance level can be chosen from one of the following options:

Category 1	General ward (HOSPITA GENERAL) of public and private hospitals with recognised fees (SWICA contract hospitals) in Switzerland and the Principality of Liechtenstein. This category can be chosen with a guarantee that allows a higher insurance in a semi-private or private hospital ward without a medical examination
Category 2	Semi-private ward (HOSPITA SEMI-PRIVATE) of any public or private hospital in Switzerland and the Principality of Liechtenstein with recognised fees
Category 3	Semi-private ward (HOSPITA SEMI-PRIVATE (list)) in hospitals in Switzerland and the Principality of Liechtenstein as defined in the SWICA hospital directory
Category 4	Private ward (HOSPITA PRIVATE) of any public or private hospital in Switzerland and the Principality of Liechtenstein

Category 5	Private ward (HOSPITA PRIVATE (list)) of a hospital in Switzerland or the Principality of Liechtenstein as defined in the SWICA hospital directory
Category 6	Private ward (HOSPITA PRIVATE GLOBAL) of any public or private hospital throughout the world
Category 7	Insurance option HOSPITA COMFORTA Double room (hotel category) of any public or private hospital in Switzerland and the Principality of Liechtenstein as defined in the SWICA hospital list
Category 8	Insurance option HOSPITA COMFORTA Private room (hotel category) of any public or private hospital in Switzerland and the Principality of Liechtenstein as defined in the SWICA hospital list

Article 4 Guarantee for change of category

1. The conclusion of HOSPITA GENERAL incl. a change of category guarantee (= HOSPITA PLUS) allows a change to HOSPITA SEMI-PRIVATE or HOSPITA PRIVATE without a medical examination.
2. The change of category guarantee can be concluded as one of the following two options:
   a) Change from HOSPITA GENERAL to HOSPITA SEMI-PRIVATE (optionally category 2 or 3)
   b) Change from HOSPITA GENERAL to HOSPITA PRIVATE (optionally category 4 or 5).
3. A HOSPITA PLUS can be requested up to the end of the calendar year in which the 18th birthday falls.
4. The change from HOSPITA GENERAL to HOSPITA PLUS is possible after a medical examination has been passed.
5. The change to the higher insured category is possible up to the end of the calendar year in which the 40th birthday falls. If the change of category option is not exercised up to this point, the guarantee lapses.
6. A change can be made on the next calendar day of a month or by agreement.
7. ! After the change to the higher insured category, there is a waiting period of twelve months on all benefits. During this period, treatments in the general ward are insured.

Article 5 ! Options of deductible

1. For Categories 1–6, the insured person may select a co-payment model with a fixed deductible per calendar year of
   1000 francs
   2000 francs
   5000 francs
2. People insured under HOSPITA SEMI-PRIVATE (categories 2 and 3) can also opt for co-payment models with a deductible of 300 francs per day in hospital up to a maximum of 6000 francs per calendar year.
3. People insured under HOSPITA PRIVATE (categories 4 and 5) can also opt for co-payment models with a deductible of 300 francs per day in hospital up to a maximum of 6000 francs per calendar year with treatment in a semi-private hospital ward and 400 francs per day in hospital up to a maximum of 8000 francs per calendar year with treatment in a private hospital ward.
4. The premium is reduced according to the selected co-payment model. A co-payment (excess and deductible) that has already been paid in the basic insurance or in another supplementary insurance of SWICA is counted when calculating the maximum annual deductible in this supplementary insurance plan.
5. Insured persons may request a change to a lower level of deductible at the start of a calendar year subject to three months' notice of change. After the person has had a medical examination, SWICA may agree to the reduction or exclude or reject from the reduced deductible any illnesses and the consequences of accidents that exist when the person applies for the reduction.
6. In the case of maternity, a waiting period of 360 days applies with any change to a lower deductible.
7. The medical examination in the case of a reduction in the deductible also takes place with a simultaneous reduction in the insurance category. Exception: in the case of a reduction to HOSPITA GENERAL (option without change of category guarantee) there is no medical examination when the deductible is reduced.
8. The lifting of the deductible is equated with a reduction in deductible.

Article 6 Second medical opinion

1. In the case of insurance category 3 or 5, the insured person shall obtain a second opinion from SWICA before undergoing any surgery that is recommended. The operations for which a second opinion is required are listed in Annex 1 of these Supplementary Insurance Conditions
2. In the case of a non-emergency operation as listed in Annex 1 of these Supplementary Insurance Conditions, if an insured person does not obtain a second opinion, he or she shall share the costs paid out of the HOSPITA plan at 10 % of the total cost of the stay and the treatment, plus the deductible, but not amounting to more than 3000 francs.

III Benefits

Article 7 Entitlement to benefits in the case of illness

1. In the case of hospital stays, SWICA shall pay the cost of the stay and the treatment according to the selected insurance level.
2. In the case of general wards, the cost of the stay and the treatment shall be paid according to contractual agreement or according to the fees recognised by SWICA.
3. In the case of semi-private wards, the cost of the stay and the treatment, as well as the doctor's fees shall be paid according to the rates and terms of the agreement. In those cases where no contractually agreed rates apply, reimbursement shall be paid as a lump sum according to Article 9 Category 2 in these Supplementary Insurance Conditions. SWICA shall draw up lists and directories of contract hospitals. The insured persons can obtain further information on this from SWICA.
4. The customary private rate applies to the private ward.
5. In the COMFORTA insurance options Category 7 (double room) and Category 8 (private room), the cost of the stay and the board (hotel category) shall be paid according to the contract between SWICA and these hospitals. No benefits shall be paid for the cost of treatment, diagnosis and nursing care, because the hospital charges these at the KVG rate for basic insurance. If the insured person enters a non-contract hospital, he or she shall not be paid any benefits from Categories 7 and 8.
6. The extra costs for medically indicated treatment outside the canton shall not be charged to the supplementary insurance.
7. In the case of bone marrow and organ transplants, the benefits are based on the rates we recognise.

Article 8 Duration of benefit

Unless otherwise stipulated in these conditions, the benefits from the HOSPITA plan shall be paid for an unlimited period.

Article 9 Choice of other hospital ward/treatment abroad

1. If a hospital ward other than the one defined in the insurance plan is chosen and in the case of hospital stays abroad, the following benefits are paid in addition to those covered under the mandatory healthcare insurance:

Category 1	up to 50 francs per day for board and up to 5000 francs per calendar year for treatment costs
Category 2+3	up to 100 francs per day for board and up to 10000 francs per calendar year for treatment costs

Category 4+5	up to 150 francs per day for board and up to 30 000 francs per calendar year for treatment costs
Category 6	costs covered in full
Category 7	up to 100 francs per day for cost of stay and board
Category 8	up to 150 francs per day for cost of stay and board

2. If an insured person with a private or semi-private plan that involves one of the deductible options listed in Article 5 Paragraphs 2 and 3 opts for treatment in a general ward, the deductible in the supplementary insurance plan does not apply to treatment on the general ward. If a privately insured person with a deductible option as laid out in Art. 5 para. 3 chooses treatment in the semi-private ward, the deductible is reduced to 300 francs per day up to a maximum of 6 000 francs per year.

Article 10 Day clinics

1. If an inpatient hospital stay can be avoided by means of a lower cost outpatient procedure in a day clinic recognised by SWICA, the costs are paid from this supplementary insurance plan. The evaluation is the responsibility of SWICA.
2. No co-payment shall be expected of the insured person for costs which exceed the benefits of the compulsory health insurance.

Article 11 Special and psychiatric clinics

1. For stays in psychiatric clinics or special psychiatric wards in recognised hospitals and in rehabilitation clinics, multipurpose sanatoriums, climatological wards and sleep clinics, the following contributions shall be paid in Categories 2 to 5 supplementary to the insurance for hospital care:

Day 1–180	Costs borne according to insured hospital ward
From day 181	Category 2 + 3 80 francs per day
	Category 4 + 5 150 francs per day

   In the HOSPITA Category 6, costs are borne with no limit on the sum. In the HOSPITA Categories 1, 7 + 8, no benefits are paid.
2. These benefits shall be paid for a maximum of 720 days within 900 consecutive days.

Article 12 Maternity

1. If maternity risk is included in the insurance plan, SWICA shall pay the same benefits as in the case of illness. Following delivery, SWICA shall also pay the cost of the stay and treatment of the infant from the insurance of the mother, provided the infant is insured by SWICA and for as long as the infant remains with the mother in the hospital.
2. The entitlement to benefit in the case of maternity begins after 360 days from the start of the insurance.

Article 13 Health spa treatments

1. In the case of spa treatments which are prescribed by a doctor, approved beforehand by SWICA, and provided in a recognised health spa in Switzerland or in special cases – upon request and with the prior approval of SWICA – abroad, SWICA shall pay the following contributions to the costs of the stay and the treatment for not more than 30 days per calendar year:

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

   In Categories 7 + 8 no benefits shall be paid.
2. The payment of contributions to the spa treatment is conditional upon the insured person submitting to a medical examination on admission and discharge and undergoing intensive balneological and physiotherapeutic treatments.
3. The prescription for spa treatment shall be submitted to SWICA not less than 14 days before entering the spa.

Article 14 Convalescence stays

1. In the case of convalescence treatments which are prescribed by a doctor, medically indicated, approved by SWICA beforehand and provided in a health spa which appears in the SWICA list, SWICA shall pay the following contributions towards the stay for not more than 30 days per calendar year:

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

   In Categories 7 + 8 no additional benefits shall be paid.
2. The prescription for convalescence shall be submitted to SWICA not less than 14 days before entering the spa.

Article 15 Home care

1. SWICA shall pay the following contributions to the documented costs for the care of insured persons at home within the person's own household:

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

   In Categories 7 + 8 no benefits shall be paid.
2. The need for care by the insured person must be shown with a doctor's certificate.
3. The contributions shall also be paid to family members or relatives if they can show loss of earnings arising from the provision of such care.
4. These benefits shall be paid for a maximum of 720 days within 900 consecutive days.

Article 16 Home help

1. SWICA shall pay the following contributions, for not more than 60 days per calendar year, towards the documented costs for home help which is necessary for work in the insured person's own household:

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

   In Categories 7 + 8 no benefits shall be paid.
2. The need for home help must be confirmed by a doctor's certificate.
3. The contributions shall also be paid to family members or relatives if they can confirm loss of earnings arising from the provision of such home help.

Article 17 Orthodontic surgery

1. For orthodontic surgery, SWICA shall bear the costs which are not covered based on the rates for of the general ward of the public hospital in the canton of residence closest to the insured person's place of residence, amounting to not more than 10 000 francs per calendar year.
2. In the case of outpatient treatment, SWICA shall bear the costs not covered under the rates defined in the Federal Law on Accident Insurance (UVG) by applying the rate factor for health insurers, at the most 10 000 francs per calendar year.
3. In Categories 7 + 8 no benefits shall be paid.

Article 18 Emergency transports and transfers

SWICA shall pay up to 90 % of the effective overall costs (other benefits paid shall be taken into account) for emergency or medically indicated transfers to the nearest doctor or hospital, as follows:

Category 1	5 000 francs per calendar year
Category 2–6	unlimited

In Categories 7 + 8 no benefits shall be paid.

Article 19 Costs of repatriation and search/rescue operations

1. SWICA shall pay 90 % of the repatriation costs from abroad to Switzerland and the costs for the search/rescue of an insured person, amounting to the following maximum contributions per event:
   Category 1 5 000 francs
   Category 2–6 20 000 francs
   In Categories 7 + 8 no additional benefits shall be paid.
   Payment of the benefits listed above is conditional upon the SWICA emergency call centre being contacted.
2. In the case of such operations being undertaken without the approval of SWICA, SWICA may reduce the benefits or refuse payment.

IV Lists and directories

Article 20 Lists and directories

The lists and directories mentioned in these General Insurance Conditions shall be placed at the disposal of the insured person at any time.

V Premiums

Article 21 Choice of premium model

The premiums are set annually by SWICA in the form of a rate. The decisive criterion is the rate applicable for the selected premium model. Under the HOSPITA supplementary plan, the insured person has a choice of the following two models:

1. Premium model: Age at entry
   If the insured person chooses the "age at entry" model, then his or her age at the time of concluding the insurance agreement is the definitive criterion for determining the premium.
2. Premium model: Age of insured person
   If the insured person chooses the "age of insured person" model, then the premium is regularly adjusted at the beginning of each calendar year to his or her new age group.
3. For insured persons who are accepted into the insurance plan before the age of 18 or before the age of 25 at a special rate for children or adolescents, respectively, the next level up is calculated for the premium from the start of the policy year which follows the 18th or 25th birthday. Unless notification the insured person expressly requests assignment to "age at entry" model, the person will be automatically assigned to the actual "age of insured person" model.
4. A change from the "age at entry" model to the actual "age of insured person" model or vice versa must be requested in writing by the insured person.

VI General provisions

Article 22 Coordination with other insurance companies

1. The benefits covered by these conditions shall only be paid supplementary to the basic healthcare insurance of SWICA and COMPLETA TOP healthcare insurance plans. If the basic insurance cover is provided by a different insurance plan, then no benefits shall be paid from the HOSPITA plan for costs which would be borne out of the healthcare insurance and the COMPLETA TOP insurance plan, if such insurance agreements had been concluded with SWICA.
2. The co-payment percentage of the insured person is calculated separately in every SWICA insurance line, the basis in each case being the aggregate costs.

Article 23 Applicable law

Supplementing these provisions, the General Insurance Conditions of SWICA and the conditions of other supplementary insurers apply.

Annex 1

List of operations in which a second medical opinion must be sought from SWICA before the planned surgical procedure

Gynaecology/obstetrics

1. Hysterectomy (removal of the womb)
2. Planned caesarean section

Orthopaedic surgery

3. Operation of hallux valgus (correction of big toe deformity)
4. Hip and knee replacements
5. Arthroscopy (examination of the interior of a joint)
6. Repair of ligaments in knee and ankle joints

Neurosurgery

7. Herniated disc operation (slipped disc)

Urology

8. Prostatectomy (removal of the prostate)

Ear/nose/throat surgery

9. Tonsillectomy/adenoidectomy (removal of tonsils/adenoids)

Abdominal surgery

10. Cholecystectomy (removal of gall bladder) except in cases of suspected malignancy

Eye treatment

11. Cataract operation
12. Cornea transplant

Other

13. Treatment for varicose veins

DENTA dental treatment insurance

I General scope

Article 1 Purpose
SWICA shall pay the cost of dental treatment, dental prostheses and preventive care from the DENTA insurance plan.

Article 2 Insurable persons
1. Anyone who has not yet reached the age of 60 can apply for this insurance plan.
2. The SWICA acceptance form must be completed by a dentist. The costs of the dental treatment examination shall be charged to the applicant.

II Scope of insurance

Article 3 Scope of insurance
A DENTA insurance agreement can be concluded with the following options:
Benefit category 1:
50 % of the dentist's fees, amounting to not more than 500 francs within a calendar year
Benefit category 2:
50 % of the dentist's fees, amounting to not more than 1000 francs within a calendar year
Benefit category 3:
75 % of the dentist's fees, amounting to not more than 1500 francs within a calendar year
Benefit category 4:
75 % of the dentist's fees, amounting to not more than 2000 francs within a calendar year
To calculate the percentage share of the costs, for which the effective total costs serve as the basis, the contributions of all healthcare, accident, supplementary, and additional insurance plans as well as public offices are taken into account.

III Benefits

Article 4 Benefits
1. SWICA shall pay for the dental treatments carried out by a certified dentist according to the insurance plan chosen.
2. For insured persons who have not yet reached the age of 25, double contributions shall be paid in the case of orthodontic treatments.
3. No obligation exists in respect of dental care products and cosmetic treatment.
4. SWICA shall pay no benefits for the consequences of accidents which occurred before the start of the insurance.
5. If the insurance starts during the calendar year, the entitlement to benefit (insured maximum rate) is calculated pro rata according to the number of insured months.

Article 5 Decisive criterion for rates
SWICA shall pay for dental treatments which have been carried out in accordance with economic principles. The debtor in respect of the dentist is the insured person.

Article 6 Exclusion of benefits
For teeth missing at the time of entry into the insurance plan, there shall be no entitlement to benefit in the case of later replacement.

IV General provisions

Article 7 Supplementary benefits
The benefits covered by these conditions shall be paid supplementary to the benefits from the STANDARD healthcare insurance and any further supplementary insurances with SWICA. If the mandatory healthcare costs are insured with another health insurance company, then no benefits shall be paid from the DENTA plan for costs which would be reimbursed out of the basic healthcare insurance and COMPLETA TOP insurance plans, if such insurance agreements had been concluded with SWICA.

Article 8 Applicable law
Supplementing these provisions, the General Insurance Conditions of SWICA and the conditions of other supplementary insurers apply.

INFORTUNA accident insurance

General scope

Provision of insurance
SWICA Healthcare Insurance Ltd, Römerstrasse 38, 8401 Winterthur, hereinafter referred to as SWICA.

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

I Scope

Article 1 Purpose
These Supplementary Insurance Conditions govern the individual accident insurance supplementary to the healthcare insurance (KVG), accident insurance (UVG), military insurance (MVG), and disability insurance (IVG). The General Insurance Conditions are deemed an integral part of this insurance agreement, provided they do not contradict these Supplementary Insurance Conditions.

II Choice of insurance plans

Article 2 Insurance plans
The insured person may choose from the following insurance plans:
- Payment of a lump sum in the event of death from an accident
- Payment of a lump sum in the event of disability from an accident
- Treatment cost insurance as a supplement to healthcare insurance (KVG), accident insurance (UVG), military insurance (MVG), disability insurance (IVG)

III Conclusions of insurance agreement

Article 3 Conclusion of agreement
The accident insurance agreement can be concluded up to the statutory age for retirement (AHV). An increase in insurance is equivalent to a new entry.

IV Payment of a lump sum in the event of death or disability from an accident

Article 4 Insurance sums
1. The insurance sums listed in the policy apply.
2. The maximum guarantee of the insurer for one and the same person from all accident insurance currently provided by the insurer together is limited, insofar as it covers aviation risk without any special premiums, to 500 000 francs for an aviation accident in the case of death and 1 000 000 francs in the case of full disability (with a corresponding reduction in the case of partial disability).
3. From the age of 70 onwards, the following maximum insurance sums apply:
   - in the case of death 50 000 francs
   - in the case of disability 100 000 francs

   Existing insurances shall be reduced accordingly when this age limit is reached.
4. For insured persons who have passed the age of 70 at the time of the accident, the progression to disability insurance is not applicable.
5. The lump sum on death for children up to the age of 30 months is limited to 2 500 francs and for children up to the age of 12 to 20 000 francs.

Article 5 Death
1. If the accident can be shown to have resulted in the death of the insured person immediately or within five years of the date of the accident, the insurer shall pay the sum insured for death to the survivors named herein, who are entitled to the sum in the following sequence on the following scale:
   a) The full lump sum on death to the surviving spouse, in the absence of whom to the children, in the absence of whom to the parents and in the absence of whom to the legal heirs, excluding public bodies. Spouses and children from a marriage entered into after the accident have no entitlement.
   b) As an amendment to the regulations governing beneficiaries, the insured person can designate or exclude beneficiaries by notifying SWICA in writing. Such a declaration may be revoked or amended at any time by notification of SWICA in writing.
   c) If there are no entitled persons as listed under letters a and b, the insurer shall pay the costs of the funeral, but not more than 10 % of the lump sum on death.
2. A disability lump sum paid out as defined in Article 6 will be counted with the lump sum on death.

Article 6 Disability
1. If the disability results in a disability of the insured person within five years of the date of the accident which is considered to be probably permanent, the insurer shall pay the agreed insurance sum for the case of disability. In the case of full disability, this sum shall be payable in full, and in the case of partial disability the sum shall be payable in part corresponding to the degree of the disability.
2. Full disability is regarded as the loss of or inability to use both arms or hands, both legs or feet, the simultaneous loss of an arm or a hand and a leg or a foot, complete paralysis, and total blindness.
3. In the case of partial disability, that part of the insured sum intended for full disability shall be paid according to the degree of disability. The appraisal shall be made on the basis of the following percentages:

Loss of:	Degree of disability
Upper arm	70%
Forearm	65%
Hand	60%
Thumb with metacarpal joint	25%
Thumb, metacarpal joint preserved	22%
Proximal digit of thumb	10%
Index finger	15%
Middle finger	10%
Ring finger	9%
Little finger	7%
A leg at the thigh	60%
A leg below the knee	50%
A foot	45%
A big toe	8%
Other toes, each	3%
Eyesight of one eye	30%
Eyesight of second eye for one-eyed subjects	50%
Hearing in both ears	60%
Hearing in one ear	15%
Hearing in one ear if that of the other ear was already completely lost before the start of the insurance event	30%
Kidneys	20%
Sense of smell	10%
Sense of taste	10%
Very painful functional deficit of the vertebral column	50%

In the case of only partial loss or incapability, a correspondingly lower degree of disability applies. For cases not listed here, the degree of disability is determined on the basis of the doctor's findings

with regard to the rates for damage to physical integrity shown in Annex 3 of the ordinance on accident insurance (UVV).

4. In the case of simultaneous loss or loss of use of several parts of the body as a result of the same accident, the degree of disability shall as a rule be determined by the addition of the percentage points. However, it can never amount to more than 100 %. With the loss of all the fingers of a hand, the maximum disability lump sum payable shall be the sum corresponding to the loss of the hand.
5. If parts of the body or the use thereof were wholly or partially lost before the accident, the degree of disability shall be established with a deduction of the degree of pre-existing disability determined according to the above principles.
6. The lump sum insurance for disability is applicable with progressive insurance sums (exception: Article 4, Paragraph 4): Progression 350 %. Compensation of more than 25 % in the event of a disability 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. The insured person is entitled to the disability benefit.
8. If retraining is necessary as a result of an accident for which the insurer has paid benefits, the insurer shall bear the reasonable cost of such retraining, but not more than 10 % of the insured disability sum.

V Treatment costs

Article 7 Benefits

The insurance covers the healthcare benefits and cost reimbursements not covered by the compulsory healthcare insurance (KVG), accident insurance (UVG), military insurance (MVG) or disability insurance (IVG), namely:

a) Procedures performed or prescribed by a doctor, dentist or chiropractor with a federal licence to practise or equivalent qualification from another country.
b) In the case of hospital stays, SWICA covers the costs of a private hospital ward.
c) The costs of naturopathic treatment carried out according to therapeutic methods of complementary medicine are covered by SWICA, provided the treatment is administered by a SWICA-recognised doctor, a SWICA-recognised naturopath or a person recognised by SWICA as practising complementary medicine. SWICA keeps a list of recognised healing methods and a directory of the recognised therapists. The list and the directory are adjusted regularly, and the insured person can inspect them or request extracts thereof.
d) The costs of medically prescribed psychotherapy by an independent psychotherapist to treat a mental disorder. The psychotherapist must have a qualification recognised by the federal or cantonal authorities or be a member of the Swiss Psychotherapists Association (SPV).
e) Medically prescribed home care by qualified nursing staff. Such staff may include nurses provided by nursing associations and home care organisations, as well as home helps (excluding family members).
f) Costs for courses of rehabilitation and spa treatment.
g) Medical treatments abroad.
h) Appropriately designed aids to compensate for physical damage or functional deficits.
i) Damage to devices which replace a part or function of the body; in the case of glasses, hearing aids and dental prostheses, the insured person is entitled to claim compensation only in the event of physical damage requiring treatment.
j) Medically indicated journeys and transports, also any necessary rescue operations or transport of the body. Search operations for the rescue of the insured person are subject to a limit of 20 000 francs.

Article 8 Hospitals and health spas

1. A hospital is deemed to be an institution or ward thereof which is intended for inpatient treatment of diseases or consequences of accidents, is under constant medical supervision, and has the necessary properly trained nursing staff and suitable medical facilities at its disposal.
2. A health spa is deemed to be an institution which is intended for follow-up treatment or rehabilitation, is under medical supervision, and has the necessary properly trained nursing staff and suitable medical facilities at its disposal.

Article 9 Deductible

Deductibles, excesses and fees imposed by the healthcare insurance or the compulsory accident insurance are not covered by this insurance.

VI General provisions

Article 10 Insured accidents

1. The insurance covers all occupational and non-occupational accidents which occur during the contract term.
2. An accident is deemed to be the sudden, unintended damaging effect of an unusual external factor on the human body, which may result in an impairment of physical or mental health or lead to death.
3. The following is a conclusive list of the types of physical injury which are deemed equivalent to an accident even without the influence of unusual external factors, provided they are not attributable to disease or degeneration:
   a) Bone fractures, unless they are unequivocally attributable to a disease;
   b) Dislocation of joints;
   c) Torn meniscus;
   d) Torn muscle;
   e) Pulled muscle;
   f) Tendon rupture;
   g) Ligament injuries;
   h) Ear drum injuries.

Article 11 Exclusions and reductions in benefit

1. Accidents that fall under Article 9 of the General Insurance Conditions are excluded from this insurance.
2. SWICA or the insurer waives its legal right to reduce benefits in the event of an accident resulting from gross negligence.

Article 12 Coincidence of the consequences of an accident with diseases, ailments and the consequences of earlier accidents

If the consequences of the accident are substantially aggravated by pre-existing diseases, disabilities or the consequences of earlier accidents which have not just been induced by the new accident, the insurance benefits shall be reduced commensurately. This restriction does not apply for treatment costs.

Article 13 Area of applicability

The insurance is valid worldwide.

SALARIA daily benefits insurance under the VVG

I General contract basis

Article 1 What is the basis of this contract?

This contract is based on:

1. The General Insurance Conditions, any supplementary conditions and the provisions laid down in the policy and any supplements;
2. The Insurance Contract Act (VVG) from 2 April 1908 for matters which are not covered by the items mentioned under Paragraph 1;
3. All contractual agreements between SWICA and the policyholder or the insured person must be made in writing.

II Scope of insurance protection

Article 2 ! What does the insurance cover include?

1. SWICA provides insurance cover against the financial consequences of disease and childbirth within the limits of the agreed benefits. It compensates the insured person for actual and documented loss of pay and earnings up to a maximum of the level of insured daily benefit.
2. For householders, the documentation of a loss of pay and earnings up to the insured sum of 40 francs is not a precondition for the obligation of SWICA to pay benefits.

Article 3 What do we define as an illness?

An illness is any impairment of physical or mental health which is not the consequence of an accident and which requires a medical examination or treatment or which results in incapacity for work.

Article 4 Who is insured?

All persons who have their place of residence in Switzerland and the Principality of Liechtenstein and have reached the age of 15 but not yet reached the age of 65 can take out SALARIA insurance in the context of their earning capacity.

Article 5 Where does the insurance apply?

1. The insurance is confined to Switzerland and the Principality of Liechtenstein.
2. Insured persons who fall ill abroad are entitled to benefits for 10 days. This restriction does not apply to hospital stays, provided they are necessary for medical reasons.
3. If an insured person who is unfit for work travels abroad without our approval, this person is not entitled to any benefits during the period of the stay abroad.
4. For cross-border commuters, the restrictions defined in Paragraphs 1–3 only apply in the case of stays outside the border region.

Article 6 What happens in the case of a disease resulting from gross negligence?

SWICA waives it right by law to reduce the insurance benefits if the insured person has induced the illness through gross negligence.

Article 7 ! In what cases is there no insurance protection?

No entitlement to benefits exists in the case of:

a) Diseases for which compensation is provided under the compulsory accident insurance (UVG).
b) Damage to health resulting from the effects of ionising radiation. However, damage to health resulting from medically prescribed radiotherapy for an insured disease is covered.
c) Diseases resulting from incidents of war. If the insured person is overtaken by the outbreak of such incidents outside Switzerland, however, insurance cover remains in effect for 14 days after the first occurrence of such incidents.

III Insurance benefits

Article 8 ! When does the entitlement to compensation apply?

1. If the insured person is medically confirmed to be unfit for work, SWICA shall pay the insured compensation in the case of full incapacity for work according to the actual and proven loss of pay.
2. In the case of a partial incapacity for work of at least 25 %, the compensation shall be paid according to the degree of incapacity.
3. Following childbirth, the obligation for payment of benefits shall be suspended for eight weeks. This does not apply in the case of an insurance for a childbirth benefit.

Article 9 What do we define as incapacity for work?

Incapacity for work is the full or partial inability to perform work that can be reasonably expected of that person within his or her job or area of responsibility to date owing to an impairment of physical or mental health. After three months of incapacity for work, employment which can be reasonably expected of a person in another job or area of responsibility is also included in this definition.

Article 10 ! How is the waiting period calculated and what is deemed to be a relapse?

1. The waiting period begins with the first day of the medically confirmed minimum of 25 % incapacity for work, but not sooner than three days before the first medical treatment. It is to be calculated for every new case of illness. The days of partial incapacity for work of at least 25 % count as whole days for calculating the waiting period.
2. With regard to the waiting period and the period of benefits,
   – a recurrence of the illness (relapse) is regarded as a new case of illness if the insured person was not incapacitated for a period of 12 months as a result of the illness;
   – a new illness is regarded as a new case if the insured person has fully resumed work for at least two months after the period of incapacity for work.

Article 11 ! How long are daily benefits paid?

1. Daily benefits are paid for 720 days within 900 consecutive days, counting any agreed waiting period. In the case of a change from a group to an individual contract, any benefits already paid shall be counted.
2. Days of partial incapacity for work of at least 25 % count as full days for assessing the duration of the benefits.
3. If an additional illness occurs during a case of illness, the days for which the person is entitled to benefits for the first case are taken into account in the period during which benefits are paid.
4. From statutory (AHV) retirement age onwards, daily benefits continue to be paid out for a maximum of 180 days for all current and future insurance cases, but not beyond the age of 70. If the insured person is unfit for work when he or she reaches the statutory (AHV) age of retirement, entitlement to benefit ceases unless the insured person can show that the employment contract had continued during the period of incapacity for work.
5. The obligation to provide benefits ends when the insurance cover ends.

Article 12 When does entitlement to childbirth benefits apply?

1. A childbirth benefit which is included in the insurance agreement is paid for 56 days for every birth. Any waiting period that is agreed is not counted in the duration of benefits.
2. If the insurance agreement for a childbirth benefit was concluded for the mother less than 270 days before the time of childbirth, no childbirth benefit is payable.
3. State social security benefits are taken into account in the benefits of SWICA from childbirth benefits insurance. For the period during which an insured person receives benefits from the SWICA insurance for childbirth benefit or from state social security benefits, the obligation of SWICA to pay benefits from the daily benefits insurance is suspended.
4. The childbirth benefit is not counted in the duration of benefits as defined in Article 11, Paragraph 1.

Article 13 Unemployment

1. If the insured person is deemed to be unemployed within the meaning of Article 10 of the Unemployment Insurance Act (AVIG), SWICA shall pay the benefits up to the level of the lost unemployment compensation as follows:
   a) half the daily benefit with incapacity for work of more than 25%;
   b) the full daily benefit with incapacity for work of more than 50%.
2. Unemployed insured persons have the unconditional right to change their current daily benefits insurance into an insurance of the same value with a waiting period of 30 days subject to adjustment in the premium.

IV Start and duration of insurance protection

Article 14 Start 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.

Article 15 Right of withdrawal

1. Within the first 7 days after the signing of the application, the applicant has the right to withdraw his or her application. The withdrawal must be sent by registered letter to SWICA Healthcare Organisation, Head Office, P.O. Box, 8401 Winterthur.
2. With the sending of a declaration of withdrawal, any existing provisional insurance cover as well as the definitive cover also ceases retrospectively.

Article 16 ! Exclusion of cover/refusal

1. Diseases which are or were present at the time of acceptance may be excluded (exclusion of cover). If information about diseases was withheld at the time of acceptance, the exclusion of cover may be applied retrospectively. SWICA may refuse to conclude an agreement without giving any reasons.
2. For diseases excluded from cover, there shall be no entitlement to benefits. This applies also if information about diseases was withheld at the time of acceptance.
3. In the case of any new or increased insurance cover, SWICA may demand a medical examination. By virtue of the signature on the application, SWICA is empowered to make the necessary enquiries of official departments, doctors and third parties.
4. If the person under obligation to provide information withholds or incorrectly discloses substantial details which he or she knew or must have known when the agreement was concluded, SWICA may give written notice of termination of the contract within four weeks after becoming aware of this non-disclosure and may demand the repayment of all benefits relating to the breach of obligation since the start of the agreement.
5. In the case of increased insurance cover, the same provisions apply as for new admissions.

Article 17 When may the insurance be changed?

Insurance cover may be reduced at the end of any month. While benefits are being received, the reduction of the daily benefits may only be made by mutual agreement.

Article 18 ! When does the insurance cease?

1. Daily benefits insurance can be terminated from the end of a calendar year, subject to notice of three months. The notice is deemed to be in time if it is received by SWICA not later than the last day before the start of the three-month period of notice.
2. Daily benefits insurance can be terminated by the insured person after incapacity for work for which SWICA is paying benefits. At the latest 14 days after receipt of the benefits, the insured person may terminate the corresponding part of the agreement. The cover ceases 14 days after receipt of the notice by SWICA.
3. SWICA waives its right to dissolve the agreement after the occurrence of an insured event, except in cases of attempted or committed insurance fraud. In such cases, SWICA may terminate the agreement within 14 days after becoming aware of the fact.
4. Even without notice of termination, the insurance automatically ceases when the insured person has had his or her normal place of residence abroad for three months. Cross-border commuters may remain insured as long as they receive unemployment benefits and, in the case of incapacity for work, can prove loss of earnings.

5. Daily benefits insurance also ceases
   a) when benefits with the unemployment insurance cease
   b) when the statutory retirement (AHV) age is reached. This does not apply to persons who are still in permanent employment and completely fit for work, which would result in documented loss of earnings in the event of illness. Daily benefits insurance definitively ceases when such an insured person has received daily benefits for 180 days after reaching AHV age
   c) with death
   d) on exhaustion of the entitlement to benefits.

Article 19 What happens after cancellation of the insurance?

1. Consequences of diseases and delayed effects and relapses which occur after termination of the insurance are not insured.
2. The entitlement to benefits ceases in all cases with the termination of the agreement.

V Obligations in a case of illness

Article 20 Period for notification of the illness

1. Claims for daily benefits must be submitted within five days of expiry of the waiting period. However, if a waiting period of more than 30 days is agreed, the claim must be made not later than after 30 days' incapacity for work or gainful employment. A doctor's certificate must be submitted with the claim. The corresponding costs are charged to the insured person.
2. If notification of the illness is not received until later, then the day on which it arrives is deemed the first day of incapacity for work.
3. If the illness lasts for more than one month, SWICA requires a monthly report on the degree and duration of incapacity for work. In this case, SWICA shall pay daily benefits on a monthly basis.

Article 21 Obligations of the insured person

The insured person shall do everything that serves the investigation of the disease and its consequences. In the sense of an obligation to minimise loss, the insured person must refrain from all activities that are incompatible with the incapacity for work or with the receipt of daily benefits and which delays the recovery process. The doctors who treat or have treated the insured person shall be released from their duty of confidentiality towards SWICA.

Article 22 Consultation of an approved doctor

1. The insured person shall consult an approved doctor as soon as possible after the onset of an illness and ensure that this is properly treated. The insured person shall follow the instructions of the doctor and the nursing staff.
2. SWICA may request an examination by a doctor of its own choosing. In this case, SWICA bears the travel costs of the most favourable means of public transport as well as other expenses as laid down in SUVA guidelines.
3. SWICA is entitled to make patient visits and request additional documents and information, in particular doctor's certificates.
4. If an insured person discontinues or refuses a treatment or reintegration into working life which can be reasonably expected of the person and which promises a substantial improvement in capacity for work or a new employment opportunity, or if the person does not on his or her own initiative contribute what can reasonably be expected of this person, then the benefits may be reduced or refused either temporarily or for a lengthy period.

Article 23 Duty to minimise loss

1. An insured person unable to work in his or her usual profession shall seek a job in another line of work within three months or register with the authorities for disability or unemployment insurance.
2. If the insured person does not make use of his or her residual capacity for work, daily benefits shall be calculated on the basis of the insured person's duty to minimise loss.
3. If the insured person fails to register with the unemployment insurance or the disability insurance, SWICA is entitled to stop payments of daily benefits. Any benefits are calculated on the basis of the assumed benefits payable from these insurances.

Article 24 What happens if the insured person is also entitled to benefits from third parties?

1. If the insured person is also entitled to benefits from state or company insurance schemes or has received benefits from a third-party liability insurance, SWICA shall supplement these payments to the value of the insured daily benefits.
2. If the level of entitlement to a disability pension has not yet been settled, SWICA may pay the insured daily benefits on a voluntary basis in the form of an advance. In this case, SWICA shall reclaim any excess benefits paid from the beginning of the entitlement to a disability pension onwards. Any advance is subject explicitly to it being set off against the federal disability pension (IV). The offset amount is prorated based on the disability pension granted for the same period and may be made without the additional authorisation of the insured person.
3. In the framework of voluntary advance payments in place of a liable third party, SWICA shall pay daily benefits within the limits of its benefits to cover loss of earnings only if the claims of the insured person or the person with entitlement have been assigned in writing.
4. If several insurances with concessioned companies exist to cover loss of earnings, the insured loss of earnings from this agreement shall only be covered in proportion to the benefits guaranteed by all insurers involved.
5. If the insured person reaches a settlement with a third party without the prior agreement of SWICA, SWICA's obligation to pay benefit shall not apply.
6. SWICA is not under an obligation to pay benefit if the insured person does not lodge his or her claim against a third party in good time or make any effort to obtain compensation.
7. The insured person shall immediately inform SWICA about the nature and extent of all benefits of third parties.

Article 25 Consequences of failing to meet obligations in the event of an illness

In cases of noncompliance with the obligations set forth in Articles 20–24, SWICA can reduce or refuse its benefits, unless it is proven that the act in question was not culpable and had no influence on the consequences and findings of the illness or accident.

VI Premium

Article 26 When are the premiums due?

The premiums are payable in each case in Swiss francs on the first day of the month of a period of payment.

Article 27 Late payment

1. If the premium is not received within one month of the due date, SWICA shall issue a reminder to pay within 14 days of this reminder being sent. If the reminder is ignored, the obligation to pay benefits is suspended with effect from expiry of the period of notice.
2. SWICA is entitled to reclaim costs generated by insured persons in default of payment, such as the cost of reminders, enforcement proceedings and interest on arrears etc. or to set these costs off against entitlements to reimbursement.

VII Additional provisions

Article 28 Accident insurance

1. If a daily benefit in the event of accidents has been agreed, SWICA shall also grant insurance protection against the financial consequences of accidents, physical damage similar to that suffered in an accident and occupational illnesses supplementary to Article 2 of these General Insurance Conditions.
2. The insurance covers occupational accidents, physical damage similar to that suffered in an accident, occupational illnesses and non-occupational accidents which occur or are caused during the period of this supplementary insurance agreement. The definitions used in statutory accident insurance (UVG) also apply to accidents, bodily injury similar to accidents, and occupational diseases.
3. If the insured person has caused the accident as a mistake, the insured daily benefits shall be reduced in accordance with UVG practice.
4. There shall be no entitlement to insured benefits for accidents:
   a) which the insured person has deliberately caused;
   b) resulting from earthquakes in Switzerland and the Principality of Liechtenstein;
   c) resulting from the events of war in Switzerland and the Principality of Liechtenstein;
   d) resulting from the events of war abroad. However, if war breaks out for the first time and takes the insured person by surprise in the country where he or she is staying, insurance cover remains in force for a further 14 days from the outbreak of war;
   e) during military service in a foreign army;
   f) resulting from criminal acts the insured person commits or attempts to commit;
   g) resulting from unrest of any kind and the measures taken to quell any such unrest, unless the insured person can show that he or she was not involved on the side of the agitators either actively or by incitement;
   h) occurring during participation in motor vehicle races or rallies, including training races; or
   i) damage to health resulting from the effects of ionising radiation of any kind. The insurance does, however, cover damage to health caused by medically prescribed radiotherapy because of an insured accident. Damage to health resulting from occupationally related irradiation is likewise insured if it would justify an obligation to pay benefits as laid down in the UVG.
5. Moreover, the provisions of these General Insurance Conditions and the agreement apply by analogy.

Article 29 Place of performance and legal venue

1. The obligations arising from this agreement shall be fulfilled in Switzerland and in Swiss currency. The insured person undertakes to notify SWICA of a Swiss bank or postal account as the address for payment.
2. The insured person may opt for an ordinary court of law and his or her place of residence in Switzerland or the Principality of Liechtenstein as the legal venue for any court action.

Article 30 Tax at source

For insured persons subject to tax at source, the tax shall be deducted from the benefits.

Article 31 Offsetting and reclaiming of payments in error

Daily benefits paid in error shall be reimbursed by the insurer upon written request. SWICA has the right to offset any such payments. The insured person does not have any offsetting rights.

Article 32 Prohibition of assignment and pledges

Claims against SWICA may be neither assigned nor pledged. Assignment or pledging of any such claims over SWICA cannot be enforced.

Article 33 To whom should notifications be addressed?

1. All notifications can be addressed to the agency responsible or to SWICA's Regional Agency or Head Office in Winterthur.
2. Notifications with legal force from SWICA to the insured person are sent to the most recent address in Switzerland on file.

Glossary

These terms form an integral part of the General Insurance Conditions.

Accident
An accident is the sudden, unintended damaging influence of an unusual external event on the human body which leads to an impairment of physical or mental health or to death.

Agreements on free movement of persons
Agreements on relations between Switzerland and EU/EFTA member states which came into force on 1 June 2002. With the agreement on free movement of persons, the same living, employment and work conditions apply to EU/EFTA and Swiss citizens both in Switzerland and in the member states of the EU and EFTA.

ATSG
Swiss federal law on the general part of the social security law of 6 October 2000, in force since 1 January 2003.

Basic healthcare insurance
Basic insurance is the healthcare insurance that is compulsory by law for all people living in Switzerland.

BPV
Swiss Federal Office of Private Insurances. Is part of the Federal Department of Finance.

Care management
SWICA offers care management services with over 50 specialists. They support our insured persons in the event of illness or accident. They also handle organisational matters and accompany convalescing patients in order to avoid long-term absences or even disability.

Complementary medicine
Complementary medicine includes all forms of therapy that do not come under the heading of orthodox medicine. SWICA keeps a directory of recognised therapists. SWICA Customer Service sends the insured person extracts from the list at any time according to his or her individual wishes (e.g. therapists in a certain specialist field and in a certain region). The scope of the online directory (www.swica.ch) is also been constantly extended.

Commitment to provide cover
The consent of the health insurance company to pay a benefit for a planned treatment. Before a hospital stay, it is important to obtain a commitment to provide cover from the customer services department responsible.

Co-payment
When insured persons make use of medical services (for example, visits to the doctor, medicines, therapists), they bear part of the cost themselves. This is what is understood as co-payment. It comprises
– the annual franchise in the basic healthcare insurance;
– the excess in the basic healthcare insurance;
– the excess in supplementary insurance.
The co-payment (annual franchise and excess) is counted towards all insurance agreements concluded with SWICA.
This is one of the particular advantages of SWICA over competitors, which add the co-payments from all insurance plans.

EDI
Federal Department of Home Affairs.

Emergency
An emergency is a situation in which medical treatment cannot be delayed.

Deductible
The deductible in basic healthcare insurance is the percentage share of the costs paid by the insured person for medical treatment and medicines. It usually amounts to 10 % (see below for exceptions) and has an upper limit. Children and adolescents up to the age of 18 pay a maximum deductible of 350 francs per year, and adults a maximum of 700 francs.
The deductible in basic healthcare insurance amounts to 20 % if expensive original medicines are used instead of generics without any medical reason.
The deductible in supplementary insurance plans is a fixed sum, which first has to be paid by the insured person in the case of medical treatment (charged to a supplementary insurance).
For further explanations, see ‘co-payment’.

Excess
The excess is one of two co-payment elements in compulsory healthcare insurance. The excess is required by law, and the level of the excess, which can be chosen by the insured person, defines the fixed annual sum which he or she pays for medical services. The legally stipulated excess amounts to 300 francs per annum for adults aged 19 years or more, who thus pay the first 300 francs which is charged by doctors, pharmacies etc. for medical services. No annual excess is levied for children and adolescents aged up to 18 years.
The insured person may increase the excess voluntarily (optional excess) and receives a discount on the basic healthcare insurance premium in return. Optional excesses are also possible for children and adolescents aged up to 18 years.
For further explanations, see ‘co-payment.’

Exclusion of cover
Exclusion of an existing condition from one type or several types of insurance for a fixed or unlimited period.

FINMA
Swiss Financial Market Supervisory Authority. Is part of the Federal Department of Finance.

Generics
Generics are medicines which contain the same active substance as the original product. They are imitation products and cannot be sold until the patent on the original product has expired.

Hospital list/directory of SWICA
List and directory of hospitals from which the insured person can choose for his treatment. The SWICA Customer Service sends the insured person extracts from the list according to his or her individual wishes (e.g. hospitals in a certain region). The scope of the online lists and directories (www.swica.ch) is constantly updated.

Illness
An illness is any impairment of physical or mental health which is not the consequence of an accident and which requires medical investigation or treatment or results in incapacity for work.

Inpatient treatment
Inpatient treatment is regarded as treatment involving a hospital stay of at least 24 hours or one night.

Insurance year
The insurance year corresponds to the calendar year.

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

KVV
Ordinance on healthcare insurance of 27 June 1995, in force since 1 January 1996.

List of pharmaceutical products with special uses (LPPV)
List of medicines which are not covered by the health insurers either from the compulsory healthcare insurance or from supplementary insurance plans according to VVG.

Lists and directories
All lists and directories of service providers mentioned in the insurance conditions, which are relevant for the assessment of benefits, can be placed at the disposal of the insured person. The SWICA Customer Service sends the insured person extracts from the lists according to his or her individual wishes (e.g. therapists in a certain specialist field and in a certain region). The scope of the online lists and directories (www.swica.ch) is also been constantly extended.
The lists and directories applicable at the time when the insured person makes use of services insured by SWICA are consulted for an assessment of the entitlement to benefits.

Maternity
Maternity covers pregnancy and delivery as well as the following period of recovery of the mother.

MiGel
"Mittel- und Gegenstände-Liste". List of the objects and aids (hearing aids, crutches, etc.) reimbursable by the health insurance companies as an obligatory benefit within the framework of the compulsory healthcare insurance.

Negative list
The negative list is a list of products which are not reimbursable by SWICA. This includes the LPPV (List of pharmaceutical products with special uses), medicines which are not registered by Swissmedic, food supplements and others.

Non-disclosure
Non-disclosure is when a person concluding a supplementary insurance agreement fails to answer any questions on health either truthfully or in full. As such it constitutes a breach of this person's obligations insofar as facts relevant to the assessment of risk which this person knew or must have known were not declared.

Notice of termination/amendment
The notice of termination/amendment is the period between the declaration of intent to terminate or amend an agreement and the point when this takes effect. To ensure that the period of notice is observed, the notice must be received by SWICA in writing not later than the last working day before the period of notice expires.

Orthodontic surgery
Orthodontic surgical treatment includes procedures after the growth of the body and the jaw has been completed in cases where there is a severe malposition of the jaw or a disproportionate relationship between upper and lower jaw that cannot be remedied by simple means.
Orthodontic surgery does not include the setting of implants and any sinus lift surgery that may be indicated (thickening of maxillary sinus). This is a direct tooth replacement, which is regarded as dental treatment.

Orthodox medicine
The medicine taught at University. Orthodox medicine employs only medicines and methods of treatment with proven efficacy. It embraces most of the knowledge and experience of western medicine.

Outpatient treatment
Intervention or treatment without an overnight stay in hospital, i.e. in which the stay lasts less than 24 hours.

Premium
The premium is the fee paid by the policyholder in exchange for the guarantee of insurance cover by the insurer. As a result of cost differences, the premiums may vary between cantons and regions. For insured persons up to the age of 18 (children), the insurer must set a lower premium in the compulsory healthcare insurance. Insurers can also do the same for their insured members who have not yet reached the age of 25. The premiums are paid in advance.

Premium reduction
People in modest financial circumstances are entitled to a reduction of the premium in the basic healthcare insurance. The responsibility for this varies from canton to canton. To clarify your entitlement, please contact your local community authority.

Repatriation
Repatriation measures apply when a return journey by public or private transport is not possible for medical reasons. Repatriation to the country of residence usually takes place with medical support, e.g. by ambulance, stretcher or aeroplane.

Relapse
The recurrence of an illness.

Second opinion
If there is any doubt as to whether a treatment or operation is necessary or appropriate, you can obtain a second opinion free of charge from another approved specialist.

Service provider
Service providers according to the Health Insurance Act are, in particular, doctors, pharmacists, chiropractors, midwives, and persons who provide services at the request of or on behalf of a doctor, and also laboratories, hospitals, nursing homes and spas which meet the legal requirements.

Specialities list (SL)
After approval of a new medicine by Swissmedic, a company can apply for inclusion of this medicine in the federal specialities list. The SL is a positive list: medicines listed in the SL must be reimbursed by health insurers, provided they have been prescribed by the doctor for the condition for which the medicines are registered in the SL.

Supplementary insurance
In addition to the compulsory healthcare insurance (basic insurance), voluntary supplementary insurance plans are also available. These can be concluded on an individual basis. However, the insurance companies can reject applications for insurance or accept them with an exclusion clause.

Swissmedic (formerly IKS)
Medicines may only be marketed in Switzerland if their safety, efficacy and quality have been adequately proved and verified. Swissmedic, the Swiss Agency for Therapeutic Products, is responsible for their approval.

UVG
Federal Law on Accident Insurance of 20 March 1981, in force since 1 January 1984.

VVG
Insurance Contract Act of 2 April 1908, in force since 1 January 1910.

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SWICA Healthcare Organisation
Because health is everything
Phone 0800 80 90 80 (24 hours a day), swica.ch