MANDATORY HEALTHCARE AND DAILY BENEFITS INSURANCE

GENERAL INSURANCE CONDITIONS (GIC) UNDER THE KVG.

Version of 2024, valid from 1 January 2024

BECAUSE HEALTH IS EVERYTHING SWICA

COMMENTS

These General Insurance Conditions apply to SWICA Healthcare Insurance Ltd, Römerstrasse 38, 8400 Winterthur.

To enhance readability, only the masculine form has been used for all references to people.

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GENERAL INSURANCE CONDITIONS FOR MANDATORY HEALTHCARE AND DAILY BENEFITS INSURANCE.

I. GENERAL

ART. 1 UNDERLYING PRINCIPLES

1. These GIC and any Supplementary Insurance Conditions that apply are not conclusive and merely supplement the statutory provisions.
2. They apply to healthcare and daily benefits insurance under the KVG.

ART. 2 SCOPE OF COVER

Healthcare insurance complies with the federal government's legal provisions and covers the cost of diagnosing and treating illness, maternity as well as accident-related conditions, provided that accident cover has not been suspended. The insurance covers statutory benefits under the Federal Health Insurance Act (KVG).

Daily benefits insurance covers a person's lost earnings, taking into account the federal government's legal provisions and the Supplementary Conditions.

ART. 3 LEGAL BASIS

The legal basis of healthcare insurance and daily benefits insurance is the current Federal Health Insurance Act (KVG) and the Federal Act on the General Part of the Social Insurance Law (ATSG), the respective implementation provisions, the GIC, and any Supplementary Conditions that may apply.

ART. 4 INSURER

Unless otherwise specified in the Supplementary Conditions, the insurance carrier is SWICA Healthcare Insurance Ltd, Römerstrasse 38, 8400 Winterthur, hereinafter referred to as "Insurer".

ART. 5 ASSOCIATION MEMBERSHIP

Anyone insured with the Insurer in accordance with social healthcare provisions is also a member of the SWICA Healthcare Organisation. Membership ends when the insurance ends or based on a request to terminate the insured person's membership.

II. FORMS OF INSURANCE

ART. 6 GENERAL

1. The Insurer provides ordinary healthcare insurance and special forms of insurance. Special forms of insurance include plans that offer a limited choice of service provider and plans that offer a selectable annual excess.
2. For voluntary daily benefits insurance under the KVG, special supplementary conditions apply.
3. The selectable excess amounts are defined in the provisions of the KVV.
4. Insurance plans with limited choice of service provider are subject to special Supplementary Conditions.
5. Contrary provisions in the Supplementary Conditions take precedence over those of the GIC.

III. INSURANCE RELATIONSHIP

ART. 7 INSURED PERSONS

The statutory provisions define the group of persons who are subject to the insurance obligation. The insurance covers the individuals mentioned in the policy.

ART. 8 ENROLMENT CONDITIONS

1. Enrolment requires a written declaration. Persons unable to act of their own accord must have a legal representative sign the declaration on their behalf. The questions on the application must be answered fully and truthfully. All the documents necessary for enrolment in the insurance must be submitted to the Insurer.
2. Enrolment in healthcare insurance is possible only if the same type of cover is not in effect with another insurer at the same time.

ART. 9 LEGAL EFFECT OF SIGNING THE APPLICATION FORM

With the written statement on enrolment, the insured person acknowledges these GIC and the Supplementary Conditions of the Insurer.

ART. 10 BEGINNING OF INSURANCE

1. The beginning of the insurance is defined by the statutory provisions. The enrolment date must be within three months from when the person was born or became a Swiss resident, provided that the insurance application was submitted in writing to the Insurer during this period. In this case, the insurance starts on the date of the birth or when the person took up residence in Switzerland.
2. The Insurer sends the insured person a policy that has the start date of the insurance.
3. If enrolment is delayed, the insurance starts on the enrolment date, i.e. at the earliest on the date when the insurance application reaches the Insurer. In this case, insurance benefits are due only as of the enrolment date. The Insurer can charge additional premiums for delays that are not exempt under statutory provisions.
4. The premiums are due when the insurance begins. If the insurance relationship begins during a calendar month, the premiums apply exactly on that day of the month.

ART. 11 SWITCH INVOLVING SPECIAL FORMS OF INSURANCE

1. A switch from ordinary healthcare insurance to another type with limited choice of service provider offered by the Insurer is possible at any time to the first day of the following month.
2. A switch from one special form of insurance to another special form of insurance offered by the Insurer is possible only by observing a one-month notice period to the end of a calendar year.
3. Choosing a higher excess is possible only at the beginning of a calendar year.
4. A switch to a lower excess amount is possible only by observing a one-month notice period to the end of a calendar year.

ART. 12 CHANGE OF RESIDENCE

1. Any change of address and relocation of civil-law residence must be notified to the Insurer within 30 days. A change of residence that must be notified also includes cases where the person's primary place of activity is moved to a care centre or an institution (e. g. a treatment centre). The insured person bears any disadvantages from violations of the notification obligation.
2. If a change of residence results in a change of premium, the new premium comes into effect on the month closest to the date of the change of residence. In the absence of such a date, the Insurer adjusts the premium to the beginning of the month closest to the date of the address change notification.
3. The consequences of omitted or late notification are laid out in Art. 22.
4. A change of premium due to a change of residence does not result in the right to switch the Insurer. If the special form of insurance under the current insurance policy is unavailable at the new place of residence, the person will need to switch to another insurance model from the Insurer.

ART. 13 SUSPENSION OF ACCIDENT COVER

1. Insured persons who are mandatorily (UVG) covered for accident risks can have their accident cover suspended. The Insurer suspends such cover at the insured person's request if there is proof that occupational and non-occupational accident cover under the UVG is fully in effect. In this case, the premium is adjusted accordingly. Suspension of accident cover requires the insured person's written request and begins no earlier than on the day following the day when the application reaches the Insurer, but not retroactively. If the insurance begins during a month, the premium is adjusted exactly to that day.
2. Under the KVG, accident-related conditions are insured as soon as accident cover under the UVG ends fully or partially.
3. The insured person must notify the Insurer within 30 days if he discontinues mandatory accident insurance under the UVG. Accident cover under mandatory healthcare insurance is reinstated as soon as cover under the UVG ends. The obligation to pay premiums applies as of the first day after UVG cover ends.

ART. 14 SUSPENSION OF INSURANCE

1. Persons who are subject to military insurance for more than 60 consecutive days are exempt from the obligation to pay premiums from the date when the obligation begins if they notify the Insurer at least eight weeks before the start date. If this deadline is not observed, the Insurer will stop charging premiums from the next possible date, at the latest eight weeks after the notification.
2. Daily benefits insurance cannot be suspended.

ART. 15 END OF INSURANCE

1. The insurance ends if the insured person:
   - changes to another insurance company
   - dies
   - relocates abroad, provided that mandatory insurance under the bilateral agreements with the EU/EFTA is in effect
   - discontinues his civil-law residence in the Insurer's area of activity
   - is no longer subject to the statutory insurance obligation
2. The insured person (or his heirs) must notify the Insurer in writing if the insurance relationship is terminated.

ART. 16 CHANGE OF INSURER

1. The insured person can switch from the Insurer to another insurance company as of 30 June and 31 December, or as of 31 December in the case of other forms of insurance, by giving three-months written notice.
2. When notified of a new premium, the insured person can switch to another insurance company to the end of the month prior to the month for which the new premium applies and by observing a one-month notice period.
3. The termination or change of insurer is valid only if notice was given in writing by the given deadline. For termination to be valid, the notice must reach the insurer's reception area by 17:00 on the last workday before the notice period ends (the postmark date is not decisive).
4. The change comes into effect only once the new insurer's confirmation of cover reaches the current insurer.
5. Termination has no effect if outstanding premiums, co-payments, default interest, and debt collection fees remain unpaid when the notice period ends.
6. The insurance relationship ends once the Insurer has given written notice.
7. After the insurance ends, any benefit entitlement expires five years after the end of the month for which the benefit was due.
8. Insured persons who leave the plan owe premiums, co-payments and fees until the insurance ends.
9. Excess and deductible amounts that have been applied during the year will be offset for persons who enrol in the insurance during that year. In this case, the insured person must submit the respective documents of the previous insurer.

IV. BENEFITS

ART. 17 INSURED BENEFITS

1. The Insurer covers the statutorily prescribed insurance benefits in accordance with the terms laid out in these GIC. The Insurer provides the same benefits for accident-related conditions as for illnesses.
2. Entitlement to benefits arises once the insurance begins and remains in effect for as long as cover is in effect. Entitlement to benefits does not apply to costs incurred after the insurance ends (including in connection with claims pending at that time). The date of treatment or insured benefits claim is decisive for determining eligibility for benefit entitlement.
3. Whenever benefits are claimed, the Insurer must be provided with detailed invoices and cover note requests, or with confirmation of incapacity for work in connection with claims for daily benefits within five years after the invoice date. Once this period ends, all entitlement to benefits ends also (limitation period under Art. 24 ATSG). As a rule, the invoices and documents must be submitted in German, French, Italian, or English. For invoices in other languages, a translation into one of the languages mentioned above by an official translation agency must be included.
4. The Insurer will cover the cost of such services if efficacy, appropriateness, and cost-effectiveness are given. Services are deemed to be cost-effective if they address solely what is in the insured person's interest and necessary for the treatment.
5. The Insurer covers the services of providers recognised under the KVG.
6. The insured person can freely choose from among the recognised providers of outpatient treatment. The Insurer covers the cost at maximum at the rate valid at the insured person's place of residence or work or in the vicinity thereof.
7. Medications are covered if prescribed by a doctor or chiropractor and they are on the special medicines list (SL) or the list of medicines with tariff (ALT). Prescribed medication must comply with the authorised indication and be applied as specified.
8. For inpatient treatment, the insured person can choose any hospital on a canton's list. However, the costs are covered at maximum at the rate valid for the canton of residence.
9. If the service provider is used for medical reasons in connection with outpatient or inpatient treatment, the costs are covered at the rate valid for this service provider.
10. For insured persons who stay abroad temporarily, the Insurer in principle covers only the cost of emergency treatment.
11. In particular, the Insurer does not provide benefits (in Pt. 6 the benefit is granted but deferred):
    1. for non-authorised service providers,
    2. for examinations and treatments whose efficacy, appropriateness, and cost-effectiveness is not given,
    3. for which there are no detailed invoices,
    4. if the person refuses to be seen by a medical examiner,
    5. for the duration of the delay in case of late enrolment,
    6. for the duration of a benefits delay until full payment of all outstanding amounts in statutorily defined cases.
12. The Insurer will reclaim benefits that were paid by mistake or for wrongful reasons.

ART. 18 SUBSIDIARITY

1. The insured person must notify the Insurer about the benefit obligations of, or benefits received from, other insurance companies or liable parties if the Insurer is liable for benefits for the same insurance case.
2. If the Insurer pays an advance to the insured person in connection with an insurance case for which a third party is liable, the Insurer covers the insured person's claims up to the amount this third party has paid in accordance with legal provisions at the time of the event. The Insurer then reclaims this amount from the third party. This does not apply to the excess and deductible and to other non-statutory benefits that the insured person himself must reclaim from the third party.

V. PREMIUMS AND CO-PAYMENTS

ART. 19 PREMIUMS

1. The premiums are set based on the rates approved by the supervisory authority. The premiums are tiered by age group and region.
2. The respective premium, which is due at least one month in advance, is shown in the insurance policy. By special agreement, it can be paid every two months, every three months, every six months, or annually.
3. In the month of enrolment, the premium is due on the exact day on which the insurance begins. In the month on which the person withdraws from the insurance or dies, no further premiums are owed after the day of withdrawal or death, and any amounts that were paid for the time after this date are reimbursed.
4. The Insurer invoices the premiums in Swiss francs. Amounts are reimbursed only in Swiss francs. The applicable payment periods are shown in the premium invoice. The Insurer defines the terms and conditions that apply in this case.

ART. 20 CO-PAYMENT/BENEFIT REIMBURSEMENT

The insured person contributes to the cost of claimed benefits under the KVG (incl. benefits for accidents) through his co-payments – subject to statutory exceptions or conflicting provisions in the Supplementary Conditions of an alternative insurance model with limited choice of provider. This co-payment breaks down into a fixed annual contributions (excess) and a percentage (deductible) of the amount being claimed. In statutorily prescribed cases, a per-day contribution as defined by the Federal Council is due in the case of hospitalisation, in addition to the co-payment.

1. The maximum annual deductible, the excess levels, and the hospitalisation contribution are calculated based on legal provisions.
2. The decisive factor in determining the excess and deductible is the date of the treatment or the time when the insured benefit is claimed.
3. In maternity cases, no co-payments apply to examinations and treatments as defined in the implementation provisions. Similarly, no co-payments apply between the thirteenth week of pregnancy and the eighth week after confinement in cases involving healthcare benefits in accordance with Art. 25 and 25 a KVG.
4. The deductible for an original medicine for which a generic one is also available may be higher and can exceed the limit as defined by law.
5. Co-payments are invoiced in Swiss francs. The applicable payment periods are shown in the benefit statement. The Insurer defines the terms and conditions that apply in this case.
6. Benefits and services the insured person has paid for are refunded in Swiss francs.

ART. 21 LATE PAYMENT AND BANK/POST OFFICE CHARGES

1. Insured persons who fail to pay the premiums and co-payments despite a written reminder will receive a payment request from the Insurer and be given a 30-day extension by which to settle the matter. If the insured person fails to pay the outstanding premiums, co-payments, and interest on arrears (5 % of the outstanding premium) despite the payment request, the Insurer will initiate debt collection proceedings. The Insurer discloses the name of the insured person against whom debt collection proceedings have been initiated to the cantonal authorities at their request.
2. The cost of the debt collection proceedings are passed on to the insured person. In addition, a reasonable processing fee (reminder and collection fees) can be applied to expenses that would not have been incurred if payment had been made on time.
3. A fee can be applied to amounts due under an instalment plan in effect for settling an outstanding amount.
4. The insured person has various options for paying premiums, co-payments and other invoices without charges. SWICA may pass on to the insured person any fees charged for payments made at a bank or post office counter or at similar physical access points or for payments sent from abroad.

VI. RIGHTS AND OBLIGATIONS

ART. 22 OBLIGATION TO NOTIFY, INFORM AND COOPERATE

1. The insured person must provide the Insurer with the information and documents it needs to clarify the insurance obligations and entitlement to benefits, to determine whether the right of recourse can be enforced, and to calculate the premiums and benefits. The insured person is aware that, based on statutory provisions, the Insurer is authorised to view the documents of other insurance companies, service providers, authorities and other parties, and to process such information.
   If an insured person has knowingly obtained or attempted to obtain insurance benefits by falsifying information or by other unlawful means, the Insurer can mandate specialists to review the matter, as part of its effort to combat insurance fraud, and then charge the insured person for the additional costs it incurred.
2. If another social insurer is liable for the statutory benefits, the insured person must claim the amount from that insurer. If the insured person refuses to file such a claim, the Insurer can use its right to file claims.
3. The insured person must notify the Insurer's organisational unit as shown on the insurance policy about any change in his personal situation that affects the insurance relationship (e.g. change concerning the marital status, legal representative, premium payer, place of residence, gender, etc.) within one month. The insured person bears the cost of any disadvantages arising from violations of the notification obligation. In the case of late notification, the Insurer can demand payment of missing premiums. The Insurer must refund premium credits that cannot be offset against amounts the insured person owes. In addition, the Insurer can suspend benefit payments as a precautionary measure if the insured person has violated his notification obligations under this paragraph or has failed to certify his existence or marital status in due time, or if there is substantiated suspicion that he is receiving benefits unlawfully.
4. The insured person must inform the Insurer within 20 days if he moves his place of residence to a location outside of Insurer's area of activity (in Switzerland or abroad). If the insured person culpably omits such notification, the insurance terminates in accordance with the provisions of the KVG.

ART. 23 OBLIGATION TO MINIMISE DAMAGE

1. In cases involving illness, maternity, or the effects of an accident, the insured person must take all the necessary steps to promote recovery and abstain from any actions that could prevent or delay recovery. The insured person must follow the recognised treating service provider's instructions in connection with all treatments and examinations that are administered. The insured person may not cause the service provider to perform any unnecessary and uneconomical treatments, examinations or clarifications. Benefits can be reduced or denied if the insured person jeopardises his recovery or refuses to cooperate with the Insurer.
2. The Insurer can demand that the insured person undergoes an examination by a medical examiner or doctor of its choice at the Insurer's expense.

ART. 24 PAYMENT DETAILS

1. The insured person must provide the Insurer with the payment details of a bank or postal account in Switzerland for cashless reimbursements. Payments to this account are deemed to have been made. If the absence of such payment details, the Insurer's payments are deemed to have been made when sent to the most recently known address of the insured person. In such a case, the Insurer has the right to apply an expense contribution per payment. Customers residing outside of Switzerland can provide the account details of a bank in their country of residence.
2. The Insurer always issues its payments in Swiss francs. In the case of an account with a financial institution domiciled abroad, the insured person is liable for all expenses and fees the foreign bank charges. The same applies when insured persons residing abroad make payments to the Insurer from an account with a foreign financial institution.

ART. 25 REIMBURSEMENT

The insured person must reimburse the Insurer any wrongfully obtained benefits and other monetary advantages (e.g. premium refunds/discounts), irrespective of whether such amounts were paid to him or to a third party (e.g. a doctor or hospital). The right to claim reimbursement ends three years after the Insurer has become aware of the matter, but no later than five years after the Insurer has paid the benefit in question.

ART. 26 PLEDGING AND ASSIGNMENT

The insured person is not permitted to pledge or assign any claims against the Insurer to a third party. Any assignment or pledge is invalid. This does not apply to exceptions under the law.

ART. 27 INSURED PERSON'S CARD

1. The insured person receives from SWICA an insured person's card that officially documents vis-à-vis other service providers the type of insurance in effect. If the corresponding contracts have been purchased, the card also enables the holder to obtain prescribed and authorised medication from a pharmacy without having to pay for it in cash. The card is issued based on KVG provisions and the information it contains complies with EU standards and serves as proof that the holder is covered during stays in an EU country. The holder can thus present the card to obtain medically necessary treatment by public service providers in the EU and EFTA area that then bill the Insurer. For purchases of VVG-compliant insurance, the information can also include details about the scope of cover, incl. supplementary cover.
2. Presenting the insured person's card to a hospital in Switzerland does not result in a legally binding guarantee that the costs will be covered.
3. The insured person's card is valid for as long as insurance cover is in effect. It may not be lent out, transferred, or made available to a third party. The Insurer must be notified immediately if the insured person loses or misplaces the card. The insured person must destroy the card immediately if insurance cover ceases to be valid.
4. If the insured person intentionally misuses the card, the cardholder is liable for any damage caused to the Insurer. In particular, wrongfully obtained insurance benefits must be reimbursed to the Insurer and any fees incurred in this connection must be paid.

VII. DATA PROTECTION

ART. 28 DATA PROCESSING AT SWICA

1. SWICA obtains and uses the personal data of insured persons in accordance with the Data Protection Act and its implementing provisions, social insurance law, and SWICA's data protection provisions which are available at swica.ch/data-privacy. The data privacy statement has declaratory significance and is not part of the contract. It applies for the duration of the contractual relationship between SWICA and the insured person.
2. In particular, processing involves master and contract data (such as first name, surname, address, postcode, date of birth, email address, phone number [mobile and fixed line], bank details, marital status, number of children, data on authorised representatives, financial information on income), health data (diagnoses, symptoms, medication, operations carried out, etc.), data on treatment and its course, benefit costs, data on the personal and interpersonal situation, personality profiles, data from other insurers and service providers, and data on debt collection and bankruptcy law matters.
3. SWICA processes the data in particular during the process of purchasing mandatory health insurance (consultation, request, etc.) and while managing the contract (administering benefits, providing information and customer care, customer journey and integrated care, handling product offers, marketing [if consent provided] etc.). SWICA also uses mathematical and automated methods to analyse personal data (profiling) [if consent provided] for statistical purposes. The information gained helps it to develop and improve the quality and utility of its services and products for current, former and prospective customers and to inform its policyholders about these.

4. The data categories mentioned in Section 2 can be processed for the purpose of providing integrated care and individual health counselling during a review and assessment of whether benefits meet the standards of efficacy, appropriateness and cost-effectiveness. In this connection, SWICA can access the health data it has available and advise its customers accordingly. Integrated care and individual health consultation means that SWICA can advise and inform its customers about the course of treatment, appropriate treatment programmes and suitable service providers. It also means that SWICA can provide its customers with other information about improving the personal and health situation (e.g. information about any intolerances). The santé24 telemedicine service can also conduct the consultation at the customer's request and provided that consent to disclose the data to santé24 has been obtained.
   The current data privacy statement explains what other data is processed. Personal data is processed in particular for purposes for which SWICA is legally authorised and which serve to fulfil its statutory and regulatory duties or to protect its legitimate interests. SWICA also processes the data for purposes to which the insured person consented when enrolling in mandatory healthcare insurance in accordance with the KVG.
5. In compliance with the applicable data protection provisions and so far as is necessary for the stated purposes, SWICA may share personal data with third parties (such as other insurers, independent examining doctors, authorities, lawyers and external experts, computer centres and service providers) in Switzerland and abroad. Data may also be shared for the purpose of coordinating benefits with foreign healthcare providers, in recourse proceedings or to uncover and prevent insurance fraud.
   Personal data may also be shared with third parties to whom services such as IT are outsourced in Switzerland or abroad. SWICA contractually obliges its third parties to maintain confidentiality and secrecy and to comply with the Swiss Data Protection Act.
6. For more information about data processing, please refer to SWICA's Data Privacy Statement. The Data Privacy Statement is valid for the duration of the contractual relationship between SWICA and the insured persons. It comprises an integral part of the insurance relationship and provides further information about the data categories being processed, the data processing procedures and purposes, the basis for data processing, the rights of insured persons with regard to data processing by SWICA, and the duration of data processing and data retention periods.

VIII. ADMINISTRATION OF JUSTICE

ART. 29 ADMINISTRATION OF JUSTICE

1. If the insured person disagrees with the Insurer's decision, he can ask the Insurer to issue a written and substantiated administrative order with information on legal remedies within 30 days.
2. An appeal can be lodged in writing against the Insurer's administrative order at the Insurer's Head Office within 30 days from when the order was issued. The appeal must include the reasons.
3. Appeal decisions by the Insurer can be challenged at the competent cantonal insurance court within 30 days after the appeal under administrative law was lodged. The cantonal insurance court can also be petitioned if the Insurer does not issue an administrative order or appeal decision at the affected person's request.
4. Decisions by the insurance court can be challenged in the Federal Supreme Court within 30 days in accordance with the Federal Supreme Court Act.
5. The administrative order or the appeal decision has legal effect once the appeal period ends or the judgement becomes final.
6. The Insurer can withdraw the suspensive effect of an objection in its administrative order or appeal decision, even if the order/decision concerns a monetary benefit. Excluded are administrative orders/appeal decisions on the reimbursement of unlawfully received benefits.

IX. MISCELLANEOUS PROVISIONS

ART. 30 NOTIFICATIONS AND WRITTEN FORM

1. All of the insured person's notifications and documents relating to benefit entitlement (including legally valid signature of the insured person or his statutory representative) must be addressed to the Insurer in writing. For some notifications, the Insurer can permit also email and other forms of electronic communications, to the extent permissible by law. Announcements by the Insurer that affect the insurance relationship are communicated publicly in legally binding form in circulars, on the website, in customer publications, or in other suitable ways.
2. All the Insurer's notifications are legally valid when sent to the most recent contact details the insured person provided to the Insurer. Insured persons who stay abroad for more than three months must provide the Insurer with a postal address in Switzerland to which it can send items.
3. The lists and directories mentioned in the GIC or the SC are continuously updated and are available on the internet or from the Insurer's organisational unit mentioned in the insurance policy. The lists and directories valid at the time of treatment always take precedence.
4. The term "in writing" as used in these GIC applies by extension also to any electronic notifications the Insurer has deliberately chosen and that are legally permissible.
5. Instead of a handwritten signature, the Insurer also accepts a qualified electronic signature within the meaning of the Federal Act on Electronic Signatures of 19 December 2003 or applicable federal regulations. Contrary statutory or contractual arrangements are reserved.

ART. 31 DIGITAL SERVICES

Additional agreements (on offers, rights and obligations, access rights, etc.) apply to the digital services the Insurer makes available. These agreements become binding on the insured person whenever he uses such services, unless other provisions take precedence.

ART. 32 TECHNICALITIES

The German version of these GIC is the original version. The French, Italian, and English versions are translations. In case of any discrepancies regarding their content, the German version is authoritative.

ART. 33 ENTRY INTO FORCE

These GIC for insurance under the KVG enter into force on 1 January 2022. The SC are valid from the respective effective date. The Insurer can change the GIC and SC at any time (subject to the necessary prior approval of the supervisory authority) by informing the insured persons accordingly.

GLOSSARY

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

Agreement on Free Movement of Persons
Agreement on Free Movement of Persons between Switzerland and the EU plus EU member states (citizens of states belonging to the European Free Trade Association [EFTA] are subject to the same provisions regarding the right to free movement).

ATSG
Federal Act on the General Part of the Social Security Law of 6 October 2000

Congenital defects
Congenital defects refers to illnesses that existed already at birth.

Co-payments
The insured person fundamentally participates in the costs by paying an excess, a deductible, and a hospitalisation contribution. For adults, co-payments fundamentally break down into the selected annual excess plus a 10%* deductible that applies to costs exceeding the excess amount. In the case of children, the co-payment fundamentally includes the excess if one was selected, plus a deductible of 10%* of the costs.
The deductible for an original medicine for which a generic one is also available may be higher and can exceed the limit as defined by law.
Co-payments are applied in the following sequence:
- Hospitalisation contribution
- Excess
- Deductible

No co-payments apply to maternity benefits. In the case of healthcare benefits, no co-payments apply as of the thirteenth week of pregnancy and for eight weeks after confinement.
In addition to the co-payment, a contribution as defined by the Federal Council is due in statutorily defined cases involving hospitalisation.
If the Insurer pays the invoices of service providers directly, the Insurer charges the insured person the costs it assumed up to the excess limit or up to the deductible amount exceeding the excess. The hospitalisation contribution is invoiced regardless of whether the co-payment limits have been reached. Contrary provisions in contracts between the Insurer and third parties are reserved.

DSG
Swiss Federal Act on Data Protection of 19 June 1992

Emergency
An emergency refers to a situation where immediate treatment must be administered for medical reasons. An emergency generally arises through the sudden and unforeseeable need to administer treatment.

Generic medicines
Successor medication approved by Swissmedic that essentially has the same effect as the original preparation. Generic medicines have the same active ingredients in the same quantity and doses as the original preparation; however, the excipients may vary. Generic medicines can be offered at a lower price because the patent of the original preparation has expired.

GIC
General Insurance Conditions in accordance with the Federal Health Insurance Act (KVG)

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.

Incapacity for work
Incapacity for work is the full or partial inability to perform work that can be reasonably expected of the person within his job or area of responsibility at the time owing to impaired physical or mental health. For longer periods of incapacity for work, reasonable work in another job or remit must also be considered.

Insurance with limited choice of service provider
An ordinary healthcare insurance plan gives insured persons free choice of suitable authorised service providers when looking for cover for outpatient treatment. With the consent of the Insurer, the insured person can opt for a more affordable form of care, whereby the Insurer limits the choice of service provider. Insurance with limited choice of service provider constitutes a special form of insurance.

*In the case of some medication on the EDI's list, the deductible can amount to 20%.

KVG
Federal Health Insurance Act of 18 March 1994

KVV
Health Insurance Ordinance of 27 June 1995

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

UVG
Federal Accident Insurance Act of 20 March 1981

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