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1 General provisions

1.1 Principle

The basic insurance is the compulsory health care insurance required by the Federal Health Insurance Act (KVG).

It provides benefits in the event of illness, accidents and maternity.

1.2 Provisions of Swiss law

In addition to these rules, the provisions of the Swiss Federal Act on the General Part of Social Insurance Law (ATSG) dated 6.10.2000, the KVG of 18.3.1994 and the accompanying implementing provisions also apply.

2 General conditions

2.1 Affiliation conditions

2.1.1 General

Any person resident in Switzerland can take out the basic insurance, thus becoming a policyholder of the health fund.

2.1.2 Cross-border commuters

The health fund also insures cross-border commuters and their family members.

2.1.3 Other persons residing in the EU, Iceland or Norway

The health fund insures persons residing in the EU, Iceland or Norway who must be covered by compulsory insurance in Switzerland.

This provision is based on the agreement between the EU and Switzerland on the freedom of movement of persons and the EFTA agreement (Iceland, Norway). Where reference is made below to the agreement on freedom of movement of persons, this also applies by analogy to the EFTA agreement.

2.1.4 Special affiliation conditions

The health fund may, in particular, issue different affiliation conditions and formalities for special operations and mergers.

2.2 Affiliation procedure

2.2.1 Application

The application for affiliation is made in writing on a pre-printed form. The questions on the form must be answered truthfully and in full.

In the case of incapacitated persons, the application for affiliation must be made by a legal representative.

2.2.2 Insurance policy

On affiliation, new policyholders receive an insurance policy and a copy of the rules.

2.3 Start of insurance

2.3.1 General

Membership begins on the date of affiliation confirmed by the health fund.

2.3.2 Birth or removal to Switzerland

In the event of affiliation within three months of birth or taking up residence in Switzerland, the insurance cover begins on the date of birth or commencement of residence.

2.3.3 Cross-border commuters

Cross-border commuters and their family members who do not obtain exemption from compulsory insurance under the KVG must take out insurance within three months of the starting date of their cross-border commuter's permit. If affiliation takes place on time, insurance cover begins on the date on which the permit takes effect. If they take out insurance at a later date, the insurance begins on the date of affiliation.

2.3.4 Other persons residing in the EU

Pensioners and persons drawing Swiss unemployment benefits who reside in an EU member state and require compulsory insurance on the basis of the agreement between the EU and Switzerland on the freedom of movement of persons must take out insurance within three months of the date on which the obligation to obtain insurance begins. If affiliation takes place on time, insurance cover begins on the date on which insurance becomes compulsory. If they take out insurance at a later date, the insurance begins on the date of affiliation.

2.3.5 Late application

In the event of late application, the insurance begins on the date of joining. In the event of late affiliation without an acceptable reason, the policyholder must pay a premium supplement in accordance with statutory provisions.

2.4 Change of domicile

2.4.1 General

Changes of address and transfer of domicile must be reported to the health fund within 30 days. Transfer of the place of domicile as defined in civil law is regarded as a change of place of residence.

2.4.2 Abroad

Employees who are posted abroad by a company with a registered office in Switzerland continue to be insured for two years and, on request, for a total of up to six years. Persons who reside in a member state of the EU and remain subject to compulsory insurance in Switzerland under the terms of the agreement on the freedom of movement of persons together with persons in the public service working abroad are subject to compulsory insurance for an unlimited period. Family members can also retain insurance cover to the same extent.

On leaving the country, a contact address in Switzerland must be given.

If treatment is given in an EU member state, the health fund meets the costs in accordance with the social insurance scales applicable in the country concerned. In other foreign countries, the health fund pays up to a maximum of twice the charge scales and prices applicable at the last place of residence in Switzerland.

Benefits are paid only if detailed original invoices are submitted, containing the following information:

- date of treatment,
- diagnosis,
- type of therapy and treatment,
- number of consultations/duration of hospital stay,
- receipted original prescriptions,
- daily charges and ancillary costs (hospital).

Persons who move abroad and no longer require compulsory insurance pursuant to the KVG may continue to be insured

under the Federal Insurance Contract Act (ICA), pursuant to the mondial insurance conditions.

2.5 Cancellation of accident cover

2.5.1 Criterion

Persons who have compulsory insurance for occupational and other accidents may apply for cancellation of the accident cover with a corresponding premium reduction.

The premium is reduced on the first day of the month following the application.

2.5.2 Policyholder's duty of notification

Policyholders terminating accident insurance pursuant to the Law on Accident Insurance (UVG) must notify the health fund accordingly within one month.

In the event of the policyholder's failure to meet this obligation, the health fund may require payment of the premium portion for accident cover with default interest from the termination of accident cover under UVG to the time at which the health fund is notified thereof.

2.6 Termination of the insurance

2.6.1 General

The insurance is terminated:

- a) when notice is given,
- b) on moving abroad, unless the insurance obligation continues to apply,
- c) on death,
- d) on official deletion.

In the event of any infringement of the membership obligations, the right to exclude the member on statutory grounds is reserved.

2.6.2 Termination by the policyholder

The policyholder may terminate the policy by giving three months' notice to the end of any calendar half-year.

When notified of a new premium, the policyholder may give one month's notice of termination to the end of the month preceding the entry into force of the new premium.

The insurance relationship with the health fund does not terminate until the new insurer has notified it that the person concerned is insured without interruption of insurance cover.

2.6.3 Consequences of termination

On termination of the insurance no legal claims on the health fund exist, apart from outstanding insurance benefits.

However, the policyholder must discharge all his financial obligations to the health fund.

3 Benefits

3.1 General benefit provisions

3.1.1 Entitlement

Entitlement exists throughout the period of membership.

3.1.2 Sickness benefits

The basic insurance covers the costs of diagnosis and treatment of illnesses and their consequences.

The benefits include:

- medical and chiropractic examinations, treatments and care, together with the medically prescribed services of third parties,

- medically prescribed drugs, analyses and remedial aids,
- medical or medically prescribed preventive measures,
- hospital accommodation in a general ward,
- medical rehabilitation measures,
- nursing-home care,
- Spitex care services,
- a contribution to medically prescribed spa treatment,
- a contribution to rescue costs and the costs of transport required for medical reasons,
- contributions to dental treatment.

The term "illness" denotes any impairment of physical or mental health which is not the consequence of an accident and which requires a medical examination or treatment or causes incapacitation from work.

Benefit coverage is determined by the provisions of the ATSG and the KVG and the associated implementation provisions.

3.1.3 Benefits in the event of accident and childbirth complications

To the extent that accident and invalidity insurance or third-party providers do not cover these benefits, in the event of accident or childbirth complications the same benefits are paid as in the case of illness.

Accident means the sudden, unintentional harmful effect of an exceptional external factor on the human body, resulting in an impairment of physical or mental health or death.

3.1.4 Maternity benefits

Maternity benefits are the same as those provided as in the event of illness, together with the special maternity benefits.

3.1.5 Benefits abroad

Benefits for treatment abroad are provided according to the provisions of federal law, particularly in emergencies. Full details of treatment costs must be provided.

In a member state of the EU, the health fund pays the costs according to the social insurance scales applicable in the country concerned. In other foreign countries, the health fund pays up to a maximum of twice the costs, which are reimbursed in Switzerland.

Cross-border commuters and other persons requiring compulsory insurance in Switzerland under the agreement on the free movement of persons, but residing in a member state of the EU, may seek treatment in their country of residence under the terms of the agreement on the free movement of persons.

3.1.6 Benefit conditions

The health fund pays the costs of services which are effective, expedient and economical. Services are regarded as economical if they are confined to the extent that is in the policyholder's interests and necessary for the purposes of treatment.

To provide the best possible care for its policyholders, the health fund may agree to associated measures with authorized service providers with a view to assuring the most effective, expedient and economical treatment for policyholders through improved cooperation and coordination between the service providers and the health fund. The insurer may instruct a health consultant to take these measures.

The health fund only accepts services which are provided by persons or institutions listed in the KVG and for whom or which the necessary training and authorization conditions have been satisfied.

3.1.7 Billing, reimbursement

Except where otherwise agreed between the health fund and the service providers, the policyholder is liable for the fees.

Where the policyholder claims the health fund benefits, he must submit detailed bills and prescriptions with the necessary information (membership number, etc.). Where entitlement to benefits exists, the health fund reimburses the policyholder with its share of the cost.

The policyholder may ask for bills to be checked by the health fund before payment.

3.1.8 Obligations of the policyholder

The policyholder must do everything which is conducive to recovery and refrain from doing anything that would delay it. In particular, he must comply with the instructions of medical personnel. The policyholder shall assist the activity of the health consultant in the framework of associated measures taken by the insurer and shall give that consultant any information required.

Where medical or professional examinations are necessary and reasonable to make an assessment, the policyholder must undergo such examinations.

The policyholder must provide all information needed to assess the claim and determine the insurance benefits free of charge. In particular, the policyholder shall notify the insurer of all benefits provided by third parties in the event of illness, accident and invalidity.

In individual cases, a policyholder who claims insurance benefits must authorize all persons and offices, in particular the employer, medical practitioners, insurance providers and official bodies to release the information needed to assess claims for benefits, insofar as the persons or offices concerned are not already required by law to provide such information.

On request, the policyholder must agree to an examination by a second doctor or by the medical consultant of the health fund. The health fund meets the costs.

The policyholder must notify the health fund of the occurrence of an accident within ten days. He must provide the health fund with all the relevant information.

Where a policyholder claiming benefits fails in an inexcusable manner to comply with his obligations to provide information or to cooperate, the health fund may either rule on the claim to benefits on the basis of the documents or reject the claim.

3.2 Outpatient treatment

3.2.1 Duration of benefits

For outpatient treatment, benefits are paid for an unlimited period pursuant to the KVG.

3.2.2 Service providers (persons or institutions)

The following persons and institutions particularly qualify as recognized service providers:

- doctors,
- pharmacists,
- chiropractors,
- midwives,
- laboratories,
- issuing offices for aids and objects used for examination or treatment.

- On medical instructions:

- physiotherapists,
- ergotherapists,
- nurses,
- speech therapists.

3.2.3 Benefit coverage

The health fund pays the costs of outpatient treatment according to the contracts and charge scales applicable at the policyholder's place of residence or work.

3.2.4 Choice of practitioner

The policyholder may choose freely among the persons authorized to provide treatment pursuant to the KVG. The special conditions applicable to policyholders who have opted for the insurance variant with limited right of choice, *casamed*, are reserved.

On treatment by persons or institutions authorized under the KVG, the policyholders enjoy charge scale protection, in other words the services must be invoiced according to the contracts and charge scales agreed with the health funds.

The health fund provides no benefits in respect of treatment by persons or institutions not subject to the KVG. These service providers must inform policyholders before treatment that the treatment is not covered by insurance benefits.

If the costs of external treatment are higher than the costs of treatment at the policyholder's place of residence or work, the excess costs shall be borne by the policyholder.

If external treatment is necessary for medical reasons, the costs are covered according to the contracts and charge scales applicable at the place of treatment.

If the policyholder repeatedly switches practitioners for the same illness, benefits may be made conditional on the consent of the health fund.

3.2.5 Drugs

The health fund pays the costs of medically prescribed drugs that appear on the drugs list with the charge scale (ALT) and the specialities list (SL) of the Federal Department of Home affairs (FDHA).

3.2.6 Analyses

The health fund pays the costs of medically prescribed analyses which are performed for diagnostic purposes or to verify therapy, provided that they figure on the analyses list (AL) of the Federal Department of Home affairs (FDHA) and are performed by a chemist or laboratory authorized under the KVG.

3.2.7 Aids

The fund covers the costs of aids and devices for the purpose of examination and treatment as set out on the EDI list (MiGeL) and up to the amounts set out in it. The aids and devices must be issued by a supplies store recognised under the KVG or by a person authorised to provide treatment under the KVG.

Where the cost of an aid exceeds the amount set out in the MiGeL, the insured person shall cover the difference.

3.2.8 Complementary medicine

The health fund will reimburse costs incurred by insureds for treatment based on the methods of complementary medicine set out below, provided that the doctors providing the treat-

ment have obtained further, FMH-certified qualifications in the following disciplines or methods:

- Acupuncture
- Chinese medicine
- Homeopathy
- Neural therapy
- Phytotherapy
- Anthroposophic medicine

3.2.9 Preventive medicine

The health fund pays the costs of preventive examinations or measures conducted on medical instructions under the Health Care Services Regulation, in particular children's vaccinations and precautionary gynaecological examinations. Unlike maternity benefits, these benefits are covered by standard cost sharing.

3.3 Inpatient treatment

3.3.1 Hospitalization

The health fund pays benefits for hospitalization if the diagnosis, the state of health of the policyholder or the totality of medical treatment requires inpatient treatment in a hospital's intensive-care or rehabilitation department.

If the need for hospitalization no longer exists, the health fund pays the same benefits for the hospital stay as for a stay in a nursing home or care by Spitex services at home.

3.3.2 Duration of benefits

The entitlement to benefits for inpatient treatment lasts as long as hospitalization is necessary.

3.3.3 Benefit coverage

The health fund pays the costs of a hospital stay pursuant to the contracts and charge scales applicable to general wards of hospitals in the canton where the policyholder lives.

The applicable charge scale is that of the hospital responsible for providing the policyholder's medical care on the basis of the classification by benefit category in the cantonal hospital plan.

3.3.4 Choice of hospital in general

The policyholder may choose freely among the hospitals that satisfy the authorization requirements under the KVG and appear on the hospital list for the canton of residence.

The provisions for policyholders who have concluded the insurance variant with a limited right of choice, *casamed*, are reserved.

3.3.5 Elective treatment outside the canton

If the costs of hospital treatment outside the canton are higher than those in a hospital in the canton of residence which is responsible according to the benefit category, the policyholder must pay the difference.

3.3.6 Treatment outside the canton for medical reasons

If treatment outside the canton is necessary for medical reasons, the costs are paid according to the contracts and charge scales applicable to the hospital concerned.

The following types of treatment outside the canton are deemed to be medically necessary:

- emergency treatment,
- treatment that cannot be provided in any hospitals in or outside the canton appearing on the hospital list for the canton of residence.

When treatment takes place for medical reasons in a public or publicly supported hospital outside the canton, the policyholder's canton of residence pays the difference between the actual treatment costs and the hospital charge scales and contracts that apply in the canton where the person concerned is resident.

3.3.7 Tariff protection

The hospitals authorized to provide treatment under the KVG must charge for inpatient treatment, including accommodation costs, at the flat rates agreed with the health funds. An additional charge may only be made for any special diagnostic or therapeutic services specially agreed with the health funds.

3.3.8 Treatment in private wards

If the policyholder arranges to be treated in a private or semi-private ward of a hospital appearing on the hospital list of the canton of residence, within or outside the canton of residence, the health fund will pay benefits equivalent to the charges for the general ward of the KVG hospitals responsible according to the benefit category in the canton of residence or, if there is a medical indication, by analogy with the charges for the general ward of the hospital concerned.

3.3.9 Billing, reimbursement

When its policyholders are hospitalized, the health fund grants a cost credit within the limits of the benefit entitlement once the diagnosis requiring hospital admission is available. If no agreement exists between the health funds and the hospital, the policyholder must pay the hospital's fees himself.

3.4 Medical rehabilitation measures

The costs of medical rehabilitation are met if it serves to restore the policyholder's physical or mental capability so that he can return to his habitual living environment.

The provisions on outpatient and inpatient treatment shall also apply.

If the medical treatment does not serve to permit a return to the habitual living environment, benefits are paid according to the nursing-home or Spitex charge scales.

3.5 Treatment in a nursing home

The health fund pays for examinations, treatment and nursing care conducted on medical instructions in a nursing home approved under the KVG.

Benefits are either paid on a flat-rate basis by agreement with the nursing home, or paid for on the basis of an individual benefit account.

The provisions on inpatient treatment and Spitex benefits also apply to nursing-home treatment.

3.6 Spitex

The health fund pays for examinations, treatments and nursing care conducted at home on medical instructions by recognized Spitex services or carers. No benefits are available for the costs of home helps.

Medical instructions apply for a maximum of three months (six months in the case of long-term patients). Spitex costs are met in accordance with cantonal and local contracts and charge scales with Spitex services. They may, in particular, be billed according to a time-based or flat-rate charge. A maximum daily or weekly time requirement may be set in the charge scale contracts.

3.7 Spa treatment

3.7.1 Benefit coverage

The health fund pays a daily contribution to the costs of spa treatments undergone on medical instructions.

CHF 10.–

21 days per calendar year

3.7.2 Choice of spa

The policyholder has the choice of recognized spas in Switzerland under medical direction.

The contribution to the costs of spa treatment is made irrespective of whether the insured person receiving treatment stays at the spa itself or in a hotel, guest house or private rooms at the spa location.

3.7.3 Procedure for spa treatment

The medical prescription for spa treatment, including the diagnosis, must be sent to the health fund two weeks before treatment begins.

If a course of treatment is interrupted, partial treatment costs can only be met if the interruption was due to an illness or other compelling reasons and a certificate to that effect is provided by the spa doctor.

3.8 Transport and rescue costs

In the case of transport (required on medical grounds) by a transport company recognized pursuant to the KVG for treatment by a person or institution authorized under the KVG, falling within the policyholder's right of choice, the health fund will contribute to the rescue costs.

50%, up to a maximum of CHF 500.– per calendar year

The health fund will contribute to the costs of an essential rescue operation carried out in Switzerland by a KVG-recognized rescue company.

50%, up to a maximum of CHF 5000.– per calendar year

3.9 Dental treatment

3.9.1 Dental treatment in the event of serious illness

The health fund will pay the costs of dental treatment required because of illness if:

- this is due to a serious, unavoidable disease of the masticatory system,
- this is caused by a serious general illness or its consequences,
- this is necessary to treat a serious general illness or its consequences.

3.9.2 Dental accident

The health fund will pay the costs of dental damage caused by an accident.

3.9.3 Benefit coverage

The costs of treatment by dentists approved under the KVG pursuant to the contractual and charge agreements with the health funds are met.

3.9.4 Procedure for dental treatment

Payment of the costs of dental treatment is conditional on presentation of a diagnosis, treatment plan and cost estimate.

3.10 Maternity

3.10.1 Benefit coverage

During pregnancy and in connection with childbirth, the health

fund pays the same benefits as in the event of illness. Medical check-ups conducted by doctors or midwives or on medical instructions during the pregnancy and for ten weeks after the birth are also covered. In the absence of special medical indications, the costs of a maximum of seven examinations during the pregnancy and one post-natal check-up will be met.

The health fund pays the costs of birth at home, in hospital or in a maternity clinic according to the contractual agreements and charge scales.

The provisions on outpatient, inpatient and part-inpatient treatment also apply to childbirth benefits.

3.10.2 Nursing costs for the child

The health fund pays the part of the costs of nursing for the child which is not otherwise covered, as long as the child is in the hospital with the mother, from the mother's basic insurance, provided that the child is insured with the health fund.

3.10.3 Preparation for birth and advice on breastfeeding

The health fund contributes to the costs of a birth preparation course and a maximum of three consultations on breastfeeding if these are given by an approved professional.

CHF 100.–

3.11 Limitation of benefits

3.11.1 Reduction and cessation of benefits

No entitlement to benefits exists for the treatment of illnesses or consequences of an accident that a different insurer or a third party is required to meet.

The benefits may be temporarily or permanently reduced or – in serious cases – withheld if the policyholder fails to undergo reasonable treatment, refuses such treatment or fails to cooperate in a reasonable manner.

Written advance warning must be issued to the policyholder, pointing out that benefits are liable to be reduced or withheld altogether.

3.11.2 Excessive billing and uneconomical treatment

In the event of manifestly excessive billing or uneconomical treatment, the health fund may withhold or appropriately reduce its payment. It may make its payment conditional on the assignment of a claim for reduction. Payments already made may be reclaimed by the health fund from the service provider, or by the policyholder in the case of sums paid personally.

3.11.3 Repayment obligation

Benefits drawn in error or without justification may be reclaimed by the health fund.

3.12 Relationship with third-party benefits, excessive compensation

3.12.1 General

When a third party is liable for a notified case of illness by law or on the basis of a contract or negligence, etc. the policyholder's claims against the third party shall be transferred to the health fund to an extent equal to the benefits provided by the health fund. If more than one party is liable, they shall bear joint and several responsibility for the claims for redress made by the health fund.

3.12.2 Social insurance

The health fund provides no benefits which can be obtained

from other social insurance schemes (UVG, IV, MV, AHV, AIV, etc.). The policyholder must submit his claim to a benefit to the relevant social insurance scheme.

In relation to the other social insurance benefits, the health fund provides preliminary benefits pursuant to statutory provisions.

3.12.3 Excessive compensation

Benefits of the health fund or their coincidence with the benefits of other social insurance schemes or other benefit providers may not exceed the costs of illness or accident accruing to the policyholder by reason of the insurance claim.

If the health fund establishes that compensation is excessive, it will reduce benefits accordingly.

4 casamed variant

4.1 General

As a variant of basic cover, policyholders may conclude a casamed contract. This limits the choice of medical practitioners and institutions.

Treatment under the casamed variant is effected within the limits of systems based on the family-doctor principle. casamed may be limited to policyholders living in a particular region.

4.2 Choice/termination of casamed

casamed can be selected on joining the health fund or at the beginning of any subsequent calendar month.

For a switch to casamed variants, which provide for no exempt sum or only for the ordinary exempt sum, insured persons with an elective exempt sum are subject to the time limits and leaving conditions applicable to such elective exempt sums.

casamed policyholders wishing to switch to the ordinary basic or leave the health fund entirely must give three months' advance notice expiring at the end of a calendar year.

When notified of a new premium, the policyholder may terminate his insurance relationship with the health fund by giving one month's advance notice expiring at the end of the month preceding the month when the new premium comes into force.

When the insured person is away from home for an extended period and cannot receive the treatment necessary in an emergency from the responsible casamed family doctor, the health fund may arrange for an immediate switch to basic cover.

4.3 General benefit conditions

The basic benefits are provided by casamed if they are supplied, prescribed or arranged by the casamed family doctor with whom the policyholder is registered.

The health fund designates casamed doctors who have exclusive responsibility for the treatment of casamed policyholders.

Telemedical institutions may be approved by the health fund as casamed family doctors.

4.4 Exceptions

4.4.1 Ophthalmologists, gynaecologists and paediatricians
No prior consultation with the casamed family doctor is required for the reimbursement of the costs of routine treatment by ophthalmologists, gynaecologists and paediatricians.

The health fund is entitled to restrict the choice of such doctors. The health fund may set an age limit for treatment by paediatricians.

Costs of treatment by a further specialist and of operations performed on outpatients or inpatients will be reimbursed only after consulting the casamed family doctor.

4.4.2 Emergencies

Emergencies are covered by basic, regardless of the chosen service provider. Policyholders must report the emergency to their casamed family doctor within 20 days. The right is reserved to submit the medical indication to a medical consultant for verification, and to reduce benefits if a referral form is not submitted (after the event).

4.5 Other service providers

With a view to the provision of services at reasonable cost, the health fund may designate further service providers such as hospitals, pharmacists, medical-supplies stores, etc. who will have sole authority to provide medical care or supply materials to casamed policyholders.

4.6 Exclusion of benefits, casamed variant exclusion

4.6.1 Exclusion of benefits

If a policyholder presents himself for treatment to a service provider that he cannot normally select, other than in one of the exceptional cases appearing on an exhaustive list, all costs will be charged to him.

4.6.2 casamed variant exclusion

In the event of repeated breaches of the conditions, the health fund may reassign the policyholder from the casamed variant to the ordinary insurance variant.

4.7 Procedure

4.7.1 Choice of casamed family doctor or of the responsible telemedical institution

The health fund gives the policyholder a list providing the following information:

- casamed family doctors,
- local range of benefits,
- procedures for registering with casamed family doctors,
- other service providers such as pharmacists, hospitals, medical-supplies stores etc.

The policyholder registers with a casamed family doctor of his or her own choice, or is registered with a telemedical institution.

4.7.2 Change of casamed family doctor

In the casamed system, policyholders may switch to a different casamed family doctor at the beginning of any calendar quarter, giving one month's notice.

Different arrangements may exist, based on regional agreements between the health fund and the doctors participating in casamed.

In special cases, in particular:

- change of residence,
- removal of the family doctor's practice,
- a dispute between the casamed policyholder and the selected casamed family doctor,
- the departure of the casamed family doctor from the system

shorter notice periods apply with the consent of the health fund.

casamed policyholders agree that documents needed for their subsequent treatment should be forwarded to the new casamed family doctor.

4.7.3 Prescribed services

Where services are prescribed, the health fund may require the policyholder or the casamed family doctor to provide evidence, before reimbursement is made, that this service was provided according to the family-doctor principle.

If a service provider to whom the member was referred by the casamed family doctor wishes to refer the patient on, the consent of the responsible casamed family doctor must be obtained.

The health fund or casamed cooperation partners may supply service providers with electronic equipment to facilitate fast, secure communication between service providers and to optimize service coordination and control.

The health fund ensures that all parties comply with the provisions of the Data Protection Act.

5 Cost sharing

5.1 Ordinary cost sharing

5.1.1 General

Federal law requires every policyholder to meet part of the costs of the services provided by means of an annual exempt sum and an excess.

Up to the age of 18	Adults
No (regular) exempt sum	CHF 300 per calendar year

5.1.2 Exempt sum per year

Adults are subject to a fixed annual exempt sum per calendar year.

5.1.3 Excess

The excess is equal to 10% of the costs of the services provided in excess of the annual exempt sum.

Up to the age of 18	Adults
10%, to a maximum of CHF 350.- per calendar year	10%, to a maximum of CHF 700.- per calendar year

5.1.4 Excess on drugs

The excess for single-source drugs is 20% of the costs exceeding the annual exempt sum if the speciality list includes generics with a maximum price at least 20% lower than the maximum price of the single-source drug. This does not apply to single-source drugs expressly prescribed for medical reasons.

5.1.5 Cost sharing for maternity

Except for pharmaceutical products and remedial aids, no contribution will be payable towards the costs of maternity benefits.

5.1.6 Maximum cost share for families

The maximum cost share for the children of a family is:

Total of CHF 1000.- per calendar year

5.2 Contribution to hospital accommodation costs

In addition to ordinary cost sharing, policyholders must make a daily contribution to the costs of hospital accommodation.

CHF 15.- per day

No contribution is payable for children and for young adults undergoing education or training (up to the age of 25).

5.3 Elective exempt sum

5.3.1 General

Children, adolescents and adults may opt for a higher exempt sum with a corresponding reduction in the basic premium.

The elective exempt sum is expressed as a fixed sum per calendar year.

5.3.2 Choice/termination of the elective exempt sum

The choice of a higher exempt sum can only be made at the beginning of a calendar year.

The elective exempt sum for policyholders joining the health fund during the course of a year is calculated pro rata temporis.

Policyholders may switch to a lower exempt sum, a different insurance variant or a different insurer by giving three months' advance notice expiring at the end of a calendar year.

When notified of a new premium, the policyholder may terminate his insurance relationship with the health fund by giving one month's advance notice expiring at the end of the month preceding the month when the new premium comes into force.

5.3.3 Amount of the elective exempt sum

Policyholders can choose between the following higher exempt sums per year:

Adults	Children
CHF 500.-	CHF 200.-
CHF 1000.-	CHF 400.-
CHF 1500.-	CHF 600.-
CHF 2000.-	
CHF 2500.-	

5.3.4 Excess

The excess is the same as under normal cost sharing.

5.3.5 Maximum cost share for families with more than one child

If more than one child in a family is insured with Sympany, the cost share shall be twice the maximum amount for each child (optional franchise and deductible). If different franchises have been selected for each child, Sympany shall determine the maximum amount.

6 Premiums

6.1 Determination

6.1.1 General

Premiums are stated in the rate book.

They may be graduated according to local cost differences.

6.1.2 Premium reductions

Reduced premiums apply:

- to children and adolescents up to their 18th birthday,
- to adults up to their 25th birthday,
- on cancellation of accident cover,
- to policyholders who choose an elective exempt sum,
- to policyholders who conclude a casamed variant.

6.1.3 Premium contributions

Policyholders may apply for premium contributions to be paid by the canton or local authority where they live. The health fund may reach agreement with the canton or local authority under which the premium contribution is directly deducted from the premium.

6.2 Premium exemption during military and civilian service

For military, civil defence or civilian service lasting for more than 60 consecutive days, exemption from premium payments is granted for months in which cover is provided by military insurance.

Exemption from premiums is granted if application is made in the same calendar year. The application must be accompanied by evidence of military or other service.

6.3 Premium supplement

On late affiliation to basic without valid reason, a premium supplement is charged for twice the duration of the delay.

Maximum: 50%

6.4 Extra contributions

For periods in which exceptional claims are made, the health fund may charge additional contributions.

6.5 Payment

6.5.1 Due date/payment period

Premiums are payable in advance. The shortest payment period is one calendar month. Premiums are payable without interruption, even in the event of illness, accident, incapacitation and when entitlements to claim are suspended. If membership begins or ends in the course of a calendar month, the entire monthly premium is due.

6.5.2 Delay in payment

If, despite reminders, an insured delays payment of outstanding premiums or contributions to costs, enforcement proceedings shall be initiated. The cantons may compile a list of persons who, despite enforcement measures, fail to discharge their obligation to pay premiums. On being notified by the canton, the health insurer shall defer acceptance of the costs of these persons' benefits with the exception of emergency treatment. The costs of reminders and any additional administrative costs incurred as a result of the delay in payment shall be met by the insured.

Any additional costs due to special expenses requested by the policyholder shall be settled in advance. The health fund shall decide the amount of the additional costs.

In addition to these costs, the health fund can charge 5% interest on arrears on outstanding contributions.

The health fund can net its benefits against due premiums and cost shares until the initiation of an application for continuation. This option shall not be open to the policyholder.

6.5.3 Pledging/assignment

Claims against the health fund cannot be pledged and may only be assigned in the cases for which provision is made in the KVG.

7 Group insurance

7.1 General

The health fund may conclude group contracts for particular groups of persons in order to simplify its administration.

7.2 Variant provisions

Benefits and premiums for persons covered by group insurance are in principle the same as for individual policyholders.

Different provisions may, in particular, be adopted for:

- a simplified affiliation procedure,
- a different premium-payment mode,
- group partner as the premium payer,
- transfer of information obligations to the group partner,
- a different procedure for processing benefits and cost shares,
- a simplified procedure for accident exclusion.

7.3 Transfer to individual insurance

Policyholders who cease to belong to the group of persons covered by the group contract, or policyholders whose group contract lapses, automatically continue to be insured by the individual insurance scheme of the health fund responsible for their place of residence.

8 Legal

8.1 Ruling

If a policyholder or an applicant for affiliation does not accept a decision, the health fund will, on request, issue a reasoned written ruling with an indication of means of legal redress within 30 days.

8.2 Appeal

An appeal against this ruling can be lodged with the health fund within 30 days of notification. The health fund considers the appeal and issues a reasoned written decision with an indication of the means of legal redress.

8.3 Cantonal insurance court

An appeal against decisions on objections may be lodged with the cantonal insurance court within 30 days of notification of the decision.

An appeal may be lodged by any person who is affected by the contested ruling or decision on an objection and who has an interest which deserves to be protected in the setting aside or amendment of such a ruling.

The insurance court of the canton where the policyholder or the appellant third party resides shall have jurisdiction. An appeal may also be made to the insurance court if the health fund fails to issue a ruling or a decision on an objection within the specified time limit.

If the policyholder or the appellant third party is resident abroad, the insurance tribunal of the canton in which the last Swiss place of residence was situated, or in which the last Swiss employer was based, shall have jurisdiction; if neither

of these places can be determined, the insurance tribunal of the canton in which the health fund has its registered office shall have jurisdiction.

8.4 Force of law

The ruling or decision on an objection handed down by the health fund takes full legal effect if no objection or appeal has been lodged within the period allowed or if the appeal has been dismissed with due force of law. Rulings concerning payments are enforceable court judgements within the meaning of Art. 80 of the Law on Debt Collection and Bankruptcy (SchKG).

8.5 Legal protection

In the event of disputes between the policyholder and service providers within the meaning of the KVG with regard to fees, the health fund may, at the policyholder's request, represent him/her at his/her expense in the competent courts, provided that the legal application appears to have some prospects of success.

9 Final provisions

9.1 Amendments

Policyholders must be notified of amendments to these rules in writing, in the policyholder's journal or by official publication.

9.2 Entry into force

These rules take effect on 1 January 2010. They entirely supersede all previous rules and provisions on statutory health care insurance.

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Common provisions

1 Insurance fundamentals

1.1 Purpose

By way of addition to the KVG (Federal Health Insurance Act) health insurance, additional insurance and further types of insurance are provided pursuant to these general terms and conditions of insurance.

1.2 Insurance providers

The insurance providers are the insurance companies listed in the individual insurance departments (henceforth referred to as the insurers).

The intermediary health insurance fund is the one listed on the insurance policy (henceforth referred to as the health fund). It is authorized to take any action on behalf of the insurance provider and for its account.

1.3 Insurance cover

The insurance covers the financial consequences of illness, accident and maternity for the period for which the insurance is concluded.

Accident cover may be excluded where this is stipulated in the provisions of individual insurance departments.

1.4 General terms and conditions of insurance (GTC)

The GTC regulate the insurance relationship unless special provisions are stipulated in the individual agreement. The common provisions of the GTC apply to all the insurance departments listed below. Details of benefits are set out in the provisions on the individual insurance departments. Where the individual insurance departments differ from the general conditions, the provisions of the individual insurance department take priority.

1.5 Conditions governing group insurance

The GTC also apply to group insurance for treatment costs. The individual group agreement may contain different conditions, in particular in respect of affiliations, scope of benefits, premium fixing, duration of insurance, termination and the division of rights and obligations between the policyholder and the insured person. The provisions of the group agreement take priority over the general insurance conditions.

The policyholder is entitled to inspect the terms of the group agreement relating to the insurance relationship.

1.6 Federal Insurance Contract Act (ICA)

Save where otherwise stipulated in the contractual provisions, the provisions of the Federal Insurance Contract Act of 2 April 1908 shall apply.

2 Insurance departments

2.1 Insurance possibilities

The insurance departments pursuant to these GTC are as follows:

- plus,
- premium,
- general supplement,
- private supplement,
- hospita general, semi-private, private, private accident, global, flex, comfort,
- salto,
- mondial,
- dental,
- tourist,
- protect,
- capita accident,
- capita illness.

casamed and/or mondial variants of individual insurance departments exist.

2.2 Changes in insurance departments

Insurance departments may be adjusted to changing needs, supplemented or redistributed by the insurer, while safeguarding existing rights.

2.3 Selected insurance departments

The insurance policy specifies the insurance departments chosen. Special provisions or agreements which differ from the general insurance conditions are also specified in the insurance policy.

3 Insured persons

3.1 Individual insurance

Insured persons are listed in the insurance policy.

3.2 Group insurance

Classes of persons covered by or eligible for insurance cover are specified in the group contract. The persons or groups of persons listed in the insurance policy are insured.

4 Start and duration of the insurance

4.1 Procedure for arranging insurance

4.1.1 Application

The insurance application is submitted in writing using the pre-printed health-fund form. The questions on the form must be answered truthfully and in full. Persons not competent to act on their own behalf can only be insured by their legal representative.

4.1.2 Obligation to provide information

If incorrect or incomplete information is given in the application, the insurer may terminate the contract within four weeks of the date on which it becomes aware of the fact. Cancellation of the contract entails the lapse of the insurer's obligation to pay benefits for past insured events to which the inaccurate or incomplete information is relevant. If the benefit has already been paid, the health fund is entitled to a refund.

In submitting the application, the applicant authorizes the health fund to obtain from medical practitioners and other insurers the information needed to conclude the insurance and clarify its subsequent obligation to pay benefits.

The health fund may require a medical certificate or order a medical examination at its own expense. The policyholder must make sure that he is able to provide the necessary information about the insured person.

4.1.3 Refusal or exclusion of benefits

The health fund may refuse applications or exclude individual benefits from the insurance cover.

4.1.4 Documentation

When the policy is concluded the policyholder receives

- the policy document,
- the general terms and conditions of insurance.

4.1.5 Right of cancellation

The insurance application may be withdrawn within 14 days of the date of signature. If a declaration of cancellation is made, all the insurer's obligations lapse.

If the content of the insurance policy or the supplements thereto do not coincide with the agreements reached, the policyholder must ask for them to be corrected within four weeks of receipt of the document, failing which the content shall be deemed to have been approved.

4.2 Start of insurance

Insurance begins on the date specified in the policy document.

4.3 Duration of insurance

4.3.1 Insurance term

The insurance runs in each case for one calendar year from 1 January to 31 December.

4.3.2 Longer insurance period

If insurance is taken out for a period of at least three full calendar years, a discount may be granted.

4.3.3 Time of conclusion of the insurance

The insurance may be taken out at any time during the calendar year. The premium will then be calculated on a pro rata basis.

4.3.4 Extension of insurance

At the end of each year the insurance contract is tacitly extended by a further year unless the policyholder has given the required notice of termination.

Any changes made by the insurer take effect at the beginning of the new policy term.

4.4 Change of insurance

4.4.1 Changes by the policyholder

Applications to amend the insurance contract with increased cover or for which a health declaration is required are treated as applications for a new insurance contract.

If the insurance cover is reduced, the provisions on notice of termination shall apply.

4.4.2 Changes by the insurer

If, after conclusion of the insurance, far-reaching changes occur in the background conditions affecting the provision of insurance against the financial consequences of illness, maternity and accident, such as an increase in the number

of medical personnel or new categories of medical personnel, extension of the range of medical services, introduction of new cost-intensive forms of therapy or medication and similar developments or amendments to the legislation on social insurance, the insurer is authorized to adjust the insurance provisions accordingly.

The policyholder is notified of these new contractual conditions 30 days before they come into force at the beginning of the new policy term. The policyholder is then entitled to withdraw from the insurance departments concerned within 30 days of notification and with effect from the date of the contract change. If no notice of termination is given by the policyholder, he/she shall be deemed to have consented to the new contractual conditions.

4.5 Suspension of insurance

4.5.1 Condition

Cancellation of the insurance may be requested for all or some of the insurance departments, provided that evidence of other insurance cover is supplied. The procedure for the conclusion of a new policy (application, obligation to provide information, possibility of rejection, documentation, right of cancellation) also applies to the agreement on suspension. A reduced premium is charged during the suspension period.

4.5.2 Duration and scope of suspension

Suspension begins after the application has been made, but not before the beginning of the month in which the reason for suspension occurred.

Suspension must be requested for at least three months and may be concluded for a period of up to six years. A subsequent extension of the suspension may be requested. If the insurer cannot agree to such extension, the contract lapses.

A contact address in Switzerland must be given for persons resident abroad.

When the reason for suspension ceases to exist, the insurance cover is revived in full if this is requested within 30 days. If the insurance cover is not reactivated within this period, the insurance lapses without further formalities.

5 Termination of insurance

5.1 Termination by the policyholder

5.1.1 Ordinary termination

Written notice of termination of the policy or of an insurance department may be given by 30 September of any year to take effect on 31 December. The right to stipulate different notice provisions for individual insurance departments is reserved.

5.1.2 Termination in the event of a claim

After every event for which the insurer has paid benefits, the policyholder may give written notice of withdrawal from the relevant part of the contract, i.e. from the relevant insurance department, within 14 days of disbursement or of his becoming aware that the insurer was going to pay benefits. The premium is payable until the contract is terminated.

5.1.3 Right of transfer on termination of the group contract

Insured persons whose cover lapses when a group contract is terminated are entitled to switch to an individual insurance contract with the same level of insurance. Any switch to a

higher level of insurance cover shall necessitate making a new health declaration. This right of transfer must be exercised within 30 days of the end of the collective agreement.

No right of transfer exists if the policyholder has signed a new group agreement for the same persons with a different insurer.

5.2 Waiver of termination by the insurer

The insurer expressly waives its statutory right to terminate the contract on expiry of its term and to withdraw from the contract if a claim is made. The right of termination of group contracts is an exception. The right is also reserved to terminate the contract on the grounds of actual or attempted insurance fraud.

5.3 Other grounds for termination

The insurance expires in the following cases:

- a) on the death of the insured person,
- b) on removal abroad (except for cross-border commuters, employees posted abroad or if a mondial policy is taken out),
- c) on reaching the age limit stipulated for insurance cover,
- d) on the exhaustion of the rights to draw all the benefits in an insurance department,
- e) if the contract is not extended after reaching the maximum policy term in mondial or in the event of a suspension.

6 Benefits

6.1 Definitions

6.1.1 Sickness

Sickness means any impairment of physical or mental health which is not the consequence of an accident and which necessitates a medical examination or treatment or results in incapacity.

6.1.2 Accident

Accident means the sudden, unintentional harmful effect of an exceptional external factor on the human body, resulting in an impairment of physical or mental health or death. If they are not unambiguously attributable to an illness or degeneration, the following types of physical injury are always equated with accidents even without any unusual external influence, this list being exhaustive:

- a) broken bones,
- b) dislocated joints,
- c) torn meniscus,
- d) torn muscles,
- e) strained muscles,
- f) torn tendons,
- g) ligament lesions,
- h) eardrum injuries.

Damage to objects inserted following an illness to replace a body part or a body function that was not caused by an accident do not constitute physical injury within the meaning of the above paragraph.

Occupational illnesses acknowledged as accidents under the Swiss Federal Law on Accident Insurance (UVG) are also classified as accidents.

6.1.3 Maternity

Benefits in connection with pregnancy and childbirth are the same as those for illness if at the time of the birth the mother has been covered by the insurer for at least 270 days, or in the

event of equivalent previous insurance by another insurer if the health fund confirms that the insurance application was submitted at least 270 days before the birth.

6.2 Scope of benefits

6.2.1 Geographical scope

The insurance applies in principle to benefits provided in Switzerland and to emergency treatment worldwide.

The provisions on geographical validity set out in the insurance provisions of the individual insurance departments take precedence.

For cross-border commuters, insurance protection also covers benefits provided at their place of residence.

6.2.2 Temporal scope

An entitlement to benefits exists for the duration of the insurance. No entitlement to benefits exists for costs incurred after the termination of the insurance. Determining factors are the treatment date or the time when the insured benefit is claimed.

6.3 Insured benefits

6.3.1 Benefit coverage

Insured benefits are those provided under the cover specified in the policy and the provisions for individual insurance departments.

6.3.2 Economical treatment

Treatment is covered if it is economical, effective, expedient and medically necessary. In other words, the costs of medical treatment are met if it is confined to actions which are in the interests of the insured person and conducive to the purpose of the treatment.

In order to ensure that its insured persons receive optimum treatment, the health fund may agree associated measures with approved service providers with the object of providing the most effective, expedient and economical treatment for the insured person through improved cooperation and coordination between itself and service providers. The health fund may instruct a health consultant to take these measures.

If bills are manifestly excessive, the health fund may reduce the benefits accordingly or make payment conditional on the assignment of a claim for a reduction.

6.3.3 Treatment by recognized medical personnel

Treatment by medical personnel or medical institutions is insured if they are recognized under the KVG. Benefits provided by other persons or institutions are insured in cases where provision for this is made in the individual insurance departments.

6.4 Limitation of benefits

6.4.1 Pre-existing illnesses and accidents

The health fund may decline to cover illnesses and consequences of accidents that exist or had previously existed at the time when the policy is concluded. Alternatively it may reject the application in its entirety. For complementary insurance with reservations, the benefits that were already covered in the former insurance department are subject to no restrictions in the new insurance department or class.

The insured person is notified in writing of the limitation of cover.

6.4.2 Exclusion of benefits

No entitlement to insurance benefits exists:

- a) in respect of illnesses and consequences of accidents already in existence when the policy was concluded that were excluded from cover by the health fund,
- b) in respect of illnesses and consequences of accidents already in existence when the application was submitted that were disclosed either partially or not at all,
- c) during a waiting period,
- d) if a treatment does not serve to remedy a health problem or its consequences, except for measures to prevent the threatened occurrence or deterioration of a health problem if the patient was already ill,
- e) for treatment by a service provider not recognized by the health fund,
- f) for dental treatment for which the relevant insurance department does not expressly provide cover,
- g) while cover is suspended,
- h) in the event of late payment, from the expiry of the reminder period until all liabilities have been met in full,
- i) if the insured person is involved in acts of war, unrest and similar events and during foreign military service,
- j) in the case of illness or accident as a consequence of warlike events which began more than 14 days previously,
- k) in the case of illness or accident as a consequence of active involvement in criminal actions, fights and other acts of violence,
- l) for the consequences of earthquakes and other natural disasters,
- m) for the health consequences of major industrial incidents or accidents involving nuclear power,
- n) for organ transplants for which the Swiss Association for the Community Tasks of Health Insurers (SVK), Solothurn, has agreed flat-rate charges, regardless of where the transplant is conducted,
- o) for statutory and agreed cost shares applying to compulsory health care insurance,
- p) for epidemic diseases.

All other benefit exclusions and limitations are specified in the provisions relating to the individual insurance departments.

6.4.3 Limitation of benefits

Benefits can be reduced:

- a) in the event of the wilful infringement of obligations by the policyholder or insured person,
- b) if an illness or accident was the result of gross negligence, particularly the abuse of alcohol, drugs or other substances,
- c) in the event of health damage attributable to a hazardous action, i.e. if the insured person exposes himself to an especially serious risk without taking or being able to take precautionary measures to reduce the risk to a reasonable level. This does not include actions taken to rescue persons. The term hazardous action within the meaning of this provision includes, in particular, participation in motor vehicle races or training for them, or in hazardous sports unless these are organised, operated and supervised by qualified professionals. The insurer keeps a list of all sports considered to be hazardous. This list is not exhaustive and can be viewed by the insured persons at any time,
- d) if the health damage was caused deliberately, including as a consequence of attempted suicide or self-harm,
- e) if the documentation needed to process the insurance claim is not forthcoming within four weeks despite a written reminder.

7 Obligations in the event of sickness or accident

7.1 Notification obligation

Insured persons must submit their benefit claims to the health fund within the time limits specified in the provisions for individual insurance departments. The occurrence of an accident must be reported within a maximum of ten days.

The report must be truthful. Where benefits are claimed, the health fund must be supplied with full information together with the necessary medical and administrative particulars. Only detailed, legible original bills will be accepted.

7.2 Damage limitation

The insured person must do everything possible to reduce the damage, in particular taking every action conducive to recovery and refraining from any action that might delay it. The insured person shall assist the activity of the health consultant in the framework of associated measures taken by the health fund and shall give him any information required.

7.3 Obligation to provide information

Where the health fund is concerned, the insured person releases medical practitioners and other medical personnel, together with insurers, from their confidentiality obligation. The health fund may seek such information as is necessary.

On request, the insured person must agree to an examination by a second doctor or by the health fund's medical consultant. The insurer will bear the costs.

The insured person must inform the health fund about all benefits provided by third parties in the event of illness, accident and invalidity. On request, invoices issued by third parties must be submitted to the health fund.

In the case of persons not competent to act on their own behalf, the policyholder must ensure that the obligation to provide information is met.

8 Premiums and payments

8.1 Fixing the premiums

8.1.1 General

Premiums for each insurance department are set out in rate tables.

8.1.2 Amount of premiums

The amount of premiums is determined by reference to risk, for example, by reference to the insured's age, place of residence, or the proportion of the risk to be borne by the insured person himself or his insurer.

Premium changes as a result of switching to another risk group are made automatically.

A reduced premium is charged for suspended insurance.

8.1.3 Family discount

Premium discounts may be granted for families, in particular for children up to the age of 18, in cases where a policy is concluded for a period of at least three full calendar years or if a couple arranges identical cover.

A children's discount is subject to the following conditions:

- where the insurance term is at least three years:
 - one parent must have at least the same insurance cover with Sympany as the child and they must live together in the same household.

- for premium exemptions for the third child and subsequent children:
the two oldest siblings, aged up to 25 and living together in the same household, must have at least the same insurance cover with Sympany.

8.2 Adjustment of premium scales and cost sharing

Premium scales and cost sharing may be adjusted in the light of costs and the pattern of claims.

Policyholders are given 30 days' advance notice of premium adjustments. The policyholder is entitled, within 30 days of notification by the health fund, to withdraw from the relevant insurance department with effect from the date on which the premium adjustment is due to take effect. Premium adjustments due to an automatic switch to a higher age range give rise to an extraordinary right of termination on the same terms.

If no notice of termination is given, the policyholder is deemed to have consented to the premium adjustment.

8.3 Premium payment

8.3.1 Due date

Premiums are payable in advance in accordance with the due dates and days of grace specified in the premium demand. Premiums must be paid without interruption, i.e. in the event of accident, illness, pregnancy and maternity, incapacity or when the entitlement to benefits is suspended.

If the insurance begins or ends during a calendar month, the premium is payable for the whole month.

8.3.2 Payment arrears

If the obligation to pay a premium or a cost share is not met by the policyholder within a further period of 30 days, a written reminder is issued to settle the outstanding premiums or cost shares within 14 days. The reminder notifies the policyholder of the consequences of failing to make payment.

The costs of reminders and any additional enforcement costs incurred in connection with outstanding payments are charged to the insured person.

If no payment is made despite the reminder, the obligation to provide benefits for treatment or loss of income shall be suspended from the expiry of the grace period until the outstanding premiums, plus interest and administrative costs, have been settled in full.

For illnesses, accidents and their consequences which occur while the obligation to provide benefits is suspended, no insurance cover is in force even if the outstanding sums are subsequently paid.

The health fund may withdraw from the contract at any time after the expiry of the reminder period. If the outstanding premium is not collected with due legal effect within two months of the expiry of the reminder period, the contract lapses.

8.4 Profit share

8.4.1 Principle

If the insured adult person presents a favourable risk profile, he or she may benefit from any excess, i.e. the insurer's net profit.

8.4.2 Condition

A condition for a possible profit share is that the insured person must not have drawn any benefits from the insurer or the health fund for at least one calendar year. This applies to all insurance departments, including compulsory health care insurance or daily allowance insurance pursuant to the KVG.

8.4.3 Disbursement

Any profit share is paid in the form of a single non-recurring payment, at least one year after the calendar year in which no benefits have been drawn. It can only be paid to persons who are insured at the time of the disbursement.

8.5 No-claims discount (NCD)

8.5.1 Principle

In the variant with a no-claims discount, a premium discount is granted if no claims are made.

8.6 Other payment provisions

8.6.1 Offsetting

The health fund may offset any benefits against claims on the insured person or policyholder. The insured person and the policyholder have no right of offset vis-à-vis the health fund.

8.6.2 Pledging and assignment

Claims against the health fund cannot be pledged or assigned without its consent.

8.6.3 Disbursement of benefits

Service providers' fees, subject to any agreement to the contrary between them and the insurer, are payable by the insured person. The health fund disburses benefits to the insured person by credit transfer to his bank or post office account. Account details must be supplied to the health fund in good time. If beneficiaries request a different disbursement method, the health fund may make a charge in respect of the additional costs incurred.

If other agreements and charge scales exist between the insurer and service providers, the health fund makes direct payments to them. In the event of direct payment to the benefit providers by the health fund, the insured person is required to reimburse the health fund with the agreed cost participation within 30 days of billing.

Fee agreements between the invoice issuer and insured persons are not binding on the insurer. A benefit entitlement exists only within the framework of the charge scale acknowledged by the insurer for the corresponding service provider. Benefits paid without justification are reclaimed by the health fund.

8.6.4 Time barring

The insured person's entitlement to benefits from the insurer expires two years after the occurrence of the circumstance that gave rise to the insurer's liability to pay benefits.

9 Third-party benefits

9.1 Subsidiarity

9.1.1 General

If a third party is liable for a reported case of illness or accident by law or through its own fault, the insurer is not liable to provide benefits or is at most liable to pay the amount not otherwise covered.

There is no obligation to provide benefits under the present terms and conditions of insurance to the extent that claims exist against third parties.

9.1.2 Public benefits

There is no obligation to provide benefits under these terms and conditions of insurance to the extent that claims to benefits or reductions exist against cantonal and local authorities.

9.1.3 Multiple insurance

Where several insurers are liable to provide benefits, a calculation is made to determine how much each insurer would have had to pay had he been solely responsible. This provision applies even if the obligation of the other insurers to provide benefits is merely subsidiary. The compensation payable in accordance with these terms and conditions is limited to that portion of the overall sum insured which corresponds to this cover.

9.1.4 Waiver of benefits

Where insured parties waive benefits from third parties in whole or in part without the consent of the health fund, the obligation to provide benefits under these terms and conditions of insurance shall lapse. Capitalization of a benefit claim is also treated as a waiver.

9.2 Social insurance

No benefits covered by social insurance schemes (KV, UV, IV, MV, AHV, AIV, etc.) will be paid. Benefit claims must be registered with the insured person's social security scheme.

9.3 Advance payment of benefits and redress

Advance payments may be made in relation to third parties other than the social insurance schemes. A requirement is that the insured person must have made reasonable efforts to enforce his claims without success and is willing to assign his claims against third parties to the health fund in the amount of the benefits provided.

9.4 Overinsurance

The insured person must not gain any profit on the benefits provided under these general terms and conditions of insurance when the benefits paid by third parties are taken into account. In the event of overinsurance, the benefits are reduced accordingly.

10 Customer card

Persons insured with Sympany receive a personal customer card from the health fund. This serves to identify them to service providers.

Otherwise the relevant conditions of the basic insurance apply.

11 Data protection

Processing of data about insured persons shall be governed by the provisions of the Federal Data Protection Act of 19 June 1992.

If data processing is entrusted to a third party, the health fund shall ensure that data are processed only as they would be by itself.

The health fund only obtains and processes data (e.g. personal particulars, information about the state of health, verification of the details given in the application, cash collection, claim

processing) required for the insurance contract to be processed pursuant to the ICA. The health fund treats the information obtained as completely confidential.

The health fund forwards data to third parties only if the disclosure is directly related to the implementation of the contract. In other cases, the health fund provides information only with the consent of the insured person.

The health fund shall store the data carefully and take appropriate technical and organizational measures to prevent unauthorized access to the data.

12 Notices

The health fund must be notified in writing of changes in the personal circumstances of insured persons that are material to the insurance, such as a change of domicile, within 30 days. If the insured person fails to meet his obligation to report a change in his personal circumstances relevant to premium calculation, any difference in the premium is due retroactively.

A contact address in Switzerland must be supplied for persons resident abroad.

All notices from the policyholder or the insured person must be addressed to the relevant business office of the health fund.

Written notices from the health fund or the insurer are sent with legal validity to insured persons or policyholders at their last known address or at the contact address in Switzerland, or by means of the policyholder's journal.

13 Jurisdiction

In the event of disputes arising from policies under these general terms and conditions and any special provisions, the complainant may refer the matter to the courts at his Swiss place of residence or at the place of business of the insurer or the health fund.

14 Entry into force

These general terms and conditions of insurance (GTC) for supplementary insurance and additional insurance pursuant to the ICA take effect on 1 January 2010. They supersede all previous insurance provisions.

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general supplement and private supplement

1 Insurance fundamentals

1.1 Purpose

The general supplement and private supplement provide benefits for out-patient medical treatment elsewhere than at the place of residence or work, for preventive measures, remedial aids, dental treatment, alternative treatment and healing methods, transport costs, search, rescue and recovery operations and elective drugs; a breastfeeding allowance is also payable.

The private supplement also insures the costs of treatment by doctors who are not under KVG contract, and whose services are therefore not covered by the KVG. It also makes contributions to alternative medical services abroad and travel costs.

As a rule the benefits are provided in addition to all the other insurance departments in these general terms and conditions of insurance (GTC).

The benefits of compulsory health care insurance (basic) take precedence over those provided under this insurance department.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the provisions of both the general supplement and the private supplement. In the event of any conflict, the provisions of the general supplement and private supplement take precedence over the common provisions.

1.4 Insured persons

The general supplement is available to persons of any age. The private supplement is restricted to persons who have not yet reached their 60th birthday.

1.5 Right of transfer to similar insurance departments

Persons insured under a general supplement are entitled to transfer to plus natura or plus, and persons insured under private supplement are entitled to transfer to premium natura or premium. The transfer may be made on 1 January of the subsequent year and must be announced by no later than 30 September of the current year. This right of transfer shall only apply to insured persons who have taken out one of the eligible products prior to 31 December 2011.

1.6 Benefit conditions

Benefits are only payable if the treatment is medically indicated and if it is administered by persons who are recognized by the health fund. Information about whether persons are recognized must be obtained from the health fund.

1.7 Benefits abroad

Benefits under the private supplement are also paid abroad, except in the casamed variant and when otherwise specified.

2 Medical treatment

2.1 Treatment elsewhere than at the place of residence or work

In addition to the benefits provided by basic, treatment by KVG health fund doctors other than at the place of residence or work of the insured person is fully covered as per the KVG charge scale applicable at the place of treatment.

2.2 Treatment by doctors not under KVG contract

The private supplement provides benefits according to the KVG charge scale for treatment by medical practitioners who are not under KVG contract.

Reimbursement is available for a maximum of 50 hours of psychotherapeutic treatment.

2.3 Private consultations with hospital doctors who are not under KVG contract

The private supplement provides benefits on the recognized charge scale for outpatient consultations with senior university hospital doctors who are not under KVG contract.

A maximum of 50 hours psychotherapeutic treatment is paid for at the KVG charge scale under the private supplement.

2.4 Medical treatment abroad

2.4.1 Elective treatment

The private supplement covers the costs of medical treatment abroad up to a maximum of twice the KVG charge scale at the place of residence of the insured person. global insurance provides full cost cover at the normal local rate.

Reimbursement is available for a maximum of 50 hours of psychotherapeutic treatment.

2.4.2 Emergency treatment

In the case of emergency medical treatment abroad, full costs are covered under the general supplement and private supplement in addition to the basic benefits.

2.5 Duration of benefits

Subject to any provision to the contrary in the terms and conditions for the general supplement and private supplement, benefits are not time limited.

3 Prevention

3.1 Vaccinations

The following contributions to the costs of vaccinations to prevent infection are payable per calendar year:

90%, to a maximum of CHF 200.-

No benefits are provided for vaccinations that are undertaken for occupational reasons, whose effect is medically disputed or that are still in the research stage.

3.2 Check-ups

After two successive calendar years without claiming benefits, a contribution to the documented costs of a medical check-up is payable under basic as follows:

general supplement	90% of costs, to a maximum of CHF 300.-
private supplement	90% of costs, to a maximum of CHF 600.-

3.3 Precautionary gynaecological examinations

The costs of one precautionary gynaecological examination per calendar year are insured at the KVG charge rate, provided that no such benefits are received in the same calendar year under KVG insurance.

3.4 Maternity

3.4.1 Preparation for birth

The following maximum sum per pregnancy is paid towards the documented costs of an antenatal course with a qualified professional, including rehabilitation gymnastics:

CHF 200.–

3.4.2 Breastfeeding allowance

A breastfeeding allowance of

CHF 250.–

is payable. This allowance is paid if the insured mother breast-feeds her child for ten weeks, whether exclusively or not. Evidence must be provided on the health fund's breastfeeding allowance form.

3.5 Courses on health-promoting behaviour

The following contribution is paid within two calendar years to the documented costs of a medically prescribed course to learn health-promoting behaviour (e.g. giving up smoking, back training, dietary advice) given by qualified personnel:

general supplement	90% of costs, to a maximum of CHF 300.–
private supplement	90% of costs, to a maximum of CHF 500.–

The insurer designates recognized courses on forms of behaviour conducive to good health. The list of recognized courses, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

3.6 Further preventive measures

Contributions may be paid to further recognized preventive measures.

4 Remedial aids

4.1 Corrective lenses

The following contribution is paid to insured persons above the age of 18 within five calendar years towards the costs of corrective lenses and contact lenses.

general supplement	CHF 270.–
private supplement	CHF 420.–

The following annual contribution is paid for children up to the age of 18:

general supplement	CHF 270.–
private supplement	CHF 420.–

4.2 Other remedial aids

A contribution towards the costs of hiring or purchasing recognized, medically indicated remedial aids for which no benefits are available under basic is available as follows:

50% of costs, to a maximum of CHF 250.– per calendar year

The insurer designates recognized remedial aids. The list of recognized aids, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

Costs incurred for the operation, maintenance and repair of these remedial aids are not covered.

5 Dental treatment

5.1 Wisdom teeth

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital inpatient, the costs are covered up to the amount of the contractually fixed daily allowance in a general ward in the canton of residence.

5.2 Benefits for children and young people

The following benefit entitlement exists for children and young people up to the age of 25:

- The following sum is payable towards the costs of an examination (including X-ray) if no dental treatment (conservative, prosthetic, etc.) is required at the same time:

CHF 60.– per calendar year

- Towards the costs of orthodontic treatment as per the recognized charge scale:

general supplement	70% of the costs subject to a maximum of CHF 5 000.–
private supplement	70% of the costs subject to a maximum of CHF 12 000.–

These benefits are provided for treatment after insurance has been in force for at least three years. The benefit is conditional on the presentation of a diagnosis of the existing anomaly in the position of the teeth, the proposed treatment and a cost estimate. If an equivalent prior insurance exists when the contract is signed, Sympany does not require a waiting period provided that at least one parent is also insured with it. Benefits already drawn from the previous insurers are imputed against the above benefits.

5.3 Public benefits

Benefits are paid in addition to any benefits provided by the cantonal and local authorities, according to their respective legislation on public dental care. Contributions from the cantonal and local authorities are offset against the benefits of this insurance department.

5.4 Service providers and charge scales

Benefits are reimbursed according to the scale applicable to dental benefits under compulsory health care insurance. If the dentist makes a higher charge than that stipulated by compulsory health care insurance, the difference is payable by the insured person.

The term "dentist" denotes a practitioner who has acquired the appropriate Swiss federal or equivalent diploma or who has been granted authorization to pursue the profession by the canton on the basis of evidence of scientific qualifications.

5.5 Treatment abroad

Treatment abroad is covered provided that the medical personnel concerned have undergone training equivalent to that of their counterparts in Switzerland and the costs do not exceed Swiss costs.

6 Alternative medicine

6.1 Empirical medical methods

Where medical indications exist, the costs of empirical medical methods employed by a doctor are covered. The insurer draws up a list of acknowledged methods and benefit limits.

6.2 Alternative therapists and treatment methods

Sympany pays contributions in the field of alternative medicine provided that it recognizes the treatment method and the therapist or naturopath administering it. Contributions are paid as follows:

general supplement	Up to CHF 70.- per hour of therapy (60 minutes)
private supplement	Up to CHF 100.- per hour of therapy (60 minutes)

The insurer designates recognized treatments and therapists. Lists of recognized treatments and therapists undergo constant adjustment and extension. The list of recognized treatments and therapists can be inspected at the health fund's offices at any time.

No costs are paid for forms of therapy or for treatment by therapeutic personnel appearing on the insurer's negative list (NL).

The health fund fixes the number of hours for which payment is made in the light of medical necessity.

6.3 Additional benefits under private supplement

The following benefits are available under private supplement for the documented costs of further treatments by qualified personnel:

Up to CHF 50.- per hour, up to CHF 1 000 per calendar year

Alternative medical treatment provided in a country adjacent to Switzerland is covered in accordance with the above provisions up to a maximum of the standard charge at the place of treatment.

6.4 Natural treatments

Sympany pays 90% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and oligosols, provided that they are not covered by basic and do not figure on the insurer's negative list (NL).

6.5 Maximum benefits

Benefits in the field of alternative medicine are limited by

- the contribution per hour of therapy,
- the number of hours of therapy,
- the list of alternative treatment methods recognized by Sympany,
- the list of therapeutic practitioners and naturopaths recognized by Sympany,
- cost sharing for medical treatment and natural curative agents,
- time limits (per calendar year).

No additional excess is imposed for forms of therapy with limited reimbursement.

Total benefits in the field of alternative medicine are subject to the following maxima:

general supplement	CHF 3 000.- per calendar year
private supplement	CHF 6 000.- per calendar year

6.6 Benefit conditions

Benefits are payable after prior application has been submitted to the health fund. The health fund may ask a medical consultant to review the medical indication and the qualifications of the doctors and therapists concerned. The health fund may decline to pay benefits if the patient is undergoing parallel treatment at the same time.

7 Elective drugs

Contributions towards the costs of drugs prescribed by a doctor that have been approved by the insurer and the Swiss Agency for Therapeutic Products and do not appear on the drugs list with the charge scale (ALT), the KVG specialities list (SL) or the insurer's negative list (NL) are payable as follows in each calendar year:

general supplement	50%, to a maximum of CHF 2 500.-
private supplement	90%, to a maximum of CHF 5 000.-

8 Spas

A contribution to spa treatment undergone on medical instructions is payable as follows per calendar year:

50%, for a maximum of 12 admissions

9 Psychotherapeutic treatment

9.1 Benefit coverage

The insurance provides benefits for up to 100 hours of treatment for mental disorders by qualified psychotherapeutic specialists who are not medical practitioners but are in possession of a cantonal authorization to practise independently.

Up to CHF 60.- for each of the first 50 hours

Up to CHF 50.- for each subsequent hour

9.2 Benefit conditions

Benefits are paid after the application for reimbursement has been approved by the health fund's medical consultant.

After the expiry of the number of hours of treatment approved by the health fund, but at the end of the first 50 hours of therapy at the latest, the therapist must again report the progress of the therapy and the therapy plan to the medical consultant.

No benefits are paid for psychotherapy undergone for the purpose of self-realization, personality development or learning. In addition, no benefits are payable for parallel treatment by a different psychologist or psychiatrist.

9.3 Relationship with compulsory health insurance

Psychotherapeutic benefits are payable under this insurance department only until they qualify as compulsory benefits in basic and are covered by it.

10 Transport costs, search, rescue and recovery operations, travel expenses

10.1 Transport costs, search, rescue and recovery operations in an emergency

10.1.1 Benefit coverage

The following contribution

CHF 15 000.- per calendar year

is payable towards the costs of:

- medically necessary emergency transportation to the nearest suitable hospital by appropriate means of transport,
- return transportation to a suitable hospital in the insured person's canton of residence for inpatient treatment,
- search and rescue operations.

Transportation by air is paid for only if it is essential for medical or technical reasons.

10.1.2 Excess

The insured person is liable for the following excess in respect of each claim.

CHF 100.–

10.1.3 Search operations

In addition to the costs of the rescue or recovery of an insured person, the costs of search operations are payable as follows:

CHF 20 000.– per calendar year

10.1.4 Third-party benefits

Subject to any contractual provisions to the contrary if the insured person is a member (patron) of an air-rescue service or similar organization, benefits are limited to sums not provided by the organization(s) in question.

10.2 Travel expenses

Where the insured person regularly receives medical treatment other than at his place of residence, general supplement and private supplement contribute to the public-transport costs thereby incurred. This benefit is payable only if appropriate treatment cannot be provided at his place of residence or in the immediate vicinity.

90%, up to a maximum of CHF 100 per calendar year

private supplement contributes to the taxi costs incurred for transport between the insured person's place of residence and the place where he receives outpatient treatment. This benefit is payable only if the insured person is unable for medical reasons to use public transport or his own private vehicle.

90%, up to a maximum of CHF 400.–* per calendar year
*(maximum amount incl. costs for public transport)

11 casamed variant

11.1 General

Persons insured under general supplement and private supplement can only have casamed variant insurance if they are covered by the casamed variant of basic insurance. The following additional provisions apply to persons insured under the casamed variant.

The following additional provisions apply to persons insured under the casamed variant of basic insurance.

11.2 General benefit conditions

Benefits under the general supplement and private supplement are payable for services provided according to the family-doctor principle: they must be provided or prescribed by the casamed family doctor with whom the insured person is registered, or delivered on his instructions.

The health fund may designate telemedical institutions as casamed family doctors.

11.3 Doctors not under KVG contract

No benefits are payable under the casamed variant of the private supplement for treatment by doctors (including hospital doctors) who are not under KVG contract, or for elective medical treatment abroad.

11.4 Special benefits

The costs of birth preparation, the breastfeeding allowance, transport, search, rescue and recovery costs and dental check-ups are reimbursed without consulting the casamed family doctor or the telemedical institution.

11.5 Other specialists

Instead of the casamed family doctor, the health fund may designate other specialists who may provide, prescribe or arrange the services covered by the general supplement and the private supplement.

11.6 Preventive measures, alternative medicine, elective drugs

The health fund may authorize the casamed family doctor or its designated specialists to provide, prescribe or arrange other preventive measures, alternative medical services or elective drugs than those listed in the general supplement and private supplement.

11.7 Other service providers

With a view to the provision of care at reasonable cost, the health fund may designate other service providers such as pharmacists, therapists, medical-suppliers stores or other service providers from which persons insured under casamed must exclusively obtain medical treatment or supplies.

11.8 Emergencies

Emergencies are covered by both the general supplement and private supplement, regardless of the choice of service provider.

The health fund may ask its medical consultant to review the medical indication.

11.9 Exclusion of benefits

If the insured person – other than in an emergency – presents himself for treatment to a service provider who is not on the authorized list, he is liable for all the costs.

11.10 Benefit processing

11.10.1 Flat-rate allowance

The insurer or health fund may agree with casamed family doctors that the benefits under the general supplement and private supplement will be paid on a flat-rate basis.

11.10.2 Prescribed services

Where services are prescribed, the health fund may require evidence from the insured person or from the casamed family doctor, before reimbursing the costs, that the service was in fact delivered according to the family-doctor principle.

If a service provider to whom the member was referred by the casamed family doctor wishes to refer the patient on, the consent of the responsible casamed family doctor must be obtained.

The health fund or casamed cooperation partners may supply service providers with electronic equipment to facilitate fast, secure communication between service providers and to optimize service coordination and control.

The health fund ensures that all parties comply with the provisions of the Data Protection Act.

12 Cost share

Unless otherwise stipulated in a particular case, benefits under this insurance department – provided that they are not limited – are subject to a 10% excess.

Insured persons over the age of 18 undergoing elective medical treatment abroad (private supplement) are subject to an annual deductible equivalent to the ordinary deductible stipulated in KVG. This deductible also applies in the case of maternity benefits.

Where alternative medical treatments are given by physicians and therapists, insureds over the age of 18 may be charged an annual excess equal to the normal excess laid down by the KVG.

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11 casamed variant

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12 Cost share

plus and premium

1 Insurance fundamentals

1.1 Purpose

plus, plus natura, premium and premium natura provide benefits for out-patient medical treatment elsewhere than at the place of residence or work, for preventive measures, remedial aids, the preventive dental and orthodontic treatment of children, alternative treatment and healing methods, transport costs, search, rescue and recovery operations and elective drugs; a breastfeeding allowance is also payable.

As a general rule, premium also pays benefits abroad. premium also covers the costs of treatment by doctors who are not under KVG contract, and whose services are therefore not covered by the KVG.

The natura variants pay increased benefits in the field of alternative medicine. Unless otherwise stipulated, the benefits and provisions of plus natura are equal to those of plus, and those of premium natura are equal to those of premium.

As a rule, benefits are provided in addition to all the other insurance departments in these general terms and conditions of insurance (GTC). The benefits of compulsory health care insurance (basic) take precedence over those provided under this insurance department.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the provisions of both plus and premium. In the event of any conflict, the provisions of plus and premium take precedence over the common provisions.

1.4 Insured persons

plus is available to persons of any age. premium is restricted to persons who have not yet reached their 60th birthday.

1.5 Benefit conditions

Benefits are only payable if the treatment is medically indicated and if it is administered by persons who are recognized by the health fund. Information about whether persons are recognized must be obtained from the health fund.

1.6 Benefits abroad

Benefits under premium are also paid abroad, except in the casamed variant and when otherwise specified.

2 Medical treatment

2.1 Treatment elsewhere than at the place of residence or work

In addition to the benefits provided by basic, treatment by KVG health fund doctors other than at the place of residence or work of the insured person is fully covered as per the KVG charge scale applicable at the place of treatment.

2.2 Treatment by doctors not under KVG contract

premium provides benefits as per the recognized KVG charge scale for outpatient consultations with senior university

hospital doctors and for treatment by doctors who are not under KVG contract.

2.3 Medical treatment abroad

2.3.1 Elective treatment

premium covers the costs of medical treatment abroad up to a maximum of twice the KVG charge scale at the insured person's place of residence. global covers the full cost as per the normal local rate.

2.3.2 Emergency treatment

plus and premium pay any costs of emergency medical treatment abroad that are not covered by basic.

2.3.3 Duration of benefits

Subject to any provision to the contrary, benefits under plus and premium are not timelimited.

3 Prevention

3.1 Vaccinations

The following contributions to the costs of vaccinations to prevent infection are payable per calendar year:

80%, max CHF 220.-

No benefits are provided for vaccinations which are undertaken for occupational reasons, whose effect is medically contested or which are still in the research stage.

3.2 Check-ups

After two successive calendar years without claiming benefits, a contribution to the documented costs of a medical check-up is payable under basic as follows:

plus	Up to CHF 300.-
premium	Up to CHF 600.-

3.3 Precautionary gynaecological examinations

The costs of one precautionary gynaecological examination per calendar year are insured at the KVG charge rate, provided that no such benefits are received in the same calendar year under KVG insurance.

3.4 Maternity

3.4.1 Preparation for birth

The following maximum sum per pregnancy is paid towards the documented costs of an antenatal course with a qualified professional, including rehabilitation gymnastics:

CHF 200.-

3.4.2 Breastfeeding allowance

A breastfeeding allowance is payable. This allowance is paid if the insured mother breastfeeds her child for ten weeks, whether exclusively or not. Evidence must be provided on the health fund's breastfeeding allowance form.

CHF 250.-

3.5 Getting fit

The following contributions are payable to the documented costs of a course recognized by the health fund on forms of behaviour conducive to good health (e.g. giving up smoking, back training, dietary advice):

plus	Up to CHF 150.- per calendar year
premium	Up to CHF 250.- per calendar year

The insurer designates recognized courses and institutions teaching forms of behaviour conducive to good health. The list of recognized courses and institutions, which undergoes constant adjustment and extension, can be inspected at any time at the health fund's offices.

3.6 Keeping fit

The following contributions are payable towards further recognized preventive measures such as sport, fitness and relaxation courses:

plus	Up to CHF 200.– per calendar year
premium	Up to CHF 300.– per calendar year

The health fund designates recognized institutions, preventive measures, cost contributions and benefit limits. The list of recognized institutions, preventive measures, cost contributions and benefit limits, which undergoes constant adjustment and extension, can be inspected at any time at the health fund's offices.

4 Remedial aids

4.1 Corrective lenses

The health fund makes the following contributions to the costs of spectacles or contact lenses required for visual correction:

plus	A total of CHF 270.– within 3 calendar years
premium	A total of CHF 420.– within 3 calendar years

The following contribution is payable for children up to 18 years of age:

plus	A total of CHF 270.– per calendar year
premium	A total of CHF 420.– per calendar year

4.2 Other remedial aids

A contribution towards the costs of hiring or purchasing recognized, medically indicated remedial aids for which no benefits are available under basic is available as follows:

50%, max. CHF 250.– per calendar year

The health fund designates recognized remedial aids. The list of recognized aids, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

Costs incurred for the operation, maintenance and repair of these remedial aids are not covered.

5 Dental treatment

5.1 Wisdom teeth

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital inpatient, the costs are covered up to the amount of the contractually fixed daily allowance in a general ward in the canton of residence.

5.2 Benefits for children and young people

The following benefit entitlement exists for children and young people up to the age of 25:

The following contribution is payable towards the costs of an examination (including X-ray) if no dental treatment (conservative, prosthetic, etc.) is required at the same time:

CHF 60.– per calendar year

Contributions towards the costs of orthodontic treatment as per the recognized charge scale:

plus	70%, max CHF 10 000.–
premium	70%, max CHF 15 000.–

These benefits are provided for treatment after insurance has been in force for at least two years. If an equivalent prior insurance exists when the contract is signed, the insurer does not require a waiting period provided that at least one parent is also insured with it. Benefits already drawn from the previous insurers are imputed against the above benefits. The benefit is conditional on the presentation of a diagnosis of the existing anomaly in the position of the teeth, the proposed treatment and a cost estimate.

5.3 Public benefits

Benefits are paid in addition to any benefits provided by the cantonal and local authorities, according to their respective legislation on public dental care. Contributions from the cantonal and local authorities are offset against the benefits of this insurance department.

5.4 Service providers and charge scales

Benefits are reimbursed according to the scale applicable to dental benefits under compulsory health care insurance. If the dentist makes a higher charge than that stipulated in compulsory health care insurance, the difference is payable by the insured person.

The term "dentist" denotes a practitioner who has acquired the appropriate Swiss federal or equivalent diploma or who has been granted authorization to pursue the profession by the canton on the basis of evidence of scientific qualifications.

5.5 Treatment abroad

Treatment abroad will be covered provided that the medical staff's training is equivalent to the Swiss standard and that the costs do not exceed the costs in Switzerland.

6 Alternative medicine

6.1 Maximum overall limits

In the field of alternative medicine the following overall limits apply to medical treatment, recognized therapeutic methods and natural treatments:

plus	CHF 3 000.– per calendar year
plus natura	CHF 6 000.– per calendar year
premium	CHF 6 000.– per calendar year
premium natura	CHF 10 000.– per calendar year

6.2 Medical treatment

plus and premium reimburses the costs of the following alternative methods of medical treatment:

- empirical medical methods.

The health fund designates recognized empirical medical methods, charges and benefit limits. The list of recognized methods, charges and benefit limits, which undergoes constant adjustment and extension, can be inspected at any time at the health fund's offices.

6.3 Alternative therapists and treatment methods

plus and premium pay contributions in the field of alternative medicine provided that it recognizes the treatment method and the therapist or naturopath administering it. Contributions are paid as follows:

plus and premium	50% of documented costs
plus natura and premium natura	80% of documented costs

The plus natura and premium natura schemes will make the following contributions towards the documented costs of non-recognized methods employed by qualified persons:

plus natura	50%, max CHF 1 000.– per calendar year
premium natura	50%, max CHF 2 000.– per calendar year

No costs are paid for forms of therapy or for treatment by therapeutic personnel appearing on the insurer's negative list (NL).

The health fund designates recognized forms of treatment, therapists and benefit limits.

The health fund can specify the number of treatment sessions as a function of medical necessity.

The list of recognized forms of treatment, therapists and benefit limits, which undergoes constant adjustment and extension, can be inspected at any time at the health fund's offices.

6.4 Benefits abroad

Alternative medical treatment provided in a country adjacent to Switzerland is covered by plus natura and premium natura in accordance with the above provisions at the standard charge at the place of treatment.

6.5 Natural treatments

plus and premium pay 80% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and oligosols, provided that they are not covered by basic and do not figure on the insurer's negative list (NL).

6.6 Limitation of benefits

Benefits in the field of alternative medicine are limited by:

- overall limits,
- benefit limits (number of treatment sessions, maximum charge per hour of treatment, charge scale),
- list of alternative therapy methods recognized by the health fund,
- list of therapists and naturopaths recognized by the health fund,
- cost shares,
- time limits (per calendar year).

6.7 Benefit conditions

Benefits are payable after prior application has been submitted to the health fund. The health fund may ask its medical consultant to review the medical indication and the qualifications of doctors and therapists. The health fund may refuse benefits if the insured person is drawing benefits for alternative medical treatment of the same condition from this or another insurance department at the same time.

7 Elective drugs

Contributions towards the costs of drugs prescribed by a doctor that have been approved by the insurer and the Swiss Agency for Therapeutic Products and do not appear on the drugs list with the charge scale (ALT), the KVG speciality list (SL) or the health fund's negative list (NL) are payable as follows in each calendar year:

plus	80%, max CHF 3 000.– per calendar year
premium	80%, max CHF 6 000.– per calendar year

8 Spas

A contribution to spa treatment undergone on medical instructions is payable as follows per calendar year:

50%, max 12 admissions

9 Psychotherapeutic treatment

9.1 Benefit coverage

The insurance provides benefits as follows for treatment for mental disorders by qualified psychotherapists who are not medical practitioners but are in possession of a cantonal authorization to practise independently:

plus	50%, max CHF 1 000.– per calendar year
premium	50%, max CHF 2 000.– per calendar year

9.2 Benefit conditions

Benefits are paid after the application for reimbursement has been approved by the health fund's medical officer consultant.

No benefits are paid for psychotherapies which are followed for the purpose of self-realization, development of the personality or for learning purposes. In addition, no benefits are payable for parallel treatment by a different psychologist or psychiatric specialist.

9.3 Relationship with compulsory health care insurance

Psychotherapeutic benefits are payable under this insurance department only until they qualify as compulsory benefits in basic and are covered by it.

10 Transport costs, search, rescue and recovery operations, travel expenses

10.1 Transport costs, search, rescue and recovery operations in an emergency

10.1.1 Benefit coverage

The following overall contribution towards:

- medically necessary emergency transportation to the nearest suitable hospital by an appropriate means of transport,
- return transportation to a suitable hospital in the canton in which the insured person resides for inpatient treatment,
- search, rescue and recovery operations is payable:

CHF 40 000.– per calendar year

Under hospita the costs of emergency transportation, return transportation and rescue operations organized by the 24-hour emergency helpline are met in full.

Transportation by air is paid for only if it is essential for medical or technical reasons.

10.1.2 Excess

The insured person is liable for the following excess in respect of each claim.

CHF 200.–

10.1.3 Third-party benefits

Subject to any contractual provisions to the contrary if the insured person is a member (patron) of an air-rescue service or similar organization, benefits are limited to sums not provided by the organization(s) in question.

10.2 Travel expenses

In cases where a medical treatment is not available at the insured person's place of residence or in its immediate vicinity and he therefore has to receive regular treatment elsewhere, the following contributions to the transport costs (public transport and taxi) thereby incurred are payable:

plus	Up to CHF 100.– per calendar year
premium	Up to CHF 400.– per calendar year

11 casamed variant

11.1 General

Persons insured under plus and premium can only have casamed variant insurance if they are covered by the casamed variant of basic insurance. The following additional provisions apply to persons insured under the casamed variant.

11.2 General benefit conditions

Benefits under plus and premium are payable for services provided according to the family-doctor principle: they must be provided or prescribed by the casamed family doctor with whom the insured person is registered, or delivered on his instructions.

The health fund may designate telemedical institutions as casamed family doctors.

11.3 Treatment abroad and by doctors not under KVG contract

No benefits are payable under the casamed variant of premium for treatment by doctors (including hospital doctors) who are not under KVG contract, or for elective medical treatment abroad.

11.4 Special benefits

The costs of birth preparation, the breastfeeding allowance, transport, search, rescue and recovery costs and dental check-ups are reimbursed without consulting the casamed family doctor or the telemedical institution.

11.5 Other specialists

Instead of the casamed family doctor, the health fund may designate other specialists who may provide, prescribe or arrange the services covered by plus or premium.

11.6 Preventive measures, alternative medicine, elective drugs

The health fund may authorize the casamed family doctor or its designated specialists to provide, prescribe or arrange other preventive measures, alternative medical services or elective drugs than those listed in plus or premium.

11.7 Other service providers

With a view to the provision of care at reasonable cost, the health fund may designate other service providers such as pharmacists, therapists, medical-supplies stores or other service providers from which persons insured under casamed must exclusively obtain medical treatment or supplies.

11.8 Emergencies

Emergencies are covered by plus regardless of the choice of service provider.

The health fund may ask its medical consultant to review the medical indication.

11.9 Exclusion of benefits

If the insured person – other than in an emergency – presents himself for treatment to a service provider who is not on the authorized list, he is liable for all the costs.

11.10 Exclusion

In the event of repeated breaches of the conditions, the health fund may reassign the insured person from the casamed variant to the ordinary insurance variant.

11.11 Benefit processing

11.11.1 Flat-rate allowance

The insurer or the health fund may agree with the casamed family doctor to cover his costs under plus and premium by means of a flat-rate allowance.

11.11.2 Prescribed services

Where services are prescribed, the health fund may require evidence from the insured person or from the casamed family doctor, before reimbursing the costs, that the service was in fact delivered according to the family-doctor principle.

If a service provider to whom the insured person was referred by the casamed family doctor wishes to refer the patient on, the consent of the responsible casamed family doctor must be obtained.

The health fund or casamed cooperation partners may supply service providers with electronic equipment to facilitate fast, secure communication between service providers and to optimize service coordination and control.

The health fund ensures that all parties comply with the provisions of the Data Protection Act.

12 Cost share

Unless otherwise stipulated in a particular case, benefits under this insurance department are subject to a 10% deductible, provided that they are not limited. Insured persons over the age of 18 undergoing elective medical treatment abroad (premium) are subject to an annual deductible equivalent to the ordinary deductible stipulated in KVG. This deductible also applies in the case of maternity benefits.

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8 hospita variant with a no-claims discount (NCD)

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1 Insurance fundamentals

1.1 Purpose

The purpose of hospita insurance is to meet the costs of treatment in intensive-care hospitals in the event of illness, accident and maternity that would not otherwise be covered. It also makes contributions to the costs of spa treatment, long-term treatment, home help outside hospital (Spitex) and transportation.

hospita benefits are paid out in addition to compulsory health care insurance in accordance with compulsory health care insurance (KVG) (basic). Of the total costs, the maximum share payable is the proportion not covered by basic or by some other compulsory health care insurance.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the hospita provisions. In the event of any conflict, the hospita provisions take precedence over the common provisions.

1.4 Conclusion of the policy

hospita is open to persons who have not yet reached their 60th birthday. hospita private accident is available only in combination with one of the following insurance departments:

- plus, plus natura, premium, premium natura,
- general supplement, private supplement.

1.5 Benefit conditions

1.5.1 General

Benefits are paid only if the treatment is necessary for medical reasons and is administered in an intensive-care hospital. The treatment must be performed by service providers recognized under the KVG.

1.5.2 Intensive-care hospitals

An intensive-care hospital is a medical institution that provides medical and nursing care, equipped with the necessary technical infrastructure to treat patients in need of constant medical observation for reasons of illness, accident or childbirth.

1.5.3 Hospital list

Hospital treatment must take place in hospitals that appear on the approved list of the canton of location or canton of residence in accordance with Art. 39 KVG.

Reduced benefits are payable for treatment in other hospitals.

1.5.4 Treatment outside the canton for medical reasons

In accordance with statutory provisions (Art. 41/3 KVG), the canton of residence meets the additional costs of medically indicated hospitalization outside the canton.

1.6 Accident coverage

Accident cover may be excluded from hospita insurance (except for hospita private accident). The purpose of hospita private accident insurance is to meet the costs of treatment in

the private ward of an intensive-care hospital in the event of an accident for which no other cover exists.

1.7 Insurance possibilities

1.7.1 Benefit levels

hospita insurance operates at the following benefit levels:
hospita general: treatment in the general ward of an intensive-care hospital with a recognized charge scale anywhere in Switzerland (multiple occupancy).

hospita semi-private: semi-private ward (two-bed room) of an intensive-care hospital with a recognized charge scale anywhere in Switzerland.

hospita private: private (single-bed) room in an intensive-care hospital anywhere in Switzerland.

hospita private accident:

- emergency treatment in the event of an accident: private ward of an intensive-care hospital anywhere in the world,
- treatment of the consequences of an accident: private ward of an intensive-care hospital anywhere in Switzerland in the event of an accident.

hospita global: private (single-bed) room in an intensive-care hospital anywhere in the world.

hospita flex: a general or semi-private ward of an intensive-care hospital of the patient's choice with a recognized charge scale anywhere in Switzerland, or a private ward of an intensive-care hospital of the patient's choice anywhere in Switzerland (a cost share will be payable).

hospita comfort: intensive medical treatment and care in a hospital contracted to comfort, as hospita general (general ward). Accommodation costs are met for a room with one or two beds, depending on the insured cover. The hospita comfort benefit level may be restricted to insured persons residing in a particular region.

1.7.2 Hospitals with a recognized charge scale

Hospitals under contract are those with which the insurer has agreed defined charge scales. The health fund has a list of hospitals under contract with a recognized charge scale, which is available for inspection at any time.

1.7.3 Hospitals under contract to hospita comfort

hospita comfort hospitals are those with which the insurer has agreed defined charge scales as appropriate. The health fund has a list of hospita comfort hospitals, which is constantly adjusted and can be inspected at the health fund's offices at any time.

1.7.4 Absent criteria, maximum charges

If a hospital has no ward-classification criteria or applies criteria that differ from those set out in these provisions, its wards are treated as private for insurance purposes. The health fund may fix maximum charges for general and semi-private wards, and then use these as a criterion for classifying insured hospital wards. These maximum charges depend on the rates charged by and agreements with a comparable hospital with a recognized charge scale located in the region where the insured person lives.

Any maximum charges specified by the health fund can be inspected at its offices.

1.7.5 Hospital classification

Hospitals that do not meet these classification criteria, i.e. that have no general or semi-private ward or only a private ward within the meaning of these provisions, will be listed by the health fund. This list is available for inspection.

2 Inpatient treatment

2.1 Intensive care

2.1.1 Benefit conditions

hospita provides inpatient benefits to insured persons requiring hospital treatment within the meaning of basic.

2.1.2 Benefit coverage

In addition to the benefits provided by basic, hospita meets the costs of hospital accommodation in a ward covered by the selected insurance level.

The cost share payable under basic, including the daily contribution to the costs of hospital accommodation, is not covered.

2.1.3 Treatment in a higher class of hospital ward

If treatment takes place in a hospital ward of a higher category than is covered, the following maximum benefits apply.

hospita general: the costs which would have been incurred in an insured hospital ward. If these cannot be determined, hospita pays a daily flat rate:

CHF 30.- per day

hospita semi-private: the costs which would have been incurred in an insured hospital ward. If these cannot be determined, hospita pays a daily flat rate:

CHF 120.- per day

hospita comfort: insured persons with cover in a two-bed room under hospita comfort will receive benefits equivalent to their insurance cover if they stay in a single-bed room of a comfort-contracted hospital.

If persons holding hospita comfort insurance are treated and accommodated in a private or semi-private ward of a comfort-contracted hospital, benefits corresponding to their insurance cover are payable.

2.1.4 Treatment in an unlisted hospital

If treatment is obtained in a hospital that does not appear on a cantonal hospital list, the following maximum benefits are payable:

hospita general/comfort	Flat rate of CHF 30.- per day
hospita semi-private/private/private accident/flex	The additional costs that would have been incurred for accommodation in the insured ward of a reference hospital in the canton of residence rather than the general ward.
hospita private accident (emergency)/global	Full cost cover

2.1.5 Treatment in a non-contracted hospital

Where a person insured under hospita comfort is treated in a hospital that does not appear on the health fund's list of comfort-contracted hospitals, benefits are limited to the cost of a general ward or the reference charge scale of a comfort-contracted hospital in his canton of residence.

2.2 Long-term treatment

2.2.1 Definition

A chronic condition is defined as a long-term illness requiring nursing care but not a permanent medical standby.

2.2.2 Benefit coverage

hospita pays the following flat-rate daily allowances if:

- the treatment of a chronically ill person requires accommodation in a suitable and recognized hospital, or
 - accommodation in an intensive-care hospital takes on the features of long-term treatment for the chronically ill.
- In this case the insurer may reduce its benefits after giving one month's notice. The duration of benefits is reduced by the number of hospital days after the date on which notice is given.

	Days 1 to 90	Days 91 to 180
hospita semi-private/flex	CHF 50.-	CHF 25.-
hospita private/private accident	CHF 70.-	CHF 35.-
hospita global	CHF 90.-	CHF 45.-

These benefits are payable for treatment in the insured ward, no more than once within three calendar years. If treatment is provided in a ward of a lower category than the patient is insured for, benefits are payable according to the hospita variant for the ward actually used.

2.3 Inpatient rehabilitation

If medical treatment is provided in a multi-purpose sanatorium recognized by the health fund or in a medical-rehabilitation ward or clinic, hospita covers the full costs for the first 60 days in accordance with the provisions on intensive care. After that, benefits for long-term treatment are payable – taking account of time already spent in the facility.

	Days 61 to 90	Days 91 to 180
hospita semi-private/flex	CHF 50.-	CHF 25.-
hospita private/private accident	CHF 70.-	CHF 35.-
hospita global	CHF 90.-	CHF 45.-

A list of recognized sanatoriums and rehabilitation institutions can be inspected at the health fund at any time.

2.4 Psychiatric clinics

hospita covers the full costs of inpatient treatment in a psychiatric clinic and psychiatric treatment in an intensive-care hospital or a special clinic for 90 days, in accordance with the provisions on intensive care. No benefits are payable under hospita private accident.

If treatment lasts for longer than this, the following flat-rate daily allowances are paid for treatment in the corresponding ward:

	Days 91 to 180
hospita general/comfort	CHF 20.-
hospita semi-private/flex	CHF 50.-
hospita private	CHF 70.-
hospita global	CHF 90.-

These benefits are payable only once within a period of three calendar years. If treatment is provided in a ward of a lower category than the patient is insured for, benefits are payable according to the hospita variant for the ward actually used.

2.5 Benefits abroad

2.5.1 In emergencies

In addition to basic benefits, hospita pays the costs of emergency inpatient treatment in an intensive-care hospital during a temporary stay abroad up to the maximum for which the insured person is covered. Benefits are paid for as long as repatriation is not medically possible, subject to a maximum of one year.

2.5.2 Elective treatment abroad

hospita global benefits are also provided if the insured person travels abroad with the intention of obtaining treatment. The other benefit levels provide the same benefits as for treatment in an unlisted hospital.

2.5.3 Procedure for hospital accommodation

Persons undergoing inpatient treatment must apply to the health fund for reimbursement immediately (within no more than 10 days of admission).

3 Spa treatment

3.1 Recovery cures

A free choice may be made among the medically supervised domestic spa establishments recognized by the insurer. A list of recognized spa establishments can be inspected at the health fund's offices at any time.

hospita provides the following benefits for medically prescribed recovery cures following intensive-care hospital treatment, for a maximum of 21 days in each case:

hospita general/comfort	CHF 40.-/day
hospita semi-private/flex	CHF 70.-/day
hospita private/private accident	CHF 90.-/day
hospita global	CHF 110.-/day

3.2 Spa treatment

hospita pays the following benefits for a maximum of 21 days per calendar year:

hospita general/comfort	CHF 10.-/day
hospita semi-private/flex	CHF 20.-/day
hospita private/private accident	CHF 30.-/day
hospita global	CHF 40.-/day

A free choice may be made among the medically-supervised thermal spas recognized by the insurer. The list of recognized thermal spas, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

The contribution to the costs of spa treatment is made irrespective of whether the insured person receiving treatment stays at the spa itself or in a hotel, guest house or private rooms at the spa location.

The health fund may require an examination by the spa doctor on admission and a final check-up with a closing report to the referring doctor.

3.3 Other treatment

Where special medical indications exist, the health fund may, at the request of the medical consultant, pay a flat-rate sum for other medically prescribed spa treatments not exceeding the contribution to spa treatment.

3.4 Procedure during a spa stay

The medical prescription for a course of spa treatment, together with the diagnosis, must be submitted to the health fund two weeks before treatment commences.

If a course of treatment is interrupted, partial treatment costs can only be met if the interruption was due to an illness or other compelling reasons and a certificate to that effect is provided by the spa doctor.

4 Special benefits

4.1 Home help

4.1.1 Principle

When a hospital stay can be avoided or its duration reduced, hospita contributes, on medical instructions, to the cost of home help where this is required on grounds of health or of domestic and family circumstances.

4.1.2 Benefit coverage

hospita makes a contribution per calendar year towards the costs of recognized home helps. The benefits are payable even if there is no agreement between the service providers and the insurer.

Benefits are paid as follows:

hospita general/comfort	Up to CHF 20.-/day, max. CHF 280.-
hospita semi-private/flex	Up to CHF 35.-/day, max. CHF 490.-
hospita private/private accident	Up to CHF 45.-/day, max. CHF 630.-
hospita global	Up to CHF 55.-/day, max. CHF 770.-

If the insured person is responsible for the care of at least one child, benefits are doubled.

No benefits are payable for accommodation in a nursing home.

4.1.3 Service providers

A recognized home help is one who looks after the insured person's household on his behalf by way of trade for his or her own account, or for a Spitex organization under contract to the insurer.

Contributions are also paid if this help is provided by members of the insured person's family who suffer a demonstrable loss of earnings as a result, or can give evidence of appropriate travel expenses.

Instead of home-help benefits, the same contributions can be paid for care services provided by commercial Spitex companies if these receive no remuneration under basic.

4.2 Transport costs, rescue and recovery actions in emergencies

for:

- medically necessary emergency transportation to the nearest suitable hospital by appropriate means of transport,
- return transport to a suitable hospital in the canton of residence of the insured person for inpatient treatment,
- rescue and recovery operations

hospita pays the following total sums

hospita general/comfort	CHF 10 000.-/ per calendar year Deductible CHF 100.-/ claim
hospita semi-private/flex	CHF 30 000.-/ per calendar year
hospita private/private accident	CHF 50 000.-/per calendar year
hospita global	Unlimited

Under **plus**, **premium**, **general supplement** and **private supplement** the costs of emergency transportation, return transportation and rescue operations organized by the 24-hour emergency helpline are met in full. Benefits do not cover the excess under the **plus**, **premium**, **general supplement** or **private supplement** insurance departments.

Transportation by air is paid for only if it is essential for medical or technical reasons.

Subject to any contractual provisions to the contrary, if the insured person is a member (patron) of an air-rescue service or similar organization, benefits are limited to sums not provided by the organization(s) in question.

4.3 Rooming-in

If a small child requires inpatient treatment, hospita contributes to the cost of accommodating one of its parents in its room from the child's insurance cover.

50%, max. CHF 50.- per day

If a parent requires inpatient treatment, hospita covers the cost of accommodating the small child in the parent's room from the parent's insurance cover.

50%, max. CHF 50.- per day

4.4 Child-care service

4.4.1 Principle

hospita pays contributions towards the nursing and care of insured children aged 11 and under, provided by an institution recognized by the health fund. This is conditional on a contractual arrangement between the health fund and the institution.

4.4.2 Benefit conditions

The benefits are provided if, in the opinion of the recognized institution, the child is in need of care following an acute illness or accident. Benefits are restricted to nursing and care provided by specialist staff. Children are entitled to benefits for as long as the persons responsible for bringing them up pursue gainful employment during the period when care is required.

4.4.3 Benefit coverage

hospita makes the following contributions to the insured child's nursing and care:

Up to CHF 30.- per hour, max. CHF 600.- per calendar year

4.5 Medical treatment following accidents (hospita private accident)

4.5.1 Private consultations with hospital doctors and treatment by doctors who are not under KVG contract

If the insured person is not covered by premium or private supplement, hospita private accident contributes towards the costs of private outpatient consultations with senior university hospital doctors and of treatment by doctors who are not under KVG contract in accordance with the recognized KVG scale.

4.5.2 Emergency medical treatment abroad

In cases where emergency medical treatment is necessary abroad, hospita private accident covers the full costs over and above the benefits provided under basic where the insured person is not covered under premium or private supplement.

5 Maternity

5.1 Costs of inpatient treatment

hospita pays the costs of a hospital birth that are not otherwise covered for the mother and child according to the mother's benefit level.

If the child is not insured with Sympany, the mother's hospita pays the costs that are not otherwise covered, over and above any other insurance covering the child.

If the mother is not insured with Sympany, the child's hospita cover meets its otherwise uncovered costs in addition to the mother's insurance.

5.2 Birth in a maternity clinic

The following benefits are provided for birth in a maternity clinic recognized by the insurer that does not appear on the canton's hospital list:

hospita general/comfort	90%, max. CHF 1 000.- per birth
hospita semi-private/flex	90%, max. CHF 2 000.- per birth
hospita private/global	Full cost cover

For persons insured under hospita flex, the additional cost share as per to the hospita flex provisions does not apply.

5.3 Home help after childbirth

5.3.1 Principle

hospita pays contributions to the costs of medically prescribed home help by personnel recognized by the insurer. They are paid instead of the ordinary hospita Spitex benefits.

Contributions are also paid if this help is provided by members of the insured person's family who suffer a demonstrable loss of earnings as a result.

5.3.2 Hospital birth

The following benefits are payable following a hospital birth:

hospita general/comfort	Up to CHF 40.-/day, max. CHF 560.-
hospita semi-private/flex	Up to CHF 70.-/day, max. CHF 980.-
hospita private	Up to CHF 90.-/day, max. CHF 1 260.-
hospita global	Up to CHF 110.-/day, max. CHF 1 540.-

5.3.3 Home birth

In the event of a home or outpatient birth the following benefits are paid:

hospita general/comfort	Up to CHF 60.-/day, max. CHF 840.-
hospita semi-private/flex	Up to CHF 105.-/day, max. CHF 1 470.-
hospita private	Up to CHF 135.-/day, max. CHF 1 890.-
hospita global	Up to CHF 165.-/day, max. CHF 2 310.-

5.4 hospita private accident

hospita private accident does not provide any maternity benefits except for the rooming-in provision.

6 Accident supplement

Following an accident-related hospital stay, the remedial aids required for subsequent treatment are covered as per compulsory accident-insurance practice.

The costs of remedial aids which replace a part of the body or a body function are covered to the same extent if these were impaired in connection with an accident which necessitated hospital treatment.

7 casamed variant

7.1 General

Persons insured under hospita can only have casamed variant insurance if they are covered by the casamed variant of basic insurance.

The following additional provisions apply to persons insured under the casamed variant.

7.2 Benefit levels

The hospita general, semi-private, private, private accident, flex and comfort benefit levels apply to persons with casamed cover.

7.3 General benefit conditions

hospita general, semi-private, private, flex and comfort provide benefits for treatment delivered in accordance with the family-doctor principle: they must be provided or prescribed by the casamed family doctor with whom the insured person is registered, or delivered on his instructions.

The health fund may designate telemedical institutions as casamed family doctors.

7.4 Choice of hospital

With a view to the provision of care at reasonable cost, the health fund may designate the hospitals in which persons insured under casamed must exclusively obtain medical treatment.

7.5 Ophthalmologists, gynaecologists and paediatricians

For casamed policyholders who undergo routine treatment by ophthalmologists, gynaecologists and paediatricians, the operations being performed by such medical specialists on an outpatient or inpatient basis, benefits are paid after consulting the casamed family doctor.

7.6 Emergencies

Emergencies are covered under hospita general, semi-private, private, private accident, flex and comfort regardless of the chosen service provider. The health fund may ask its medical consultant to review the medical indication.

7.7 Exclusion of benefits

If an insured person presents himself for treatment to a service provider that he cannot normally select, other than in one of the exceptional cases appearing on an exhaustive list, all costs will be charged to him.

7.8 Exclusion

In the event of repeated breaches of the conditions, the health fund may reassign the insured person from the casamed variant to the ordinary insurance variant.

8 hospita variant with a no-claims discount (NCD)

8.1 Principle

In the variant with a no-claims discount, a premium discount is granted if no claims are made.

8.2 Observation period

The observation period begins on 1 September or at the start of insurance and ends on the subsequent 31 August. Whether a cost falls within the observation period depends on the date on which the invoice is processed.

8.3 Discount levels

The following bonus levels or discounts apply to the hospita variant with a no-claims discount:

Discount level hospita NCD	Premium under hospita no-claims discount
0	Normal hospita premium +20%
1	Normal hospita premium
2	Normal hospita premium -30%

The premium for hospita with a no-claims discount is stated in the policy document. The insurer may introduce new discount levels with effect from the beginning of a new insurance period, and also adjust discounts in the light of inflation.

8.4 NCD level adjustment

If the person insured under hospita with no-claims bonus has drawn no benefits for three successive observation periods at the same bonus level, the level is raised with effect from 1 January of the fourth year (unless he has already reached the maximum bonus level).

8.5 Level adjustment when benefits are drawn

If the insured person draws benefits during an observation period, the level is reduced by one with effect from 1 January of the following year (unless he has already reached bonus level 0).

8.6 Maternity benefits

The costs of hospital treatment for maternity and post-natal home help do not count for calculation purposes; these costs are not regarded as benefits and therefore do not have any impact on the bonus level.

8.7 Complementary insurance

Switching from hospita with a no-claims discount to standard hospita cover requires a declaration of health, except for insured persons with a maximum discount who have drawn no benefits during the current observation period.

9 hospita flex cost share

9.1 Cost-share coverage

hospita flex enables the insured person to choose a ward before admission to a hospital. The choice of ward determines the cost share.

In the event of hospital care, hospita flex benefits are subject to the following cost share per calendar year, depending on the ward chosen:

Ward	Cost share applied to hospita flex benefits
General ward	None
Semi-private ward	15%, max. CHF 1500.- per calendar
Private ward	25%, max. CHF 4500.- per calendar

This cost share also applies to maternity.

The cost share does not apply if hospita pays a flat-rate benefit in accordance with these insurance conditions, except for hospita-insured benefits in other countries. These are subject to the appropriate cost share.

The cost share may be adjusted in the light of inflation.

The statutory basic cost share is charged additionally.

9.2 Maximum cost share for families

Where two or more persons living in the same household are insured under hospita flex, any cost shares exceeding the maximum amount can be reclaimed.

Maximum amount CHF 4500.- per calendar year

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1 Insurance fundamentals

1.1 Purpose

salto meets the costs of outpatient and inpatient treatment and of emergencies in other countries that are otherwise not covered.

salto provides benefits for medical treatment elsewhere than at the place of residence or work, for vaccinations, remedial aids, wisdom teeth extractions, transport costs, search, rescue and recovery operations and for courses on health-promoting behaviour.

salto is also designed to meet otherwise uncovered costs for medical treatment in an intensive-care hospital in the event of illness, accident or maternity.

salto also makes contributions to the otherwise uncovered costs of emergency treatment abroad in the event of illness, accident and premature childbirth, and of services during holidays, business travel or periods spent abroad.

salto benefits are supplementary to those under all other insurance policies concluded with Sympany.

salto provides benefits in addition to compulsory health care insurance (basic). Of the total costs, the maximum share payable is the proportion not covered by social insurance (including basic with a different insurer).

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the salto provisions. In the event of any conflict, the salto provisions take precedence over the common provisions.

1.4 Insured persons

salto can be commenced at any time between the insured person's 18th and 31st birthdays.

1.5 Automatic transfer to the plus, hospita general and tourist insurance departments

salto expires on 31 December of the year in which the insured person celebrates his 32nd birthday. Transfer to the plus, hospita general and tourist departments takes place automatically on 1 January of the following year. No new health declaration is required for this automatic transfer. Any existing restrictions of insurance cover in accordance with the common provisions, however, will remain in effect.

1.6 Early transfer to the plus, hospita general and tourist insurance departments

Insured persons can transfer early to the plus, hospita general and tourist insurance departments without a new health declaration with effect from 1 January of any year. Insured persons are also entitled to transfer to mondial insurance. This need not take place on 1 January.

A transfer or switch in the event of pregnancy is also possible at any point in the year. Existing cover restrictions in accordance with the common provisions remain in effect.

1.7 Benefit conditions

1.7.1 General

Benefits are only payable if the treatment is medically indicated and if it is administered by persons who are recognized accordingly by the health fund. Information about whether persons are recognized must be obtained from the health fund.

Benefits for inpatient treatment are payable only for as long as the insured person requires hospitalization within the meaning of basic and receives treatment in an intensive-care hospital. The treatment must be performed by service providers recognized under the Federal Health Insurance Act (KVG).

1.7.2 Intensive-care hospitals

An intensive-care hospital is a medical institution that provides medical and nursing care, equipped with the necessary technical infrastructure to treat patients in need of constant medical observation for reasons of illness, accident or childbirth.

1.7.3 Hospital list

Additionally, hospital treatment must take place in hospitals that appear on the approved list of the canton of location or canton of residence in accordance with Art. 39 KVG. Reduced benefits are payable for treatment in other hospitals.

1.7.4 Treatment outside the canton for medical reasons

In accordance with statutory provisions (Art. 41/3 KVG), the canton of residence meets the additional costs of medically indicated hospitalization outside the canton.

1.7.5 Hospitals with a recognized charge scale

Hospitals under contract are those with which the insurer has agreed defined charge scales. The health fund has a list of hospitals under contract, which is available for inspection at any time.

1.7.6 Absent criteria, maximum charges

If a hospital has no ward-classification criteria or applies criteria that differ from those set out in these provisions, its wards are treated as private for insurance purposes. In this event the insurer can set maximum charges for the general ward based on those of a comparable hospital with a recognized charge scale, located in the region where the insured person lives.

Any maximum rates set by the insurer can be inspected at the health fund's offices.

2 Outpatient treatment

2.1 Medical treatment other than where the patient lives and works

In addition to the benefits provided by basic, treatment by KVG health fund doctors other than at the place of residence or work of the insured person is fully covered as per the KVG charge scale applicable at the place of treatment.

2.2 Emergency medical treatment abroad

salto meets the costs of emergency medical treatment abroad that are not covered by basic.

2.3 Duration of benefits

Subject to any provision to the contrary in the salto insurance provisions, benefits are not limited in time.

3 Inpatient treatment

3.1 Intensive care

3.1.1 Benefit coverage

salto covers the costs of a general ward (multiple occupancy) in an intensive-care hospital with a recognized charge scale anywhere in Switzerland that are not met by basic.

The cost share payable under basic, including the daily contribution to the costs of hospital accommodation, is not covered.

3.1.2 Treatment in a higher class of hospital ward

If treatment takes place in a higher class of hospital ward than is covered by insurance, cover is limited to the costs that would have been incurred in the insured ward. If these costs cannot be determined, salto pays a flat rate

CHF 30.– per day

3.1.3 Treatment in an unlisted hospital

If the treatment is given in a hospital which does not appear on a cantonal hospital list, a maximum flat rate of CHF 30.– per day is payable.

CHF 30.– per day

3.2 Inpatient rehabilitation

If medical treatment is provided in a multipurpose sanatorium recognized by the insurer or in a medical rehabilitation ward or clinic, salto meets the full costs for the first 60 days in accordance with the provisions on intensive care.

A list of recognized sanatoriums and rehabilitation institutions can be inspected at the health fund's offices at any time.

3.3 Psychiatric clinics

In accordance with the provisions on intensive care, salto pays the full costs of inpatient treatment in a psychiatric clinic and psychiatric treatment in an intensive-care hospital or special clinic for a period of 90 days.

These benefits are payable only once within a period of three calendar years.

3.4 Benefits abroad in emergencies

salto meets the costs of emergency inpatient treatment in the general ward of an intensive-care hospital during temporary residence abroad that are not covered by basic benefits. If the costs incurred are higher, salto pays additional benefits under Assistance.

Benefits are paid for as long as repatriation is not medically possible, subject to a maximum of one year. Persons undergoing inpatient hospital treatment must apply to the health fund for reimbursement immediately (within no more than 10 days of admission).

4 Maternity

4.1 Costs of inpatient treatment

salto meets the mother's costs for a hospital birth in a general ward anywhere in Switzerland to the extent that these are not covered by basic.

If the child has no insurance of its own, the mother's salto insurance pays the costs for the child in a general ward anywhere in Switzerland that are not otherwise covered.

4.2 Birth in a maternity clinic

salto pays the following benefits per birth in a maternity clinic recognized by the health fund but not appearing on a cantonal hospital list:

90%, to a maximum of CHF 1 000.–

5 Assistance abroad

5.1 Additional Assistance benefits

For up to 100 days' travel per calendar year, Assistance contributes as follows to the otherwise uncovered costs of inpatient treatment, family visits and special return trips, transportation and rescue operations:

Up to CHF 50 000.–

Cost shares and excesses are not covered.

5.2 Family visits and special return trips

If an insured person falls seriously ill or suffers a serious accident abroad and has to be hospitalized for more than 7 days, the insurer organizes and pays for a visit to his bedside by a person close to him (1st-class rail travel or economy class air travel).

If an insured person must be repatriated for urgent medical reasons for treatment as an inpatient in a suitable hospital in his canton of residence, the 24-hour emergency helpline organizes a special return journey for family members travelling with him or for a person close to him. The additional costs incurred are covered.

If an insured person falls ill or suffers an accident and cannot set out on the planned return journey because he is in hospital, the 24-hour emergency helpline organizes a special return journey for the insured person, family members travelling with him or a person close to him. The additional costs incurred are covered.

5.3 Advance towards hospital costs

If an insured person requires hospitalization abroad, the insurer makes the following advance contribution to his hospital costs if necessary:

Up to CHF 20 000.–

If part of this advance payment is not covered by the insured person's existing insurance, it is charged to him. The sum reclaimed must be repaid within 30 days.

5.4 Notifying persons at home

Where measures are organized by the 24-hour emergency helpline, the insured person's family members are notified of what has happened and what action has been taken.

5.5 Arranging hospitals and medical contacts abroad

If necessary, the 24-hour emergency helpline arranges for the insured person to visit a doctor or a hospital in the vicinity of where he is staying. In the event of communication problems, the 24-hour emergency helpline provides interpretation facilities.

5.6 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be provided where he is staying, the doctors at the 24-hour emergency helpline provide medical advice.

This advice is just that: advice. It may not under any circumstances be regarded as a diagnosis.

5.7 Benefit exclusions

In addition to the benefit restrictions of the Sympany Insurances Ltd Common provisions, no entitlement to insurance benefits exists:

- for illnesses and the consequences of accidents that already existed when the journey began, or that the insured person knew were imminent and would require medical treatment,
- if the insured person travels abroad for the specific purpose of treatment, care or childbirth,
- if the 24-hour emergency helpline has not given its permission in advance for search operations, repatriation, family visits or special return travel.

The insurer cannot be expected to arrange emergency transportation or repatriation if these are rendered impossible by extraneous circumstances such as strike, riot, acts of violence, major industrial accidents, radioactivity, natural disasters, epidemic illnesses or force majeure.

5.8 Obligations in the event of a claim

5.8.1 Notification of the 24-hour emergency helpline

The 24-hour emergency helpline must always be notified without delay of sudden illness, accident or premature birth necessitating hospital treatment or assistance in Switzerland or abroad.

5.8.2 Exemption from the confidentiality obligation

The insured person releases the doctors and other medical personnel treating him, as well as the insurers, from their obligation of secrecy vis-à-vis the 24-hour emergency helpline and/or the insurer.

5.8.3 Notification of claim

The insured person must notify the health fund of his claim immediately, providing all the relevant information together with full medical and administrative particulars. Only detailed, legible original bills will be accepted. If the details on the bill are insufficient and the requested supplementary information is not forthcoming, benefits are fixed at the discretion of the insurer.

5.8.4 Unused rail or air tickets

The claimant must forward unused rail or air tickets to the health fund without being called upon to do so. If unused tickets have been sold or their value refunded by third parties, insurance benefits are reduced by the compensation received. If the claimant fails to meet this obligation, the insurer may require him to refund an amount determined at the insurer's discretion or reduce his claim for benefits by such an amount.

6 Accident supplement

Following an accident-related hospital stay, remedial aids needed for subsequent treatment are covered as per compulsory accident-insurance practice.

The costs of remedial aids are covered to the same extent where those aids replace a part of the body or a body function if these were impaired in connection with an accident which necessitated hospital treatment.

An excess of 10% is payable by the insured person on these benefits.

7 Prevention

7.1 Vaccinations

The following contributions are payable per calendar year to the costs of vaccinations to prevent infection:

90% of actual costs, to a maximum of CHF 220.- per calendar year

No benefits are provided for vaccinations that are undertaken for occupational reasons, whose effect is medically disputed or that are still in the research stage.

7.2 Precautionary gynaecological examinations

The costs of one precautionary gynaecological examination per calendar year are insured at the KVG charge rate, provided that no such benefits are received in the same calendar year under KVG insurance. An excess of 10% applies to this benefit.

7.3 Getting fit

salto makes the following contribution to the documented costs of a course recognized by the health fund on forms of behaviour conducive to good health (e.g. giving up smoking, back training, dietary advice):

CHF 150.- per calendar year

The health fund designates recognized courses on forms of behaviour conducive to good health. The list of recognized courses, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

7.4 Keeping fit

The following contributions are payable towards further recognized preventive measures such as sport, fitness and relaxation courses:

A total of CHF 200.- per calendar year

The health fund designates recognized institutions, preventive measures, cost contributions and benefit limits. The list of recognized institutions, preventive measures, cost contributions and benefit limits, which undergoes constant adjustment and extension, can be inspected at any time at the health fund's offices.

8 Remedial aids

8.1 Corrective lenses

The health fund makes the following contributions to the costs of spectacles or contact lenses required for visual correction:

CHF 420.- per 3 years

8.2 Other remedial aids

A contribution towards the costs of hiring or purchasing medically indicated remedial aids for which no benefits are available under basic is available on medical instructions as follows:

50%, up to a maximum of CHF 250.– per calendar year

The health fund designates recognized remedial aids.

The list of recognized aids, which undergoes constant adjustment and extension, can be inspected at the health fund's offices at any time.

Costs incurred for the operation, maintenance and repair of these remedial aids are not covered.

9 Dental care/wisdom teeth

9.1 General

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital inpatient, the costs are covered up to the amount of the contractually fixed daily allowance in a general ward in the canton of residence. An excess of 10% is payable by the insured person on these benefits.

9.2 Service providers and charge scales

Benefits are reimbursed according to the scale applicable to dental benefits under compulsory health care insurance. If the dentist makes a higher charge than that stipulated in compulsory health care insurance, the difference is payable by the insured person.

The term "dentist" denotes a practitioner who has acquired the appropriate Swiss federal or equivalent diploma or who has been granted authorization to pursue the profession by the canton on the basis of evidence of scientific qualifications.

9.3 Treatment abroad

Treatment abroad is covered provided that the medical personnel concerned have undergone training equivalent to that of their counterparts in Switzerland and the costs do not exceed Swiss costs.

10 Transport costs, search, rescue and recovery operations

10.1 Transport costs, rescue and recovery actions in emergencies

10.1.1 Benefit coverage

The following overall contribution towards the costs of:

- medically necessary emergency transport to the nearest suitable hospital by an appropriate means of transport,
- return transportation to a suitable hospital in the canton in which the insured person resides for inpatient treatment,
- für search, rescue and recovery operations

is payable:

CHF 40 000.– per calendar year

If the costs incurred are higher, salto pays additional benefits under Assistance for transport costs and rescue operations.

Transportation by air is paid for only if it is essential for medical or technical reasons.

10.1.2 Excess

The insured person is liable for the following excess in respect of each claim:

CHF 100.–

10.1.3 Third-party benefits

Subject to any contractual provisions to the contrary if the insured person is a member (patron) of an air-rescue service or similar organization, benefits are limited to sums not provided by the organization(s) in question.

11 casamed variant

11.1 General

Persons insured under salto can only have casamed variant insurance if they are covered by the casamed variant of basic insurance.

The following additional provisions apply to persons insured under the casamed variant.

11.2 General benefit conditions

Benefits under salto are payable for services provided according to the family-doctor principle: they must be provided or prescribed by the casamed family doctor with whom the insured person is registered, or delivered on his instructions.

The health fund may designate telemedical institutions as casamed family doctors.

11.3 Special benefits

Transport costs, costs for search, rescue and recovery operations, extractions of wisdom teeth as well as supplementary services abroad are reimbursed without prior consultation of the casamed medical practitioner.

11.4 Choice of hospital

With a view to the provision of care at reasonable cost, the health fund may designate the hospitals in which persons insured under casamed must exclusively obtain medical treatment.

11.5 Ophthalmologists, gynaecologists and paediatricians

For casamed policyholders who undergo routine treatment by ophthalmologists, gynaecologists and paediatricians, the operations being performed by such medical specialists on an outpatient or inpatient basis, benefits are paid after consulting the casamed family doctor.

11.6 Other specialists

Instead of the casamed family doctor, the health fund may designate other specialists who may provide, prescribe or arrange the services covered by salto.

11.7 Other service providers

With a view to the provision of care at reasonable cost, the insurer may designate other service providers such as chemists, therapeutic personnel, medical-supplies store or similar service providers to which medical treatment or supplies for casamed insurance holders must be entrusted exclusively.

11.8 Emergencies

Emergencies are covered under salto regardless of the chosen service provider. The health fund may ask its medical consultant to review the medical indication.

11.9 Exclusion of benefits

If a policyholder presents himself for treatment to a service provider that he cannot normally select, other than in one of the exceptional cases appearing on an exhaustive list, all costs will be charged to him.

11.9.1 casamed variant exclusion

In the event of repeated breaches of the conditions, the health fund may reassign the policyholder from the casamed variant to the ordinary insurance variant.

11.10 Benefit processing

11.10.1 Flat-rate allowance

The insurer or the health fund may agree with casamed family doctors that the benefits under salto will be paid on a flat-rate basis.

11.10.2 Prescribed services

In the case of arranged benefits and prior to reimbursement of the costs, the health fund may, if necessary, require the insured person or the casamed family doctor to give evidence that the benefits provided have been performed according to the family-doctor principle.

12.5 Level adjustment when benefits are drawn

If the insured person draws benefits during an observation period, the level is reduced by one with effect from 1 January of the following year (unless he has already reached bonus level 0).

12.6 Maternity benefits

The costs of hospital treatment for maternity do not count for calculation purposes; these costs are not regarded as benefits and therefore do not have any impact on the bonus level.

12.7 Complementary insurance

Switching from salto with a no-claims discount to standard salto cover requires a declaration of health, except for insured persons with a maximum discount who have drawn no benefits during the current observation period.

12 salto variant with a no-claims discount (NCD)

12.1 Principle

In the variant with a no-claims discount, a premium discount is granted if no claims are made.

12.2 Observation period

The observation period begins on 1 September or at the start of insurance and ends on the subsequent 31 August. Whether a cost falls within the observation period depends on the date on which the invoice is processed.

12.3 Discount levels

The following bonus levels or premiums apply to the salto variant with a no-claims discount:

Discount level salto with a no-claims discount	Premium under salto no-claims discount
0	Normal salto premium +20%
1	Normal salto premium
2	Normal salto premium -30%

The premium for salto with a no-claims discount is stated in the policy document. The insurer may introduce new discount levels with effect from the beginning of a new insurance period, and also adjust discounts in the light of inflation.

12.4 NCD level adjustment

If the person insured under hospita with no-claims bonus has drawn no benefits for three successive observation periods at the same bonus level, the level for salto no-claims discount is raised by one level with effect from 1 January of the fourth year (unless he has already reached the maximum bonus level).

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1 Insurance fundamentals

1.1 Purpose

The purpose of mondial is to provide insurance for the financial consequences of illness, accident and maternity for persons who are not covered by the Swiss compulsory health care insurance or for cross-border commuters who have opted not to be bound by the Swiss legal requirement to have health insurance.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

The intermediary health insurance fund (henceforth referred to as the health fund) is listed in the policy document.

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the mondial provisions. In the event of any conflict, the mondial provisions take precedence over the common provisions.

1.4 Conclusion and duration of the insurance

1.4.1 New policies

New policies are arranged in accordance with the procedure set out in the common provisions. The maximum age at inception is 60.

1.4.2 Switching to mondial

Persons who have been insured with the health fund for at least one year in a different insurance department have a right of transfer to the mondial insurance variant at the same level of cover. Transfer is possible at any age.

1.4.3 Right of transfer

Insured persons who return to Switzerland from abroad or become subject to compulsory Swiss health insurance are entitled to transfer to the ordinary insurance variant of their mondial cover. This applies in all insurance departments.

2 Insurance possibilities

2.1 General

mondial basic (ICA) cover and all the insurance departments covered by the general terms and conditions of insurance (GTC) may be arranged within mondial, except hospital comfort and, in the case of cross-border commuters, compensa.

2.2 Exclusion of accident cover

Accident cover can be excluded from mondial basic.

2.3 Exempt sum and excess

The agreed exempt sum applies to mondial basic.

The excess and contributions to hospital accommodation costs are governed by the provisions of the KVG.

3 Benefits

3.1 Principle

Cover is determined by the provisions applicable to individual insurance departments and the chosen extent of cover.

The benefits of basic policies in accordance with the KVG also apply to mondial basic (ICA) policies. Where these provisions or the common provisions of the general conditions (GTC) for supplementary insurance or other insurances according to the Federal Insurance Contract Act (ICA) diverge from basic insurance under the KVG, they shall take precedence over the regulations of the basic insurance.

mondial can provide additional benefits for cross-border commuters for outpatient treatment and prevention in their country of residence, as per the insurer's list.

For persons in Switzerland without a residence permit, mondial covers the costs of emergency treatment in an intensive-care hospital. Illnesses and consequences of accidents already in existence when the policy was concluded are not covered. These limitations do not apply to persons who already have mondial cover at their foreign place of residence.

The charges applicable in Switzerland or in the country where the insured person is resident or where treatment takes place in the EU are the determining factor. Further benefit provisions in the individual insurance departments are reserved.

If treatment takes place in a hospital ward of a higher category than the insured person is covered for, or if charges are manifestly exaggerated, the insurer limits benefits to the charge scales applicable for insurance cover at the location of the health fund's registered office.

3.2 Treatment in the country of residence or abroad

Non-emergency treatment is covered in the insured person's country of residence, Switzerland and the EU.

If the provisions of the individual insurance departments contain rules for benefits abroad, then "abroad" is understood to mean every country except Switzerland and the country where the insured person resides.

4 Obligations

4.1 Obligations in the event of sickness and accident

Benefits are provided only if detailed original bills are submitted to the health fund containing the following information:

- treatment date,
- diagnosis,
- types of treatment,
- number of consultations/duration of hospital stay,
- receipted original prescriptions,
- daily charges and ancillary costs (hospital).

Persons undergoing inpatient treatment must apply to the health fund for reimbursement within no more than 10 days of admission.

4.2 Other notifications

The insured person must provide the health fund with a contact address and bank account details in Switzerland. The insurer sends communications to the contact address in Switzerland with legally binding effect.

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dental

1 Insurance fundamentals

1.1 Purpose

dental pays contributions to the costs of dental treatment. It also encourages preventive measures.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the dental provisions. In the event of any conflict, the dental provisions take precedence over the common provisions.

1.4 Conclusion of the policy

dental may be taken out up to the age of 60. Conditions existing at inception such as damaged or missing teeth, poor tooth positions, jaw anomalies, etc. are not covered.

The insured person must have had his last dental check-up or treatment no more than one year before inception.

Newborn and newly affiliated children for whom plus, premium, general supplement or private supplement cover has also been arranged with the insurer enjoy unlimited cover under dental piccolo until their 15th birthday.

1.5 Benefit conditions

Diagnostic and therapeutic measures that are dentally necessary and scientifically recognized are covered, provided that the treatment is also economical.

Reimbursement is based on the SSO tariff for dentists with the social insurance charge point (based on the KVG, UVG, MVG and IVG). The term "dentist" denotes a practitioner who has acquired the appropriate Swiss federal or equivalent diploma or who has been granted authorization to pursue the profession by the canton on the basis of evidence of scientific qualifications.

dental provides its benefits on a subsidiary basis, i.e. after or in addition to statutory health care or accident insurance and to benefits provided by the cantons and local authorities. If cover by other insurance companies exists, benefits are paid pro rata.

1.6 Treatment abroad

Treatment abroad is covered, provided that the medical personnel concerned have undergone training equivalent to that of their counterparts in Switzerland and the costs do not exceed Swiss costs.

2 Insurance possibilities

The following insurance possibilities exist:

- dental piccolo up to the age of 15,
- dental.

2.1 dental piccolo

2.1.1 Benefits

For children and young people up to the age of 15, the following sum is payable towards the costs of an examination (including X-ray) if no dental treatment (conservative, prosthetic, etc.) is required at the same time:

Up to CHF 50.– per calendar year

2.1.2 Automatic transfer

The insured person is automatically transferred from dental piccolo to dental a on reaching his 15th birthday, the transfer taking effect from the beginning of the following year with no limitation of benefits. However, he has a right of withdrawal within three months of being notified of the transfer.

2.2 dental

2.2.1 Benefit variants

Variant	maximum benefit claim per calendar year	Exempt sum
dental a	75%, max. CHF 1 000.–	Exempt sum CHF 500.–
dental b	50%, max. CHF 500.–	
dental c	50%, max. CHF 1 000.–	
dental d	75%, max. CHF 1 000.–	
dental e	75%, max. CHF 1 500.–	
dental f	75%, max. CHF 3 000.–	
dental g	75%, max. CHF 5 000.–	Exempt sum CHF 500.–
dental h	75%, max. CHF 5 000.–	

Where a variant involves an exempt sum, the insurer may reduce it for children up to the age of 15.

Where the variant involves a deductible, this is charged as a fixed sum per calendar year. The maximum benefit claim per calendar year is calculated on the residual amount over and above the deductible.

2.2.2 Preventive dentistry and check-ups

If no dental treatment (conservative, prosthetic, etc.) has been provided during the treatment period, dental contributes to the costs of a check-up, including an X-ray examination and preventive treatment, as follows:

Up to CHF 100.– per calendar year

The cost share under the selected benefit variant does not apply.

2.2.3 Benefits/treatment period

Within the framework of the chosen benefit class, insurance covers all the costs of dental treatment including laboratory costs. No benefits are paid for dental-care products.

Sums insured are paid out once in the calendar year.

2.2.4 Waiting period

Entitlement to dental benefits begins:

- after a waiting period of 12 months for prosthetic care (e.g. crowns, bridges, prostheses, pivot teeth, built-up teeth and apparatus to correct incorrect tooth and jaw positions, including temporary measures, repairs and the associated dental treatment and check-ups),
- after a waiting period of 6 months for all other treatment.

The waiting period also applies to any increases in cover. Benefits for preventive treatment and check-ups are not subject to any waiting period.

2.2.5 Submitting claims

To lodge a claim, the insured person must present the detailed original invoice to the health fund immediately (within a maximum of 30 days of the invoice date). The invoice must show the duration of treatment and the individual services performed according to the dental charge scale.

3 casamed variant

3.1 General

The casamed variant of dental presupposes that the insured person has basic casamed cover.

The following additional provisions apply to the casamed variant.

3.2 Benefit variants

The following benefit variants are available to persons with casamed cover:

dental d	75%, max. CHF 1 000.–
dental f	75%, max. CHF 3 000.–
dental h	75%, max. CHF 5 000.–

3.3 Benefit conditions

Benefits are paid if care has been provided, prescribed or arranged by a casamed dentist recognized by the health fund with whom the insured person is registered.

3.4 Emergencies

Emergencies are covered under dental regardless of the chosen service provider. The health fund may ask its medical consultant to review the medical indication.

3.5 Exclusion of benefits

If a policyholder presents himself for treatment to a service provider that he cannot normally select, other than in one of the exceptional cases appearing on an exhaustive list, all costs will be charged to him.

3.6 Exclusion

In the event of repeated breaches of the conditions, the health fund may reassign the policyholder from the casamed variant to the ordinary insurance variant.

3.7 Premiums

A reduced premium applies to the casamed variant.

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tourist

1 Insurance fundamentals

1.1 Insurance cover

The insurance provides benefits in respect of costs which are not otherwise covered for emergency treatment in the event of illness, accident or premature birth during holiday or business travel or any periods spent abroad. It also provides benefits in respect of transport, search, rescue and repatriation costs, together with ancillary services.

1.2 Insurance provider

The insurance provider is Sympany Insurances Ltd, Basel (henceforth referred to as the insurer).

1.3 Common provisions

The common provisions of Sympany Insurances Ltd are an integral component of the tourist provisions. In the event of any conflict, the tourist provisions take precedence over the common provisions.

2 Eligibility

2.1 Insured persons

2.1.1 Eligible persons

tourist is available to persons of any age.

2.1.2 Individuals

Insured persons are listed in the policy document.

2.1.3 Families

The policyholder named on the insurance policy is insured, together with his spouse or partner and their children up to the age of 25 living with the policyholder in the same household.

2.2 Condition

This cover is available only in conjunction with at least one of the following insurance departments:

- plus, premium, general supplement, private supplement, hospita, salto.

tourist cover for families is conditional on at least one of the parents holding one of these policies

3 Benefits

3.1 Scope of benefits

3.1.1 Geographical scope

The insurance covers emergency treatment elsewhere than in the canton of residence, both in Switzerland and anywhere else in the world.

3.1.2 Temporal scope

Benefits will only be provided until such time as repatriation is medically acceptable. The obligation to provide benefits in respect of illnesses and accidents occurring during the period of insurance shall in any event expire no later than 91 days after the end of the selected period of 21 or 42 days.

3.2 Benefit conditions

Benefits will be provided only if the treatment is expedient and necessary for medical reasons, and is provided by persons with the necessary authorization.

3.3 Treatment costs

tourist pays benefits to cover the costs of emergency out-patient or inpatient treatment over and above compulsory health care insurance under the KVG, mondial basic insurance and accident insurance under the UVG and any other existing insurance cover.

It covers illness, accident and premature birth at normal local or contractually agreed rates. A birth is regarded as premature if it is unforeseen and takes place more than six weeks before the medically attested expected birth date.

The statutory cost share applying in Switzerland is not covered.

3.4 Transport costs, search, rescue and recovery operations

If an insured person falls seriously ill, suffers a serious accident or dies, the insurer – on the basis of a medical report – provides and pays for the following services organized by the 24-hour emergency helpline:

- a) medically necessary rescue operations and emergency transport by an appropriate means of transport to the nearest suitable place of treatment,
- b) search operations undertaken to rescue and recover the insured person, plus recovery operations

To a maximum of CHF 20 000.– per insured person

- c) medically necessary transportation of the sick or injured person to a suitable hospital in his canton of residence for inpatient treatment,
- d) return transport of the deceased to his place of residence.

3.5 Bedside visits and additional travel costs

3.5.1 Bedside visits

If an insured person falls seriously ill or suffers a serious accident abroad and has to be hospitalized for more than 7 days, the insurer organizes and pays for a visit to his bedside by a person close to him (1st-class rail travel or economy class air travel).

3.5.2 Special return journey

If an insured person must be repatriated for urgent medical reasons for inpatient treatment in a suitable hospital in his canton of residence, the 24-hour emergency helpline organizes a special return journey for family members travelling with him or for a person close to him. The additional costs incurred are covered.

If an insured person falls ill or suffers an accident and cannot set out on the planned return journey because he is in hospital, the 24-hour emergency helpline organizes a special return journey for the insured person, insured family members travelling with him or a person close to him. The additional costs incurred are covered.

3.6 Sums insured

The following variants are available:

3.6.1 tourist 50/100

Sums insured (all benefits) are as follows:

Up to CHF 50 000.– per insured person

Up to CHF 100 000.– per insured family

The following variants are available (duration of stay abroad):

Up to max. 21 days

Up to max. 42 days

3.6.2 tourist 250/500

Sums insured (all benefits) are as follows:

Up to CHF 250 000.- per insured person

Up to CHF 500 000.- per insured family

The following variants are available (duration of stay abroad):

Up to max. 21 days

Up to max. 42 days

3.7 Services

3.7.1 Advance towards hospital costs

If an insured person requires hospitalization abroad, the insurer advances up to CHF 20 000 towards the costs involved. If part of this advance payment is not covered by the insured person's existing insurance, it is charged to him. The sum reclaimed must be repaid within 30 days.

3.7.2 Notifying persons at home

Where measures are organized by the 24-hour emergency helpline, the insured person's family members are notified of what has happened and what action has been taken.

3.7.3 Arranging hospitals and medical contacts abroad

If necessary, the 24-hour emergency helpline arranges for the insured person to visit a doctor or a hospital in the vicinity of where he is staying. In the event of communication problems, the 24-hour emergency helpline provides interpreting assistance.

3.7.4 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be provided where he is staying, the doctors at the 24-hour emergency helpline provide medical advice.

This advice is just that: advice. It may not under any circumstances be regarded as a diagnosis.

3.8 Limitation of benefits

3.8.1 Principle

The rules concerning the limitation of benefits pursuant to the common provisions of Sympany Insurances Ltd do not apply to tourist.

3.8.2 Exclusion of benefits

No entitlement to insurance benefits exists:

- for illnesses and the consequences of accidents that already existed when the journey began, or that the insured person knew were imminent and would require medical treatment,
- if the insured person travels abroad for the specific purpose of treatment, care or childbirth,
- for illness or the consequences of accidents that have been excluded from cover under any existing insurance arranged for the insured person by the intermediary health fund,
- if the 24-hour emergency helpline has not given its permission in advance for search operations, repatriation, family visits or special return travel,
- if the insured person is involved in acts of war, unrest and similar events and during foreign military service,

- in the event of illness or accident as a consequence of warlike events which began more than 14 days previously,
- in the event of illness or accident as a consequence of active involvement in criminal actions, fights and other acts of violence,
- if an illness or accident was the result of gross negligence, particularly the abuse of alcohol, drugs or other substances,
- in the event of health damage attributable to a hazardous action, i.e. if the insured person exposes himself to an especially serious risk without taking or being able to take precautionary measures to reduce the risk to a reasonable level. This does not include actions taken to rescue persons. Hazardous action within the meaning of this provision particularly means engaging in high-risk sports as well as other activities involving a comparable degree of risk. The health fund maintains a list of all the high-risk sports that are regarded as hazardous. This list, which is not exhaustive, can be inspected by insured persons at any time,
- if the health damage was caused deliberately, including as a consequence of suicide, attempted suicide or self-inflicted injury,
- for benefits covered by social insurance or mondial basic.

The insurer cannot be expected to arrange emergency transportation or repatriation if these are rendered impossible by extraneous circumstances such as strike, riot, acts of violence, major industrial accidents, radioactivity, natural disasters, epidemic illnesses or force majeure.

3.8.3 Limitation of benefits

If bills are manifestly overcharged, the insurer may reduce the benefits accordingly or make payment dependent on the assignment of a claim for a reduction.

3.9 Time barring

The insured person's claim to benefits from the insurer expires two years after the occurrence of the circumstance which caused the insurer to become liable to provide benefits.

4 Cost share

No cost share is charged on benefits provided by tourist.

5 Obligations in the event of a claim

5.1 Notification of the 24-hour emergency helpline

The 24-hour emergency helpline must always be notified without delay of sudden illness, accident or premature birth necessitating hospital treatment or assistance in Switzerland or abroad.

5.2 Exemption from the confidentiality obligation

The insured person releases doctors and other medical personnel treating him, as well as the insurers, from their obligation of secrecy vis-à-vis the 24-hour emergency helpline and/or the health fund.

5.3 Notification of claim

The insured person must notify the health fund of his claim immediately, providing all the relevant information together with full medical and administrative particulars. Only detailed, legible original bills will be accepted. If the details on the bill are insufficient and the requested supplementary information is not forthcoming, benefits are fixed at the discretion of the insurer.

5.4 Unused rail or air tickets

The claimant must forward unused rail or air tickets to the health fund without being called upon to do so. If unused tickets have been sold or their value refunded by third parties, insurance benefits are reduced by the compensation received. If the claimant fails to meet this obligation, the health fund may require him to refund an amount determined at its discretion or reduce his claim for benefits by such an amount.

6 Third-party benefits

6.1 General

If a third party is liable for a reported case of illness or accident by law or through its own fault, the insurer is not liable to provide benefits or is at most liable to pay the amount not otherwise covered.

6.2 Waiver of benefits

Where insured parties waive benefits from third parties in whole or in part without the consent of the insurer, the obligation to provide benefits under these terms and conditions of insurance shall lapse. The capitalization of a claim shall also be regarded as a waiver.

6.3 Social insurance

No benefits covered by social insurance schemes (KV, UV, IV, MV, AHV, AIV, etc.) are paid. Benefit claims must be registered with the insured person's social security scheme.

If an insured person has no valid compulsory health care insurance under the KVG or mondial basic cover, the insurer pays only the benefits that it would have paid if he had.

6.4 Multiple insurance cover

Where several insurers are liable to provide benefits, a calculation is made to determine how much each insurer would have had to pay had he been solely responsible. This provision applies even if the obligation of the other insurers to provide benefits is merely subsidiary. The compensation payable in accordance with these terms and conditions is limited to that portion of the overall sum insured which corresponds to this cover.

6.5 Existing policies with Sympany Insurances Ltd

Other existing additional policies with Sympany Insurances Ltd take precedence over benefits under tourist.

6.6 Air-rescue service and similar organizations

Subject to any contractual provisions to the contrary if the insured person is a member (patron) of an air-rescue service or similar organization, benefits are limited to sums not provided by the organization(s) in question.

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1 Insurance fundamentals

1.1 Insurance provider

protect healthcare legal expenses insurance is provided by Coop Rechtsschutz AG, Aarau (hereinafter referred to as the insurer).

The intermediary health insurance fund (henceforth referred to as the health fund) is stated on the policy document.

1.2 Common provisions

The common provisions of Sympany Versicherungen AG are an integral component of these legal protection provisions for patients. In the event of any discrepancies, the provisions of protect healthcare legal expenses insurance shall take precedence over the common provisions of Sympany Versicherungen AG.

1.3 Group policy

Healthcare legal expenses insurance is provided on the basis of a group contract concluded between Sympany Versicherungen AG and the insurer.

2 Scope of cover

2.1 Contractual basis

The subject matter of the contract complies with the present General Terms and Conditions of Sympany protect, the Federal Insurance Contract Act (ICA), the Insurance Supervision Act (ISA) and the Ordinance on the Supervision of Private Insurance Companies (SO).

2.2 Insured disputes

The following types of dispute are insured in connection with impairment to health:

- Legal liability disputes (e.g. with medical service providers, with motor vehicle owners following traffic accidents etc.)
- Insurance law disputes (e.g. with liability, accident, health, disability insurance, etc.)

2.3 Subsidiarity

An entitlement to legal protection only exists where and to the extent that benefits do not have to be provided by another insurer. Disputes with medical service providers and their liability insurance are excluded from subsidiarity.

2.4 Non-insured disputes

The insurance does not grant cover for

- Cases that are not explicitly listed
- Cases in which the underlying event occurred before the present insurance contract entered into force
- Disputes between the insured and Coop Rechtsschutz or bodies thereof or between the insured and attorneys and experts involved in an insured legal protection case
 - Cases in connection with
 - psychiatric and psychotherapeutic treatment
 - fees and invoices (excepting those for services not rendered)
 - premium invoices from Sympany
 - defence against claims for damage

3 Insured persons

Persons who have arranged protect insurance with Sympany are insured. All persons insured with the aforementioned person on a joint policy are also insured.

Should an insured person die as a consequence of an insured event, his legal successors are insured for the event in question.

4 Commencement, duration and termination of the insurance

4.1 General

The commencement, duration and termination of the insurance are determined by the common provisions of Sympany Insurances Ltd.

This cover is available only in conjunction with at least one of the following insurance departments:

- plus, premium, general supplement, private supplement, hospita, salto, dental.

Where a person who meets the conditions of protect leaves the joint policy, protect insurance cover remains in force. The insured person, however, has a right of withdrawal within three months of being notified accordingly.

4.2 Termination of the group policy

The insurance expires on the termination of the collective insurance contract between the insurer and Sympany Insurances Ltd. The insured person must be notified in writing of the termination no less than one month before the expiry of the insurance cover.

5 Geographical validity

The insurance cover applies throughout the world.

6 Temporal validity

The time of the underlying event is authoritative in respect of the temporal insurance cover. Legal protection is only provided in cases where the underlying event occurred after the protect contract was concluded. The underlying event is deemed to be the time when the loss or damage occurred; in insurance law cases the time of the event that triggers the insurance claim shall be authoritative, and otherwise the time of the notification that triggers the dispute.

7 Insured benefits

The insurer shall grant the following benefits:

- representation of legal interests by the legal services of Coop Rechtsschutz
- payment of a maximum of CHF 250 000 per case (or of CHF 50 000.- in cases outside Europe and countries bordering the Mediterranean Sea):
 - the costs of attorneys assigned to the case
 - the costs of experts assigned to the case
 - court costs and other procedural costs charged to the insured person
 - costs of collecting the compensation awarded to the insured person
 - compensation costs awarded to the other party and payable by the insured person.

The following shall not be paid:

- damage compensation
- costs for which a third party is liable.

Any procedural costs and legal fees awarded to the insured person must be surrendered to the insurer. For the rest, proceedings will be conducted in accordance with the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO).

8 Legal protection

8.1 Notification of a legal protection claim

The insurer or the health fund must be immediately notified of the occurrence of a legal protection claim, in writing should they so request. The insured person must assist the insurer in processing the legal protection claim, grant the necessary powers of attorney and information and pass on to him without delay notices received, in particular from authorities. If the insured person is responsible for any breach of these obligations that involve the insurer in additional costs, it may reduce benefits. Benefits may be withheld altogether in the event of a serious breach.

8.2 Processing a legal protection claim

The insurer, after consulting the insured person, takes such measures as are necessary to protect its interests. If it proves necessary to take legal advice, in particular for legal or administrative proceedings or in the event of conflicts of interest, the insured person has a free choice of lawyers. The attorney is instructed solely by the insurer. Failure to comply with this provision may lead the insurer to reduce benefits. Where there are no valid reasons for a change of lawyer, the insured person bears the resulting costs.

8.3 Disputes procedure

In the event of disputes about further action, especially in cases that the insurer regards as hopeless, the insured person may initiate arbitration proceedings. The arbitrator is jointly appointed by both parties.

Otherwise the procedure is based on the concordat concerning proceedings of the arbitration tribunal.

If an insured person takes proceedings at his own expense, contractual benefits are payable if the outcome of the proceedings is more favourable than the insurer expected.

9 Legal venue

The place of jurisdiction shall be the Swiss place of residence of the insured person or Aarau.

capita accident (risk capital in the event of death or invalidity caused by an accident)

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1 Insurance fundamentals

1.1 Insurance provider

The insurance carrier is Sympany Versicherungen AG, Basel (hereinafter referred to as the "insurer").

1.2 Common provisions

The Common provisions of Sympany Insurances Ltd are an integral component of the provisions governing cover against death or invalidity due to accident. In the event of any conflict, the provisions governing cover against death or invalidity due to accident take precedence over the common provisions of Sympany Insurances Ltd.

2 Scope of cover

The insurance covers all occupational and non-occupational accidents, including occupational illnesses if at the time of their occurrence they are eligible for compensation by virtue of the Federal Law on Accident Insurance (UVG, articles 6–9).

The term "accident" denotes the sudden, unintended harmful influence of an unusual external factor on the human body. In addition, the following are classified as accidents as well as the bodily damage referred in the common provisions of Sympany Insurances Ltd:

- damage to health caused by the involuntary aspiration of gases and vapours and by the inadvertent ingestion of toxic and corrosive substances,
- drowning,
- the following health damage insofar as the insured person suffers it involuntarily and it is caused by an insured accidental event: freezing, heatstroke, sunstroke and health damage caused by ultraviolet radiation (except sunburn).

3 Insured persons

3.1 Principle

Cover applies to individuals who have announced the intention of concluding accident insurance in accordance with the present GTC.

3.2 Maximum age at inception

The insurance is open to anybody below the age of 65.

4 Commencement and duration of the insurance

4.1 General

The commencement and duration of the insurance are determined by the common provisions.

An accident and its consequences are insured only if the accident occurred during the insurance period.

4.2 Amendments to the insurance

The insured sum can be increased by policyholders below the age of 65.

5 Termination of insurance

5.1 Principle

Termination of the insurance is governed by the common provisions of Sympany Insurances Ltd.

6 Geographical validity

Insurance cover is valid throughout the world. In the event of removal to a foreign country the continuation of the insurance is subject to the mondial provisions.

7 Sums insured

7.1 Insurance variants

The sums insured are stated in the insurance policy.

7.2 Maximum sums for aviation accidents

The insurer's maximum guarantee for a single individual under all the accident insurance policies in force with it is subject to the following limit for an aviation accident:

In the event of death: up to CHF 500 000.-

In the event of total invalidity: CHF 1 000 000.-
(reduced proportionally for partial invalidity)

7.3 Maximum insurable sums

7.3.1 Maximum sums for children

The maximum sums insured on the death of children are as follows:

Up to the age of three CHF 2 500.-

Up to the age of 15 CHF 20 000.-

Benefits on the death of children under this and all other insurance policies may not exceed the following sums:

Children who have not yet reached the age of two years and six months CHF 2 500.-

Children who have not yet reached the age of twelve CHF 20 000.-

7.3.2 Maximum sums above the age of 65

The following maximum sums apply with effect from 1 January of the calendar year following the insured person's 65th birthday:

On death: CHF 20 000.-

On invalidity: CHF 60 000.-

Any existing higher sums insured are accordingly reduced on that date.

7.3.3 Insured invalidity sum after retirement

Progression in invalidity insurance lapses from 1 January of the calendar year following the insured person's 65th birthday. The percentage compensation corresponds to the degree of invalidity.

8 Death benefit

8.1 Beneficiaries

Where the death of the insured person can be shown to be due to an accident, either immediately or within five years of the date of its occurrence, insured death benefit is payable by

the insurer to the survivors specified below whose ranking and entitlement are as follows:

- a) The entire death benefit:
- to the surviving spouse,
 - in the absence of such a surviving spouse: children, adopted children and stepchildren in equal parts,
 - in their absence: parents in equal parts, or the surviving parent,
 - in their absence: brothers and sisters, provided that they were not yet 25 years old at the time of the accident.

The existence of a higher-ranking person or group of persons excludes all lower-ranking persons and groups of persons.

Spouses and children of a marriage concluded after the accident are not entitled to death benefits.

- b) The insured person may override the foregoing provision, designating or excluding beneficiaries by notifying the health fund accordingly in writing. The insured person can cancel or amend any such declaration at any time by notifying the health fund accordingly in writing.
- c) If no beneficiaries as per paragraphs a and b exist, the insurer makes the following contribution to the costs of burial:

10% of the death benefit, to a maximum of CHF 10 000.-

8.2 Imputation of the invalidity benefit

The death benefit is reduced by any invalidity benefit already paid out in respect of the same accident.

9 Invalidity benefit

9.1 Principle

If the accident results in the invalidity of an insured person that is likely to be permanent, the insurer pays the agreed invalidity benefit: total invalidity – the full sum insured, partial invalidity – a proportion of the sum insured corresponding to the degree of invalidity. The degree of invalidity is determined definitively on the basis of the condition (deemed likely to be permanent) of the insured person, but in any case within five years of the accident. In this case the current degree of invalidity is determined at the time the decision is taken. Any changes in the degree of invalidity after the latter is determined, i.e. relapses or subsequent consequences, will not be compensated.

Any loss of income or incapacity caused by the event is not taken into account when determining the degree of invalidity. Only the insured person is entitled to invalidity benefit.

9.2 Total invalidity

Total invalidity means:

- the loss of, or of the use of, both arms or hands,
- the loss of, or of the use of, both legs or feet or the simultaneous loss of one arm or hand and one leg or foot,
- total paralysis,
- total blindness.

9.3 Partial invalidity

The benefit paid in the event of partial invalidity is the proportion of the total sum insured corresponding to the

degree of invalidity. The calculation is based on the following percentages:

Loss of or complete loss of the use of	Percentage
Arm above the elbow	70%
Arm below the elbow	65%
Hand	60%
Thumb and metacarpal joint	25%
Thumb, metacarpal joint undamaged	22%
Tip of the thumb	10%
Index finger	15%
Middle finger	10%
Ring finger	9%
Little finger	7%
Leg above the knee	60%
Leg below the knee	50%
Foot	45%
One big toe	8%
Other toes, each	3%
Sight of one eye	30%
Sight of the other eye	50%
Hearing of both ears	60%
Hearing of one ear	15%
Hearing of one ear if that of the other had already been entirely lost before the insured event occurred	30%
Sense of smell	10%
Sense of taste	10%
One kidney	20%
Spleen	5%
Grave, extremely painful functional restriction of the spinal column	50%

In the event of partial loss, or partial loss of use, a correspondingly reduced degree of invalidity applies.

For cases which are not listed here, the degree of invalidity shall be determined in accordance with the same guidelines as for determining damage of integrity pursuant to the Federal Law on Accident Insurance (UVG) or the Ordinance on Accident Insurance (UVV). In this case, the tables published by the Swiss National Accident Insurance Fund (SNAIF) on compensation for damage to integrity in accordance with the Federal Law on Accident Insurance apply.

In the event of simultaneous loss or simultaneous loss of use of several parts of the body caused by the same accident, the degree of invalidity is generally determined by adding the percentages together. It can never exceed 100%, however. The benefit payable on the loss of all the fingers on one hand is limited to the benefit that applies to the loss of the hand itself.

9.4 Severe disfigurement

For severe, permanent disfigurement of the human body caused by an accident (cosmetic damage, e.g. scarring) for which no invalidity benefit is payable but that creates a more difficult social position for the insured person, the insurer shall pay the following proportions of the agreed invalidity benefit up to a maximum of:

- 10% of the insured sum agreed in the policy for disfigurement of the face, and/or

- 5% for disfigurement of other parts of the body that are normally visible.

The benefits for aesthetic damages are limited to CHF 20 000.-, and no progression is applied to the degree of invalidity determined.

9.5 Pre-existing bodily deficiencies

If pre-existing bodily deficiencies are made worse in consequence of an accident, this does not confer an entitlement to higher compensation (except for loss of the second eye or the hearing of the second ear). If the insured person had already wholly or partially lost, or lost the use of, parts of his body before the accident, the degree of invalidity is reduced by the pre-existing degree of invalidity determined according to the above principles.

Where pre-existing illnesses or conditions not caused by the accident make its consequences significantly worse, the insurance benefits are proportionately reduced, at the time the degree of invalidity is determined and not when the amount of capital invalidity benefit is decided.

9.6 Invalidity compensation

In the event of invalidity of more than 25%, compensation increases progressively to 350% of the agreed sum insured.

Degree of invalidity in %	Compensation in % of the agreed sum insured	Degree of invalidity in %	Compensation in % of the agreed sum insured
1	1	28	34
2	2	29	37
3	3	30	40
4	4	31	43
5	5	32	46
6	6	33	49
7	7	34	52
8	8	35	55
9	9	36	58
10	10	37	61
11	11	38	64
12	12	39	67
13	13	40	70
14	14	41	73
15	15	42	76
16	16	43	79
17	17	44	82
18	18	45	85
19	19	46	88
20	20	47	91
21	21	48	94
22	22	49	97
23	23	50	100
24	24	51	105
25	25	52	110
26	28	53	115
27	31	54	120

Degree of invalidity in %	Compensation in % of the agreed sum insured	Degree of invalidity in %	Compensation in % of the agreed sum insured
55	125	78	240
56	130	79	245
57	135	80	250
58	140	81	255
59	145	82	260
60	150	83	265
61	155	84	270
62	160	85	275
63	165	86	280
64	170	87	285
65	175	88	290
66	180	89	295
67	185	90	300
68	190	91	305
69	195	92	310
70	200	93	315
71	205	94	320
72	210	95	325
73	215	96	330
74	220	97	335
75	225	98	340
76	230	99	345
77	235	100	350

10 Limitation of benefits

10.1 Principle

The benefit-limitation rules in the common provisions of Sympany Insurances Ltd do not apply to capita accident (death or invalidity due to accident).

10.2 Benefit exclusions

No entitlement to insurance benefits exists:

- as a consequence of war, civil war and/or circumstances similar to war
 - in Switzerland, the principality of Liechtenstein and/or neighbouring countries,
 - abroad, unless the accident occurs within 14 days of the first occurrence of such events in the country in which the insured person is staying and where he was taken by surprise by the outbreak of the warlike events,
- as a result of an earthquake in Switzerland or the principality of Liechtenstein,
- as a result of exceptional risks such as:
 - foreign military service,
 - participation in warlike actions, acts of terrorism or the commission of crimes,
 - the consequences of any form of unrest unless the insured person can show that he was not involved on the side of the perpetrators, either actively or through incitement,
- as a result of the deliberate commission or attempted commission of crimes or offences by the insured person, including if said offence was only considered,
- in consequence of the effects of ionizing radiation and damage caused by nuclear energy,

- in the event of an accident in which the insured person has a blood alcohol content of two parts per thousand or more by weight, unless there is manifestly no causal relationship between drunkenness and the accident,
- as a result of acts of daring (actions by which the insured person exposes himself to a particularly serious risk without taking or being able to take measures to limit the risk to a reasonable extent),
- as a result of suicide or self-inflicted injury caused by the insured person deliberately, regardless of whether or not his judgement was impaired at the time,
- as a result of the deliberate ingestion or injection of medicines, drugs or chemical products,
- as a result of medical treatment or surgery that was not necessitated by an insured accident,
- when using aircraft as a military pilot, other military crew member or parachutist,
- in military parachute jumps,
- when travelling by aeroplane if the insured person has deliberately infringed official regulations or is not in possession of the appropriate official licences and permits,
- for the statutory and regulatory cost contributions by the insured person to compulsory health care insurance.

10.3 Benefit reductions

10.3.1 Accidents: extraneous factors

Where extraneous factors have an effect on an insured accident the insurer shall only pay a proportion of the agreed benefits, determined on the basis of a medical examination. Here, the benefits will be reduced by the extraneous factors when the degree of invalidity is determined and not when the amount of the capital invalidity benefit is decided.

10.3.2 Breach of obligations in the event of a claim

Benefits may be reduced if the insured person deliberately fails to meet his obligations.

10.3.3 Further benefit reductions

Benefits may be further reduced in the light of the provisions of the UVG (articles 37-39) applicable at the time when the accident or the occupational illness occurred.

10.4 Death caused by a potential beneficiary

Where a beneficiary deliberately causes the death of the insured person during the commission of a crime or offence, he is not entitled to pecuniary benefits. Where a beneficiary causes the death of the insured person by gross negligence, the pecuniary benefits due to him are reduced. In particularly grave cases they may be refused entirely.

11 Retraining costs

Where occupational retraining is necessary after an accident for which the insurer has provided benefits, the insurer pays reasonable costs up to a maximum of 10% of the insured invalidity benefit.

12 Procedure in the event of a claim

Any accident that may make the insurer liable for benefits shall be reported to Sympany without delay.

A death must be reported immediately, in all cases within no more than ten days.

The insured person must undergo examinations conducted by any medical practitioner retained by the insurer at its expense, and follow his instructions.

The insured person shall immediately provide any information requested by the insurer about his present and previous state of health and about the accident and his recovery from it.

The insured person or the persons entitled to claim benefits must justify their claims at their own expense by producing medical certificates. These may also be obtained by the insurer.

The insured person is required to release all doctors by whom he is treated following the accident or illness from the obligation of secrecy to enable them to provide the insurer with the information it requests.

Where the insured persons or persons entitled to claim benefits culpably fail to meet any of these obligations, the insurer shall be authorized to reduce benefits by the amount by which they would have been reduced if it had received notification at the proper time, unless such persons can show that the conduct in breach of their contractual obligations had no influence on the consequences of the accident and on the determination thereof.

13 Notices to the insurer

All communications and notices must be sent to Sympany. The insurer acknowledges such communications and notices as having been sent to it. All notifications by the insurer are sent with valid legal effect to the last address in Switzerland given by the person insured or entitled to claim.

14 Applicable law

This insurance shall otherwise be governed by the regulations of the Federal Insurance Contract Act (ICA) of 2 April 1908.

capita illness risk capital upon death or disability as a result of illness (GCI capita illness)

Sympany

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capita illness

1 Basis of the insurance

1.1 Basis

The insurance contract covering risk capital upon death or disability as a result of illness shall be based on the individual insurance application, the insurance policy, the Common Provisions (Sympany CP) and the General Conditions of Insurance (GCI capita illness) and, subsidiarily, the provisions of the Swiss Federal Act on Insurance Contracts 2 April 1908 (ICA).

1.2 Object and scope of the insurance

The object of this supplementary risk capital insurance policy shall be to protect the insured against the financial consequences of death or disability as a result of illness.

The scope of this supplementary risk capital insurance policy shall be a one-off capital payment covering the financial consequences of death or disability as a result of illness.

1.3 Policy conditions (GCI)

The present General Conditions of Insurance (GCI capita illness) describe the rights and obligations of the insured and/or their beneficiaries. In particular, they determine the capital entitlement of the insured in the event of disability and that of the beneficiaries in the event of the death of the insured as a result of illness.

The Common Provisions (Sympany CP) form an integral part of this risk capital insurance policy. In the event of any discrepancies, the General Conditions of Insurance (GCI capita illness) shall take precedence over the Common Provisions (Sympany CP).

1.4 Insurance carrier

Sympany has underwritten all insurance benefits accruing upon death or disability in the event of illness that arise from this insurance contract (GCI capita illness) in a collective insurance contract. The insurance carrier in the collective insurance contract is Swiss National Life Insurance Ltd, Bottmingen (hereinafter the "insurer"), and the policyholder is Sympany. Upon death or disability in the event of illness, the insurer shall render the insurance benefits owing under this insurance contract (GCI capita illness) via Sympany to the insured persons and/or the beneficiaries. All claims arising from this insurance contract (GCI capita illness) shall be brought against the insurer exclusively.

1.5 Insured persons

Individuals resident in Switzerland and cross-border commuters, as well as members of the families of these persons, who voluntarily take out insurance in accordance with the General Conditions of Insurance (GCI capita illness) are insurable under this policy.

The insurance is available to individuals who are insured under a health or supplementary health insurance policy of the health fund at the time of application or who have applied for such a policy and will become insured of the health fund.

1.6 Insurance year

The insurance year commences on 1 January and ends on 31 December.

1.7 Age

For the purposes of this insurance policy, the age of the in-

sured ("effective age") shall be deemed the difference between the calendar year and the year of birth.

1.8 Acceptance

Acceptance by the insurer shall be based on the answers given to the medical questions contained in the application. No medical examination shall be required if the application for insurance is submitted during the first 90 days of the insured person's life, counted from the date of birth.

2 Insurance cover

2.1 Commencement of insurance cover

The health fund shall give the applicant written notice of the day on which the insurance cover shall commence. This date shall be no earlier than the date confirmed on the insurance policy.

2.2 Conditions of insurance cover

The insurance cover shall apply, if the policyholder is entirely fit for employment at the start of insurance cover, is not subject to periodical medical treatment or check-ups and if his initial or later insured benefits do not exceed certain sum limits predetermined by the insurer. Where one or more of these conditions are not met, the insurance cover shall not apply or the sum insured shall be adjusted to the acceptable values (see 4.3.2).

2.3 Exclusion

No insurance cover shall be provided if the claim stems from an illness, a handicap or the consequences of an accident that existed before commencement of the insurance cover.

In addition, no insurance cover shall be provided for small children during their first 90 days of life (counted from their date of birth) or for claims which are the result of an illness, a handicap, or the consequences of an accident that happened or originated during these first 90 days.

2.4 Discontinuation of insurance cover

The insurance cover shall be discontinued if the insured engages in military service for peacekeeping purposes in areas of conflict (e.g. for UNO "Blue Caps" and OSCE "Yellow Caps").

2.5 Geographical scope of the insurance cover

The insurance cover shall be valid in all countries of the world.

3 Commencement, duration and termination of cover

3.1 Commencement and duration of cover

The insurance cover shall begin no earlier than birth and no later than on the 60th birthday of the insured (maximum age).

The term of the insurance contract shall end no later than on the 65th birthday of the insured (final age).

This insurance policy may be concluded at any time before the insured reaches the maximum age and at any time during the calendar year. Cover can be applied to commence on the first day of any month.

3.2 Amendment of cover

The sum insured may be increased within the parameters of the age categories and sums insured predetermined by the insurer (see 4.3.2) at any time before the insured reaches the maximum age. This shall be done by way of a corresponding application.

3.3 Suspension of cover

Cover may not be suspended.

3.4 Termination of cover

The insurance policy and the cover it provides shall expire should any of the following events occur:

- The insured dies.
- The insured moves abroad (except if the insured gains cross-border commuter status).
- The insured reaches the final age (the day after his 65th birthday)
- The capital disability insurance policy shall expire if a capital disability benefit is paid out.
- The policy is cancelled in accordance with the Common Provisions (Sympany CP).

4 Benefits

4.1 Overview of benefits

Under the insurance cover the insurer shall pay the beneficiary or beneficiaries the following benefits in the event of death or disability as a result of illness:

- In the event of death:
 - Capital death benefit;
- In the event of occupational disability presumed permanent (disability):
 - Capital disability benefit.

4.2 Definitions

4.2.1 Disability

Disability means full or partial incapacity to work as a result of illness which is expected to be permanent.

4.2.2 Illness

An illness is an impairment of the physical or mental health of the insured person and not intended by the insured person, which is diagnosed by a physician and is not a consequence of an accident.

4.2.3 Incapacity to work

Incapacity to work is the complete or partial inability of the insured person to perform reasonable work in his former profession or field of responsibility as a result of the impairment of his physical or mental health.

4.2.4 Occupational disability

Occupational disability is the complete or partial loss of the insured's ability to pursue gainful employment or self-employment in the relevant, balanced labour market as a result of an impairment of physical or mental health that remains after reasonable treatment and rehabilitation.

The insured is considered occupationally disabled if he is incapable of pursuing his profession or any other reasonable gainful employment and therefore suffers a loss of earnings as a result of impairment of physical or mental health which is diagnosed by a medical practitioner.

Occupational disability is deemed as being permanent if the insured can prove that continued medical treatment cannot be expected to result in a significant improvement in his ability to work and that such occupational disability is likely to last throughout life.

4.2.5 Reasonableness

An activity is deemed reasonable if it reflects the insured's former permanent occupation and his previous position in life,

even if he requires retraining to obtain the necessary knowledge.

4.3 Sums insured

4.3.1 Amount of sums insured

The sums insured specified in the insurance policy shall apply. The maximum statutory capital death benefit shall be CHF 2,500 for children under the age of 2½ years.

4.3.2 Maximum sums insured

The maximum sums insured depend on the age of the insured as per the following table.

Age category	Category name	Maximum sum insured for death	Maximum sum insured for disability
0-3 years	Infants	up to CHF 20,000.-*	up to CHF 100,000.-
4-15 years	Children	up to CHF 20,000.-	up to CHF 100,000.-
16-50 years	Adults	up to CHF 300,000.-	up to CHF 300,000.-
51-55 years	Adults	up to CHF 200,000.-	up to CHF 200,000.-
56-65** years	Adults	up to CHF 100,000.-	up to CHF 100,000.-

* The maximum statutory lump sum death benefit shall be CHF 2,500 for children under the age of 2½ years.

** Up until the final age as per 3.1.

If the insured reaches a higher age category, the sums insured shall be reduced to the maximum sum insured in that new age category and the premiums shall be adjusted accordingly. In all other cases the sums insured shall remain unchanged.

4.3.3 Superseding causes

If the insured dies before the capital disability sum is paid, only the capital death benefit sum shall be paid out. If no death benefit is insured, no capital disability benefits are paid, if the insured dies before it is paid out.

4.3.4 Progressive reduction in capital benefits between the ages of 57 and 65

The death and disability benefits shall be reduced progressively each and every year between the ages of 57 and 65 annually by 10% of the sum insured as per the following table, while the premium shall remain unchanged.

Age	Capital insured max. CHF	Capital benefit	Amount paid out max. CHF	Premium
56	100,000.-	100%	100,000.-	100%
57	100,000.-	90%	90,000.-	100%
58	100,000.-	80%	80,000.-	100%
59	100,000.-	70%	70,000.-	100%
60	100,000.-	60%	60,000.-	100%
61	100,000.-	50%	50,000.-	100%
62	100,000.-	40%	40,000.-	100%
63	100,000.-	30%	30,000.-	100%
64	100,000.-	20%	20,000.-	100%
65	100,000.-	10%	10,000.-	100%

4.4 Capital disability benefit

4.4.1 Entitlement to capital disability benefit

The insured is entitled to the agreed capital disability benefit if he becomes permanently incapacitated before reaching the final age.

4.4.2 Time of entitlement to capital disability benefit

The insurer shall pay out the capital disability benefit at the earliest after a waiting period of 24 months. The waiting

period commences on the day on which the insured first consults a physician about the illness that led to his incapacity and the doctor confirmed that he was at least 50% incapacitated.

In the event of a relapse or of a new incapacity occurring within 12 months at the end of a period of an incapacity already reported and due to the same medical problem, no further waiting period shall apply.

If benefits have been granted by the Swiss Federal Disability Insurance before the end of the waiting period and/or if the permanent occupational disability is deemed to be permanent before the end of the waiting period, the insured capital disability sum may be partially or completely paid out at an earlier date. The insurer shall decide this on a case-by-case basis.

4.4.3 Assessment basis of capital disability benefit

The capital invalidity benefit is determined on the basis of the disability capital insured, the age of the insured at the beginning of the waiting period e.g. at the time his incapacity was first medically confirmed, and the degree of occupational disability determined by the insurer.

4.4.4 Grading of capital disability benefit

The capital disability benefit shall be graded and determined in accordance with the degree of occupational disability of the insured person.

- If the degree of occupational disability is deemed to be between 70% and 100%, the insured shall be entitled to the full capital disability benefit.
- If the degree of occupational disability is deemed to be at least 50% but less than 70%, the insured shall be entitled to a capital disability benefit in proportion with the degree of disability determined.
- If the degree of occupational disability is deemed to be less than 50%, the insured shall have no entitlement to a capital disability benefit.

4.4.5 Changes in the degree of occupational disability

If the degree of occupational disability changes subsequent to the payment of capital disability benefit, there shall be no adjustment in benefits to reflect the new degree of occupational disability.

4.4.6 Determining the degree of occupational disability for gainfully employed and/or self-employed adults

For gainfully employed or self-employed adults, the degree of occupational disability shall be determined based upon the loss of earnings suffered by the insured.

For gainfully employed adults with a regular income, the degree of occupational disability shall be based upon the income subject to state pension deductions (AHV) earned in the month preceding commencement of the waiting period. For gainfully employed adults with fluctuating or irregular income, the loss of earnings shall be based upon the average income subject to state pension deductions (AHV) earned over the two calendar years preceding commencement of the waiting period.

For self-employed adults, the degree of occupational disability shall either be based upon the average income subject to state pension deductions (AHV) earned in the two calendar years preceding commencement of the waiting period or it shall be based upon the actual loss of earnings suffered by the insured

in the two preceding financial years. The income earned from gainful employment prior to the occurrence of occupational disability shall be compared with that which the insured person has earned since the occurrence of occupational disability or that which he could have earned in a balanced labour market; the difference expressed as a percentage of the former income shall be deemed to be the degree of occupational disability.

4.4.7 Determining the degree of occupational disability of part-time employed and/or unemployed adults

For adults with no gainful employment and those who completely or partially surrender employment for reasons unrelated to health, the degree of occupational disability shall be determined on the basis of an activity comparison. The activity comparison measures, weights and compares the activities and tasks of the insured before the illness occurred with those subsequent to its occurrence. The activities and tasks carried out prior to commencement of occupational disability shall be set in proportion to those which can still be carried out following commencement of occupational disability. The inability to be active in the former field of activity and work shall be treated as occupational disability. The difference, expressed as a percentage of the former activities, shall be the degree of occupational disability.

For adults in partial gainful employment, the degree of occupational disability shall be determined in accordance with the combined method of the Swiss Federal Disability Insurance (IV).

4.4.8 Determining the degree of occupational disability for infants and children

Occupational disability of infants and children shall be measured according to the degree to which the insured will be incapable of taking on employment.

For children who have not entered into any occupational training, occupational disability shall be measured according to whether and to what extent the insured will later be able to carry out an occupational activity in the future. The degree of occupational disability reflects the presumed income reduction attributed to the reduced capacity to work in relation to income based on the annual median income ascertained in the salary structure survey conducted by the Swiss Federal Statistical Office.

For children currently in occupational training, the assessment shall be based on the income that would have been earned on the relevant labour market following completion of the occupational training. The degree of occupational disability reflects the presumed income reduction attributed to the reduced capacity to work in relation to income based on the annual median income ascertained in the salary structure survey conducted by the Swiss Federal Statistical Office and relevant for the occupation for which the training has begun.

4.5 Capital death benefit

4.5.1 Entitlement to capital death benefit

Entitlement to the capital death benefit arises upon the death of the insured, provided he has not reached the final age.

The insurer waives its legal right to reduce the capital death benefit if the death of the insured was a result of gross negligence.

4.5.2 Assessment basis of capital death benefit

The capital death benefit shall be calculated in accordance with the capital death benefit and the age of the insured at the time of death.

4.5.3 Beneficiaries

The capital death benefit shall be paid to the persons named as beneficiaries in the application. The insured may choose the named beneficiaries freely and may make changes at any time before his death. No changes in the named beneficiaries shall be effective unless they are made by written notification.

If no beneficiary is named in the contract, the statutory order of priority of beneficiaries shall apply (surviving spouse; if none, the children; if none, the other legal heirs of the insured).

4.6 Exclusions of insurance benefits

4.6.1 In the event of an accident

No entitlement to benefits upon death or occupational disability as a result of illness shall exist if the insured occurrence was a result of an accident as defined by the Common Provisions (Sympany CP) of the health fund.

Occupational illnesses as defined by Swiss Federal Accident Insurance (UVG) shall likewise form no basis for benefits on death and occupational disability as a result of illness.

4.6.2 Physical injury deemed similar to an accident

No entitlement to benefits in case of death or occupational disability as a result of illness shall exist in case of physical injuries deemed similar to accidents. Physical injuries deemed similar to accidents and not considered illnesses are:

- Health impairment and its consequences when caused by involuntary inhalation of gases or vapours or by unintentional intake of poisonous or caustic matter.
- The physical injuries listed in the Common Provisions (Sympany CP).
- Frost injuries, heatstroke, sunstroke and health impairments caused by ultraviolet radiation and their consequences except for sunburn.
- Involuntary drowning.

4.6.3 Intentional self-inflicted occupational disability

No entitlement to benefits for occupational disability shall exist if the insured intentionally causes his occupational disability or illness (e.g. self-harm, attempted suicide). This shall also apply if the insured takes the action and is at the same time not mentally competent to judge his action.

The insurer waives its legal right to reduce the capital disability benefit if the occupational disability was a result of the insured's gross negligence.

4.6.4 Prenatal body injuries, birth defects and their consequences

No entitlement to disability or death benefits shall exist if the insured's occupational disability or death is a result of prenatal body injuries, birth defects or their consequences.

4.6.5 Suicide and injury as a result of attempted suicide

There shall be no entitlement to death benefits if the insured commits suicide within three years of application or if the insured dies of injuries as a result of attempted suicide committed within three years of application. This shall also apply if the insured is not competent to judge his action or has a reduced capacity to make judgements at the time he enters into the act which leads to his death.

4.6.6 Ionising rays and nuclear energy

No entitlement to death or disability benefits shall exist if the insured becomes ill as a result of exposure to the effects of ionising rays from nuclear energy.

4.7 Reduced entitlement to insurance benefits

4.7.1 Coincidence of multiple causes

In the event that a number of different causes coincide, the insurer shall recognise claims insofar as they are not the subject of accident or military insurance.

4.7.2 Coincidence of capital disability and capital death benefits

In the event of death, the sum of the disability benefits already paid out to the insured shall be deducted from the capital death benefit.

4.8 Securing benefits and payment

4.8.1 Inalienable rights

Any benefits arising from this insurance policy (GCI capita illness) shall be exclusively for the personal livelihood of the beneficiaries. The benefits may not be pledged, assigned or seized under debt enforcement law before payment becomes due.

4.8.2 Verification of insurance claim

The standard documents to be submitted for claim verification are as follows:

- In the event of death:
Extract from the family register/medical certificate of death/
official certificate of death
- In the event of occupational disability:
Medical certificate/medical records/IV files/AHV statement/
annual salary statement, payslips and balances.

The insurer shall be entitled to demand further information and evidence and to make further enquiries of its own. The insurer shall also be entitled to demand that the insured be examined by a designated physician. The insured's physician shall be released from the duty of medical confidentiality in his dealings with the insurer.

4.8.3 Payment of the insurance benefits

The insurance benefits shall be paid out when the beneficiaries have submitted all documents required for the verification and assessment of the claim.

The insurance benefits shall become due after a period of four weeks from the date upon which the insurer has received all documents and information required on the basis of which it is satisfied that the claim is valid. Insurance premiums are to be paid until this date.

The insurance benefits shall be paid out in Swiss francs (CHF).

5 Special provisions

5.1 Obligations of the insured in the event of illness

The insured shall be subject to an obligation to cooperate and to mitigate loss. The insured shall grant the insurer the authority to request files and information from hospitals, physicians, government offices, insurance companies, social security institutions and third parties and to release these institutions from the duty of confidentiality.

The insured shall without delay provide the insurer with all information requested regarding his previous and present state of health and the course of the illness.

The insurer retains the right to require the insured to undergo an examination by a physician designated by the insurer. The insured shall undergo the examinations and follow the instructions of the physician appointed by the insurer at its expense.

In the event that the beneficiaries fail to fulfil one or more of these obligations, the benefits shall not be paid out and the insurer shall be permitted to deny benefits. Should this occur, the obligation to pay premiums shall continue.

5.2 Premiums

The premiums shall be calculated according to the age category of the insured and the size of the sums insured. When set or adjusted, premiums shall remain guaranteed for one calendar year. There shall be no tariff guarantee.

5.3 Conduct in the event of a claim

The insurer must be notified without delay of an occupational disability that is likely to trigger the insurer's obligation to pay benefits.

Notification of death must be made to the insurer within 10 days.

The documents required for claim verification and assessment must also be submitted without delay.

5.4 Notifications and disclosures

All notifications and disclosures shall be addressed to the health fund. In the event of a claim, benefits due from the insurer shall be paid out via the health fund.

5.5 Military service

Active service – without warlike activities – in order to safeguard Swiss neutrality or to maintain public order within Switzerland shall be deemed military service during times of peace and shall be covered by this insurance policy. In the event that Switzerland engages in war or warlike activities, the relevant provisions issued by the Federal Council shall apply.

5.6 Place of performance

The place of performance shall be the beneficiary's place of residence in Switzerland or Liechtenstein. In the event that such a place of residence does not exist, the place of performance shall be the domicile of the health fund.

5.7 Jurisdiction and applicable law

In the event of a dispute arising from the capita illness insurance contract, the beneficiaries may choose either the legal venue of their place of residence in Switzerland or the legal domicile of the insurer (Swiss National Life Insurance Ltd, Bottmingen) as the place of jurisdiction. The contract is exclusively subject to Swiss law.

5.8 Entry into force and amendments

The General Conditions of Insurance (GCI capita illness) above are effective as of 1 January 2011.

The insured shall be notified of any amendments to the General Conditions of Insurance (GCI capita illness) at least three months prior to their entry into force.

In the event of doubt or legal dispute, the German version is authoritative.

