General Conditions of Insurance (GCI)
Health Insurance
Managed Care (FLHI/KVG)

Note:
- For reasons of readability only the male pronoun is used.

The conditions of insurance are valid for the following insurers:
- Visana Ltd, Weltpoststrasse 19, 3000 15
- sana24 Ltd, Weltpoststrasse 19, 3000 15
- vivacare Ltd, Weltpoststrasse 19, 3000 15
- Galenos Ltd, Weltpoststrasse 19, 3000 15

1. General principles

1.1 What is Managed Care insurance?
The insurer offers Managed Care insurance in specifically defined insurance regions (Managed Care networks). Managed Care insurance is based on the current provisions of the Federal Law on Health Insurance (FLHI/KVG), the Federal Law governing the General Part of Social Insurance Law (GPSIL/ATSG), the relevant administrative regulations, and the General Conditions of Insurance (GCI).
Managed Care insurance is a form of the basic insurance required by law and is based on the provisions of Article 41 paragraph 4 and Article 62 of the Federal Law on Health Insurance (FLHI). The name of the insurer can be found on your insurance policy.

1.2 What is the underlying principle of the Managed Care insurance?
Managed Care insurance is based on the gatekeeper principle and provides insured persons with comprehensive support, advice and medical care. The gatekeeper (Managed Care doctor) coordinates all the patient's medical treatment.
On taking out Managed Care insurance, insured persons agree to consult the Managed Care doctor they have selected for all medical examinations and treatment and/or for referral to specialists and other service providers.

1.3 How is a Managed Care network organized?
Doctors in the Managed Care network are either contracted directly to the insurer or to another separate operating company.

1.4 Who is your Managed Care doctor?
The insured person chooses his Managed Care doctor from the list of Managed Care doctors. Other than in emergencies, or for outpatient ophthalmic consultations, preventive gynecological examinations and obstetrical care, the Managed Care doctor has to be consulted first if any outpatient or stationary treatment is required.
The Managed Care doctor advises the insured on the choice of a gynecologist.

1.5 What benefits does Managed Care insurance provide?
Managed Care insurance provides the mandatory benefits foreseen by the legislation for illness, accidents, congenital defects, pregnancy and maternity.

1.6 What conditions apply in emergencies?
Emergency treatment is covered within the scope of the mandatory benefits foreseen in the legislation provided the treatment is given by a doctor or a service provider authorized to provide services under the provisions of the FLHI. An emergency is a situation where the insured person needs urgent medical treatment from an objective medical viewpoint and the Managed Care doctor cannot be reached in time or is unavailable because of the distance or time involved.

1.7 May accident cover be suspended?
Accident cover may be suspended if the insured person has appropriate cover in accordance with accident insurance legislation (FLAI/UVG). Written request for suspension of accident insurance has to be made to the insurer. Insured persons have to notify the insurer of all changes in accident insurance cover within one month.

1.8 May you choose the annual deductible you wish to pay?
The Managed Care plan offers you the option of contracting for an annual deductible. The higher annual deductibles charged are offered in compliance with the conditions of the Ordinance on Health Insurance (OHI/KVV).

1.9 How does the insurer communicate with insured persons? What duty to notify do you have?
a) Official newspaper
Insured persons are informed about modifications of the conditions of insurance and about information of a general nature in the Visana Group's official newspaper; such information is binding. One copy of the official newspaper is sent to each household.
b) Insurance policy
Each insured receives personal confirmation of his insurance protection in the form of an insurance policy.
c) Duty of insured persons to notify the insurer
Insured persons have a duty to notify the organizational unit of the insurer indicated on the insurance policy of all changes in personal circumstances that may affect the insured relationship (e.g. change of domicile) within one month of such changes.
d) Breaches of the duty to notify the insurer
Any prejudice resulting from willful violation of the obligation to notify must be borne by the insured.

2. Benefits

2.1 What are you insured for?
The benefits provided by Managed Care insurance are offered in explicit compliance with the provisions of the FLHI.

2.2 Who provides medical services?
Under the Managed Care plan, the Managed Care doctor of your choice is responsible for outpatient treatment, medical care and consultation (restricted choice of physician).

2.3 Which services are accepted under the insurance?
Managed Care insurance accepts the costs for medicinal drugs, analyses and therapeutic measures prescribed by the Managed Care doctor if the FLHI stipulates such measures should be paid by the insurer. Services provided by doctors who are not members of a Managed Care network will be accepted analogously provided such are necessary in an emergency or if the insured is referred to another service provider by the Managed Care doctor.

2.4 May other service providers be consulted?
Specialists or other service providers may be consulted on referral by the Managed Care doctor. Managed Care insurance accepts the costs stipulated in the FLHI.

2.5 What benefits are paid for stationary treatment?
If stationary treatment is provided in the general ward of a listed hospital, the insurer accepts its share of the costs at the prevailing tariff for listed hospitals in the insured person's canton of residence. If treatment is required for medical reasons in a hospital that is not on the hospital list of the canton of residence, the insurer accepts its share of the costs at the prevailing tariff for individuals resident in the canton where the stationary facility is located.

2.6 When is the approval of the Managed Care doctor necessary?
Other than in emergencies, individuals may not be referred to acute hospitals without the express approval of the Managed Care doctor.

2.7 What is not insured?
Costs incurred for outpatient or hospital services other than in cases of accident (in compliance with paragraph 1.6) without prior referral by the Managed Care doctor are borne by the insured person.

2.8 When do benefits have to be repaid?
Benefits which are wrongfully gained or paid in error must be repaid to the insurer.

2.9 When does entitlement to benefits begin?
Entitlement to benefits begins on the day the insurance commences. The date of treatment determines whether you are entitled to benefits.

2.10 Where is the insurance valid?
As a matter of principle benefits will be paid for treatment received in Switzerland.

2.11 What benefits will be provided for treatment abroad?
During stays in EU member states, Iceland or Norway, insureds are entitled to medically necessary treatment; in this respect the type of benefit and the length of stay envisaged will be taken into consideration. In all other countries insureds are only entitled to emergency treatment. An emergency is deemed to exist if situations arise in which insured persons need medical treatment during a temporary stay abroad and it would be unreasonable for them to return to Switzerland. No emergency exists in situations where insured persons go abroad expressly to receive treatment.
After having received treatment abroad, the insured person is obliged to inform the Managed Care doctor without delay.
The Managed Care insurance accepts the cost of childbirth abroad as laid down in the legislation if this is required to ensure the child gains citizenship rights.
The level of benefits is regulated by the Federal Law on Health Insurance (FLHI).

2.12 What applies in a situation with a number of insurers or liable third parties?
The insured is obliged to inform the insurer if other insurance companies or third parties are liable to pay benefits for an insured incident. The insured also has to inform the Insurer if benefits are received. The insurer has to be informed before any agreement to waive payments or benefits is signed. Insured persons are obliged to provide information about any claims they may have against other bearers of insurance or liable third parties.

2.13 How is the relationship between the insurer and other social insurers regulated?
The relationship between the Managed Care insurance and other social insurances is regulated in the legislation.

2.14 Do insured persons have to subrogate claims on third parties to the insurer?
From the date of the insured incident the insurer is subrogated to the rights of the insured in all claims of the insured on third parties to the extent of the statutory benefits.

2.15 How do you receive refunds?
Insured persons undertake to provide the insurer with a Swiss bank or post office account as the payment address. If insured persons neglect to inform the Insurer of such, the cost of payment has to be borne by the insured persons.

3. Premiums and participation in costs

3.1 What premiums do you have to pay?
The premiums for Managed Care insurance are arranged in compliance with the insurer's premium tariffs, which have been approved by the supervisory authorities. This tariff is calculated according to age group and is lower than that charged for regular basic insurance.
Individuals who are subject to the military insurance for more than 60 consecutive days are freed from the obligation to pay premiums from the day subjection to the insurance begins provided the insurer is notified at least eight weeks before they become subject to the insurance. If this deadline is ignored the insurer ceases to charge premiums from the date notification is received, but at the earliest when military service begins.

3.2 What are the existing age groups?
The following age groups have been established:
I. Children until completion of the 18th year of life
II. Insureds aged from 19 to the end of the 25th year of life
III. Insureds from the age of 26 upward
Transfer from age group I to II or from group II to III takes place at the end of the calendar year in which the insured completes his 18th or 25th year of life.

3.3 How much do you have to pay in participation?
According to the legislation
- Adults pay the annual deductible and an excess payment, which amounts to 10%* of the costs in excess of the deductible;
- Children pay 10%* in excess and the annual deductible if a deductible is chosen.

*An excess of 20% may be charged for certain original preparations and generic drugs.

The maximum annual excess payment for adults is CHF 700.– and for children CHF 350.–. If a number of children from the same family are insured with the same insurer, the total annual participation in costs for the children will not exceed the maximum sum of CHF 950.–.
The date of treatment is valid for calculating the deductible and the excess payments.

In addition to participation in costs, the law stipulates that a payment of CHF 15.– per day be made for cases of hospitalization.

3.4 What happens if you are in arrears with payments?

a) Premiums/participation in costs
If an insured person fails to pay premiums or shares of participation in costs when due, the insurer duns the insured and sets a time limit of 30 days for payment. If the insured person fails to pay outstanding premiums, shares in participation in costs and interest on arrears despite having received the dunning letter, the insurer shall begin a debt collection procedure. Simultaneously the insurer notifies the responsible cantonal agency. Five percent (5%) interest is payable on premium arrears.

b) Dunning notices
Dunning notices are sent in writing.

c) Costs
The cost of the debt collection procedure and other expenses incurred may be charged to the account of the insured who is in arrears. If a dunning notice is sent or the debt collection procedure started, a charge can be made for the expenses incurred.

d) Change of insurer
Insured persons who have not yet paid in full all outstanding premiums, amounts due for participation in costs, interest on arrears and expenses incurred in debt collection may not change to another insurer.

3.5 What benefits does the insurance not cover?

Benefits in excess of those foreseen by the legislation on the basic insurance are not covered.
A non-mandatory supplementary insurance is required to cover such benefits.

4. Admission

4.1 What are the conditions for admission to the insurance?

All persons insured with the Insurer domiciled in an area where the Insurer offers Managed Care insurance may transfer from the regular basic insurance to Managed Care insurance; the transfer can take place at any time. The civil law domicile determines whether persons live in an area where Managed Care insurance is offered.

5. Leaving the insurance

5.1 What periods of notice apply?

Managed Care insurance may be terminated in the regular manner at the end of a calendar year while observing a three-month period of notice. Notice of termination must be received by the insurer at the latest on the last working day before the period of notice begins. The right to terminate the insurance under extraordinary circumstances pursuant to Article 7 paragraphs 2 to 4 FLHI remains reserved.

5.2 What happens if you change your domicile?

If the new domicile is in a location where there is no Managed Care network, insured persons with Managed Care insurance are transferred to the regular basic insurance provided by the insurer; the transfer takes place at the beginning of the month following relocation. The insured person has to notify the insurer within one month of moving if he relocates to an area not served by the Managed Care network.
If insured persons relocate to an area in which the insurer operates a further Managed Care network, they are entitled to continue their Managed Care insurance within the new Managed Care network. The insurer should be notified within one month of the event if the insured moves out of the area served by the Managed Care network or if his insurance is continued by a new Managed Care network.

5.3 What happens if the Managed Care doctor dissolves the contract?

If the selected Managed Care doctor dissolves the contractual relationship with the insurer or the Managed Care operating company, insured persons registered with the doctor may choose to register with any Managed Care doctor or change to the regular basic insurance offered by the insurer within 30 days of receiving a written request to do so by the insurer. If the insurer is not notified of a new Managed Care doctor within the period stipulated, the insured person will be transferred automatically to the regular basic insurance offered by the insurer at the beginning of the following month.

5.4 What happens if the contract between the insurer and all the doctors in a Managed Care network is dissolved?

If the contract between the insurer and the company operating the Managed Care service or, respectively, all doctors in a Managed Care network, is dissolved, the Managed Care insurance (FLHI) ceases to exist. In the absence of notification to the contrary on the part of the insured person, the insured person shall be transferred to the insurer's regular basic insurance.

5.5 What happens if the Managed Care doctor can no longer provide care?

If the Managed Care doctor can no longer provide medical treatment because of a change in the insured person's circumstances (e.g. if an insured is admitted to a nursing home), the insurer is entitled to transfer the insured person to the insurer's regular basic insurance; the transfer takes place at the beginning of a calendar month and a 30 day period of notice is observed.

6. Transmission of data

6.1 What type of data is transmitted to others?

The insurer and the Managed Care operating companies and/or Managed Care doctors exchange data required for case management mutually as required. Such data may be transmitted by electronic means.
The insurer regularly sends lists of insured persons registered with a Managed Care doctor to the Managed Care operating company including the details of insurance of each customer insured by means of this type of insurance.
The operating company informs the insurer about further service providers to which Managed Care doctors refer individual insured persons.
The insurer sends each Managed Care doctor an overview of the medical benefits claimed by each insured person registered with him.

7. Duties of Managed Care insureds

7.1 How do you choose your Managed Care doctor?

Persons insured under Managed Care insurance select their Managed Care doctor from the specific list of Managed Care doctors.
The insured person may change doctor once at most within a calendar year; the change takes place at the beginning of a month and a period of notice of one month has to be observed. Persons insured under the Managed Care insurance are obliged to inform both the previous Managed Care doctor and the insurer about the change. They release the Managed Care doctor from the obligation to maintain patient confidentiality and authorize him to give information about treatment given and to pass on the patient's records to the new Managed Care doctor.

7.2 How do you proceed in an emergency?

In emergencies persons insured under the Managed Care insurance have to contact their Managed Care doctor.
If the doctor cannot be reached, they have to consult his deputy or the emergency service at their place of residence or wherever they are at the time. If persons insured under the Managed Care insurance are hospitalized in an emergency or if they receive treatment by an emergency doctor, they are obliged to inform their Managed Care doctor as soon as possible and to pass on the emergency doctor's report to him.

7.3 How should you proceed if you need stationary treatment?

Persons insured under the Managed Care insurance are obliged to get the approval of their Managed Care doctor before being admitted to acute hospitals (except in emergencies).

7.4 What duties do you have if you are referred to a specialist?

If persons insured under the Managed Care insurance are referred to a specialist by a Managed Care doctor and the specialist recommends that the insured consult a further doctor or be admitted to a stationary facility for treatment or diagnosis, Managed Care insureds are obliged to inform their Managed Care doctor and get his approval.

7.5 How should you proceed if you need to consult a gynecologist?

Insured persons may consult the gynecological and obstetric specialist of their choice in the domicile canton for preventive gynecological examinations and obstetric care. The Managed Care doctor advises the insured on the choice of a gynecologist. The insured is required to obtain the approval of the Managed Care doctor in advance for all other gynecological treatment.

7.6 Do you need approval for spa cures?

Obligatory benefits for spa cures are only paid if the cure has been prescribed or approved by the Managed Care doctor.

7.7 What right to information does your Managed Care doctor have?

Persons insured under the Managed Care insurance consent to the condition whereby the Managed Care doctor and the Managed Care operating company have access to the necessary data on treatment and invoicing concerning the insured person's medical treatment.

7.8 Penalties

If the insured is repeatedly in breach of the regulations, the insurer is entitled to exclude the insured from Managed Care insurance at the end of a calendar month; a one-month period of notice has to be observed. This results in the insured being automatically transferred to the regular basic insurance offered by the insurer. After an exclusion from Managed Care insurance, re-admittance is possible at the earliest at the beginning of the next calendar year.

8. Supplementary provisions

8.1 Who is responsible for issuing formal decisions and decisions on appeals?

Formal rulings and decisions on appeals are issued by the insurer.

8.2 Who is liable in cases of incorrect or inadequate medical treatment?

Neither the insurer nor the Managed Care company can be held liable for incorrect or inadequate medical treatment; the service provider is solely liable.

9. Enactment and entry into force

9.1 When do the GCI take force?

The General Conditions of Insurance (GCI) take force on 1.1.2021.
The insurer reserves the right to modify these conditions at any time.