



Terms and conditions of insurance

Edition 2012

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ÖKK BASIS

ÖKK Kranken- und Unfallversicherungen AG
General terms and conditions of insurance (AVB), Edition 1.1.2012

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1. Insurance fundamentals

1.1. Insurance carrier

The ÖKK Kranken- und Unfallversicherungen AG, Landquart (ÖKK) is the insurance carrier.

1.2. Legal basis

These General Conditions of Insurance (AVB), the Health Insurance Law (KVG) and the Swiss Federal Act on the on the general part of the Social Insurance Law (ATSG) apply.

1.3. Purpose

ÖKK BASIS is the compulsory health care insurance required according to KVG.

It provides benefits in the case of illness, accident and maternity.

2. Insurance

2.1. Insured persons

Persons, who reside in the territory covered by ÖKK are insured in particular. The group of persons insured is based on Art.3 KVG.

2.2. Acceptance procedure

2.2.1. Application

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

2.2.2. Insurance policy and AVB

The insured person receives an insurance policy and these AVB following acceptance.

2.3. Duration of insurance

The beginning and end of the insurance is in compliance with Art 5 KVG.

2.4. Change of domicile

2.4.1. General

ÖKK must be notified of changes of address and change of domicile within 30 days. Transfer of the place of residence as defined in civil law is regarded as a change of place of residence.

2.4.2. Moving abroad

Employees, who are sent abroad by a company with a registered office in Switzerland continue to be insured for two years and, on request, for 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 remain insured to the same extent.

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

If treatment is given in a member state of the EU, ÖKK BASIS provides the benefits according to the social insurance tariff applicable in the country concerned.

In other foreign countries, ÖKK pays up to a maximum of twice the amount of the tariff applicable at the last place of residence in Switzerland.

2.5. Accident cover

2.5.1. Suspension of insurance cover

Insured persons, who have compulsory insurance for occupational and non-occupational accidents may apply for suspension of the accident cover

The premium is adjusted at the beginning of the month following the application.

2.5.2. Withdrawal from the accident insurance

The insured persons have to inform ÖKK within a month if they withdraw from the accident insurance as per UVG.

2.6. Change of insurance types

The change of deductible is carried out at the beginning of a calendar year. In the case of a change-over to a lower deductible, it is possible to give three months' notice of termination to the end of a calendar year.

A change-over of ÖKK BASIS in ÖKK BASIS CASAMED or ÖKK BASIS ECOPLAN or vice versa is carried out at the beginning of a calendar month. In the case of a change-over from ÖKK BASIS CASAMED or ÖKK BASIS ECOPLAN in ÖKK BASIS the notice period of termination is three months to the end of a calendar year.

2.7. The end of the insurance contract

2.7.1. General

The insurance ends

- when notice is given;
- on moving abroad, except if the insurance obligation continues to apply;
- on death;
- on official deletion.

The statutory reasons for exclusion of infringement of obligations as an insured person remain reserved.

2.7.2. Notice of termination

The insured person may give three months advance notice to the end of a six month calendar year period.

When the new premiums are announced the insured person may give one month's notice of termination to the end of the month preceding the entry into force of the new premium.

In both cases, the date of receipt of the termination notice by ÖKK is decisive.

The insurance relationship with ÖKK only ends when the new insurance company informs that the insured person is insured with them without interruption to the insurance cover.

2.7.3. Consequences of termination of the insurance

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

The insured persons must meet their financial obligations towards ÖKK.

3. Benefits

3.1. General benefit conditions

3.1.1. Entitlement to claim

The entitlement to claim exists for the duration of the insurance.

3.1.2. Illness, accident, congenital defects, maternity benefits

ÖKK BASIS provides benefits for diagnosis and treatment of illnesses, accidents, congenital defects and maternity.

The benefits comprise in particular:

- medical and chiropractic examinations, treatments and care measures;
- medically prescribed pharmaceuticals, analyses and aids;
- medical or medically prescribed preventive measures;
- hospital stay according to the standard of the general ward;
- medical rehabilitation measures;
- nursing care in a nursing home;
- nursing benefits outside hospitals;
- medically prescribed spa treatment;
- rescue costs and medically required transport costs;
- dental treatment.
- maternity benefits

3.1.3. Benefits provided abroad

ÖKK BASIS provides benefits for treatments abroad in the case of an emergency. For treatment in a member state of the EU, ÖKK BASIS provides benefits according to the social insurance tariffs applicable there. In the country concerned. In other foreign countries, ÖKK BASIS provides benefits up to double the amount of the tariff applicable at the Swiss place of residence.

Frontier workers of both genders and other persons requiring compulsory insurance in Switzerland under the agreement on 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.

3.1.4. Condition of benefit payments

ÖKK BASIS covers 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 insured person's interest and they are necessary for the treatment purpose.

ÖKK may agree to accompanying measures with service providers in order to ensure the most effective, expedient and economical treatment for the insured person.

ÖKK provides benefits for recognised service providers as per KVG.

3.1.5. Billing, reimbursement

The insured person owes the service provider the services charged, if the bill is not directly settled between ÖKK and the service provider.

If the insured persons claim reimbursement from ÖKK, they have to submit invoices and prescriptions. After checking the entitlement to benefit, ÖKK reimburses the amount of the invoice minus the cost sharing to the insured person.

The insured person may ask ÖKK to verify invoices prior to payment.

3.1.6. Obligation to cooperate

The insured persons must do everything, which is conducive to the cure and desist from any action, which may delay the cure. In particular, they have to follow the instructions of medical personnel.

The insured person supports the health consultant's activities as part of ÖKK's accompanying measures and provide them with the necessary information.

Where medical or professional examinations are necessary and reasonable, the insured person must undergo such examinations. The insured persons must provide ÖKK with all information required to assess the claim and rate the insurance benefits at their own cost. In particular, the insured person shall report all benefits from third parties in the case of illness, accident or disability.

In individual cases, the insured person must authorise all persons and bodies, such as employers, medical practitioners, insurance companies and authorities to provide the information required to assess benefit claims, insofar as the person or bodies concerned are not already required by law to provide such information.

The insured person must agree to an examination by a second doctor or by the medical examiner of ÖKK. ÖKK bears the costs.

The insured persons must inform ÖKK about an accident at the latest within ten days. They provide ÖKK with all the necessary information.

If the insured person fails, in an inexcusable manner, to provide information or to cooperate, ÖKK may either rule on the benefit claim on the basis of the documents or refrain from examining the application for benefits.

3.2. Outpatients' treatment

3.2.1. Duration of benefits

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

3.2.2. Service provider

Recognised service providers are in particular:

- doctors;
- pharmacist;
- chiropractors;
- midwives;
- laboratories;
- issuing offices for means and objects;
- physiotherapists;
- ergotherapists;
- nurses;
- speech therapists.

3.2.3. Scope of benefits

ÖKK BASIS provides benefits for out-patient treatment according to the contracts and tariffs applicable at the place of residence or work of the insured person.

ÖKK BASIS provides benefits in line with the applicable contracts and tariffs for medically necessary out-patient treatment outside the place of residence or work of the insured person.

3.2.4. Choice of the service provider

The insured person may choose the service providers authorised to provide treatment in compliance with KVG.

Services are invoiced according to the contracts and tariffs between the service provider and ÖKK.

3.2.5. Medication

ÖKK BASIS provides benefits for medically prescribed medication as per the list of medicines with tariff (ALT/LMT) and the list of pharmaceutical specialities (SL/LS) of the Federal Department of the interior (EDI).

3.2.6. Analyses

ÖKK BASIS provides benefits for medically prescribed analyses, which serve diagnostic purposes or to verify a therapy, provided that they are included in the analysis list (AL) of the EDI and are performed by a pharmacist or a laboratory.

3.2.7. Aids

ÖKK BASIS provides benefits for means and objects as per means and objects list (MiGeL).

3.2.8. Alternative medicine

ÖKK BASIS provides benefits for medical alternative medical treatment as per healthcare benefit directive (KLV).

3.2.9. Preventive medicine

ÖKK BASIS provides benefits for examinations or measures prescribed by a doctor as per KLV, in particular children's vaccinations and gynaecological preventive examinations.

3.3. Inpatient treatment

3.3.1. Hospital

ÖKK BASIS provides benefits for acute in-patient treatment and medical rehabilitation in line with the standard of the general ward of a hospital.

The insured person can choose a hospital in Switzerland, which is listed on a hospital list of a canton (listed hospital).

ÖKK BASIS provides benefits up to the amount of the tariff, which applies in a listed hospital in the canton of residence.

ÖKK BASIS provides benefits for medically required treatment and in the case of an emergency up to the amount of the tariff applicable in the listed hospital of the location canton of residence.

ÖKK BASIS provides benefits for treatment in a half-private and private ward of a listed hospital up to the amount of the tariff applicable in the general ward of a listed hospital in the canton of residence.

3.3.2. Confirmation of assumption of costs, reimbursement

ÖKK confirms to the insured person to assume the costs provided the diagnosis for hospital admission is available as part of their benefit entitlement.

3.4. Nursing care

ÖKK BASIS provides benefits for medically prescribed out-patient nursing care, which are provided by organisations outside the hospital or nurses at the insured person's home.

ÖKK BASIS provides benefits for medically prescribed nursing services in a recognised nursing home pursuant to Art. 39 para. 3 KVG.

3.5. Spa treatment

ÖKK BASIS provides benefits of up to CHF 10 per day, up to 21 days per calendar year for a medically prescribed spa treatment.

The insured person can choose a recognised therapeutic spa managed by a doctor in Switzerland.

ÖKK BASIS also provides benefits, if the insured person is not staying in the therapeutic spa as an in-patient.

ÖKK is to be sent the medical prescription with diagnosis two weeks prior to starting the spa treatment.

ÖKK BASIS provides benefits in cases where the spa treatment is interrupted if the interruption was caused by an illness or other

compelling reasons and a certificate has been issued to that effect by the spa doctor.

3.6. Transport and rescue costs

ÖKK BASIS provides benefits of 50%, up to CHF 500 per calendar year of the costs of a medically required transport.

ÖKK BASIS provides benefits of 50%, up to CHF 5'000 per calendar year of the costs of a rescue operation in Switzerland.

3.7. Dental treatment

ÖKK BASIS provides benefits for dental treatment caused by severe illness and accidents as per KLV.

ÖKK BASIS provides benefits in line with the contractual and tariff agreements, if the dentist is authorised to carry out treatments as per KVG and a diagnosis, treatment plan and cost estimate are available.

3.8. Maternity

3.8.1. Scope of benefits

ÖKK BASIS provides benefits for medically prescribed and necessary examinations performed by doctors or midwives during the pregnancy and for ten weeks after the birth. Without special medical indication a maximum of seven examinations during the pregnancy and one subsequent check-up will be reimbursed.

ÖKK BASIS provides benefits for a home birth, birth in a hospital or in a maternity clinic as per contractual or tariff agreements.

3.8.2. Nursing costs for the child

ÖKK BASIS of the mother provides benefits for the nursing costs of the child as long as the child is in the hospital with the mother, if it is insured with ÖKK.

3.8.3. Antenatal courses and advice on breastfeeding

ÖKK BASIS provides benefits up to CHF 100 for an antenatal course and reimburses the costs of up to three consultations on breastfeeding.

3.9. Limitations of benefits

3.9.1. Reduction and cessation of the benefits

For the treatment of illnesses or consequences of an accident which are covered by a different insurance or by a third party, no entitlement to benefits exists.

The benefits may be temporarily or permanently reduced or, in serious cases, withheld if the insured person fails to undergo reasonable treatment, refuses such treatment or fails to cooperate of their own accord.

In the first instance, a written warning must be issued to the insured person, who will then be notified that the benefits will be reduced or withheld.

3.9.2. Excessive billing and uneconomical treatment

In the event of excessive billing or uneconomical treatment, ÖKK can withhold or reduce its payment. It may make its payment conditional on assignment of the claim to a reduction. Reimbursements, which have already been made, may be claimed back from the service provider by ÖKK or by the insured person.

3.9.3. Obligation to repay

Benefits drawn in error or without justification may be claimed back by ÖKK.

3.10. Third party benefits, excessive compensation

3.10.1. Third party benefits

If a third party is liable for an illness or an accident by law, or on the basis of a contract or negligence, the insured person's claims against the third party shall be transferred to ÖKK to the extent of the benefits provided.

If other social insurances have an obligation to provide benefits, ÖKK has a duty to pay in advance.

3.10.2. Excessive compensation

Benefits from social insurance schemes and from other parties liable to provide benefits, must not exceed the costs caused to the insured person by the insurance case.

In the case of excessive compensation, ÖKK reduces their benefits.

4. ÖKK BASIS CASAMED

4.1. Purpose

ÖKK BASIS CASAMED is a special type of ÖKK BASIS. The choice of service providers is limited.

4.2. Principle

ÖKK specifies the general practitioners, who are generally entrusted with the treatment of the insured persons (general practitioner principle).

Telemedical institutions may be approved by ÖKK as CASAMED medical practitioners.

It is possible to change the general practitioner. The insured person or insured need to be informed. The documents required for treatment are forwarded to the new general practitioner.

ÖKK can restrict the choice of doctors, therapists or other service providers such as hospitals, pharmacies, medical supply stores.

ÖKK can stipulate an age limit for treatment by paediatricians.

ÖKK BASIS CASAMED provides benefits, if the service is provided or prescribed by the general practitioner, with whom the insured person is registered. If they carry out subsequent treatment, the general practitioner is to be consulted.

ÖKK BASIS CASAMED does not provide benefits, if the service is provided by a service provider, who cannot be selected. The insured person bears the costs.

ÖKK can transfer the insured person to the ÖKK BASIS in the case of repeated conduct in breach of the regulations.

If the general practitioner cannot ensure the treatment due to long-term physical absence of the insured person, ÖKK can carry out an immediate transfer to ÖKK BASIS.

4.3. Exceptions

ÖKK BASIS CASAMED provides benefits for routine treatment by ophthalmologists, gynaecologists and paediatricians without prior consultation of the CASAMED practitioner. If they carry out subsequent treatment, the general practitioner is to be consulted.

ÖKK BASIS CASAMED provides benefits in emergencies without restrictions in the choice of doctors or other service providers. The insured persons inform their general practitioner about the emergency within 20 days.

The verification of the medical indication by a medical examiner remains reserved.

5. ÖKK BASIS ECOPLAN

5.1. Purpose

ÖKK BASIS ECOPLAN is a special type of ÖKK BASIS. The choice of hospitals is limited.

5.2. Principle

ÖKK specifies the hospitals, which are generally entrusted with the treatment of the insured persons.

ÖKK BASIS ECOPLAN does not provide benefits, if the service is provided by a hospital, which cannot be selected. The insured person bears the costs.

ÖKK can transfer the insured person to the ÖKK BASIS in the case of repeated conduct in breach of the regulations.

if the responsible hospital cannot ensure the treatment due to long-term physical absence of the insured person, ÖKK can carry out an immediate transfer to ÖKK BASIS

5.3. Exceptions

ÖKK BASIS ECOPLAN provides benefits for treatments, which can not be provided by a ECOPLAN hospital

ÖKK BASIS CASAMED provides benefits in emergencies without restrictions in the choice of hospitals.

Verification of the medical indication by a medical examiner remains reserved.

6. Cost sharing

6.1. Standard cost sharing

6.1.1. Deductible and retention

Insured persons contribute to the costs of the service provided to them with a deductible and retention.

The deductible is CHF 300 per calendar year for adults. It is not applicable for children.

The retention is 10 % of the services in excess of the deductible, maximum CHF 700 for adults and CHF 350 for children per calendar year.

The cost sharing of all children of a family insured with ÖKK BASIS of a family is limited to CHF 1'000 per calendar year.

Cost sharing does not apply to maternity.

6.1.2. Retention for medication

The insured person generally contributes 10% when using medication. For original pharmaceuticals, which are considerably more expensive than the active ingredient composition, a retention of 20 % applies. Details are governed by the Healthcare service regulation (KLV).

6.1.3. Hospital contribution

The insured person contributes to the stay in hospital with an amount of CHF 15 per day.

Children up to and including 18 years of age, young adults up to and including 25 years of age, if they are in education, and women receiving maternity services, are exempt from paying this contribution.

6.2. Optional deductible

The insured person can choose a higher deductible instead of the standard deductible

Adults	CHF 500
	CHF 1'000
	CHF 1'500
	CHF 2'000
	CHF 2'500
Children	CHF 200
	CHF 400
	CHF 600

Some optional deductibles are not offered in all insurance variants

The cost sharing of all children of a family insured with ÖKK BASIS is limited to twice the maximum amount (optional deductible and retention) of the cost share for one child.

if children have different optional deductibles, the deductible is determined based on the highest deductible for all children of one family insured in the in ÖKK BASIS.

7. Premium

7.1. Premium rating

ÖKK specifies the premiums. The premiums may be graduated according to local cost differences.

7.2. Premium reduction

Reduced premiums apply:

- up until and including the 18th year of age;
- up until and including the 25th year of age;
- on suspension of the accident cover
- with optional deductible;
- in ÖKK BASIS CASAMED;
- in ÖKK BASIS ECOPLAN.

7.3. Premium discounts

The individual premium reduction is in accordance with Art.65 KVG.

7.4. Premium exemption during military and civilian service

insured persons are exempt from paying premiums if they are subject to the military insurance (MV) for more than 60 consecutive days.

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

7.5. Additional contributions

For periods, in which exceptional claims are made, ÖKK may charge additional contributions.

7.6. Payment

7.6.1. Due date and payment period

The premium is to be paid in advance. The shortest payment period is the calendar month. The premiums are payable without inter-

ruption, also in the case of illness, accident, incapacity to work or when the entitlement to claim lies dormant. If the insurance begins or ends in the course of a calendar month, the entire premium for the month is due.

7.6.2. Late payment

If insured persons do not pay outstanding premiums or cost sharing, ÖKK will send them a request for payment after a minimum of one reminder in writing. In it, ÖKK stipulates an extension to the due date of thirty days and informs insured persons about the consequences of delayed payments. If insured persons do not pay their premiums, cost sharing and arrears interest within the deadline stipulated, ÖKK will initiate debt recovery.

As long as insured persons have not paid outstanding premiums, cost sharing as well as the arrears interest and debt recovery costs in full, they cannot change the insurance company.

7.6.3. Pledging and assignment

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

8. Group insurance

8.1. General

ÖKK can conclude collective insurance contracts for specific groups of persons.

8.2. Alternative conditions

Persons covered by group insurance are in principle subject to the same benefits and premiums as individual insureds.

The insurance conditions can differ from these AVB. The conditions of the collective insurance contract take precedence over these AVB.

Alternative conditions primarily concern:

- simplified affiliation procedure
- another premium payment mode;
- the group insurance partner as premium payer
- the transfer of the obligation to inform to the group insurance partner;
- different procedure for processing benefits and cost shares;
- simplified procedure for accident exclusion.

8.3. Transfer to individual insurance

An insured person, who ceases to belong to the group of persons covered by the group contract or whose group contract lapses, continues to be insured by the individual insurance scheme.

9. Legal matters

9.1. Ruling

If an insured person or an applicant do not agree to a decision, ÖKK will issue a reasoned written ruling with an indication of legal means of recourse on request within 30 days.

9.2. Appeal

An appeal can be made against this ruling to ÖKK within 30 days of notification. ÖKK verifies the appeal and issues a reasoned

written decision on the appeal with an indication of the means of legal redress.

9.3. Cantonal insurance court

An appeal may be made against the decisions on objections to the cantonal insurance court within 30 days of notification of the decision on the objection.

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 ruling.

The insurance tribunal of the canton where the insured person or the appellant resides is responsible. An appeal may also be made to the insurance court if ÖKK fails to issue a ruling or a decision on an objection within the specified time limit.

Where the place of residence of the insured person or the appellant third party is situated abroad, the insurance tribunal of the canton, in which the last Swiss place of residence was situated or in which the last Swiss employer had its registered office is responsible. If neither of these places can be determined, the insurance tribunal at ÖKK's registered office is responsible.

9.4. Legal force

The ruling or decision on an objection handed down by ÖKK takes full legal effect if the period allowed for objection or appeal has not been used or if the appeal has been rejected with due force of law. Rulings concerning payments are enforceable court judgments within the meaning of Art. 80 of the Law on Debt Collection and Bankruptcy (SchKG).

9.5. Legal protection

In the event of disputes relating to fee matters between the insured person and the service providers pursuant to KVG, ÖKK may, at the request of the insured person represent him at his expense in the responsible courts providing the legal application does not appear to be futile.

10. Final provisions

10.1. Amendments

The insured person is notified about amendments to these AVB by written notice in the member's journal or by way of official publication.

10.2. Entry into force

These AVB will come into force on 1.1.2012 and supersede those dated 1.1.2011.

Common Provisions

ÖKK Versicherungen AG, Edition 1.1.2012

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1. Insurance fundamentals

1.1. Principle

By way of addition to the KVG illness 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 ÖKK Versicherungen AG, Landquart (referred to below as the Insurer).

The ÖKK PROTECT legal protection insurance for patients is provided by COOP Rechtsschutz AG, Aarau.

The ÖKK risk capital insurance in the event of death or disability caused by accident is provided by SOLIDA Versicherungen AG, Zurich.

The ÖKK risk capital insurance in the event of death or disability caused by illness is provided by Schweizerische National Leben AG, Bottmingen.

The responsible Health Insurance Fund is the Health Insurance Fund named on the insurance policy (referred to below as the Fund).

1.3. Purpose of the insurance

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

Where this is stipulated in provisions of the individual insurance departments, accident cover may be excluded.

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 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 in-surance departments differ from the general conditions, the provisions of the individual insurance department take priority.

1.5. Conditions governing the 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 in respect of the division of rights and obligations between the policyholder and the insured person.

The provisions of the group agreement take priority of the general insurance conditions.

1.6. Insurance contract act

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:

- ÖKK GENERAL SUPPLEMENT and ÖKK PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- ÖKK KOMBI: GENERAL, SEMI-PRIVATE, PRIVATE, PRIVATE ACCIDENT, GLOBAL, FLEX, KOMFORT
- ÖKK FAMILY
- ÖKK FAMILY FLEX
- ÖKK SALTO
- ÖKK MONDIAL
- ÖKK DENTAL
- ÖKK TOURIST
- ÖKK PROTECT
- ÖKK Risk capital in the event of death or disability caused by accident
- ÖKK Risk capital in the event of death or disability caused by illness
- ÖKK COMPENSA
- ÖKK GIA DAILY ALLOWANCE

Individual insurance departments are managed with CASAMED and/ or ECOPLAN variants.

2.2. Changes in the insurance departments

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

2.3. Choice of insurance departments

The insurance policy states the insurance departments chosen. Special provisions or agreements which differ from the general insurance conditions are likewise stated in the insurance policy.

3. Insured persons

3.1. Individual insurance

The persons listed in the insurance policy benefit from insurance.

3.2. Group insurance

The insured or insurable persons are specifically designated in the group contract.

The persons or groups of persons listed in the insurance policy are insured.

4. Commencement and duration of insurance

4.1. Procedure for taking out insurance

4.1.1. Application

The application to take out the insurance is made in writing on the pre-printed Fund form. The questions put on the form must be answered in full and truthfully.

Persons who are not authorized to act themselves can only be insured by their legal representative.

4.1.2. Obligation to provide information

If incorrect or incomplete indications are given in the application, the insurer may give notice to terminate the contract within four weeks of the date on which he becomes aware of the breach of the obligation to notify.

In the event of cancellation of the contract, the obligation of the insurer to provide benefits for claims which have already been made lapses if their occurrence or scope has been influenced by the significant risk circumstance which was not notified or was incorrectly notified. If the benefit has already been provided, the insurer is entitled to a refund.

By making the application to conclude the insurance policy the applicant authorizes the Fund to seek information from medical practitioners and other insurers needed to conclude the insurance and clarify any subsequent obligation to provide benefits.

The 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. Documents

When the insurance is taken out, the policy holder receives:

- the insurance policy
- the general terms and conditions of insurance

4.1.4. Right of cancellation

The application to take out the insurance may be withdrawn within 14 days of the date of signing. If a declaration of cancellation is made, all the obligations on the part of the insurer lapse.

If the content of the insurance policy, or of the supplements thereto, does not coincide with the agreements reached, the policyholder must ask for them to be corrected within 4 weeks of receipt of the document, failing which the content shall be deemed to have been approved by him.

4.2. Start of insurance

Insurance begins on the date confirmed on the insurance policy.

4.3. Duration of the insurance

4.3.1. General

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

4.3.2. Longer insurance period

If an 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 to the remaining duration of insurance.

4.3.4. Extension of insurance

The insurance contract is extended tacitly by one further year after the end of each year, unless notice of termination is given by the policyholder, respecting the stipulated period for notice.

4.4. Changes to the insurance

4.4.1. Changes requested by the policy holder

Applications for amendment of the insurance contract with

increased cover or applications for which a health declaration is required are treated as an application for a new insurance contract.

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

4.4.2. Changes made 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.

These new contractual conditions will be notified to the policyholder 30 days in advance. 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 shall be deemed to have consented to the new contract conditions.

4.5. Suspension of the 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 same procedure applies to the agreement on suspension as to the conclusion of a new insurance. During the suspension period a reduced premium is charged.

4.5.2. Duration and scope of suspension

Suspension begins after the application has been made and at the earliest at the start 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 suspension may be requested. If the insurer cannot agree to such extension the contract shall lapse.

In the case of residence abroad, the contact address must be given in Switzerland.

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 the insurance

5.1. Termination by the policy holder

5.1.1. Ordinary termination

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

5.1.2. Termination in the event of a claim

After every claim for which the insurer has provided benefits, the policyholder may withdraw in writing from the relevant part of the

contract within 14 days of the outpayment or of his becoming aware of the acceptance of services by the insurer. The premium is payable until the termination of the contract.

5.1.3. Right of transfer on termination of the group contract
Insured persons whose cover lapses by reason of termination of the group contract are entitled to change to individual insurance without 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 his statutory right to terminate on expiry of the contract or to withdraw from the contract if a claim is made. The right of termination of group contracts is an exception. Similarly, withdrawal from the contract on grounds of breach is reserved.

5.3. Other reasons for termination

The insurance likewise expires in the following cases:

- a) on the death of the insured person
- b) on removal abroad (except for frontier workers or if a ÖKK MONDIAL is taken out)
- c) on reaching the age limit stipulated for insurance cover
- d) on definitive exhaustion of the rights to draw all the benefits in an insurance department
- e) if the contract is not extended after reaching the maximum insurance term in ÖKK MONDIAL or in the event of a suspension
- f) in the cases stipulated by law, in particular if there is an outstanding premium, in the event of deception or significant increase in risk on the part of the policy holder or insured persons.

6. Benefits

6.1. Definition of terms

6.1.1. Illness

Illness 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 incapacitation from work.

6.1.2. Accident

Accident means the sudden, unintentional harmful influence 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) laceration of a muscle
- e) strained muscle
- f) rupture of a tendon
- g) lesions of a ligament
- h) injuries to the ear-drum

Injuries to objects which were inserted following an illness and replace a body part or a body function and which are not caused by accident do not constitute physical injury within the meaning of the above paragraph.

Occupational illnesses, which are acknowledged as accidents under the UVG, are likewise classified as accidents.

6.1.3. Maternity

Benefits in connection with pregnancy and childbirth are insured in the same way as illness if the insurance with the insurer had already been in force for at least 270 days for the mother at the time of the birth, or in the event of equivalent previous insurance by another insurer if the insurance application was submitted to the Fund at least 270 days before the birth.

6.2. Scope of benefits

6.2.1. Geographical scope of benefits

The insurance applies in principle to benefits provided in Switzerland and emergency treatment worldwide. The rules on geographical validity set out in the insurance provisions of the individual insurance departments take priority.

For frontier workers, the insurance protection also exists for benefits provided at their place of residence.

6.2.2. Time during which benefits are provided

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.

The date of treatment or the time at which the insured benefit is claimed are the decisive factors.

6.3. Insured benefits

6.3.1. Scope of benefits

Benefits according to the cover stated in the insurance policy and the provisions for individual insurance departments are insured.

6.3.2. Economical treatment

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

In the interest of optimum treatment of its insured persons, ÖKK may agree accompanying measures with the approved service providers with a view to the provision of the most effective, expedient and economical treatment for the assured person through improved cooperation and coordination between the service providers and ÖKK. ÖKK may instruct a health consultant to take these measures.

Where invoices are manifestly exaggerated, the insurer may reduce his benefits accordingly or make his payment conditional on an assignment of the claim to a reduction.

6.3.3. Treatment by acknowledged medical personnel

Treatment by medical personnel or medical institutions is insured if they are recognized under 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. Limitations of benefits

6.4.1. Pre-existing illnesses and accidents

Where a higher insurance is selected, there are no restrictions in the new insurance section or class on those benefits that were

already covered in the previous insurance section.

The insurer may exempt illnesses and consequences of accidents which exist at the time of conclusion of the insurance, or had previously existed, from insurance cover.

The limitation of cover will be notified to the insured person in writing.

6.4.2. Exclusion of benefits

No entitlement to insurance benefits exists

- a) for illnesses and the sequels of accidents which already existed at the time when the insurance was taken out and were excluded by the insurer from the insurance cover
- b) for illnesses and sequels of accidents which already existed when the application was made and were either not stated at all or only partly stated
- c) during a waiting period
- d) if a treatment does not serve to remedy a health problem or its consequences. Measures to prevent the threatened occurrence or deterioration of a health problem are reserved if the patient was already ill
- e) for treatment by a service provider not recognized by the insurer
- f) for dental treatment where the insurance compartment concluded does not expressly provide cover
- g) in the event of suspension of the insurance
- h) in the event of late payment, from the expiry of the reminder period until all the obligations have been settled in full
- i) in case of participation in warlike actions, unrest and similar events and during military service abroad
- k) in the event of illness and accidents as a consequence of acts of war whose outbreak dates back more than 14 days
- l) in the case of illness and accidents as a consequence of active participation in punishable actions, fights and other acts of violence
- m) for the consequences of earthquakes and other natural disasters
- n) for health damage as a consequence of major industrial incidents or accidents involving nuclear power
- o) for organ transplants for which the Swiss Association for the Community Tasks of Health Insurers (SVK) Solothurn has agreed flat-rate sums, regardless of the place where the transplant is effected
- p) for statutory and agreed cost participations by the compulsory health care insurance
- q) for epidemic diseases.

All further exclusions of benefits are covered by the provisions governing the individual insurance department.

6.4.3. Limitations of benefits

Benefits can be reduced

- a) in the event of wilful infringement of obligations by the policy holder or insured person
- b) in the event of the illness or accident being caused by gross negligence, in particular by the misuse of alcohol, medicines and other drugs

- c) in the event of health damage caused by a deliberate action, i.e. if the insured person exposes himself to a particularly serious risk without taking preventive measures or without the possibility of reducing the risk to a reasonable level. Rescue actions for persons are an exemption. In particular, participation in motor vehicle races or training for such races are treated as risks for the purpose of this provision
- d) if the health damage was caused deliberately, even as a consequence of attempted suicide or personally inflicted injury
- e) if the documents needed to ascertain the insurance claim are not produced within four weeks despite a written reminder to do so.

7. Obligation to participate in the event of illness and accident

7.1. Compulsory notification

The insured persons must submit their claims to benefits to the Fund on time in accordance with the provisions governing the 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, all information must be provided to the Fund with the necessary medical and administrative particulars. Only detailed original bills will be accepted.

7.2. Reduction of claims

The insured person must do everything possible to reduce the claim, in particular take all action conducive to a cure and desist from anything which may delay the cure.

The insured person will assist the activity of the health consultant in the framework of accompanying measures taken by ÖKK and will give that consultant the necessary information.

7.3. Obligation to provide information

The insured person releases the medical practitioners and other medical persons and insurers from their obligation of discretion to the Fund. The 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 consulting practitioner to the Fund. The insurer will pay the costs.

The insured person must give information to the Fund on all benefits provided by third parties in the event of illness, accident and disability. On request, invoices issued by third parties must be submitted to the Fund.

In the case of persons who are incapacitated, the policyholder must see to it that the obligation to provide information is respected.

8. Premiums and payments

8.1. Fixing the premiums

8.1.1. General

The premiums are set out in a premium scale for each insurance department.

8.1.2. Amount of premiums

The amount of the premiums is fixed in proportion to the risk, taking into account e.g. the age of the insured person.

Premium changes due to a change in the risk group are made automatically.

If the insured person fails to satisfy the obligation to report changed personal circumstances which determine premium calculation, any difference in the premium is due retroactively.

A reduced premium is charged for suspended insurance.

8.1.3. Premium discounts and premium waivers

ÖKK can waive the premium or grant family discounts for children and young adults up to the age of 25.

Family discount

Children, who have taken out a basic or supplementary insurance with ÖKK together with at least one parent under the same family policy are entitled to a discount.

A minimum duration of three years applies to contracts for children and parents in order to benefit from a family discount, during which time the afore-mentioned prerequisites have to be simultaneously and permanently met. Otherwise, the entitlement to a discount expires and the regular premium is owed for the remaining term of the contract.

Waiving the premium

ÖKK can grant premium exemptions for supplementary insurances from the third child providing it

- lives in the same household with one parent and both older siblings;
- is insured under the same family policy with ÖKK;
- has taken out basic insurance with ÖKK;
- the two older siblings have taken out basic insurance and at least equivalent supplementary insurance with ÖKK as well as;
- one parent has taken out basic insurance with ÖKK and supplementary insurances of an ÖKK outpatient or inpatient treatment cost insurance.

8.2. Adjustment of premium scales and cost sharing

The premium scales and cost sharing may be adjusted to the trend of costs and the pattern of claims.

Premium adjustments are notified to the policyholders 30 days in advance. The policyholder is entitled to withdraw from the relevant insurance compartment within 30 days of notification by the Fund from the date on which the premium adjustment is due to take effect.

If no notice of termination is given this is treated as consent to the premium adjustment.

If the insured persons lose their entitlement to a discount without a change in the discount conditions, this is not considered a premium adjustment. If the discount conditions change, the right to cancel applies.

8.3. Premium payment

8.3.1. Due date

Premiums are payable in advance. The premiums must be paid without interruption, i.e. in the event of accident, illness, preg-

nancy and maternity, incapacitation from work or when the entitlement to claim rests.

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 premium payment obligation or the obligation to pay the cost share is not satisfied by the policyholder within a further period of 30 days, a written reminder will be issued to settle the outstanding premiums or cost shares within 14 days. The reminder calls the attention of the policyholder to the consequences of failure to make the payment.

The costs of reminders and any additional administrative costs incurred as a result of outstanding payments shall be met by the insured party.

If no payment is made, despite the reminder, the obligation to provide benefits for treatment or loss of income shall rest from the expiry of the warning period until complete settlement of the outstanding premiums, together with interest and administrative costs.

For illnesses, accidents and their sequels which occur while the obligation to provide benefits is resting no insurance cover will exist even if the amount outstanding is subsequently paid.

The insurer may withdraw from the contract from 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 will lapse.

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 profit, i.e. net profit of the insurer.

8.4.2. Condition

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

8.4.3. Outpayment

Any profit share is paid at the earliest on the expiry of one year after the calendar year in which no claims have been made in the form of a single non-recurring payment. It can only be made to persons who are insured at the time of the outpayment.

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.

8.5.2. Departments with no-claims bonus

In the KOMBI Departments, excluding those with a discretionary excess, a variant with a no-claims bonus is available.

8.5.3. Observation period

The period between 1 September or the commencement of insurance and the following 31 August is regarded as the observation period. The date of processing a bill determines the recording of benefits in the observation period.

8.5.4. Bonus stages

In the KOMBI and ÖKK SALTO insurance versions with no-claims

bonus the following bonus stages or discounts apply:

Bonus stage	Premium NCD KOMBI/ÖKK SALTO
0	Premium ordinary KOMBI/ÖKK SALTO +20%
1	Premium ordinary KOMBI/ÖKK SALTO
2	Premium ordinary KOMBI/ÖKK SALTO -30% In HMO variant: Premium ordinary KOMBI/ÖKK SALTO -20% up to -30%

The premium for the KOMBI and ÖKK SALTO with no-claims bonus is stated on the insurance policy. The fixing of the three bonus stages may be adjusted to the trend of costs.

8.5.5. Adjustment of stages if no claims are made

If the insured person has not made any claims for three successive observation periods in the same bonus stage in the case of KOMBI with no-claims bonus, from 1 January of the 4th year an adjustment will be made by one stage unless the insured person is already in the maximum bonus stage 2.

8.5.6. Stage adjustment if benefits are claimed

If the insured person has claimed benefits during an observation period, the adjustment by one stage shall be made with effect from 1 January of the following year (maximum to discount stage 0).

8.5.7. Maternity benefits

The costs of hospital treatment for maternity and home help after birth do not count for calculation purposes; these costs are not regarded as benefits and therefore do not have any impact on the stage adjustment.

8.5.8. Higher insurance

In the case of classification in bonus stage 0 or bonus stage 1 and a simultaneous outstanding benefit claim, the change from KOMBI with no-claims bonus to ordinary KOMBI is possible only with a health declaration. This also applies to the change to ordinary KOMBI and simultaneous reduction to a lower benefit stage.

8.6. Other payment provisions

8.6.1. Offsetting

The insurer may offset any benefits against claims on the insured person or policyholder.

The insured person or the policyholder have no right to offset against the insurer.

8.6.2. Pledging and assignment

Claims on the insurer cannot be pledged or assigned without his assent.

8.6.3. Outpayment of benefits

Save where otherwise agreed between the insurer and the benefit provider, the insured person must pay the fee to the benefit providers.

If other agreements and charge scales exist between the insurer and the benefit provider, direct payment will be made by the Fund to said providers. In the event of direct payment to the benefit providers by the Fund, the insured person is required to reimburse to the Fund the agreed cost participation within 30 days of billing.

Fee agreements between the biller 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 benefit providers.

Unduly paid benefits will be claimed back by the insurer.

8.6.4. Time-barring

The benefit claim of the insured person on the insurer is time-barred within two years of the occurrence of the event on which the obligation of the insured to provide benefits was based.

9. Benefits provided by third parties

9.1. Subsidiarity

9.1.1. General

If a third party is liable by law or fault for a notified case of illness or accident, the insurer shall not be liable or shall only be liable for that part of the benefits which is 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 the cantonal and local authorities.

9.1.3. Multiple insurance

Where several insurers are liable to provide benefits, a calculation will be made to determine how much each insurer would have had to pay had he been solely responsible. This provision likewise applies if the obligation to provide benefits of the other insurers only exists subsidiarily. The compensation payable under these conditions is limited to the part of the overall insurance which corresponds to this cover.

9.1.4. Waiver of benefits

Where insured persons waive in whole or in part benefits on third parties without the consent of the insurer, the obligation to provide benefits under these conditions of insurance lapses. Capitalization of a benefit claim is also treated as a waiver.

9.2. Social insurance

No benefits are provided where these can be claimed against social insurance schemes (KV, UV, IV, MV, AHV, AVI etc.). The benefit claim must be made to the appropriate social insurance 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 on third parties to the insurer in the amount of the benefits provided.

9.4. Over-insurance

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

10. Data protection

10.1. Legal provisions

Processing of data about insured persons shall be governed by the

provisions of the Insurance Contract Act (Ger. VVG) of 2 April 1908 and the Federal data protection law of 19 June 1992.

10.2. Purpose of processing

The insurer only processes data (e.g. personal data, information on medical condition, verification of the statements in the application, collection, settlement of benefits) that are necessary for processing the insurance contract according to the VVG. The insurer treats obtained information with complete confidentiality.

10.3. Passing on data to third parties for processing

The insurer may pass on data processing completely or partially to a third party (e.g. data processing centre). If data processing is entrusted to a third party, the insurer shall see to it that the data are only processed in the same way as he would be permitted to do himself.

In other cases, the insurer provides information only with the consent of the insured person.

10.4. Storage of data

The insurer shall store the data carefully and take appropriate technical and organisational measures to prevent unauthorised access to the data.

11. Notifications

Changes in the personal circumstances of the insured persons, which are material to the insurance, such as a change of place of residence, must be notified to the Fund within 30 days in writing.

In the event of residence abroad a contact address in Switzerland must be given. All notifications by the policyholder or the insured person must be addressed to the business office of the Fund.

Notifications by the Fund or the insurer are made with legal validity in writing or by means of the house journal for insurees to the insured person or policyholder at their last known address or at the contact address in Switzerland.

12. Place of jurisdiction

In the case of disputes arising from insurance provided pursuant to these terms and conditions and any special provisions, the person bringing the action may refer the matter to the courts at the Swiss place of residence, at the places of business of the insurer (ÖKK-Versicherungen AG, Landquart) or at that of the Fund.

ÖKK GENERAL SUPPLEMENT and ÖKK PRIVATE SUPPLEMENT

ÖKK Versicherungen AG, Edition 1.1.2012

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1. Fundamentals of insurance

1.1. Purpose

The GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT provide benefits for medical treatment elsewhere than at the place of residence or work, for preventive measures, remedial aids, dental treatment, alternative therapeutic and treatment methods, spa treatment, transport costs, search and rescue actions, non-compulsory pharmaceuticals; a breast feeding allowance is also payable.

The PRIVATE SUPPLEMENT also insures the costs of treatment by doctors who have not affiliated under KVG and are therefore not otherwise covered. It also makes contributions to alternative medical care abroad and travel costs.

The benefits are provided as a supplement to all the other insurance compartments of these general terms and conditions of insurance.

The benefits of compulsory health care insurance (BASIS) take priority over those provided under this insurance compartment.

1.2. Insured persons

All persons can take out insurance under the GENERAL SUPPLEMENT without any age limit. The PRIVATE SUPPLEMENT can be concluded until the 60th birthday.

1.3. Condition for benefits

Benefits are paid only if the treatment is necessary for medical reasons and performed by persons who are recognized for this purpose by the insurer. Information must be sought from the Fund on the recognition of appropriate persons.

1.4. Benefits abroad

The benefits under the PRIVATE SUPPLEMENT are also paid abroad except where otherwise specified.

2. Medical treatment

2.1. Treatment elsewhere than at the place of residence or work

Treatment by KVG Fund doctors elsewhere than at the place of residence or work of the insured person is covered in full as an addition to the BASIS benefits according to the KVG scale valid at the place of treatment.

2.2. Treatment by medical practitioners without KVG affiliation

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

A maximum of 50 hours psychotherapeutic treatment will be reimbursed.

2.3. Private consultations with hospital doctors who are not affiliated under KVG

The PRIVATE SUPPLEMENT provides benefits for outpatients' consultations with senior university hospital doctors who are not affiliated to KVG at the recognized KVG charge scale.

A maximum of 50 hours psychotherapeutic treatment will be paid for under the PRIVATE SUPPLEMENT at the KVG scale.

2.4. Medical treatment abroad

2.4.1. Elective treatment

In the case of medical treatment abroad, the PRIVATE SUPPLEMENT covers the costs up to a maximum of twice the KVG charge scale at the place of residence of the insured person. For persons bene-fiting from global insurance, full cost cover is provided according to the normal local rate.

A maximum of 50 hours psychotherapeutic treatment will be reimbursed.

2.4.2. Emergency treatment

In the case of emergency medical treatment abroad, full costs are covered under the PRIVATE SUPPLEMENT in addition to the BASIS benefits.

2.5. Duration of benefits

Except where otherwise provided in the terms and conditions for the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT, the benefits are payable for an unlimited time.

3. Prevention

3.1. Vaccinations

90% of the effective cost of vaccinations for protection against infection is reimbursed, subject to a maximum of CHF 200.- per calendar year. No benefits are provided for vaccinations which are undertaken for occupational reasons whose effect is medically contested or which is still in the research stage.

3.2. Check-ups

After two successive calendar years without claiming benefits, a contribution will be paid as follows under BASIS to the proven costs of a check-up examination:

GENERAL SUPPLEMENT: 90% of costs subject to a max. of CHF 300.-

PRIVATE SUPPLEMENT: 90% of costs subject to a max. of CHF 600.-

3.3. Precautionary gynecological examinations

The costs of a precautionary gynecological examination are insured per calendar year at the KVG charge rate, provided that no benefits under BASIS are paid out in the same calendar year.

3.4. Maternity

3.4.1. Preparation for the birth

Towards the proven costs of a birth preparation course including rehabilitation gymnastics with a qualified professional, a maximum payment of CHF 200.- will be made for each pregnancy.

3.4.2. Breast-feeding allowance

An entitlement to a breast-feeding allowance of CHF 250.- exists. This allowance is paid out if the insured mother breast feeds her child for ten weeks, either in whole or in part. Evidence must be provided on the Insurance Fund breast-feeding allowance form.

3.5. Courses in behaviour conducive to good health

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

GENERAL SUPPLEMENT: 90% of costs subject to a max. of CHF 300.-

PRIVATE SUPPLEMENT: 90% of costs subject to a max. of CHF 500.-

The insurer designates the recognized courses to learn forms of behaviour conducive to good health. The list of acknowledged courses is constantly adjusted or supplemented and can be inspected at any time at the Insurance Fund.

3.6. Other preventive measures

Contributions are payable to further preventive measures.

4. Remedial aids

4.1. Visual aids

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

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 aids

50% of the costs of the rental or purchase price of acknowledged remedial aids for which no benefits are provided under BASIS can be reimbursed subject to a maximum total of CHF 250.- per calendar year if a medical indication exists. The insurer designates the recognized remedial aids. The list of such recognized aids is constantly adapted or supplemented and can be inspected at the Fund at any time.

Costs incurred for operation, maintenance and repair of these aids are not insured.

5. Dental care

5.1. Wisdom teeth

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital in-patient, the costs are covered up to the amount of the contractually fixed tariffs of the 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:

- costs of a check-up, including x-ray, subject to a maximum of CHF 60.- per calendar year, provided that dental treatment

(conservation, prosthetics etc.) does not have to be performed at the same time

- costs of orthodontic treatment at the acknowledged 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 an insurance period of at least three years. A condition for the benefit is the presentation of a diagnosis of the existing anomaly in the position of the teeth, the proposed means of treatment and a cost estimate.

If an equivalent prior insurance exists when the contract is signed ÖKK does not require a waiting period, provided that at least one parent is also insured with ÖKK. Benefits already drawn from the previous insurers are imputed against the above benefits.

5.3. Public benefits

Benefits are paid to supplement any other benefits provided by the cantonal and local authorities, according to their respective legislation on public dental care. The contributions by the cantonal and local authorities are offset against the benefits of this insurance compartment.

5.4. Benefit providers and charge scales

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

The term "dentist" denotes a person who is in possession of the relevant Federal or equivalent diploma, or if the canton has granted a licence to exercise the profession on the basis of a certificate of scientific qualification.

5.5. Treatment abroad

The benefits are still provided if treatment is given in a neighbouring country of Switzerland. The term neighbouring country means a country which has a common border with Switzerland.

6. Alternative medicine

6.1. Medical treatment

Under the GENERAL SUPPLEMENT and the PRIVATE SUPPLEMENT ÖKK pays 90% of the costs of medical treatment for the alternative medicine methods stated below:

- anthroposophic medicine
- Chinese medicine
- homeopathy
- neural therapy
- phytotherapy

The doctors must have completed approved further training in the corresponding method.

6.2. Empiric medical methods

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

6.3. Alternative therapists and cures

ÖKK pays contributions to treatment of alternative medicine under the condition that the method of therapy as well as the administering therapist or nature doctor are acknowledged by ÖKK. Contributions are paid as follows:

GENERAL SUPPLEMENT: subject to a maximum of CHF 70.- per hour of therapy (60 minutes)

PRIVATE SUPPLEMENT: subject to a maximum of CHF 100.- per hour of therapy (60 minutes)

The insurer designates the acknowledged forms of therapy and the therapists. The lists of acknowledged forms of therapy and of the therapists are constantly adjusted or supplemented and can be inspected at the Fund at any time.

No costs are paid for forms of therapy and treatments by therapeutic personnel included on the insurer's negative list (NL).

The Fund will fix the number of hours subject to medical necessity for which payments are made.

6.4. Additional benefits PRIVATE SUPPLEMENT

Under the PRIVATE SUPPLEMENT, a maximum contribution of CHF 50.- per hour of therapy (60 minutes) and a maximum of CHF 1,000.- per calendar year, is paid towards the proven costs of further treatment given by qualified persons.

Alternative medical treatment provided in a neighbouring country to Switzerland is covered in compliance with the above provisions up to a maximum of the charge habitually made at the place of treatment.

6.5. Natural cures

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

6.6. Maximum benefits

Benefits in the alternative medicine sector are limited by the

- amount of the contribution per hour of therapy;
- number of hours of therapy;
- list of alternative therapy methods acknowledged by the ÖKK;
- list of therapeutic practitioners or nature doctors acknowledged by the ÖKK;
- contribution to the costs of medical treatment and natural curative agents;
- time limitation (per calendar year).

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

Total benefits in the alternative medicine sector amount to the following maximum:

GENERAL SUPPLEMENT: CHF 3,000.- per calendar year

PRIVATE SUPPLEMENT: CHF 6,000.- per calendar year

6.7. Condition for benefits

The benefits are payable after prior application has been submitted to the Fund. The right to have a medical consultant of the Fund review the indication and the qualification of the doctors and therapeutic specialists is reserved. Benefits may be made conditional on the absence of any simultaneous parallel treatment.

7. Non-compulsory pharmaceuticals

The costs of pharmaceuticals which are not included on the pharmaceutical list with the charge scale (ALT) or on the speciality list (SL) according to KVG or on the insurer's negative list (NL) will be paid as follows in each calendar year:

GENERAL SUPPLEMENT: 50% subject to a maximum of CHF 2,500.-

PRIVATE SUPPLEMENT: 90% subject to a maximum of CHF 5,000.-

8. Spa treatment

A contribution of 50% to the cost of a maximum 12 admissions is paid to medically prescribed hydrotherapy in a spa per calendar year.

9. Psychotherapeutic treatment

9.1. Scope of benefits

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 the cantonal authorization to pursue an independent practice. For the first 50 hours, the insurance pays a maximum share of CHF 60.- and CHF 50.- to subsequent hours.

9.2. Condition for benefit

The benefits are paid after approval of the application for reimbursement by the consultant medical officer. After the expiry of the number of hours of treatment approved by the fund, but at the latest at the end of the first 50 hours of therapy, the therapeutic specialist must report again to the consultant medical officer on the progress of the therapy and the therapy plan.

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

These psychotherapeutic benefits are provided from this insurance compartment only until they are covered as obligatory benefits under BASIS.

10. Transport costs, search and rescue actions, travel expenses

10.1. Transport costs, search, rescue and recovery actions in an emergency

10.1.1. Scope of benefits

A contribution of up to a total of CHF 15,000.- per calendar year is payable to the costs of

- medically necessary emergency transport to the nearest suitable hospital by an appropriate means of transport;
- repatriation to a suitable hospital in the canton in which the insured person resides for the purpose of treatment as an in-patient;
- for search and rescue actions.

Transport by aircraft is only authorized if it is essential for medical or technical reasons.

10.1.2. Excess

The insured person is liable for an excess of CHF 100.- in respect of each claim.

10.1.3. Search actions

In addition to the costs of rescue or recovery of an insured person, costs for search actions up to a maximum of CHF 20,000.- per calendar year are payable.

10.1.4. Third party benefits

If membership (patronage) of an air rescue service exists, costs will only be eligible for reimbursement to the extent that these organizations have not provided any benefits. Other contractual agreements are reserved.

10.2. Travel costs

GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT cover 90% of the costs incurred during regular medical treatment elsewhere than at the place of residence for the use of public means of transport between the place of residence and the place of treatment. A condition for benefit is that the appropriate treatment cannot be provided at the place of residence or in the immediate vicinity. A maximum of CHF 100.- is payable per calendar year.

The PRIVATE SUPPLEMENT covers 90% of the taxi costs incurred for transport between the place of residence and the place at which outpatient's treatment is provided. A condition for benefit is that the insured person must be incapable for medical reasons of using public means of transport or his own private vehicle. A maximum of CHF 400.- is payable per calendar year.

11. CASAMED variant

11.1. General

The following additional provisions apply to insured persons who benefit from BASIS insurance with ÖKK in the CASAMED variant.

11.2. General condition for benefits

The benefits of the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT are paid if the services are provided according to the medical practitioner principle. These services must be provided, prescribed or occasioned by the CASAMED medical practitioner

with whom the insured person is registered.

Telemedical institutions may be approved by ÖKK as CASAMED medical practitioners.

11.3. Doctors who are not KVG affiliated

The CASAMED variant of the PRIVATE SUPPLEMENT pays no benefits for treatment by doctors (including hospital doctors) who are not affiliated under KVG and for elective medical treatment abroad.

11.4. Exceptions to the medical practitioner principle

GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT provide benefits for routine treatments of ophthalmologists, gynaecologists and paediatricians without prior consultation of CASAMED medical practitioners. The CASAMED medical practitioner is to be consulted if the treatment continues.

GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT provide benefits for alternative medical treatments, preventive treatments as part of a course for health promoting behaviour, birth preparation, transport, search, rescue and recovery, dental check-ups without consulting the CASAMED medical practitioner.

11.5. Other specialists

The Fund may designate instead of the CASAMED practitioner other specialists who may provide, prescribe or arrange the benefits covered by the GENERAL SUPPLEMENT and the PRIVATE SUPPLEMENT.

11.6. Preventive measures, alternative medicine, non-compulsory pharmaceuticals

The insurer may authorize the CASAMED medical practitioner or the designated specialists to provide other preventive measures, alternative medical benefits or non-compulsory medicines, or to prescribe or arrange such treatment other 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 insurer may designate other service providers such as chemists, therapeutic personnel, health care stores or similar service providers to which medical treatment or supplies for CASAMED insurance holders must be entrusted exclusively.

11.8. Emergencies

Despite the choice of service provider, emergencies are covered within the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT framework. However, a review of the medical indication by the medical consultant is reserved.

11.9. Exclusion of benefits

If the insured person addresses himself for treatment to a service provider, who is not on the authorized list, except in an emergency, all costs will be charged to him.

11.10. Processing benefits

11.10.1. Flat rate settlement

The insurer or Fund may agree with CASAMED practitioners that the benefits under the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT will be paid on a flat rate basis.

11.10.2. Prescribed benefits

In the case of prescribed benefits, the Fund may require evidence from the insured person or from the CASAMED medical practitioner, before reimbursement of the costs, that the service was in fact performed according to the medical practitioner principle.

If a service provider to whom the member was referred by the CASAMED medical practitioner wants to make a further referral, he will have to ask the responsible CASAMED practitioner for his consent.

ÖKK or CASAMED cooperation partners may provide electronic appliances to the service providers which will allow fast and safe communication between service providers as well as perfect co-ordination and control of services.

ÖKK makes sure to observe the provisions of personal data protection.

12. Cost share

An excess of 10% is charged on the benefits under this insurance compartment, provided that such benefits are not limited or unless otherwise stipulated in a particular case.

In the event of elective medical treatment abroad (PRIVATE SUPPLEMENT), an annual excess equivalent to the ordinary excess stipulated in KVG is levied on insured persons above the age of 18.

In the event of alternative medical treatment by doctors, an annual excess equivalent to the ordinary KVG excess may be levied on insured persons above the age of 18.

ÖKK OPTIMA

ÖKK Versicherungen AG, Edition 1.1.2010

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Where the GTC do not mention the female form, the male form explicitly includes all female persons.

1. Bases of the insurance

1.1. Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (Insurer).

1.2. Common provisions

The common provisions (CP) of the Insurer are an integral part of these general terms and conditions of insurance (GTC). In case of conflicting regulations, the GTC take priority over the CP.

1.3. Purpose

The insurance provides benefits for outpatient treatments in case of illness, accident and maternity as well as emergency cases abroad.

The insurance provides benefits for medical and dental treatments, preventative measures, aids, alternative remedies and treatment methods, transport costs, search, rescue and recovery actions, non-compulsory pharmaceuticals, natural remedies and pays nursing mother's allowance.

The insurance provides benefits as supplement to the compulsory health care insurance according to the Health Insurance Act (Ger. KVG). Of the total costs, the maximum share payable is the portion which is not covered by a social insurance.

1.4. Qualification for benefits

The Insurer will only pay benefits if the treatment is indicated for medical reasons and performed by persons who are approved by the Insurer for doing so.

1.5. Geographical scope

The Insurer provides benefits in Switzerland, if not determined otherwise.

1.6. Conclusion of the insurance

The insurance coverage can be taken out until the completion of the 60th year of life.

2. Outpatient treatment

2.1. Medical treatment

The insurance pays 90% of the costs for medical treatments by KVG approved physicians. The KVG rate in effect at the place of treatment will apply.

2.2. Medical treatment in case of an emergency abroad

The insurance pays medical treatments in case of an emergency abroad during a temporary stay abroad.

2.3. Psychotherapy by non-medical practitioners

2.3.1. Scope of benefits

The insurance pays 50% of the costs, up to CHF 1,000 per calendar year, for the treatment of mental diseases by qualified psychotherapists who are not physicians and have a cantonal licence to practice independently.

2.3.2. Qualification for benefits

The insurance pays benefits after approval of the cost transfer request by the medical examiner.

The insurance does not pay benefits in case of psychotherapies which are carried out for the purpose of self-realisation, personal development or for learning purposes.

The insurance does not pay benefits for concurrent treatments by further psychologists or psychiatrists.

2.4. Thermal bath

The insurance pays 50% of the costs for a maximum of twelve entrance fees per calendar year for visits prescribed by a physician.

2.5. Sterilisation

The insurance pays 50% of the costs, up to CHF 1,000, for sterilisation and vasectomy of adults.

3. Maternity

3.1. Birth preparation

The insurance pays up to CHF 100 per pregnancy for birth preparation courses (incl. antenatal and post-natal exercises) held by a skilled specialist.

3.2. Nursing mother's allowance

The insurance will pay CHF 150, if the mother breastfeeds her child for ten weeks.

4. Prevention

4.1. Gynaecological preventative medical check-up

The insurance will pay 90% of the costs for a gynaecological preventative medical check-up according to KVG at the KVG rate per calendar year, if no benefits for a corresponding preventative examination have been provided under the health care insurance according to KVG during the current calendar year.

4.2. Check-up examinations

The insurance pays 90% of the costs, up to CHF 300 per calendar year, for medical check-up examinations.

4.3. Vaccination

The insurance pays 90% of the costs, up to CHF 200, for medically approved vaccinations.

4.4. Health account

The insurance pays 50%, up to CHF 200 per calendar year per field, for selected preventative measures in the fields of nutrition, exercise and other preventative measures.

If preventative measures of several fields are used, the insurance will pay up to CHF 400 per calendar year.

The contribution paid for individually approved preventative measures may be limited.

The preventative measures and courses must be approved by the Insurer.

5. Aids

5.1. Visual aids

The insurance pays up to CHF 150 per calendar year for spectacle and contact lenses required for visual correction.

5.2. Other aids

The insurance pays 50% of the costs, up to CHF 250 per calendar year, for medically prescribed aids for which no benefit is paid under the health care insurance according to the KVG.

The aids must be approved by the Insurer.

Costs arising from operation, maintenance and repair of aids are not covered.

6. Dental treatment

6.1. Check-up and prophylaxis

The insurance pays up to CHF 60 per calendar year for dental check-up treatments incl. X-rays or dental prophylaxis for children and adolescents up to the age of 25.

6.2. Wisdom teeth

The insurance pays 90% of the costs for the extraction of wisdom teeth.

In case of an in-patient treatment, the insurance will pay the costs up to the amount of the contractually fixed rates of the general ward in the canton of residence.

6.3. Orthodontic treatment

The insurance pays 70%, up to CHF 5,000, for orthodontic treatments of children and adolescents up to the age of 25 pursuant to the agreed rate.

The benefits for orthodontic treatment will be provided, if an insurance duration of at least three years (qualifying period) is given.

The qualifying period does not apply, if a previous insurance of equal value exists upon conclusion of the contract.

6.4. Treatment abroad

The insurance provides benefits, if the treatment is provided in a neighbouring country of Switzerland.

6.5. Rate

The insurance pays benefits based on the rate pursuant to KVG applicable to dental services.

The Insurer will take into account contributions paid by the canton and the communities. The insurance will pay in excess of these payments.

7. Alternative medicine

7.1. Alternative medicine treatment

The insurance pays 70% of the costs, up to CHF 3,000 per calendar year, for alternative medicine treatment, if both the method

of therapy (e.g. Ayurveda, TCM, natural remedy methods) as well as the therapist or physician providing treatment are approved by the Insurer.

The Insurer denotes the approved forms of therapy and therapists and physicians. The Insurer will maintain a list of approved forms of therapy.

The insurance will pay 50% of the costs, up to CHF 500 per calendar year for further alternative medicine treatments provided by qualified persons.

The verification of the medical indication and the qualification of physicians and therapists by the medical examiner remains reserved.

The insurance does not pay benefits for several concurrent alternative medicine treatments without added-on value.

7.2. Treatment abroad

The insurance provides benefits, if the treatment is provided in a neighbouring country of Switzerland.

8. Pharmaceuticals and remedies

8.1. Non-compulsory pharmaceuticals

The insurance pays 70% of the costs for medically prescribed pharmaceuticals which are not listed in the pharmaceuticals list with rate (ALT), the specialty list (SL) pursuant to KVG or the negative list of the Insurer.

8.2. Natural remedies

The Insurer pays 70% of the costs for phytotherapeutic, homeopathic and anthroposophical remedies as well as oligosols to the extent that they are not on the Insurer's negative list.

9. Transport costs, search, rescue and recovery costs

9.1. Transport costs, rescue and recovery costs in emergency cases

9.1.1. Scope of benefits

The insurance will pay the costs for

- medically required emergency transports to the nearest appropriate hospital,
- the return transport to an appropriate hospital in the canton of residence of the insured person for in-patient treatment,
- rescue and recovery actions of an aggregate amount of up to CHF 50,000 per calendar year.

Transports in aircrafts will only be paid if they are medically necessary.

9.1.2. Excess

The excess amounts to CHF 100 per case.

9.1.3. Benefits of third parties

The insurance does not pay costs for transports which are covered by a membership (patronage) with an air rescue service or similar organisations.

9.2. Search actions

The insurance pays CHF 20,000 per calendar year for search actions in addition to the benefits for rescue or recovery.

9.3. Travel expenses

The insurance pays 90%, up to CHF 100 per calendar year, for the use of public transport between the place of residence and the place of treatment, if the treatment cannot be provided at the or within 30 kilometres of the place of residence.

10. CASAMED variant

10.1. Additional conditions

For insureds who have limited their choice of health care providers in the health care insurance pursuant to the KVG, following additional conditions will apply.

10.2. General practitioner principle

The insurance will pay benefits pursuant to the general practitioner principle for treatments to be provided, prescribed or initiated by the general practitioner chosen by the insured person.

The Insurer may accept telemedical institutions as general practitioners.

10.3. Exceptions from the general practitioner principle

The insurance will pay the costs for routine treatments of ophthalmologist, gynaecologists and paediatricians without consultation of the general practitioner. If these physicians provide further treatments, the general practitioner is to be consulted.

The insurance will pay the costs for alternative medicine treatments, preventative measures within the limits of the health account, birth preparation, transport, search, rescue and recovery, dental check-up treatments without consultation of the general practitioner.

10.4. Hospitals

The Insurer may denote hospitals which are exclusively entrusted with the care for persons insured with CASAMED.

10.5. Other specialists

Instead of the general practitioner, the Insurer may denote other specialists who provide, prescribe or initiate the treatments.

10.6. Further health care providers

The Insurer may denote further health care providers such as pharmacies, therapists, sanitary speciality shops or similar health care providers exclusively entrusted with the medical treatment or care of persons insured with CASAMED.

10.7. Emergency

The insurance covers emergencies irrespective of the general practitioner principle.

The verification of the medical indication by the medical examiner remains reserved.

10.8. Disqualification for benefits, exclusion from CASAMED variant

10.8.1. Disqualification for benefits

If the insured person seeks treatment with a health care provider not eligible, all costs are to be borne by the insured person, except in the finally listed exceptions.

10.8.2. Exclusion from CASAMED variant

The Insurer may reallocate the insured person from the CASAMED variant into the ordinary insurance variant in case of repeated behaviour violating the provisions.

10.9. Benefit payment

10.9.1. Flat-rate payment

The Insurer may agree with the general practitioner that the benefits are paid on a flat rate basis.

10.9.2. Prescribed treatments

In case of prescribed treatments, the Insurer may request proof from the insured person or the CASAMED general practitioner that the treatment has been provided pursuant to the general practitioner principle.

ÖKK PREMIUM

ÖKK Versicherungen AG, Edition 1.1.2010

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Where the GTC do not mention the female form, the male form explicitly includes all female persons.

1. Bases of the insurance

1.1. Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (Insurer).

1.2. Common provisions

The common provisions (CP) of the Insurer are an integral part of these general terms and conditions of insurance (GTC). In case of conflicting regulations, the GTC take priority over the CP.

1.3. Purpose

The insurance provides benefits for outpatient treatments in case of illness, accident and maternity as well as emergency cases abroad.

The insurance provides benefits for medical and dental treatments, preventative measures, aids, alternative remedies and treatment methods, transport costs, search, rescue and recovery actions, non-compulsory pharmaceuticals, natural remedies and pays nursing mother's allowance.

The insurance provides benefits as supplement to the compulsory health care insurance according to the Health Insurance Act (Ger. KVG). Of the total costs, the maximum share payable is the portion which is not covered by a social insurance.

1.4. Qualification for benefits

The Insurer will only pay benefits if the treatment is indicated for medical reasons and performed by persons who are approved by the Insurer for doing so.

1.5. Geographical scope

The Insurer provides benefits in Switzerland and abroad, if not determined otherwise.

1.6. Conclusion of the insurance

The insurance coverage can be taken out until the completion of the 60th year of life.

2. Outpatient treatment

2.1. Medical treatment

The insurance pays 90% of the costs for medical treatments.

2.2. Medical treatment in case of an emergency abroad

The insurance pays medical treatments in case of an emergency abroad during a temporary stay abroad.

2.3. Psychotherapy by non-medical practitioners

2.3.1. Scope of benefits

The insurance pays 50% of the costs, up to CHF 1,000 per calendar year, for the treatment of mental diseases by qualified psychotherapists who are not physicians and have a cantonal licence to practice independently.

2.3.2. Qualification for benefits

The insurance pays benefits after approval of the cost transfer request by the medical examiner.

The insurance does not pay benefits in case of psychotherapies which are carried out for the purpose of self-realisation, personal development or for learning purposes.

The insurance does not pay benefits for concurrent treatments by further psychologists or psychiatrists.

2.4. Thermal bath

The insurance pays 50% of the costs for a maximum of twelve entrance fees per calendar year for visits prescribed by a physician.

2.5. Sterilisation

The insurance pays 50% of the costs, up to CHF 1,000, for sterilisation and vasectomy of adults.

2.6. Laser eye surgery

The insurance will make a one-time payment of CHF 1,000 for laser eye surgery for visual correction for adults from the age of 18, if an insurance duration of at least three years (qualifying period) is given.

3. Maternity

3.1. Birth preparation

The insurance pays up to CHF 200 per pregnancy for birth preparation courses (incl. antenatal and post-natal exercises) held by a skilled specialist.

3.2. Nursing mother's allowance

The insurance will pay CHF 250, if the mother breastfeeds her child for ten weeks.

4. Prevention

4.1. Gynaecological preventative medical check-up

The insurance will pay 90% of the costs for a gynaecological preventative medical check-up according to KVG at the KVG rate per calendar year, if no benefits for a corresponding preventative examination have been provided under the health care insurance according to KVG during the current calendar year.

4.2. Check-up examinations

The insurance pays 90% of the costs, up to CHF 500 per calendar year, for medical check-up examinations.

4.3. Vaccination

The insurance pays 90% of the costs, up to CHF 300, for medically approved vaccinations.

4.4. Health account

The insurance pays 50%, up to CHF 300 per calendar year per field, for the costs of selected preventative measures in the fields of family, nutrition, exercise and other preventative measures.

If preventative measures of several fields are used, the insurance will pay up to CHF 600 per calendar year.

The contribution paid for individually approved preventative measures may be limited.

The preventative measures and courses must be approved by the Insurer.

5. Aids

5.1. Visual aids

The insurance pays up to CHF 200 per calendar year for spectacle and contact lenses required for visual correction.

5.2. Other aids

The insurance will pay 50% of the costs, up to CHF 300 per calendar year, for medically prescribed aids for which no benefit is paid under the health care insurance according to the KVG.

The aids must be approved by the Insurer.

Costs arising from operation, maintenance and repair of aids are not covered.

6. Dental treatment

6.1. Check-up and prophylaxis

The insurance pays up to CHF 100 per calendar year for dental check-up treatments incl. X-rays or dental prophylaxis.

6.2. Wisdom teeth

The insurance pays 90% of the costs for the extraction of wisdom teeth.

In case of an in-patient treatment, the insurance will pay the costs up to the amount of the contractually fixed rates of the general ward in the canton of residence.

6.3. Orthodontic treatment

The insurance pays 70% for orthodontic treatments of children and adolescents up to the age of 25 pursuant to the agreed rate.

The benefits for orthodontic treatment will be provided if an insurance duration of at least three years (qualifying period) is given. The qualifying period does not apply, if a previous insurance of equal value exists upon conclusion of the contract.

6.4. Treatment abroad

The insurance provides benefits, if the treatment is provided in a neighbouring country of Switzerland.

6.5. Rate

The insurance pays benefits based on the rate pursuant to KVG applicable to dental services.

The Insurer will take into account contributions paid by the canton and communities. The insurance will pay in excess of these payments.

7. Alternative medicine

7.1. Alternative medicine treatment

The insurance pays 70% of the costs, up to CHF 10,000 per calendar year, for alternative medicine treatment, if both the method of therapy (e.g. Ayurveda, TCM, natural remedy methods) as well as the therapist or physician providing treatment are approved by the Insurer.

The Insurer denotes the approved forms of therapy and therapists and physicians. The Insurer will maintain a list of approved forms of therapy.

The insurance pays 50% of the costs, up to CHF 1,000 per calendar year, for further alternative medicine treatments provided by qualified persons.

The verification of the medical indication and the qualification of physicians and therapists by the medical examiner remains reserved.

The insurance does not pay benefits for several concurrent alternative medicine treatments without added-on value.

7.2. Treatment abroad

The insurance provides benefits, if the treatment is provided in a neighbouring country of Switzerland.

8. Pharmaceuticals and remedies

8.1. Non-compulsory pharmaceuticals

The insurance pays 90% of the costs for medically prescribed pharmaceuticals which are not listed in the pharmaceuticals list with rate (ALT), the specialty list (SL) pursuant to KVG or the negative list of the Insurer.

8.2. Natural remedies

The Insurer pays 90% of the costs for phytotherapeutic, homeopathic and anthroposophical remedies as well as oligosols to the extent that they are not on the Insurer's negative list.

9. Transport costs, search, rescue and recovery costs

9.1. Transport costs, rescue and recovery costs in emergency cases

9.1.1. Scope of benefits

The insurance will pay the costs for

- medically required emergency transports to the nearest appropriate hospital,
- the return transport to an appropriate hospital in the canton of residence of the insured person for in-patient treatment,
- rescue and recovery actions

of an aggregate amount of up to CHF 100,000 per calendar year.

Transports in aircrafts will only be paid if they are medically necessary.

9.1.2. Excess

The excess amounts to CHF 100 per case.

9.1.3. Benefits of third parties

The insurance does not cover costs for transports which are covered by a membership (patronage) with an air rescue service or similar organisations.

9.2. Search actions

The insurance pays CHF 20,000 per calendar year for search actions in addition to the benefits for rescue or recovery.

9.3. Travel expenses

The insurance pays 90%, up to CHF 400 per calendar year, for the use of public transport between the place of residence and the place of treatment, if the treatment cannot be provided at the or within 30 kilometres of the place of residence.

10. CASAMED variant

10.1. Additional conditions

For insureds who have limited their choice of health care providers in the health care insurance pursuant to the KVG, following additional conditions will apply.

10.2. General practitioner principle

The insurance will pay benefits pursuant to the general practitioner principle for treatments to be provided, prescribed or initiated by the general practitioner chosen by the insured person.

The Insurer may accept telemedical institutions as general practitioners.

10.3. Exceptions from the general practitioner principle

The insurance will pay the costs for routine treatments of ophthalmologist, gynaecologists and paediatricians without consultation of the general practitioner. If these physicians provide further treatments, the general practitioner is to be consulted.

The insurance will pay the costs for alternative medicine treatments, preventative measures within the limits of the health account, birth preparation, transport, search, rescue and recovery, dental check-up treatments without consultation of the general practitioner.

10.4. Hospitals

The Insurer may denote hospitals which are exclusively entrusted with the care for persons insured with CASAMED.

10.5. Other specialists

Instead of the general practitioner, the Insurer may denote other specialists who provide, prescribe or initiate the treatments.

10.6. Further health care providers

The Insurer may denote further health care providers such as pharmacies, therapists, sanitary speciality shops or similar health care providers exclusively entrusted with the medical treatment or care of persons insured with CASAMED.

10.7. Emergency

The insurance covers emergencies irrespective of the general practitioner principle.

The verification of the medical indication by the medical examiner remains reserved.

10.8. Disqualification for benefits, exclusion from CASAMED variant

10.8.1. Disqualification for benefits

If the insured person seeks treatment with a health care provider not eligible, all costs are to be borne by the insured person, except in the finally listed exceptions.

10.8.2. Exclusion from CASAMED variant

The Insurer may reallocate the insured person from the CASAMED variant into the ordinary insurance variant in case of repeated behaviour violating the provisions.

10.9. Benefit payment

10.9.1. Flat-rate payment

The Insurer may agree with the general practitioner that the benefits are paid on a flat rate basis.

10.9.2. Prescribed treatments

In case of prescribed treatments, the Insurer may request proof from the insured person or the CASAMED general practitioner that the treatment has been provided pursuant to the general practitioner principle.

ÖKK KOMBI

ÖKK Versicherungen AG, Edition 1.1.2012

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1. Fundamentals of insurance

1.1. Purpose

The purpose of KOMBI insurance is to cover costs of treatment in intensive care hospitals in the event of illness, accident and maternity which would not otherwise be covered. It also makes contributions to spa treatment, prolonged courses of treatment, home help outside the hospitals (SPITEX) and transport costs.

The purpose of KOMBI private accident insurance is to pay the costs of treatment in the private ward of an emergency hospital in the event of an accident for which no other cover exists. It also pays contributions to spa treatment, home help outside the hospital (SPITEX) and transport costs.

The KOMBI benefits are paid out in addition to the compulsory benefits of the compulsory health care insurance pursuant to KVG (BASIS). Of the total costs, the maximum share payable is the proportion which is not covered by BASIS or by a different compulsory health care insurance. Existing hospital daily allowance and/or hospital treatment cost insurance provided by ÖKK Versicherungen AG take priority over the KOMBI benefits.

1.2. Conclusion of the insurance

KOMBI can be taken out up to the 60th birthday.

KOMBI Private Accident can only be taken out or used in conjunction with one of the following insurance sections of ÖKK:

- ÖKK GENERAL SUPPLEMENT
- ÖKK PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- ÖKK FAMILY
- ÖKK FAMILY FLEX
- ÖKK KOMBI

1.3. Condition for benefit

1.3.1. General

Benefits are paid only if the treatment is necessary for medical reasons and is given in an intensive care hospital. The treatment must be provided by service providers who are acknowledged by KVG.

1.3.2. Intensive care hospital

An intensive care hospital is an establishment which is able to provide the medical and nursing services and has the technical infrastructure needed to treat illnesses, accidents and for births which necessitate continuous medical monitoring. Hospital treatment must also be given in hospitals which appear on a cantonal hospital list pursuant to Art. 39 KVG.

1.3.3. Treatment in other hospitals

Benefits are insured pursuant to Sections 2.1.4. and 2.2. for treatment in other hospitals.

1.4. Accident cover

Accident cover may be excluded from the KOMBI insurance (with the exception of KOMBI Private Accident).

KOMBI Private Accident insurance is designed to pay the costs of treatment in the private ward of an emergency hospital in the event of an accident which would otherwise not be covered.

1.5. Insurance possibilities

1.5.1. Levels of benefits

The following benefit levels are available under KOMBI:

KOMBI General: General ward of an acute hospital with an acknowledged charge scale throughout Switzerland (room with several beds).

KOMBI Semi-private: Semi-private ward of an acute hospital with a recognized charge scale throughout Switzerland (two bed room).

KOMBI Private: Private department of an acute hospital throughout Switzerland (single bed room).

KOMBI Private Accident:

- Emergency treatment in the event of an accident: private ward of an emergency hospital anywhere in the world.
- Treatment of accident sequels: private ward of an emergency hospital anywhere in Switzerland in the event of an accident.

KOMBI Global: Private ward of an acute hospital, anywhere in the world (single bed room).

KOMBI Flex: General or semi-private ward of an acute hospital with an acknowledged charge scale throughout Switzerland of the patient's choice or private ward of an acute hospital throughout Switzerland of the patient's choice; an appropriate cost share will be payable.

KOMBI Komfort: Medical acute treatment and care in Komfort contractual hospitals in compliance with KOMBI General (general ward). The costs of a stay are covered depending on the insured cover in a room with one or two beds.

The KOMBI Komfort benefit level may be confined to insured persons residing in a particular region.

1.5.2. Hospitals with recognized charge scale

Hospitals with a recognized charge scale are those with which the insurer has reached agreements on charges or hospitals, which apply these charges without any special agreement. The Fund has a list of hospitals with acknowledged charge scales. This list is available for inspection at any time.

1.5.3. Hospitals under contract with KOMBI Komfort

Hospitals under contract are those with which the insurer has reached appropriate agreements on definition of the charge scale. The insurance fund has a list of these contractual hospitals. It is constantly adjusted and can be consulted at the Fund at any time.

1.5.4. Absence of criteria, maximum charges

If a hospital has no allocation criteria for hospital wards or applies criteria which differ from those set out in these provisions, these wards will be treated as private departments for insurance purposes. The insurer may fix maximum charges for general and semi-private wards, which are used as a criterion for allocation to the insured hospital wards.

These maximum rates depend on the charges and agreements of a comparable hospital with a recognized charge scale located in the region in which the insured person lives.

The maximum rates defined by the insurer can be inspected at the Fund.

1.5.5. Classification of hospitals

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

2. Treatment as an in-patient

2.1. Intensive care

2.1.1. Condition for benefits

KOMBI provides in-patients' benefits, on condition that, and for as long as, the insured person requires hospital treatment within the meaning of BASIS.

2.1.2. Scope of benefits

Further to the benefits provided by BASIS, KOMBI pays the costs of hospital stays in a ward insured according to the chosen insurance level.

The cost share, including the daily contribution to the costs of a hospital stay payable under BASIS, is not insured.

2.1.3. Treatment in a higher class of hospital ward

Where the treatment is given in a hospital ward in a higher category than that insured, the following maximum benefits are covered:

KOMBI General: The costs which would have been incurred in an insured hospital ward. In the event that such costs cannot be determined, the KOMBI insurance shall arrange payment of a flat rate of CHF 30.- per day.

KOMBI Semi-private: Costs which would have been incurred in the insured hospital ward. If these costs cannot be determined, a flat rate of CHF 120.- per day is paid from KOMBI.

KOMBI Komfort: Insured persons who have taken out cover in a two bed room under KOMBI Komfort will receive benefits equivalent to their insurance cover if they stay in a single bed room of a Komfort contractual hospital.

If persons holding KOMBI Komfort insurance are treated and stay in the semi-private or private ward of a Komfort contractual hospital, the benefits which correspond to his insurance cover will be reimbursed.

2.1.4. Treatment in a non-listed hospital

If the treatment is given in a hospital which does not appear on a cantonal hospital list, the following maximum benefits are covered:

KOMBI General/ Komfort: Flat rate of CHF 30.- per day.

KOMBI Semi-private/Private/Private Accident (accident sequels)/Flex: The additional costs incurred for a stay in a reference hospital in the country of residence based on a comparison between the general and insured wards.

KOMBI Private Accident (emergencies)/Global: Full cost cover.

2.1.5. Treatment in a non-contractual hospital

Where treatment of the KOMBI Komfort insured person takes place in a hospital which does not appear on the list of Komfort contractual hospitals kept by the health insurance Fund, the maximum

benefits covered will be those equivalent to the cost of a general ward or the reference charge scale of the Komfort contractual hospital in the canton of residence.

2.2. Long-term treatment

2.2.1. Definition

Situations in which a uniform long-term impairment of health occurs requiring nursing care but not a permanent medical standby are regarded as a chronic illness.

2.2.2. Scope of benefits

KOMBI pays the following flat rate daily allowances if

- care for a chronically ill person requires a stay in a suitable and acknowledged hospital, or
- if a stay in an acute hospital takes on the features of long-term treatment for chronically ill persons. In that case, the insurer may reduce his benefits after giving one month's notice. The hospital days are imputed from the initial application date against the duration of benefits

	1st to 90th day	91st to 180th day
KOMBI Semi-private/Flex:	CHF 50.-	CHF 25.-
KOMBI Private/Private Accident:	CHF 70.-	CHF 35.-
KOMBI Global:	CHF 90.-	CHF 45.-

These benefits are paid during treatment in the insured ward once in three calendar years. If treatment is provided in a ward, which is in a lower category than that insured, the benefits will be guided by the KOMBI variant for the ward in which the treatment took place.

2.3. Rehabilitation as an inpatient

If medical treatment is provided in a multi-purpose sanatorium recognized by the insurer or in a medical rehabilitation ward or clinic, KOMBI provides complete cost cover for the first 60 days according to the acute treatment provisions. The benefits for long-term treatment are then paid after imputation of the previous duration.

The recognized sanatoria or rehabilitation establishments are shown on a list, which can be consulted at any time at the Fund.

2.4. Psychiatric clinics

In the event of treatment as an in-patient in a psychiatric clinic, psychiatric treatment in an intensive care hospital or special clinic, KOMBI pays the full cost cover pursuant to the provisions for acute treatment for a period of 90 days. No benefits payable from KOMBI Private Accident.

When the treatment lasts for longer than this, the following flat-rate daily allowance is paid for treatment in the corresponding ward.

	91st to 180th day
KOMBI General/Komfort:	CHF 20.-
KOMBI Semi-private/Flex:	CHF 50.-
KOMBI Private:	CHF 70.-
KOMBI Global:	CHF 90.-

These benefits are paid once in three calendar years. If treatment is provided in a ward of a lower category than the insured levels, the benefits are payable according to the KOMBI variant for the ward in which the treatment took place.

2.5. Benefits abroad

2.5.1. In emergencies

As an addition to the BASIS benefits, KOMBI pays the costs of emergency in-patient's treatment in an acute hospital during a temporary stay abroad up to full cost cover in the insured ward. Benefits are provided for as long as medical reasons preclude repatriation.

2.5.2. Elective treatment abroad

The benefits of KOMBI Global are provided even if the insured person deliberately travels abroad for treatment.

In the other benefit levels, the same benefits are provided as for treatment in a non-listed hospital.

2.5.3. Procedure during the hospital stay

In the event of treatment as an in-patient, a cost reimbursement application must be submitted to the Fund immediately, but at the latest within 10 days of admission to the hospital.

3. Spa treatment

3.1. Recovery cures

A free choice may be made among the medically managed domestic spa establishments acknowledged by the insurer. The acknowledged spa establishments are shown on a list, which can be consulted at any time at the Fund.

KOMBI provides the following benefits for a maximum of 21 days in each case for medically prescribed recovery cures following a hospital stay as an acute patient:

KOMBI General/Komfort:	CHF 50.-/day
KOMBI Semi-private/Flex:	CHF 70.-/day
KOMBI Private/Private Accident:	CHF 90.-/day
KOMBI Global:	CHF 110.-/day

3.2. Bathing treatment

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

KOMBI General/Komfort:	CHF 30.-/day
KOMBI Semi-private/Flex:	CHF 30.-/day
KOMBI Private/Private Accident:	CHF 50.-/day
KOMBI Global:	CHF 50.-/day

The insured may select any medically supervised thermal spa which is recognised by the ÖKK. The list of recognised thermal spas is continually updated or extended and is available for inspection at any time from ÖKK.

The contribution payable to the costs of the thermal cure 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 Fund may require an examination on admission by the spa doctor and a final check-up with a closing report to the prescribing doctor.

3.3. Other treatment

At the request of the medical consultant to the Fund, a flat rate sum equivalent to not more than the spa treatment contribution may be paid for other medically prescribed spa treatments where special medical indications exist.

3.4. Procedure during the spa stay

The medical prescription for a spa treatment course must be submitted to the Fund two weeks before the start of the treatment with the diagnosis.

In the event of interruption of a course of treatment, partial treatment costs can only be accepted if the interruption was due to an illness or other compelling reasons and a certificate is supplied by the spa doctor.

4. Special benefits

4.1. SPITEX

4.1.1. Principle

Where a hospital stay can be avoided or shortened, KOMBI pays on medical prescription contributions to external home helps (SPITEX), provided that domestic and family circumstances necessitate this.

4.1.2. Scope of benefits

KOMBI pays a contribution to the costs of recognized home helps per calendar year. The benefits are provided even if an agreement does not exist between the service provider and the insurer.

Benefits are paid as follows:

KOMBI General/Komfort:	up to CHF 40.-/day, max. CHF 400.-
KOMBI Semi-private/Flex:	up to CHF 50.-/day, max. CHF 500.-
KOMBI Private/ Private Accident:	up to CHF 60.-/day, max. CHF 630.-
KOMBI Global:	up to CHF 60.-/day, max. CHF 800.-

If the insured person is responsible for the care of at least one child, the following benefits are provided:

KOMBI General/Komfort:	up to CHF 40.-/day, max. CHF 600.-
KOMBI Semi-private/Flex:	up to CHF 70.-/day, max. CHF 1,000.-
KOMBI Private/ Private Accident:	up to CHF 100.-/day, max. CHF 1,300.-
KOMBI Global:	up to CHF 110.-/day, max. CHF 1,600.-

In the event of a stay in a nursing home, no benefits are provided.

4.1.3. Service providers

An acknowledged home help is one who looks after households in lieu of the insured person by way of trade for his or her own account or for a SPITEX organization contractually approved by the insurer.

Contributions are also paid if this help is provided by members of family of the insured person and the members of family suffer a demonstrable loss of earnings as a result or can give evidence of travel expenses in an appropriate amount.

Instead of home help benefits, the same contributions can be provided for care services of commercial SPITEX companies if no remuneration is received by them under BASIS.

4.2. Transport costs, rescue and recovery actions in emergencies

The following overall contributions are paid from KOMBI to the costs of:

- medically necessary emergency transport to the nearest suitable hospital by an appropriate means of transport;

- return transport to a suitable hospital in the canton of residence of the insured person for treatment as an in-patient;
- for rescue and recovery actions

KOMBI General/Komfort:	CHF 10,000.-/calendar year towards the uncovered amount exceeding CHF 100.-/case
KOMBI Semi-private/Flex:	CHF 20,000.-/calendar year
KOMBI Private/ Private Accident:	CHF 30,000.-/calendar year
KOMBI Global:	Unlimited

Air transport is only paid if it is essential for medical or technical reasons.

No benefits will be paid for transport costs which are covered by a membership (patronage) with an air rescue service or similar organisation.

4.3. Travel expenses

KOMBI reimburses 90%, up to CHF 300 per calendar year of the costs for public transport to an insured person undergoing dialysis, radiation or chemotherapy outside a radius of 30 kilometres from the place of residence.

4.4. Children's care service

4.4.1. Principle

The KOMBI for the insured child pays contribution to the care and nursing service for children up to the age of 12 organized by a section of the Swiss Red Cross.

A requirement for this is a contractual arrangement between ÖKK and SRK.

4.4.2. Conditions for benefit

The benefits are provided if, in the opinion of the Swiss Red Cross, the child is in need of care or nursing following an acute illness or accident. The provision of services is confined exclusively to nursing and care by specialist personnel trained and instructed by the Swiss Red Cross.

Children have an entitlement to benefits for as long as the persons responsible for bringing them up pursue an employment activity during the care hours.

4.4.3. Scope of benefits

The KOMBI of the insured child pays a maximum contribution of CHF 30.- per hour to the care and nursing service subject to a maximum of CHF 600.- per calendar year.

4.5. Medical treatment of accident sequels under KOMBI Private Accident

4.5.1. Treatment by physicians not under KVG contract
KOMBI Private Accident provides benefits at the KVG rates for treatment by physicians who are not under KVG contract.

4.5.2. Private consultations with hospital physicians who are not under KVG contract

KOMBI Private Accident provides benefits at the approved rates for outpatient consultations with senior university hospital physicians who are not under KVG contract.

4.5.3 Medical emergency treatment abroad

If the insured person is not covered under the PRIVATE SUPPLEMENT, ÖKK OPTIMA or ÖKK PREMIUM, KOMBI Private Accident

covers the full costs over and above the benefits provided under BASIS for medical emergency treatment abroad.

4.6. Rooming-in

If a small child requires in-patient treatment, Kombi pays up to CHF 50.- per day from the child's insurance for the stay of one parent in the child's room.

If one parent requires in-patient treatment, Kombi pays up to CHF 50.- per day from the insurance of the parent for the stay of a small child in the room of the parent.

4.7. Daily hospital allowance

KOMBI general pays CHF 15 per day up to 730 daily allowances in hospital following a 5 day waiting period. The waiting period applies per calendar year.

5. Maternity

5.1. Costs of treatment as an in-patient

KOMBI pays the costs of a hospital birth, which are not otherwise covered, for the mother and the neonate according to the mother's agreed insurance level.

If the neonate is not insured with ÖKK, the mother's KOMBI pays the costs, which are not otherwise covered, over and above any other insurance of the child.

If the mother is not insured with ÖKK, the neonate's KOMBI pays the costs which are not otherwise covered, over and above any insurance of the mother.

5.2. Birth in a maternity clinic

In the event of birth in a maternity clinic recognized by ÖKK which does not appear on the cantonal list of hospitals, the following benefits will be provided:

KOMBI General/Komfort: up to CHF 1,000.- per birth

KOMBI Semi-private/Flex: up to CHF 2,000.- per birth

KOMBI Private/Global: full cost cover

For persons holding KOMBI Flex insurance, the additional cost share will not apply pursuant to the KOMBI Flex provisions.

5.3. Home help after childbirth

5.3.1. Principle

KOMBI pays contributions to the costs of medically prescribed home help by personnel acknowledged by the insurer.

They are paid instead of the ordinary SPITEX benefits of KOMBI.

They are also paid if the help is provided by members of family of the insured person and the members of family therefore suffer a demonstrable loss of earnings.

5.3.2. Birth in a hospital

Following a hospital birth the following rates are payable:

KOMBI General/Komfort: up to CHF 60.-/day, max. CHF 600.-

KOMBI Semi-private/Flex: up to CHF 100.-/day, max. CHF 1,000.-

KOMBI Private: up to CHF 100.-/day, max. CHF 1,300.-

KOMBI Global: up to CHF 110.-/day, max. CHF 1,600.-

5.3.3. Birth at home

In the event of a home birth or birth as an out-patient, the following rates are paid:

KOMBI General/Komfort: up to CHF 60.-/day, max. CHF 840.-
KOMBI Semi-private/Flex: up to CHF 105.-/day, max. CHF 1,500.-
KOMBI Private: up to CHF 135.-/day, max. CHF 1,900.-
KOMBI Global: up to CHF 165.-/day, max. CHF 2,310.-

5.4. KOMBI Private Accident

KOMBI Private Accident does not provide any maternity benefits (except for the rules on rooming-in).

6. Accident addition

Following an accident-related hospital stay, the remedial aids needed to treat the sequels of the accident are covered pursuant to the compulsory accident insurance practice.

The costs of remedial aids are covered on the same scale 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.

7. CASAMED variant

7.1. General

For insured persons who are insured with ÖKK in BASIS in the CASAMED variant, the following additional provisions apply in KOMBI.

7.2. Benefit levels

For CASAMED insured persons, the KOMBI General, Semi-Private, Private, Private Accident, Flex and Komfort benefit levels apply.

7.3. General condition for benefits

The KOMBI General, Semi-Private, Private, Private Accident, Flex and Komfort benefits are provided if they were performed according to the medical practitioner principle. The provision of services must be prescribed or occasioned by the CASAMED medical practitioner with whom the insured person is registered.

Telemedical institutions may be approved by ÖKK as CASAMED medical practitioners.

7.4. Choice of hospital

With a view to low cost care, the health insurance fund may designate the hospitals to which medical care for CASAMED policyholders is entrusted on an exclusive basis.

7.5. Ophthalmologists, gynecologists and pediatricians

For CASAMED policyholders who undergo routine treatment by ophthalmologists, gynecologists and pediatricians, the operations performed by such medical specialists on an out-patients or in-patients basis are paid after consultation of the CASAMED practitioner.

7.6. Emergencies

Emergencies are covered regardless of the chosen service provider under KOMBI General, Semi-Private, Private, Private Accident, Flex and Komfort. A review of the medical indication by the medical consultant may be ordered.

7.7. Exclusion of benefits

If the insured person addresses himself for treatment to a service provider, otherwise than under the exhaustive list of exceptional cases, whose choice is not open to him, all costs will be charged to him.

8. ECOPLAN variant with limited choice of hospital

8.1. General

The ECOPLAN variant with limited choice of hospital exists under KOMBI Semi-Private and Private.

ECOPLAN may be confined to insured persons living in a particular region.

8.2. Choice / termination of ECOPLAN

ECOPLAN may be chosen when KOMBI is taken out or at a later date with effect from the beginning of a calendar month.

The change from ECOPLAN to the ordinary KOMBI can be made at any time to the end of a calendar year by giving three months' prior notice.

8.3. Scope of benefits

The KOMBI benefits are provided under the ECOPLAN. Hospital care benefits are covered in so far as treatment is given in a hospital specially designated by the insurer.

The insurer designates the hospitals recognized for this cover variant. The list of ECOPLAN hospitals is constantly adapted or supplemented and can be inspected or requested at any time from the insurance fund.

8.4. Treatment in a different hospital

If the insured person undertakes treatment in a non-ECOPLAN hospital except in the exhaustively listed exceptional cases, all the costs shall be charged to the insured person.

Emergencies and treatments necessitated for medical reasons in a non-ECOPLAN hospital are covered regardless of the chosen service provider within the framework of KOMBI. Except in emergencies, this benefit is, however, only provided after making a prior application to the Fund. A review of the medical indication by the medical consultant is reserved.

9. Deductible and reimbursement in KOMBI Semi-private, Private and Global

9.1. Deductible

9.1.1 General

Adults may opt for an excess with a corresponding reduction of the premiums under KOMBI Semi-Private, Private and Global in the event of hospital treatment.

The elective excess is stated as a fixed amount per calendar year.

The excess does not apply if the insured person is admitted to the general ward (multi-bed room) of a Swiss intensive care hospital with a recognized scale of charges.

The half excess shall not be payable if the person holding KOMBI Privat or Global insurance is treated in the semi-private ward (room with two beds) of a Swiss intensive care hospital with a recognized scale of charges.

The cost share will not be provided either if flat-rate reimbursements are paid from KOMBI on the basis of these insurance conditions. This does not apply to benefits insured under KOMBI in other countries. An appropriate cost share will be levied on these benefits.

9.1.2. Change / termination of the excess

The change from a lower to a higher excess can only be made at the beginning of a calendar year.

The cancellation or change to a lower excess is possible at the earliest one year after joining the variant with an elective excess by giving three months notice to the end of a calendar year. The cancellation or change to a lower excess is treated as an application for a new insurance contract.

9.1.3. Amount of the excess

The following excesses are available for KOMBI Semi-Private, Private and Global for hospital treatment:

CHF 2,000.- per calendar year

CHF 5,000.- per calendar year

The excess may be adjusted to inflation.

The statutory BASIS cost share is additional to this excess.

9.2. Reimbursement

ÖKK KOMBI Semi-private, Private and Global reimburse insured persons from 16 years of age when selecting a cheaper hospital ward in an intensive care hospital in Switzerland.

KOMBI Semi-private; General ward up to CHF 300 a day
General ward comfort single and twin rooms up to CHF 200 a day

KOMBI Private
KOMBI Global; General ward up to CHF 400 a day
General ward comfort single and twin rooms up to CHF 300 a day
Semi-private ward up to CHF 200 a day

The amounts can be adjusted to the hospital cost development. The right of withdrawal applies as per Art.8.2 of the common provisions in the case of a reduction of the amounts.

The reimbursement is paid if no deductible has been agreed.

10. Cost sharing under KOMBI Flex

10.1. Scope of cost share

With KOMBI Flex, the insured person can choose the ward before admission to a hospital. Choice of the corresponding ward likewise determines the cost share.

In the event of hospital care, the following cost share is required per calendar year on the KOMBI Flex benefits, depending on the ward chosen.

Treatment in:	Cost share for KOMBI Flex benefits:
General ward:	None
General ward with comfort twin-bedded room:	10% up to a max. of CHF 200.- per calendar year
General ward with comfort single room	10% up to a max. of CHF 200.- per calendar year
Semi-private ward:	15% up to a max. of CHF 1,500.- per calendar year
Private ward:	25% max. CHF 4,500.- per calendar year

This cost share likewise applies in the case of maternity.

The cost share is not payable if flat-rate reimbursements are made under KOMBI pursuant to these insurance conditions. KOMBI benefits paid abroad under the insurance are an exception. An appropriate cost share is levied on them.

The cost share may be adjusted to inflation.

The statutory cost share of BASIS is charged additionally.

10.2. Maximum cost share for families

If two or more persons live in the same household or are insured under KOMBI Flex, cost shares which exceed the amount of CHF 4,500.- per calendar year may be claimed.

ÖKK FAMILY

ÖKK Versicherungen AG, Edition 1.1.2012

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The masculine form used in these AVBs also apply to females.

1. Insurance fundamentals

1.1. Insurance carrier

ÖKK Versicherungen AG, Landquart (ÖKK) is the insurance carrier.

1.2. Common provisions

The common provisions (GB) of the ÖKK are an integral part of these General conditions of insurance (GCI/AVB). In case of conflicting regulations, these GTC take priority over the common provisions.

1.3. Purpose

ÖKK FAMILY provides benefits for in-patient or out-patient treatment in the case of illness, accident and maternity as well as emergencies abroad.

ÖKK FAMILY provides benefits for medical treatment outside the place of residence or work, preventive treatments, aids, dental treatments, alternative cure and treatment methods, transport costs, search, rescue and recovery operations, non-compulsory pharmaceuticals, natural remedies spa treatment, domestic help outside the hospital and pays a breastfeeding allowance.

ÖKK FAMILY pays benefits further to all other insurance departments concluded with ÖKK under VVG [Insurance Contracts Act].

ÖKK FAMILY provides benefits before all other insurances taken out with ÖKK according to VVG. Retentions are deducted for every insurance.

1.4. Qualification for benefits

ÖKK FAMILY will only pay benefits if the treatment is indicated for medical reasons and given by persons who are approved by ÖKK for doing so.

ÖKK FAMILY provides benefits, if the in-patient treatment is provided by a hospital pursuant to Art. 39 Health insurance act (KVG).

Hospitals with recognised tariffs are hospitals, with which ÖKK has come to an agreement regarding fixing the tariff or which comply with these tariffs without agreement.

1.5. Local area of application

ÖKK FAMILY provides benefits in Switzerland if not otherwise specified.

1.6. Conclusion of insurance

ÖKK FAMILY can be taken out until the completion of the 60th year of life.

2. Outpatient treatment

2.1. Medical treatment outside the place of residence and work

Further to the BASIS benefits, ÖKK FAMILY provides 90% of the costs for treatments by KVG doctors accredited by statutory health funds carried out outside the place of residence or work of the insured person pursuant to the KVG tariff applicable at the place of treatment.

2.2. Medical treatment in the case of an emergency abroad

ÖKK FAMILY provides benefits for medical treatment in the case of an emergency abroad during a temporary stay abroad.

2.3. Psychotherapy by persons who are not physicians

2.3.1. Scope of benefits

ÖKK FAMILY pays 50 % of the costs up to CHF 1'000 per calendar year for the treatment of mental diseases by qualified psychotherapists, who are not physicians and who have a cantonal license to practise independently.

2.3.2. Qualification for benefits

ÖKK FAMILY pays benefits after the approval of the confirmation of the assumption of cost request by the medical examiner.

ÖKK FAMILY does not pay benefits in case of psychotherapies which are carried out for the purpose of self-realisation, personal development or for learning purposes, and also not in case of parallel treatments with other psychologists or psychiatrists.

2.4. Thermal bath

ÖKK FAMILY pays 50% of the costs of a maximum of twelve entrance fees for the visits prescribed by the physician per calendar year.

2.5. Sterilisation

ÖKK FAMILY pays 50%, up to CHF 1'000 for the sterilisation and vasectomy of adults .

3. In-patient treatment

3.1. Hospital treatment

3.1.1. Qualification for benefits

ÖKK FAMILY will pay benefits if the insured person requires hospital treatment within the meaning of BASIS.

3.1.2. Scope of benefits

Further to the benefits of BASIS, ÖKK FAMILY takes over the costs in case of hospital stay in the general ward.

3.1.3. Treatment in a higher class of hospital ward

If the treatment is effected in a higher class of hospital ward than the general ward, at a maximum such costs will be covered which would have been caused in the general ward. If those costs cannot be determined, ÖKK FAMILY will pay a flat rate of CHF 30.- per day.

3.1.4. Treatment in a non-listed hospital

If the treatment is effected in a hospital which is not listed in one of the cantonal hospital lists, ÖKK FAMILY will pay up to CHF 30.- per day.

3.2. In-patient rehabilitation

Where the medical treatment is carried out in a multi-purpose sanatorium or in a medical rehabilitation ward or clinic ÖKK FAMILY pays up to 60 days per calendar year on the general ward.

3.3. Psychiatric clinic

In case of in-patient stay in a psychiatric clinic, a psychiatric treatment in an emergency hospital or a special clinic, ÖKK FAMILY grants up to 90 days per three calendar years on the general ward.

3.4. Emergency abroad

ÖKK FAMILY provides benefits for in-patient treatment on the general ward of a hospital in the case of an accident during a temporary stay abroad as long as a repatriation is not possible for medical reasons. A request for transfer of costs is to be filed with ÖKK immediately, at the latest within ten days after hospitalisation.

3.5. Spa treatment

3.5.1. Recovery cures

ÖKK FAMILY pays benefits in case of recovery cures prescribed by physicians following a hospital stay amounting to CHF 50 per day, up to 21 days per calendar year.

There is free choice among the convalescent homes under medical management and approved by ÖKK.

3.5.2. Bathing treatment

ÖKK FAMILY pays CHF 30 per day, up to 21 days per calendar year. There is free choice among the spas under medical management and approved by ÖKK.

ÖKK may request an initial examination by the spa physician and a final examination with final report to the referring physician.

3.5.3. Other cures

ÖKK FAMILY may upon application by the medical examiner pay a flat rate up to the amount of the bathing treatment contribution for other cures prescribed by a physician if they are particularly medically indicated.

3.5.4. Procedure in case of spa treatment

The medical prescription with diagnosis for a spa treatment is to be filed with ÖKK two weeks prior to start of the spa treatment.

If the treatment is interrupted, partial costs will only be taken over if the interruption was caused by illness or other compelling reasons and if this is certified by the physician administering the treatment.

3.6. Domestic help

3.6.1. General

If, in case of illness or accident, a hospital stay may be avoided or shortened, ÖKK FAMILY will pay, upon medical prescription, contributions to home care outside the hospital, if this is required due to domestic and family circumstances.

3.6.2. Scope of benefits

ÖKK FAMILY pays benefits for the costs of an approved home help up to CHF 50.- per day, a maximum amount of CHF 1,000.- per calendar year. The benefit is also paid where there is no agreement between service provider and ÖKK.

If the insured person is responsible for taking care of a child, ÖKK FAMILY will pay up to CHF 100.- per day, a maximum of CHF 2,000.- per calendar year.

In case of stay in a nursing home, no benefits are paid.

3.6.3. Service providers

A domestic helper is a person, who looks after the household of the insured person on a commercial basis or for an organisation contractually approved by ÖKK.

The help by relatives of the insured person is acknowledged if the relative incurs a loss of income.

3.7. Childcare service

3.7.1. General

ÖKK FAMILY pays benefits for the rendered care and nursing

services for children until the completion of the 12th year of life.

Prerequisite is a contractual regulation between ÖKK and an organisation for childcare services approved by ÖKK.

3.7.2. Qualification for benefits

The benefit will be paid if the child requires care of nursing as consequence of acute illness or accident. The provision of benefits is limited to special personnel of the organisation approved by ÖKK.

Children whose legal guardian or parent(s) is/are gainfully employed during the time when childcare is provided have a claim for this benefit.

3.7.3. Scope of benefits

ÖKK FAMILY pays benefits for the care and nursing service of up to CHF 30.- per hour, a maximum of CHF 600.- per calendar year.

3.8. Rooming-In

If an small child requires treatment as an in-patient, ÖKK FAMILY will pay up to CHF 100 per day from the insurance of the child for a stay of one parent in the child's room.

If a parent requires treatment as an in-patient, ÖKK FAMILY will pay up to CHF 100 per day from the insurance of the parent for a stay of the small child in the parent's room.

4. Maternity

4.1. Costs of the in-patient treatment

ÖKK FAMILY covers the costs of a childbirth in the hospital, general ward which are not covered by BASIS.

If the newborn child does not have a corresponding own insurance, ÖKK FAMILY of the mother will take over the uncovered costs of the child in the hospital, general ward.

4.2. Twin-bedded room or family room

ÖKK FAMILY provides benefits of up to CHF 200 per day for additional costs in a twin or family room for childbirth in a list hospital approved by ÖKK.

The medical services and treatment costs are insured at the rate of the general ward.

4.3. Childbirth in the birth centre

ÖKK FAMILY pays benefits up to CHF 2'000 per birth in the case of childbirth in a birth centre approved by ÖKK, which is not listed in a cantonal hospital list.

4.4. Home help after childbirth

4.4.1. General

ÖKK FAMILY pays contributions to the costs of a home help prescribed by physicians and rendered by personnel approved by ÖKK.

The contributions are provided instead of benefits pursuant to clause 3.6.

The contributions are also provided if the help is carried out by relatives of the insured person and the relative can provide proof of loss of income.

4.4.2. Scope of benefits in case of childbirth in hospital

ÖKK FAMILY pays benefits following a childbirth in hospital of up to CHF 100.- per day, a maximum of CHF 700.- per calendar year.

4.4.3. Scope of benefits in case of homebirth or outpatient childbirth

ÖKK FAMILY provides benefits following a house birth or outpatient birth up to CHF 100 a day and amounting to a maximum of CHF 1,200 per calendar year.

4.5. Birth preparation

ÖKK FAMILY will pay benefits of CHF 200.– per pregnancy for the costs of a birth preparation class (incl. antenatal and post-natal exercises) if the class is held by a skilled specialist.

4.6. Nursing mother's allowance

ÖKK FAMILY pays nursing mother's allowance amounting to CHF 250.–. The nursing mother's allowance is paid where the mother breastfeeds her child for ten weeks.

5. Prevention

5.1. Check-up examinations

ÖKK FAMILY will pay 90%, up to CHF 300.– per calendar year for medical check-up examination.

5.2. Gynaecological preventive medical check-up

ÖKK FAMILY pays 90% of the costs of a gynaecological preventive check-up according to KVG at the KVG tariff per calendar year providing that no benefits have been provided from BASIS for a respective preventive check-up.

5.3. Health account

5.3.1. Scope of benefits

ÖKK FAMILY pays 50%, up to CHF 200.– per calendar year per field, for the costs of selected preventive measures in the fields family, nutrition, exercise and other prevention described by ÖKK.

The contribution paid by ÖKK FAMILY for individual approved preventive measures may be limited.

If in one year several preventive measures from different fields are used, ÖKK FAMILY will pay up to CHF 500.– per calendar year.

5.3.2. Qualification for benefits

The preventive measures and classes must be approved by ÖKK.

5.4. Vaccination

ÖKK FAMILY pays 90%, up to CHF 200 per calendar year for medically approved vaccinations.

6. Aids

6.1. Visual aids

ÖKK FAMILY pays up to CHF 200.– per calendar year for the costs of spectacle-lenses and contact lenses required for vision correction.

6.2. Other aid

Upon medical prescription, ÖKK FAMILY may pay 50% of the costs of a necessary aid adjusted to the state of health for which no benefit is paid under BASIS, up to CHF 250.– per calendar year. The benefit is paid for aids which improve the use of restricted bodily

functions, are economical and comply with the state of the state of the art of medical research. ÖKK denotes the approved aids.

What is not insured are costs that arise due to operation, maintenance and repair of these aids.

7. Dental treatment

7.1. Wisdom teeth

ÖKK FAMILY pays 90% of the for the extraction of wisdom teeth. If this is effected as in-patient treatment, the costs will be taken over up to the amount of the contractually fixed rates of the general ward in the canton of residence.

7.2. Additional benefits for children and adolescents

ÖKK FAMILY pays additionally for children and adolescents up to 25 years

- the costs of a check-up incl.x-ray up to CHF 60 per calendar year,
- 70% of the costs of orthodontic treatment pursuant to approved rate.

The benefits for orthodontic treatment will be provided if an insurance duration of at least three years (qualifying period) is given. ÖKK renounces a qualifying period where a previous insurance of equal value exists upon conclusion of the contract and at least one parent is insured with ÖKK.

7.3. Community benefits

ÖKK FAMILY offsets benefits of cantons and community. ÖKK FAMILY pays benefits further to those benefits.

7.4. Health care providers and rate

ÖKK FAMILY pays benefits based on the rate pursuant to KVG applicable to dental services. If the dentist brings to account a higher tariff, the difference has to be borne by the insured person.

The term dentist denotes a person, who has the appropriate federal diploma or an equivalent diploma or who has been granted the licence to practise as a dentist due to an academic proof of qualification by the cantonal authorities.

7.5. Treatment abroad

ÖKK FAMILY also pays benefits where the treatment is effected in a neighbouring country of Switzerland. Neighbouring countries are countries which have a joint border with Switzerland.

8. Alternative medicine

ÖKK FAMILY pays in case of alternative medicine treatments:

ÖKK FAMILY pays 70% of the costs, up to CHF 10,000 per calendar year, if the method of therapy (e.g. Ayurveda, traditional Chinese medicine, naturopathic treatments) and the therapist or the doctor are approved by ÖKK.

ÖKK specifies the approved therapy methods and therapists and doctors. ÖKK keeps a list of approved therapy methods.

ÖKK FAMILY pays 50% of the costs, up to CHF 1,000.– per calendar year for further alternative medicine treatments effected by qualified persons.

ÖKK FAMILY does not provide benefits for therapy methods and treatments and therapists, who are listed on the negative list of ÖKK.

Where the alternative medicine treatment is effected in a neighbouring country of Switzerland, it is insured at the same conditions.

The verification by the medical examiner of the medical indication and the qualification of physicians and therapists remains reserved. Benefits may be made dependent on the fact that no parallel alternative medical treatment without added-on value takes place at the same time.

No benefits are provided for parallel treatments, which are not expected to provide an advantage.

9. Pharmaceuticals and medicine

9.1. Non-compulsory pharmaceuticals

ÖKK FAMILY pays 90% of the costs of medically prescribed pharmaceuticals which are not listed in the pharmaceuticals list with rate (ALT), the specialty list (SL) pursuant to KVG or the negative list of ÖKK.

9.2. Natural cures

ÖKK FAMILY pays 90% of the costs of phytotherapeutic, homeopathic and anthroposophical cures as well as oligosols to the extent that they are not covered under BASIS and are not on the negative list of ÖKK.

10. Transport costs, rescue and recovery costs

10.1. Transport costs, rescue and recovery costs in emergency cases

10.1.1. Scope of benefits

ÖKK FAMILY pays benefits for the costs

- of medically required emergency transports to the nearest appropriate hospital in useful means of transport,
- of the back-transport to an appropriate hospital in the canton of residence of the insured person for in-patient treatment,
- of rescue and recovery actions

of an aggregate amount of up to CHF 50,000.- per calendar year.

Transports in aircrafts are paid if they are inevitable for medical or technical reasons.

10.1.2. Excess

The insured person has to bear CHF 100.- per incident.

10.1.3. Benefits of third parties

No insurance cover applies for transport costs, which is covered by the membership (patronage) with an air rescue service or similar organisation.

10.2. Search actions

ÖKK FAMILY pays in addition to the costs of the rescue or recovery in case of search actions up to CHF 20,000.- per calendar year.

10.3. Travel expenses

For regular medical treatment outside a radius of 30 kilometres from the place of residence, ÖKK FAMILY reimburses 90% of the costs of public transport, up to CHF 100 per year .

ÖKK FAMILY also provides 90%, up to CHF 300 per calendar year for insured persons undergoing dialysis, radiation or chemotherapy.

11. CASAMED variant

11.1. General

The following additional conditions apply to persons insured with ÖKK in BASIS with the CASAMED variant.

11.2. General practitioner principle

ÖKK FAMILY pays benefits pursuant to the general practitioner principle. Services have to be effected, prescribed or caused by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by ÖKK as CASAMED general practitioners.

11.3. Exceptions from the general practitioner principle

ÖKK FAMILY pays contributions to the costs of routine treatments of ophthalmologist, gynaecologists and paediatricians without consultation of the CASAMED general practitioners. If these physicians prescribe further treatments or operations or carry them out, the CASAMED general practitioner is to be consulted.

ÖKK FAMILY pays contributions to the costs of alternative medicine treatments, preventive measures within the framework of the health account, birth preparation, nursing mother's allowance, transport, search, rescue and recovery, dental check-up without consultation of the CASAMED general practitioner.

11.4. Hospitals

ÖKK may denote hospitals which are exclusively entrusted with the care for persons insured with CASAMED.

11.5. Other specialists

Instead of the CASAMED general practitioner, ÖKK may denote other specialists who effect, prescribe or cause the services.

11.6. Preventive measures, alternative medicine, non-compulsory pharmaceuticals, cures

ÖKK may empower the CASAMED general practitioners or the denoted specialists to effect, prescribe or cause other therapies than the determined preventive measures, alternative medicine treatments, non-compulsory pharmaceuticals or natural cures.

11.7. Further health care providers

ÖKK may denote further health care providers such as chemist's shops, therapists, sanitary speciality shop or similar health care providers exclusively entrusted with the medical support or care of persons insured with CASAMED.

11.8. Emergency case

ÖKK FAMILY covers emergency cases irrespective of the general practitioner principle. The verification by the medical examiner of the medical indication remains reserved.

11.9. Disqualification for benefits, exclusion CASAMED variant

11.9.1. Disqualification for benefits

If the insured person seeks treatment with a health care provider not eligible, all costs are to be borne by the insured person, except in the finally listed exceptions.

11.9.2. Exclusion CASAMED variant

ÖKK may reallocate the insured person from the CASAMED variant in the ordinary insurance variant in case of repeated behaviour violating the provisions.

11.10. Benefits payment

11.10.1. Flat-rate allowance

ÖKK may agree with the CASAMED general practitioner that the benefits are paid on flat rate basis.

11.10.2. Benefits caused

In case of benefits caused, ÖKK may, prior to the remuneration of the benefit, request proof from the insured person or the CASAMED general practitioner that the benefit has been provided pursuant to the general practitioner principle.

ÖKK FAMILY FLEX

ÖKK Versicherungen AG, Edition 1.1.2012

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The masculine form used in these AVBs also apply to females.

1. Insurance fundamentals

1.1. Insurance carrier

ÖKK Versicherungen AG, Landquart (ÖKK) is the insurance carrier.

1.2. Common provisions

The common provisions (GB) of ÖKK are an integral part of these general conditions of insurance (GCI/AVB). In case of conflicting regulations, these AVB take priority over the common provisions (GB).

1.3. Purpose

ÖKK FAMILY FLEX provides benefits for outpatient and in-patient treatments in case of illness, accident and maternity as well as emergency cases abroad.

ÖKK FAMILY FLEX provides benefits for medical treatments outside the place of work or residences, preventive measures, aids, dental treatments, alternative cure and treatment methods, transport costs, search, rescue and recovery actions, non-compulsory pharmaceuticals, natural cures, spa treatments, home help outside the hospital and pays nursing mother's allowance.

ÖKK FAMILY FLEX provides benefits as supplement to the compulsory health care insurance (BASIS). Of the maximum costs, the maximum share payable is the portion which is not covered by a social insurance (incl. BASIS with another insurer).

ÖKK FAMILY FLEX provides benefits before of all other insurances taken out with ÖKK according to VVG. Retentions are deducted for every insurance.

1.4. Qualification for benefits

ÖKK FAMILY FLEX will only pay benefits if the treatment is indicated for medical reasons and given by persons who are approved by ÖKK for doing so.

ÖKK FAMILY FLEX pays benefits in the case of in-patient treatment, if the treatment is carried out in a hospital pursuant to Art. 39 health insurance act (KVG).

Hospitals with recognised tariffs are hospitals, with which ÖKK has come to an agreement regarding fixing the tariff or which comply with these tariffs without agreement.

1.5. Local area of application

ÖKK FAMILY FLEX provides benefits in Switzerland if not otherwise specified.

1.3. Conclusion of insurance

ÖKK FAMILY FLEX can be taken out until the completion of the 60th year of life.

2. Outpatient treatment

2.1. Medical treatment outside the place of residence and work

Further to the BASIS benefits, ÖKK FAMILY FLEX pays 90% of the costs for treatment by KVG doctors accredited by statutory health funds of the insured person based on the KVG tariff applicable at the place of treatment.

2.2. Medical treatment in the case of an emergency abroad

ÖKK FAMILY FLEX provides benefits for medical treatment in case of an emergency during a temporary stay abroad.

2.3. Psychotherapy by non-medical practitioners

2.3.1. Scope of benefits

ÖKK FAMILY FLEX pays 50% of the costs up to CHF 1,000.- per calendar year for the treatment of mental diseases by qualified psychotherapists who are not physicians and have a cantonal licence to practice independently.

2.3.2. Qualification for benefits

ÖKK FAMILY FLEX pays benefits after approval of the cost transfer request by the medical examiner.

ÖKK FAMILY FLEX does not pay benefits in case of psychotherapies which are carried out for the purpose of self-realisation, personal development or for learning purposes, and also not in case of parallel treatments with other psychologists or psychiatrists.

2.4. Thermal bath

ÖKK FAMILY FLEX pays 50% of the costs of a maximum of twelve entrance fees for the visits prescribed by the physician per calendar year.

2.5. Sterilisation

ÖKK FAMILY FLEX pays 50%, up to CHF 1'000 for sterilisation and vasectomy of adults.

3. In-patient treatment

3.1. Hospital treatment

3.1.1. Qualification for benefits

ÖKK FAMILY FLEX will pay benefits if the insured person requires hospital treatment within the meaning of BASIS.

3.1.2. Scope of benefits

Further to the benefits of BASIS, ÖKK FAMILY FLEX takes over the costs in case of hospital stay in the general ward. The deductible for BASIS applies.

The insured person chooses the hospital ward with the corresponding deductible before entering the hospital.

3.1.3. Insured hospital ward and deductibles

The insured person can choose from the following wards:

Ward	Deductible
General ward:	nil
General ward with comfort twin-bedded room:	10%, max. CHF 200.- per calendar year
General ward with comfort single-bedded room:	10%,max. CHF 200.- per calendar year
General ward comfort family room (only for childbirth):	10%, up to CHF 200.- per calendar year
Semi-private ward:	15%, max. CHF 1,500.- per calendar year
Semi-private ward family room (only for childbirth):	15 %, up to CHF 1,500.- per calendar year

For childbirth in a list hospital approved by ÖKK the cost sharing does not apply for the comfort room on the general ward (single, twin, family room).

The deductible for families where all family members live within the same household is limited to CHF 3,000.- per calendar year. The deductibles can be adapted to the development of costs.

ÖKK FAMILY FLEX provides benefits up to CHF 200 per day of the additional costs in a comfort room on the general ward (single, twin, family room) or in the family room on the Semi-private ward.

3.2. In-patient rehabilitation

Where the medical treatment is effected in a multi-purpose sanatorium or in a medical rehabilitation ward or hospital recognized by ÖKK, ÖKK FAMILY FLEX grants up to 60 days per calendar year in the insured ward according to the provisions stipulated for in-patient hospital treatment in 3.1.3.

3.3. Psychiatric clinic

in the case of an in-patient stay in a psychiatric clinic, psychiatric treatment in an emergency hospital or a special clinic, ÖKK FAMILY FLEX pays up to 90 days per three calendar years on the insured ward as per the conditions of hospital treatment under section 3.1.3.

3.4. Emergency case abroad

ÖKK FAMILY FLEX provides benefits for in-patient treatment on the insured ward of a hospital in the case of an emergency during a temporary stay abroad, as per the conditions of hospital treatment under section 3.1.3 as long as a repatriation is not possible for medical reasons. A request for transfer of costs is to be filed with ÖKK immediately, at the latest within ten days after hospitalisation.

3.5. Spa treatment

3.5.1. Recovery cures

ÖKK FAMILY FLEX pays benefits in case of recovery cures prescribed by physicians following a hospital stay of CHF 50 per day up to 21 days per calendar year.

There is free choice among the convalescent homes under medical management and approved by ÖKK.

3.5.2. Bathing treatment

ÖKK FAMILY FLEX provides benefits of CHF 30 per day, up to 21 days per calendar year.

There is free choice among the spas under medical management and approved by ÖKK.

ÖKK may request an initial examination by the spa physician and a final examination with final report to the referring physician.

3.5.3. Other cures

ÖKK FAMILY FLEX may upon application by the medical examiner pay a flat rate up to the amount of the bathing treatment contribution for other cures prescribed by a physician if they are particularly medically indicated.

3.5.4. Procedure in case of spa treatment

The medical prescription with diagnosis for a spa treatment is to be filed with ÖKK two weeks prior to start of the spa treatment.

If the treatment is interrupted, partial costs will only be taken over if the interruption was caused by illness or other compelling reasons and if this is certified by the physician administering the treatment.

3.6. Home help

3.6.1. General

If, in case of illness or accident, a hospital stay may be avoided or shortened, ÖKK FAMILY FLEX will pay, upon medical prescription, contributions to home care outside the hospital, if this is required due to domestic and family circumstances.

3.6.2. Scope of benefits

ÖKK FAMILY FLEX pays benefits for the costs of an approved home help up to CHF 50.- per day, a maximum amount of CHF 1,000.- per calendar year. The benefit is also paid where there is no agreement between service provider and ÖKK.

If the insured person is responsible for taking care of a child, ÖKK FAMILY FLEX will pay up to CHF 100.- per day, a maximum of CHF 2,000.- per calendar year.

In case of stay in a nursing home, no benefits are paid.

3.6.3. Service providers

A home help is a person who looks after households instead of the insured person on a commercial basis or for an organisation contractually approved by ÖKK.

The benefit will also be paid if the help is provided by relatives of the insured person and the relatives suffer a demonstrable loss of income.

3.7. Childcare service

3.7.1. General

ÖKK FAMILY FLEX pays benefits for the rendered care and nursing services for children until the completion of the 12th year of life.

Prerequisite is a contractual regulation between ÖKK and an organisation for childcare services approved by ÖKK.

3.7.2. Qualification for benefits

The benefit will be paid if the child requires care of nursing as consequence of acute illness or accident. The provision of benefits is limited to special personnel of the organisation approved by ÖKK.

Children whose legal guardian or parent(s) is/are gainfully employed during the time when childcare is provided have a claim for this benefit.

3.7.3. Scope of benefits

ÖKK FAMILY FLEX pays benefits for the care and nursing service of up to CHF 30.- per hour, a maximum of CHF 600.- per calendar year.

3.8. Rooming-In

If a child up to the age of twelve requires treatment as an in-patient ÖKK FAMILY FLEX provides benefits from the insurance of the child for the costs of the stay of one parent in the child's room.

If a parent requires treatment as an in-patient ÖKK FAMILY FLEX provides benefits from the insurance of the parent for the costs of the stay of the child up to the age of twelve in the parent's room.

4. Maternity

4.1. Costs of in-patient treatment

If the newborn child does not have a corresponding own insurance, ÖKK FAMILY FLEX of the mother will pay the uncovered costs of the child in the insured hospital ward according to the provisions stipulated for in-patient hospital treatment in 3.1.3.

4.2. Childbirth in the birth centre

ÖKK FAMILY FLEX pays benefits up to CHF 2,000 per birth in the case of childbirth in a birth centre approved by ÖKK, which is not listed on a cantonal hospital list.

4.3. Home help after childbirth

4.3.1. General

ÖKK FAMILY FLEX pays contributions to the costs of a home help prescribed by physicians and rendered by personnel approved by ÖKK.

The contributions are also provided if the help is carried out by relatives of the insured person and the relative can provide proof of loss of income.

4.3.2. Scope of benefits in case of childbirth in hospital

ÖKK FAMILY FLEX pays benefits following a childbirth in hospital of up to CHF 100.– per day, a maximum of CHF 700.– per calendar year.

4.3.3. Scope of benefits in case of homebirth or outpatient childbirth

ÖKK FAMILY FLEX pays benefits following a homebirth or an outpatient childbirth of up to CHF 100.– per day, a maximum of CHF 1,200.– per calendar year.

4.4. Birth preparation

ÖKK FAMILY FLEX will pay benefits of CHF 200.– per pregnancy for the costs of a birth preparation class (incl. antenatal and post-natal exercises) if the class is held by a skilled specialist.

4.5. Nursing mother's allowance

ÖKK FAMILY FLEX pays nursing mother's allowance amounting to CHF 250.–. The nursing mother's allowance is paid where the mother breastfeeds her child for ten weeks.

5. Prevention

5.1. Check-up examinations

ÖKK FAMILY FLEX provides 90%, up to CHF 300 per calendar year for medical check-up examinations.

5.2. Gynaecological preventive medical check-up

ÖKK FAMILY FLEX will pay 90% of the costs of a gynaecological preventive medical check-up according to KVG at KVG rate per calendar year if no benefits for a corresponding preventive examination under BASIS have been provided in the current calendar year.

5.3. Health account

5.3.1. Scope of benefits

ÖKK FAMILY FLEX pays 50%, up to CHF 200.– per calendar year per field, for the costs of selected preventive measures in the fields family, nutrition, exercise and other prevention described by ÖKK.

The contribution paid by ÖKK FAMILY FLEX for individual approved preventive measures may be limited.

If in one year several preventive measures from different fields are used, ÖKK FAMILY FLEX will pay up to CHF 500.– per calendar year.

5.3.2. Qualification for benefits

The preventive measures and classes must be approved by ÖKK.

5.4. Vaccination

ÖKK FAMILY FLEX pays 90%, up to CHF 200 per calendar year for medically approved vaccinations.

6. Aids

6.1. Visual aids

ÖKK FAMILY FLEX pays up to CHF 200.– per calendar year for the costs of spectacle-lenses and contact lenses required for vision correction.

6.2. Other aids

Upon medical prescription, ÖKK FAMILY FLEX may pay 50% of the costs of a necessary aid adjusted to the state of health for which no benefit is paid under BASIS, up to CHF 250.– per calendar year. The benefit is paid for aids which improve the use of restricted bodily functions, are economical and comply with the state of the state of the art of medical research. ÖKK denotes the approved aids.

What is not insured are costs that arise due to operation, maintenance and repair of these aids.

7. Dental treatment

7.1. Wisdom teeth

ÖKK FAMILY FLEX will pay 90% of the costs of the extraction of wisdom teeth.

If this is effected as in-patient treatment, the costs will be taken over up to the amount of the contractually fixed rates of the general ward in the canton of residence.

7.2. Additional benefits for children and adolescents

ÖKK FAMILY FLEX pays additionally for children and adolescents up to 25 years

- the costs of a check-up incl. x-ray up to CHF 60 per calendar year,
- 70% of the costs of orthodontic treatment pursuant to approved rate.

The benefits for orthodontic treatment will be provided if an insurance duration of at least three years (qualifying period) is given.

ÖKK renounces a qualifying period where a previous insurance of equal value exists upon conclusion of the contract and at least one parent is insured with ÖKK.

7.3. Community benefits

ÖKK FAMILY FLEX offsets benefits of cantons and community. ÖKK FAMILY FLEX pays benefits further to those benefits.

7.4. Health care provider and rate

ÖKK FAMILY FLEX pays benefits based on the rate pursuant to KVG applicable to dental services. If the dentist brings to account a higher tariff, the difference has to be borne by the insured person.

The term dentist denotes any person who has the appropriate federal diploma or an equivalent or who has been granted the licence to practice as dentist due to an academic proof of qualification by the cantonal authorities.

7.5. Treatment abroad

ÖKK FAMILY FLEX also pays benefits where the treatment is effected in a neighbouring country of Switzerland. Neighbouring countries are countries which have a joint border with Switzerland.

8. Alternative medicine

ÖKK FAMILY FLEX pays in case of alternative medicine treatments:

ÖKK FAMILY FLEX will pay 70% of the costs, up to CHF 10,000.- per calendar year, if both the method of therapy (e.g. Ayurveda, TCM, naturopathic treatments) as well as the therapist or physician effecting treatment are approved by ÖKK.

ÖKK denotes the approved forms of therapy as well as the therapists and physicians. ÖKK is keeping a list of approved forms of therapy.

ÖKK FAMILY FLEX pays 50% of the costs, up to CHF 1,000.- per calendar year for further alternative medicine treatments effected by qualified persons.

ÖKK FAMILY FLEX does not pay benefits for forms of therapy and treatments of therapists who are listed on the negative list of ÖKK.

Where the alternative medicine treatment is effected in a neighbouring country of Switzerland, it is insured at the same conditions.

The verification by the medical examiner of the medical indication and the qualification of physicians and therapists remains reserved. If no improvements can be expected, no payments will be made for parallel alternative medical treatments.

9. Pharmaceuticals and medicine

9.1. Non-compulsory pharmaceuticals

ÖKK FAMILY FLEX pays 90% of the costs of medically prescribed pharmaceuticals which are not listed in the pharmaceuticals list with rate (Ger. ALT), the specialty list (SL) pursuant to KVG or the negative list of ÖKK.

9.2. Natural cures

ÖKK FAMILY FLEX pays 90% of the costs of phytotherapeutic, homeopathic and anthroposophical cures as well as oligosols to the extent that they are not covered under BASIS and are not on the negative list of ÖKK.

10. Transport costs, search, rescue and recovery costs

10.1. Transport costs, rescue and recovery costs in emergency cases

10.1.1. Scope of benefits

ÖKK FAMILY FLEX pays benefits for the costs

- of medically required emergency transports to the nearest appropriate hospital in useful means of transport,
- of the back-transport to an appropriate hospital in the canton of residence of the insured person for in-patient treatment,
- of rescue and recovery actions

of an aggregate amount of up to CHF 50,000 per calendar year.

Transports in aircrafts will be taken over if they are inevitable for medical or technical reasons.

10.1.2. Excess

The insured person has to bear CHF 100.- per incident.

10.1.3. Benefits of third parties

If a membership (patronage) with an air rescue service or similar organisation is given, ÖKK FAMILY FLEX will pay benefits if no benefits are provided by these organisations. Differing contractual agreements remain reserved.

10.2. Search actions

ÖKK FAMILY FLEX pays in addition to the costs of the rescue or recovery in case of search actions up to CHF 20,000.- per calendar year.

10.3. Travel expenses

For regular medical treatment outside a radius of 30 kilometres from the place of residence, ÖKK FAMILY FLEX reimburses 90% of the costs of public transport, up to CHF 100 per year .

ÖKK FAMILY FLEX also provides 90%, up to CHF 300 per calendar year for insured persons undergoing dialysis, radiation or chemotherapy.

11. CASAMED variant

11.1. General

The following additional provisions apply to persons insured with ÖKK in BASIS in the CASAMED variant.

11.2. General practitioner principle

ÖKK FAMILY FLEX pays benefits pursuant to the general practitioner principle.

Services have to be effected, prescribed or caused by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by ÖKK as CASAMED general practitioners.

11.3. Exceptions from the general practitioner principle

ÖKK FAMILY FLEX pays contributions to the costs of routine treatments of ophthalmologist, gynaecologists and paediatricians without consultation of the CASAMED general practitioners. If these physicians prescribe further treatments or operations or carry them out, the CASAMED general practitioner is to be consulted.

ÖKK FAMILY FLEX pays contributions to the costs of alternative medicine treatments, preventive measures within the framework of the health account, birth preparation, nursing mother's allowance, transport, search, rescue and recovery, dental check-up without consultation of the CASAMED general practitioner.

11.4. Hospitals

ÖKK may denote hospitals which are exclusively entrusted with the care for persons insured with CASAMED.

11.5. Other specialists

Instead of the CASAMED general practitioner, ÖKK may denote other specialists who effect, prescribe or cause the services.

11.6. Preventive measures, alternative medicine, non-compulsory pharmaceuticals

ÖKK may empower the CASAMED general practitioners or the denoted specialists to effect, prescribe or cause other therapies than the determined preventive measures, alternative medicine treatments, non-compulsory pharmaceuticals or natural cures.

11.7. Further health care providers

ÖKK may denote further health care providers such as chemist's shops, therapists, sanitary speciality shop or similar health care providers exclusively entrusted with the medical support or care of persons insured with CASAMED.

11.8. Emergency case

ÖKK FAMILY FLEX covers emergency cases irrespective of the general practitioner principle. The verification by the medical examiner of the medical indication remains reserved.

11.9. Disqualification for benefits, exclusion CASAMED variant

11.9.1. Disqualification for benefits

If the insured person seeks treatment with a health care provider not eligible, all costs are to be borne by the insured person, except in the finally listed exceptions.

11.9.2. Exclusion CASAMED variant

ÖKK may reallocate the insured person from the CASAMED variant in the ordinary insurance variant in case of repeated behaviour violating the provisions.

11.10. Benefits payment

11.10.1. Flat-rate allowance

ÖKK may agree with the CASAMED general practitioner that the benefits are paid on flat rate basis.

11.10.2. Benefits caused

In case of benefits caused, ÖKK may, prior to the remuneration of the benefit, request proof from the insured person or the CASAMED general practitioner that the benefit has been provided pursuant to the general practitioner principle.

ÖKK SALTO

ÖKK Versicherungen AG, Edition 1.1.2012

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1. Fundamentals of the insurance

1.1. Purpose

ÖKK SALTO provides benefits for outpatient and in-patient medical treatment, as well as in emergencies abroad.

ÖKK 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.

The purpose of the ÖKK SALTO insurance is also to pay uncovered costs for medical treatment in the case of illness, accident or maternity in an acute hospital.

In addition to that, the ÖKK SALTO insurance pays contributions to uncovered costs of emergency treatment abroad in the case of illness, accident, early childbirth and to the services during holidays, business trips or a stay abroad.

The ÖKK SALTO benefits are provided as a supplement to all other insurance compartments under VVG concluded with ÖKK.

ÖKK SALTO provides benefits in addition to the compulsory health care insurance (BASIS). Of the total costs, the maximum share payable is the proportion which is not covered by a social insurance (incl. BASIS with another insurer).

1.2. Common provisions

The common provisions of ÖKK Versicherungen AG are an integral part of the general terms and conditions of insurance (GTC) for ÖKK SALTO. If there is a conflict between the terms and conditions, the GTC take priority over the common provisions.

1.3. Insured persons

ÖKK SALTO can be taken out from the 19th birthday up to the concluded 30th year of age.

1.4. Automatic transfer to the GENERAL SUPPLEMENT or ÖKK OPTIMA, KOMBI GENERAL and ÖKK TOURIST

ÖKK SALTO expires on the 31st of December of the year in which the insured completes his/her 32nd year of age. The automatic transfer to the insurance sections GENERAL SUPPLEMENT (for contracts incepting before 31.12.2009) or ÖKK OPTIMA (for contracts incepting after 1.1.2010), KOMBI GENERAL and ÖKK TOURIST is effective as of 1st of January of the subsequent year. With the automatic transfer, there is no need for a new health declaration; however, if there are existing restrictions of insurance cover pursuant to the common provisions, they will remain unchanged.

1.5. Early transfer to the GENERAL SUPPLEMENT or ÖKK OPTIMA, KOMBI GENERAL and ÖKK TOURIST

An early transfer to the insurance sections GENERAL SUPPLEMENT (for contracts incepting before 31.12.2009) or ÖKK OPTIMA (for contracts incepting after 1.1.2010), KOMBI GENERAL and ÖKK TOURIST without new health declarations is always possible by the 1st of January. In case of a transfer to the ÖKK MONDIAL insurance the same right of transfer applies. For pregnancy a transfer or change is possible at any time of the year. Existing cover restrictions according to the common provisions remain unchanged.

1.6. Condition for benefits

1.6.1. General

Benefits are only payable, if the treatment is medically indicated and if it is given by persons who are recognized by the insurer. The Fund may give information about the acknowledgement of the relevant persons.

In-patient treatment is insured, if the treatment is given in an acute hospital. The treatment must be performed by service providers approved under the provisions of KVG.

1.6.2. Acute hospital

An acute hospital is a medical institution performing medical and nursing care and disposing of the necessary technical infrastructure to treat illnesses, accidents and for childbirths which require constant medical observation. Additionally, hospital treatment has to be arranged for in hospitals that figure on the hospital list of the canton of location according to Art. 39 KVG.

1.6.3. Treatment in other hospitals

For treatment in other hospitals benefits are payable according to section 3.1.4.

1.6.4. Treatment outside the canton for medical reasons

According to the compulsory provisions (Art. 41 para. 3 KVG) the canton of residence bears the additional costs of a medically indicated hospitalization outside the canton.

1.7. In-patient benefit level and hospital tariffs

1.7.1. ÖKK SALTO benefit level

The following benefit level is introduced for ÖKK SALTO:

- General ward (shared room) of a hospital with approved tariff in the whole of Switzerland.

1.7.2. Hospitals with recognized charge scale

Hospitals with recognized charge scale are those with which the insurer has reached agreements on charges or hospitals, which apply these charges without any special agreement. The Fund has a list of hospitals with acknowledged charge scales. This list is available for inspection at any time.

1.7.3. Absence of criteria, maximum charges

If a hospital has no allocation criteria for hospital wards or applies criteria which differ from those set out in these provisions, these wards will be treated as private departments for insurance purposes. The insurer may fix maximum charges for general and semi-private wards, which are used as a criterion for allocation to the insured hospital wards.

These maximum rates depend on the charges and agreements of a comparable hospital with a recognized charge scale located in the region in which the insured person lives.

The maximum rates defined by the insurer can be inspected at the Fund.

1.7.4. Classification of hospitals

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

2. Outpatient treatment

2.1. Medical treatment outside the place of residence and work

Further to the benefits provided by BASIS, treatment by KVG approved CHI physicians outside the place of residence or work of the insured person and according to the KVG tariff applicable at the place of treatment is fully covered.

2.2. Emergency medical treatment abroad

In the case of an emergency medical treatment abroad under the ÖKK SALTO insurance, the costs further to the benefits provided by BASIS are fully covered.

2.3. Duration of benefits

If the ÖKK SALTO insurance provisions did not arrange to the contrary, benefits are payable for an unlimited time.

3. In-patient treatment

3.1. Intensive care

3.1.1. Condition for benefits

ÖKK SALTO provides in-patients' benefits, on condition that, and for as long as, the insured person requires hospital treatment within the meaning of BASIS.

3.1.2. Scope of benefits

Further to the benefits provided by BASIS, ÖKK SALTO pays the costs of hospital stays according to the insured benefit level.

The cost share, including the daily contribution to the costs of a hospital stay payable under BASIS, is not insured.

3.1.3. Treatment in a higher class of hospital ward

Where treatment is given in a hospital ward in a higher category than that insured, the following maximum benefits from ÖKK SALTO are covered:

- The costs which would have been incurred in an insured hospital ward. In the event that such costs cannot be determined, the ÖKK SALTO insurance shall arrange payment of a flat rate of CHF 30.- per day.

3.1.4. Treatment in a non-listed 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 covered.

3.2. In-patient rehabilitation

If medical treatment is provided in a multi-purpose sanatorium recognized by the insurer or in a medical rehabilitation ward or clinic, ÖKK SALTO provides complete cost cover for the first 60 days according to the acute treatment provisions.

A list of recognized sanatoriums and rehabilitation wards or clinics can be inspected at the Fund at any time.

3.3. Psychiatric clinics

In the event of treatment as an in-patient in a psychiatric clinic, psychiatric treatment in an acute hospital or special clinic, ÖKK SALTO pays the full cost cover pursuant to the provisions for acute treatment for a period of 90 days.

These benefits are paid once in three calendar years.

3.4. Benefits abroad in emergencies

As an addition to the BASIS benefits, ÖKK SALTO pays the costs of emergency in-patient's treatment in an acute hospital during a temporary stay abroad up to full cost cover in the general ward. Benefits are provided for as long as medical reasons preclude repatriation, subject to a maximum of one year. In the event of treatment as an in-patient, a cost reimbursement application must be submitted to the Fund immediately, but at the latest within 10 days of admission to the hospital.

4. Maternity

4.1. Costs of treatment as an in-patient

ÖKK SALTO pays the cost of a hospital birth which is not covered by BASIS for the mother in a general hospital ward throughout Switzerland.

If the newborn is not insured correspondingly, the mother's ÖKK SALTO insurance pays the costs for the child which are not otherwise covered in a general ward throughout Switzerland.

4.2. Birth in a maternity clinic

In the event of birth in a maternity clinic recognized by ÖKK which does not appear on the cantonal list of hospitals, ÖKK SALTO provides benefits for 90 % of the costs up to a maximum of CHF 1,000.- for every birth.

5. Additional services abroad

5.1. Maximum cover

For travels up to 100 days per year an additional payment for not covered costs of up to CHF 50,000.- per calendar year is made in an emergency.

5.2. Travel to visit the patient and special return journey

If an insured person falls seriously ill or suffers a serious accident abroad and must remain in hospital for more than 7 days, the insurer will organize and pay for a visit to the bedside by a person close to the insured person (1st class rail ticket, economy class air travel).

If an insured person must be transported back for urgent medical reasons from abroad to a suitable hospital in the canton of residence for treatment as an in-patient, the ÖKK emergency call centre will organise the special return journey for members of family travelling with the patient or for a person close to him or her. The additional costs incurred will be covered. If an insured person falls ill or suffers an accident and cannot set out on the planned return journey by reason of a hospital stay, the ÖKK emergency call centre will organise the special return journey for the insured person, the members of family who are travelling with him/her or a person close to him/her. The additional costs incurred are covered.

5.3. Advance towards hospital costs

If an insured person has to be hospitalised abroad, the insurer will, if necessary, pay an advance of up to CHF CHF 20,000.- towards hospital costs. If part of the amount paid in advance is not covered by the existing insurance, this will be billed to the insured person for repayment within 30 days.

5.4. Notifying persons at home

If measures were organised by the ÖKK emergency call centre, the latter will notify members of family of the insured person of the circumstances and the action taken.

5.5. Arranging hospitals and medical contacts abroad

The ÖKK emergency call centre will, if necessary, arrange for an insured person to visit a physician or a hospital at the place where he/she is staying. In the event of communication problems, the ÖKK emergency call centre will provide interpretation assistance.

5.6. Medical advice from physicians

If an insured person requires medical assistance while travelling and this cannot be provided at the place where he or she is staying, the physicians at the ÖKK emergency call centre will give medical advice. This advice is only a suggestion and must not, under any circumstances, be regarded as a diagnosis.

5.7. Exclusion of benefits

Additionally to the benefit restrictions of the common provisions of ÖKK Versicherungen AG no entitlement to insurance benefits exists:

- a) for illnesses and sequels of accidents which already existed at the time when the journey began or whose existence was known to the insured person when the journey began and medical treatment was foreseeable;
- b) if the insured person has travelled abroad for the purpose of treatment, care or childbirth;
- c) if the ÖKK emergency call centre has not given its permission in advance for search actions, repatriation, travel to visit or special return travel.

If the emergency transport or repatriation is rendered impossible by circumstances external such as strike, riot, acts of violence, major industrial accidents, radioactivity, natural disasters, epidemic illnesses or force majeure, its organisation and implementation cannot be demanded.

5.8. Obligations in the event of a claim

5.8.1. Notification of the ÖKK emergency call centre

In the event of sudden illness, accident or premature birth in Switzerland or abroad necessitating hospital treatment or assistance measures, the ÖKK emergency call centre must in each case be notified without delay.

5.8.2. Release from the obligation of secrecy

The insured person releases treating practitioners and other medical personnel, as well as the insurers, from their obligation of secrecy vis-à-vis the ÖKK emergency call centre and/or the insurer.

5.8.3. Notification of claim

The insured person must notify the claim immediately to the scheme and make available all information with the necessary medical and administrative particulars. Only detailed original bills will be accepted. If the details on the bill are insufficient and the requested supplementary information is not made available, the benefits will be fixed at the due discretion of the insurer.

5.8.4. Return of rail or air tickets

Unused rail or air tickets must be forwarded to the scheme without a special request to do so. If unused tickets have been sold or refunded by third parties, the compensation obtained will be imputed against the insurance benefits. In the event of failure to

respect this obligation, the insurer may require the insured person concerned to refund an amount determined at the insurer's due discretion or offset this amount against the claim for benefits.

6. Accident supplement

Following an accident-related hospital stay, the remedial aids needed to treat the sequels of the accident are covered pursuant to the compulsory accident insurance practice.

The costs of remedial aids are covered on the same scale 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.

Of these benefits an excess of 10% is payable by the insured person.

7. Prevention

7.1. Vaccinations

90% of the effective cost of vaccinations for protection against infection is reimbursed, subject to a maximum of CHF 200.- per calendar year. 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.

7.2. Precautionary gynaecological examinations

The costs of a precautionary gynaecological examinations are insured per calendar year at the KVG charge rate, provided that no such benefits under BASIS are paid out in the same calendar year. On these benefits an excess of 10% is payable by the insured person.

7.3. Courses on health-promoting behaviour

To the proven costs of a medically prescribed course to learn health-promoting behaviour given by qualified personnel (e.g. giving up smoking) ÖKK SALTO pays a contribution of 90% of the costs subject to a maximum of CHF 300.- within two calendar years.

The insurer designates the recognized courses to learn forms of behaviour conducive to good health. The list of acknowledged courses is constantly adjusted or supplemented and can be inspected at any time at the insurance fund.

7.4. Further preventive measures

Contributions may be paid to further recognised preventive measures.

8. Remedial aids

8.1. Visual aids

The insurer pays a contribution to the costs of spectacles and contact lenses needed for correct sight to insured persons of CHF 420.- within 5 calendar years.

8.2. Other aids

50% of the costs of the rental or purchase price of necessary remedial aids adapted to the state of health for which no benefits are provided under BASIS can be reimbursed subject to medical

prescription and to a maximum total of CHF 250.– per calendar year. The insurer designates the recognized remedial aids. The list of such recognized aids is constantly adapted or supplemented and can be inspected at the Fund at any time. Costs incurred for operation, maintenance and repair of these aids are not insured.

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 in-patient, the costs are covered up to the amount of the contractually fixed tariffs of the general ward in the canton of residence. On these benefits an excess of 10% is payable by the insured person.

9.2. Benefit providers and charge scales

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

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

9.3. Treatment abroad

Benefits are also provided if treatment occurs in a neighbouring country of Switzerland. Neighbouring countries are those which have a common frontier with Switzerland.

10. Transport costs, search, rescue and recovery operations

10.1. Transport costs, rescue and recovery operations in emergencies

10.1.1. Scope of benefits

A contribution of up to CHF 20,000.– per calendar year is payable to the costs of

- medically necessary emergency transport to the nearest suitable hospital by an appropriate means of transport;
- repatriation to a suitable hospital in the canton in which the insured person resides for the purpose of treatment as an in-patient;
- for search and rescue actions.

Transport by aircraft is only authorized if it is essential for medical or technical reasons.

10.1.2. Excess

The insured person is liable for an excess of CHF 100.– in respect of each claim.

10.1.3. Third party benefits

If membership (patronage) of an air rescue service exists, costs will only be eligible for reimbursement to the extent that these organisations have not provided any benefits. Other contractual agreements are reserved.

10.2. Search operations

In addition to the costs of rescue or recovery of an insured person, costs for search actions up to a maximum of CHF 20,000.– per calendar year are payable.

11. CASAMED variant

11.1. General

For insured persons who have taken out the CASAMED variant of the ÖKK BASIS insurance, the following additional provisions apply.

11.2. General benefit conditions

The ÖKK SALTO benefits are provided if the medical practitioner principle was applied and if the benefits are supplied, prescribed or arranged by the CASAMED medical practitioner with whom the insured person is registered.

Telemedical institutions may be approved by ÖKK as CASAMED medical practitioners.

11.3. Exceptions to the medical practitioner principle

ÖKK SALTO provides benefits for routine treatments of ophthalmologists, gynaecologists and paediatricians without prior consultation of CASAMED medical practitioners. The CASAMED medical practitioner is to be consulted if the treatment continues.

ÖKK SALTO provides benefits for preventive treatments as part of a course for health promoting behaviour, birth preparation, transport, search, rescue and recovery, wisdom tooth extraction, additional services abroad without consulting the CASAMED medical practitioner.

11.4. Choice of hospital

With a view to low cost care, the health insurance fund may designate the hospitals to which medical care for CASAMED policy holders is entrusted on an exclusive basis.

11.5. Other specialists

The Fund may designate further specialists else than the CASAMED medical practitioner, who may provide, prescribe or arrange benefits covered by ÖKK SALTO.

11.6. Other service providers

With view to the provision of services at reasonable cost, the fund may designate further service providers such as chemists, therapists, medical supplies stores or related service providers who will have sole authority to provide medical care or supply to CASAMED insurance holders.

11.7. Emergencies

Regardless of the chosen service provider, emergencies are covered by ÖKK SALTO. A verification of the medical indication by the medical consultant is reserved.

11.8. Exclusion of benefits

If the insured person addresses himself for treatment to a service provider, otherwise than under the exhaustive list of exceptional cases, whose choice is not open to him, all costs will be charged to him.

11.9. Benefit processing

11.9.1. Flat-rate allowance

The insurer or the Fund may agree with the CASAMED medical practitioner to cover his or her costs under the ÖKK SALTO insurance as flat rates.

11.9.2. Arranged benefits

In the case of arranged benefits and prior to reimbursement of the costs, the Fund may, if necessary, require the insured person or the CASAMED medical practitioner to give evidence that the benefits provided have been performed according to the medical practitioner principle.

ÖKK DENTAL

ÖKK Versicherungen AG, Edition 1.1.2012

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The masculine form used in these AVBs also apply to females.

1. Insurance fundamentals

1.1. Purpose

ÖKK DENTAL provides benefits for dental treatments and preventive measures.

1.2. Conclusion of the insurance

ÖKK DENTAL may be taken out up to the age of 60.

Existing conditions at the time of conclusion of the insurance such as damaged or missing teeth, poor tooth positions, jaw anomalies etc. are not insured. The insured person is notified in writing about the limitation in benefits.

The last dental examination or treatment must have taken place no more than one year before the start of the insurance.

Children who are insured for dental treatment costs in the first year of life have unlimited insurance.

1.3. Condition for benefit

Measures of a diagnostic and therapeutic nature which are dentally necessary and scientifically acknowledged are insured, as long as the treatment is also economical.

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

ÖKK DENTAL provides its benefits on a subsidiary basis, i.e. subsequently or in addition to the statutory health care or accident insurance and to benefits provided by the cantons and local authorities. If benefits are available from other insurance companies, the benefit is provided on a proportionate basis.

1.4. Abroad

ÖKK DENTAL benefits are also provided if treatment is carried out in a neighbouring country of Switzerland. Neighbouring countries are those which have a common frontier with Switzerland.

2. Insurance possibilities

The following insurance possibilities exist:

- ÖKK DENTAL PICCOLO up to the age of 15
- ÖKK DENTAL

2.1. ÖKK DENTAL PICCOLO

2.1.1. Benefits

For children and young adults up to the age of 15, the costs of a check-up incl. x-ray are reimbursed up to CHF 40 per calendar year.

2.1.2. Automatic transfer

On the 15th birthday, transfer from ÖKK DENTAL PICCOLO to ÖKK DENTAL A takes place automatically and without benefit restriction at the beginning of the following year. The insured person has the right of withdrawal within three months of receipt of the notification.

2.2. ÖKK DENTAL

2.2.1. Benefit variants

Variant	Maximum benefit claim per calendar year
- ÖKK DENTAL A	75% to max. CHF 1,000.-, excess CHF 500.-
- ÖKK DENTAL B	50% to max. CHF 500.-
- ÖKK DENTAL C	50% to max. CHF 1,000.-
- ÖKK DENTAL D	75% to max. CHF 1,000.-
- ÖKK DENTAL E	75% to max. CHF 1,500.-
- ÖKK DENTAL F	75% to max. CHF 3,000.-
- ÖKK DENTAL G	75% to max. CHF 5,000.-, excess CHF 500.-
- ÖKK DENTAL H	75% to max. CHF 5,000.-

The insurer may reduce the exempt sum (for variants with exempt sum) for children up to the age of 15.

In the case of the variants with an excess, the latter is charged as a fixed amount per calendar year. The maximum benefit claim allowable per calendar year is calculated on the residual amount over and above the excess.

2.2.2. Preventive dentistry and check-ups

ÖKK DENTAL provides benefits for a check-up incl. x-ray and for preventive treatment CHF 100 per calendar year. Cost sharing of the benefit variant is not applied. The cost share depending on the chosen benefit variant does not apply.

2.2.3. Benefits / treatment period

Within the framework of the chosen benefit class, the insurance covers all costs of dental treatment including laboratory costs.

No benefits are paid for dental care agents.

ÖKK will pay the insured benefits per calendar year.

2.2.4. Waiting period

The benefit entitlement under ÖKK DENTAL commences

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

The waiting time also applies to increases in insurance cover. No waiting time applies to benefits for preventive treatment and check-ups.

2.2.5. Enforcement of claims

To make the claim the insured person must present the detailed original bill immediately but at the latest within 30 days following the date on the invoice. 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 presupposes that the insured person is insured with ÖKK BASIS CASAMED.

The following additional conditions apply for the CASAMED variant.

3.2. Benefit condition

The benefits are granted if care has been provided, prescribed or arranged by a CASAMED dentist approved by ÖKK, with whom the insured person is registered.

3.3. Emergencies

Irrespective of the chosen provider, emergencies are covered by ÖKK DENTAL. However, a verification of the medical indication by the consultant medical officer may be required.

3.4. Exclusion from benefits, exclusion from CASAMED variant

3.4.1. Exclusion from benefits

If insured persons present themselves to a service provider, who cannot be selected, for treatment with the exception of the exhaustive list of exceptions all costs are borne by themselves.

3.4.2. Exclusion from CASAMED variant

ÖKK is entitled to transfer the insured person from the CASAMED variant to the ordinary insurance variant in case of repeated conduct in breach of the regulations.

3.5. Premiums

A reduced premium applies in the CASAMED variant.

ÖKK TOURIST

ÖKK Versicherungen AG, Edition 1.1.2010

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1. Basics

1.1. Purpose of the insurance

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 other stays abroad. It also provides benefits in respect of transport, search, rescue and repatriation costs, together with service benefits. The cover shall be governed by the following terms and conditions.

1.2. General terms and conditions of insurance (GTC)

The general terms and conditions of insurance of ÖKK Versicherungen AG are an integral part of the conditions governing ÖKK TOURIST. In the event of any discrepancies, the conditions governing ÖKK TOURIST shall take priority over the general terms and conditions of insurance of ÖKK Versicherungen AG.

2. Conclusion, commencement and duration

2.1. Insured persons

2.1.1. Persons covered

The insurance is provided for persons who have taken out ÖKK TOURIST insurance with ÖKK. All persons may take out the insurance; no age limit applies.

2.1.2. Individuals

The persons whose names appear on the insurance policy are insured.

2.1.3. Families

The policy holder named on the insurance policy is insured, together with his/her spouse or partner and their children up to their 25th birthday, provided that the latter live in the same household as the policy holder.

2.2. Start, duration and end of insurance

The start, duration and end of the insurance are guided by the common terms and conditions of ÖKK Versicherungen AG.

The insurance can only be taken out or held in conjunction with at least one of the following insurance compartments:

- GENERAL SUPPLEMENT
- PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- KOMBI
- ÖKK FAMILY
- ÖKK FAMILY FLEX
- ÖKK SALTO

In the case of families, a condition for taking out and holding the ÖKK TOURIST Insurance is that at least one parent must hold a GENERAL SUPPLEMENT, PRIVATE SUPPLEMENT, ÖKK OPTIMA, ÖKK PREMIUM, ÖKK FAMILY, ÖKK FAMILY FLEX, ÖKK SALTO or KOMBI insurance with ÖKK.

3. Benefits

3.1. Scope of benefits

3.1.1. Geographical scope of benefits

The insurance applies to emergency treatment elsewhere than in the canton of residence in Switzerland and worldwide in all countries.

3.1.2. Duration of benefits

The services will only be provided until such time as repatriation is medically acceptable.

The obligation to provide benefits in respect of illnesses and accidents which occurred during the period of insurance shall in all cases expire no later than 91 days after the expiry of the insurance.

3.2. Condition for provision of benefits

Benefits will be provided only if the treatment is expedient and necessary for medical reasons and provided by persons who have the authorization necessary for this purpose.

3.3. Treatment costs

Over and above the compulsory health care insurance under the KVG law, accident insurance under UVG and any additional insurance cover existing with ÖKK Versicherungen AG, the insurance pays benefits to cover treatment costs in the case of emergency treatment as an outpatient or inpatient.

The cover extends to illness, accident or premature birth at the habitual local rates or the 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 applicable to Switzerland is not insured.

3.4. Transport costs, search, rescue and repatriation actions

If an insured person falls seriously ill, suffers a serious accident or dies, the insurer will – on the basis of a medical report – provide the following services organized by the ÖKK emergency call centre and pay the costs of:

- medically necessary rescue actions and emergency transport by an appropriate means of transport to the nearest suitable place of treatment;
- search actions which are undertaken with a view to rescuing or recovering the insured person and rescue/recovery operations costing up to CHF 20,000.– per insured person;
- medically necessary transport of the sick or injured person to a suitable hospital in the canton of residence for treatment as an inpatient;
- return transport of the deceased person to his or her place of residence.

3.5. Travel to visit the patient and additional travel costs

3.5.1. Travel to visit the patient

If an insured person falls seriously ill or suffers a serious accident abroad and must remain in hospital for more than 7 days, the insurer will organize and pay for a visit to the bedside by a person close to the insured person (1st class rail ticket, economy class air travel).

3.5.2. Special return journey

If an insured person must be transported back for urgent medical reasons from abroad to a suitable hospital in the canton of residence for treatment as an inpatient, the ÖKK Emergency Call Centre will organize the special return journey for insured members of family travelling with the patient or for a person close to him or her. The additional costs incurred will be covered.

If an insured person falls ill or suffers an accident and cannot set out on the planned return journey by reason of a hospital stay, the ÖKK Emergency Call Centre will organize the special return journey for the insured person, the members of family who are insured and travelling with him or her or a person close to him or her. The additional costs incurred are covered.

3.6. Cover sums

The following variants are possible:

3.6.1. ÖKK TOURIST 50/100

For all the benefits, the cover sum amounts to a total of CHF 50,000.– per insured person, subject to a maximum of CHF 100,000.– per insured family. The following variants may be taken out (duration of stay abroad):

- up to max. 17 days
- up to max. 40 days

3.6.2. ÖKK TOURIST 250/500

For all the benefits, the cover sum amounts to a total of CHF 250,000.– per insured person, subject to a maximum of CHF 500,000.– per insured family. The following variants may be taken out (duration of stay abroad):

- up to max. 17 days
- up to max. 40 days

3.7. Service benefits

3.7.1. Advance towards hospital costs

If an insured person has to be hospitalized abroad, the insurer will, if necessary, pay an advance of up to CHF 20,000.– towards hospital costs. If part of the amount paid in advance is not covered by the existing insurance, this will be billed to the insured person for repayment within 30 days.

3.7.2. Notifying persons at home

If measures were organized by the ÖKK Emergency Call Centre, the latter will notify members of family of the insured person of the circumstances and the action taken.

3.7.3. Arranging hospitals and medical contacts abroad

The ÖKK Emergency Call Centre will, if necessary, arrange for an insured person to visit a physician or a hospital at the place where he or she is staying. In the event of communication problems, the ÖKK Emergency Call Centre will provide interpretation assistance.

3.7.4. Medical advice from physicians

If an insured person requires medical assistance while travelling and this cannot be provided at the place where he or she is staying, the physicians at the ÖKK Emergency Call Centre will give medical advice. This advice is only a suggestion and must not under any circumstances be regarded as a diagnosis.

3.8. Limitations of benefits

3.8.1. Principle

The rules concerning the limitation of benefits pursuant to the common terms and conditions of ÖKK Versicherungen AG do not apply to ÖKK TOURIST.

3.8.2. Exclusion of benefits

No entitlement to insurance benefits exists:

- a) for illnesses and sequels of accidents which already existed at the time when the journey began or whose existence was known to the insured person when the journey began and medical treatment was foreseeable;
- b) if the insured person has travelled abroad for the purpose of treatment, care or childbirth;
- c) for illness or accident sequels which would have been excluded from cover under any existing insurance with ÖKK for the insured person;
- d) if the ÖKK Emergency Call Centre has not given its permission in advance for search actions, repatriation, travel to visit or special return travel;
- e) in the event of involvement in acts of war, unrest and similar events and during foreign military service;
- f) in the case of illness or accident as a consequence of warlike events which occurred more than 14 days previously;
- g) in the case of illness or accident as a consequence of active involvement in criminal actions, fights and other acts of violence;
- h) if the illness or accident is caused by gross negligence, especially as a result of the abuse of alcohol, medicines or other drugs;
- i) in the case of health damage caused by a hazardous action, i.e. if the insured person exposes himself to a risk without taking or being able to take measures to reduce the risk to a reasonable extent. 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;
- k) if the health damage was brought about deliberately, including as a consequence of suicide, attempted suicide or self-inflicted injury.

If the emergency transport or repatriation is rendered impossible by circumstances external such as strike, riot, acts of violence, major industrial accidents, radioactivity, natural disasters, epidemic illnesses or force majeure, its organization and implementation cannot be demanded.

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 shall be time-barred two years after the occurrence of the circumstance which caused the insurer to become liable to provide benefits.

4. Cost-sharing

No cost share is charged on benefits provided by ÖKK TOURIST.

5. Obligations in the event of a claim

5.1. Notification of the ÖKK Emergency Call Centre

In the event of sudden illness, accident or premature birth in Switzerland or abroad necessitating hospital treatment or assistance measures, the ÖKK Emergency Call Centre must in each case be notified without delay.

5.2. Release from the obligation of secrecy

The insured person releases treating practitioners and other medical personnel, as well as the insurers, from their obligation of secrecy vis-à-vis the ÖKK Emergency Call Centre and/or the insurer.

5.3. Notification of claim

The insured person must notify the claim immediately to the scheme and make available all information with the necessary medical and administrative particulars. Only detailed original bills will be accepted. If the details on the bill are insufficient and the requested supplementary information is not made available, the benefits will be fixed at the due discretion of the insurer.

5.4. Return of rail or air tickets

Unused rail or air tickets must be forwarded to the scheme without a special request to do so. If unused tickets have been sold or refunded by third parties, the compensation obtained will be imputed against the insurance benefits. In the event of failure to respect this obligation, the insurer may require the insured person concerned to refund an amount determined at the insurer's due discretion or offset this amount against the claim for benefits.

6. Services of third parties

6.1. General

If a third party is liable for a notified case of illness or accident by law or through his or her own fault, the insurer is not liable to provide benefits or is at most liable to pay the proportion which is 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 schemes

Benefits covered by social insurance schemes (KV, UV, IV, MV, AHV, AVI etc.) will be not be taken over. Claims must be notified to the relevant social insurance scheme. If an insured person has no valid compulsory health care insurance under KVG or equivalent cover in the Principality of Liechtenstein, the insurer provides benefits that would have been available, had such cover existed.

6.4. Existing insurance policies with ÖKK Versicherungen AG

Other existing supplementary insurance with ÖKK Versicherungen AG shall take precedence over the benefits under ÖKK TOURIST.

6.5. Air rescue service or similar organization

If membership (patronage) of an air rescue service or a similar organization exists, costs are only accepted to the extent that no benefits are provided by the organisation(s) in question. Differing contractual agreements are reserved.

ÖKK PROTECT

Edition 1.1.2011

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1. Principles of the insurance

1.1. Insurance provider

The insurance provider of the ÖKK PROTECT healthcare legal protection insurance is Coop Rechtsschutz AG, Entfelderstrasse 2, 5000 Aarau (referred to below as the insurer).

The intermediary health insurance is ÖKK.

1.2. Common provisions

The common provisions of ÖKK Versicherungen AG are an integral part of the provisions of healthcare legal protection insurance. In the event of any conflict, the provisions of the ÖKK PROTECT healthcare legal protection insurance take priority over the common provisions of ÖKK Versicherungen AG.

1.3. Collective contract

The healthcare legal protection insurance is provided on the basis of the collective contract between ÖKK Versicherungen AG and the insurer.

2. Scope of cover

2.1. Basis of contract

The content of the contract is governed by these General Conditions of the ÖKK Protect healthcare legal protection insurance, the Swiss Federal Law on Insurance Contracts (VVG), the Swiss Federal Law on the Supervision of Insurance Companies (VAG) as well as the Ordinance on the Supervision of Private Insurance Companies (AVO).

2.2. Insured disputes

The following disputes are insured in connection with damage to the insured's health:

- disputes concerning liability (e.g. with medical service providers, keepers of motor vehicles following motor accidents etc.), in particular:
 - enforcement of claims for compensation on grounds of inappropriate treatment
 - obligation to provide information to the insured person on the possible effects of medical acts
 - incorrect information and withholding of information, especially in respect of the
 - inspection of documents concerning medical examinations
 - release of x-ray pictures
 - omission to perform examinations.
- disputes concerning insurance law (e.g. with the third party liability insurance, accident insurance, health insurance, disability insurance etc.).

2.3. Subsidiarity

An entitlement to legal protection applies only and insofar as the benefits/services do not have to be paid/rendered by another insurer. Excluded are disputes with medical service providers and their liability insurers.

2.4. Disputes which are not insured

The following are not insured:

- events not specially listed
- cases which occurred before this insurance policy came into effect
- disputes between the insured and Coop Rechtsschutz AG or its governing bodies and appointed representatives
- events in connection with
 - psychiatric and psychotherapeutic treatments
 - fees and accounts (except in respect of services which have not been provided)
 - ÖKK premium statements
 - the defence of third party compensation claims.

3. Insured persons

The persons who have taken out ÖKK PROTECT insurance with ÖKK are insured.

In addition, insurance is provided for all persons who:

- are insured under a joint policy with ÖKK, together with the person named above
- children and young people up to their 18th birthday who live in the same household as the person named above and are insured with ÖKK.

Where an insured person dies as a consequence of an insured event, his or her successors-in-title are insured for that event.

4. Commencement, duration and termination of the insurance

4.1. General

Commencement, duration and termination of the insurance are determined by the common provisions of ÖKK Versicherungen AG.

The insurance can only be taken out and held in conjunction with at least one of the following insurance departments:

- GENERAL SUPPLEMENT
- PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- KOMBI
- ÖKK FAMILY
- ÖKK FAMILY FLEX
- ÖKK SALTO
- ÖKK MONDIAL-BASIS
- ÖKK DENTAL

Where a person, who satisfies the conditions of ÖKK PROTECT, leaves the joint policy, ÖKK PROTECT insurance cover remains in force. However, the insured person has a right of withdrawal within three months of due notification.

4.2. Termination of the collective contract

The insurance expires in the event of termination of the collective contract between the insurer and ÖKK Versicherungen AG. Termination must be notified in writing to the insured person at the latest one month before the insurance cover expires.

5. Geographical scope

The insurance cover is provided worldwide.

6. Duration

Legal protection is granted for disputes which occur during the period of insurance. The dispute is deemed to have arisen at the time of the infringement, in cases concerning insurance law at the time of the insured incident. With the termination of this insurance the entitlement to legal protection for cases which have arisen after this date also ceases.

7. Insured benefits

The insurer provides the following benefits:

- Protection of the insured person's legal interests through the legal service of Coop Rechtsschutz
- The payment up to CHF 250'000 (or CHF 50'000.- for cases other than Europe and countries bordering on the Mediterranean) per case for:
 - the costs of appointed lawyers
 - the costs of appointed experts
 - the costs of legal proceedings and court costs charged to the insured person
 - the costs of collecting the compensation promised to the insured person
 - the procedural costs imposed upon the insured person and payable to the other party.

The following will not be paid:

- compensation for damage
- the costs which a liable third party is required to cover.

Any judicially awarded reimbursement of fees and costs of legal proceedings and attorney's fees must be assigned.

8. Legal protection claims

8.1. Notification of a legal protection claim

The occurrence of a legal protection claim must be notified to the insurer or to ÖKK immediately and at their request in writing. 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. In the event of breach of these obligations through the fault of the insured person, the insurer may diminish his benefits if this negligence has caused additional costs to be incurred. In the case of a serious breach benefits may be withheld.

8.2. Processing a legal protection claim

After discussing the matter with the insured person, the insurer takes the measures necessary to defend his interests. If the consultation of an attorney-at-law proves necessary, in particular for court or administrative tribunal proceedings or in the event of conflicts of interest, the insured person may freely choose an attorney. Where there are no valid reasons to change an attorney the insured person must bear the resulting costs.

8.3. Procedure in the event of differences of opinion

In the event of differences of opinion over further action, especially in cases which the insurer regards as hopeless, an arbitration tribunal procedure will be organized at the request of the insured person. A person appointed jointly by both parties will be the arbitrator. The procedure is governed by the regulations of the arbitral jurisdiction according to the Swiss Code of Civil Procedure (ZPO). If an insured person takes proceedings at his own expense, the contractual services will be provided if the outcome of the main proceedings is more favourable than in the insurer's view.

9. Place of jurisdiction

The place of jurisdiction shall be the Swiss place of residence of the insured person or Aarau.

ÖKK Risk capital in the event of death or disability caused by accident

Edition 1.1.2009

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Where the GTC do not mention the female form, the male form explicitly includes all female persons.

1. Principles of the insurance

1.1. Insurance provider

The insurance provider is SOLIDA Versicherungen AG, Zurich (hereafter referred to as the insurer).

ÖKK Versicherungen AG and SOLIDA Versicherungen AG have effected a group insurance contract in order to provide insurance cover in the event of death or disability caused by an accident.

ÖKK Versicherungen AG and the broking insurance company ÖKK Kranken- und Unfallversicherungen AG (hereafter referred to as ÖKK) will not assume any liability arising from this risk capital insurance.

1.2. Common provisions

The common provisions of ÖKK Versicherungen AG (common provisions) are an integral part of the general terms and conditions of insurance (GTC) of ÖKK risk capital in the event of death or disability caused by accident. In case of divergences, the GTC will prevail the common provisions.

1.3. Age regulations

The age of the insured relevant for the insurance cover corresponds to the difference between the calendar year and the year of birth.

2. Scope of cover

The insurance covers all occupational and non-occupational accidents, including occupational illnesses, if they are eligible for compensation in virtue of the Federal Law on Accident Prevention (Ger. UVG Art. 6-9) at the time of their occurrence.

The term «accident» denotes the sudden, unintended, harmful influence of an unusual external factor on the human body. In addition to the bodily damage referred to in the common provisions, the following are classified as accidents:

- damage to health caused by the involuntary respiration of gases and vapours and by the accidental taking of toxic and corrosive substances,
- drowning,
- the following health damage in so far as the insured person incurs it involuntarily and it is caused by an insured accidental event: freezing, heat stroke, sun stroke and health damage caused by ultraviolet radiation except for sunburn.

3. Insured persons

3.1. Principle

The insurance covers individual persons who applied for an accident insurance in accordance with the present GTC and have received the corresponding insurance policy.

3.2. Maximum age of affiliation

The insurance can be taken out up to the 65th birthday.

4. Inception and duration of insurance

4.1. General

The inception and duration of the insurance are determined by the common provisions of ÖKK Versicherungen AG. Accidents as well as any consequences arising therefrom are covered if the accident occurred within the insurance period.

4.2. Changes to the insurance

The sum insured can be increased up to the 65th birthday.

5. Termination of insurance

5.1. Principle

The termination of the insurance is determined by the common provisions.

5.2. Termination of the group insurance contract

The insurance cover expires with the termination of the group in-surance contract between the insurer and ÖKK Versicherungen AG. The termination must be notified in writing to the insured no later than one month before the expiry of the insurance cover.

6. Geographical scope

The insurance applies worldwide. In the event of a removal to a foreign country, the continuation of the insurance will be determined by the provisions of ÖKK MONDIAL.

7. Sums insured

7.1. Limits of sums insured

The sums insured stated in the insurance policy apply.

7.2. Maximum sums insured

7.2.1. Maximum sums insured for children

The maximum sum insured in the event of death of children up to the age of 15 amounts to CHF 20,000.-.

The legal capital in the event of death from this and other insurances shall not exceed CHF 2,500.- for children who are not yet two and a half years old or CHF 20,000.- for children who are not yet twelve years old.

7.2.2. Maximum sums insured above the age of 65

From the age of 66, the maximum sums insured amount to CHF 20,000.- in the event of death and CHF 100,000.- in the event of disability. The progression of the disability insurance does not apply.

7.3. Maximum sums insured in case of aircraft accidents

The maximum guarantee provided by the insurer for a single person under all the accident insurance policies held by him combined is limited to CHF 500,000.- in the event of death in an aircraft accident and CHF 1,000,000.- in the event of total disability (with a corresponding reduction for partial disability).

8. Capital insurance in the event of death

8.1. Beneficiaries

If the accident results in the death of the insured person either immediately or within five years of the date of the accident, the insurer will pay the sum insured for the event of death to:

- to the surviving spouse,
- in the absence of such surviving spouse to the children, adopted children and stepchildren in equal parts,
- in their absence to the parents in equal parts,
- in their absence to the brothers and sisters, provided that they were not yet 25 years old at the time of the accident.

Spouses and children of a marriage concluded after the accident are not entitled to benefits.

The insured person may amend aforementioned provision and designate or exclude beneficiaries by notifying ÖKK in writing. Any such declaration can be cancelled or amended at any time by the insured person by written notification.

If there is no entitled person, the insurer will pay the costs of the burial subject to a maximum of 10 % of the sum insured, limited to a maximum of CHF 10,000.-.

8.2. Double sum insured in the event of death

If the same accident causes the death of both parents, the insurer will pay the double capital in the event of death of each insured parent in equal shares to minor or permanently unemployable children, step- and adoptive children in need of support.

8.3. Imputation of the disability capital

Any disability capital already paid out for the same accident is imputed against the capital in the event of death.

9. Disability capital insurance

9.1. Principle

If the accident results in a disability of an insured person that is likely to be permanent, the insurer will pay the agreed sum insured for disability:

- in the case of total disability the full sum insured,
- in the case of partial disability a part of the sum corresponding to the degree of disability.

The final determination of the degree of disability shall not be made until the condition of the insured person is deemed to be probably permanent, but no later than five years after the accident. Relevant is the current degree of disability ascertained at the time of determination. Changes to the degree of disability after this determination, i.e. relapses and late effects will not be taken into account. Any loss of income or incapacitation from work caused by the accident will not be taken into account when determining the degree of disability. Only the insured person is entitled to a disability capital.

9.2. Total disability

Total disability means

- the loss of or inability to use both arms or hands,
- the loss of or inability to use both legs or feet or the simultaneous loss of an arm or a hand and a leg or a foot,

- total paralysis,
- total blindness.

9.3. Partial disability

In the event of partial disability, the insurer will pay the proportion of the sum insured provided for total disability corresponding to the degree of disability.

The degree of disability will be determined according to the following scale:

Loss of or complete inability to use

- upper arm	70 %
- forearm	65 %
- hand	60 %
- thumb with middle finger	25 %
- thumb, middle finger undamaged	22 %
- tip of the thumb	10 %
- index finger	15 %
- middle finger	10 %
- ring finger	9 %
- little finger	7 %
- leg at the upper thigh	60 %
- leg at the lower thigh	50 %
- foot	45 %
- big toe	8 %
- toe	3 %
- sight of one eye	30 %
- sight of the 2nd eye for one-eyed persons	50 %
- hearing of both ears	60 %
- hearing of one ear	15 %
- hearing of one ear if the hearing of the other had already been completely lost before the insurance claim occurred	30 %
- sense of smell	10 %
- sense of taste	10 %
- kidneys	20 %
- spleen	5 %
- very painful and severe functional impairment of the spinal column	50 %

In the event of only partial loss or partial inability to use, a correspondingly reduced degree of disability shall apply.

If the degree of disability cannot be determined according to the scale, it will be determined according to the Federal Law on accident insurance (Ger. UVG) and the decree on accident insurance (Ger. UVV). In particular, the tables «Integritätsentschädigung gemäss UVG» (benefits in the event of bodily harm according to the UVG) published by SUVA shall apply.

In the event of simultaneous loss or simultaneous inability to use several parts of the body in consequence of the same accident, the degree of disability is generally determined by adding the percentages. However, the degree of disability cannot exceed 100 %. In the event of loss of all fingers of one hand, the disability payment applicable to the loss of that hand shall be the maximum benefit payable.

9.4. Severe disfiguration

For permanent, severe disfiguration of the human body caused by an accident (cosmetic damage, e.g. scarring) for which no disability capital is payable, but which causes a more difficult social position for the insured person, the insurer will pay the following in respect of the sum insured for disability, limited to:

- 10 % for disfiguration of the face,
- 5 % for disfiguration of other, normally visible parts of the body.

The benefit for cosmetic damage is limited to CHF 20,000.-. The progression does not apply.

9.5. Pre-existing bodily deficiencies

If the consequences of an accident have been made worse by pre-existing bodily deficiencies, except for loss of the second eye or hearing of the second ear, no higher benefits will be paid. If parts of the body had already been wholly or partially lost or become unusable before the accident, the existing degree of disability ascertained according to the aforementioned principles is deducted when determining the degree of disability.

If pre-existing illnesses or conditions, which were not caused by the accident, have made the consequences of the accident significantly worse, insurance benefits will be reduced proportionally already with the determination of the degree of disability and not when determining the disability capital.

9.6. Compensation for disability

In the event of disability of more than 25 %, compensation shall be increased progressively up to 350 % of the sum insured.

Degree of disability (%)	Compensation sum insured (%)	Degree of disability (%)	Compensation sum insured (%)
1	1	36	58
2	2	37	61
3	3	38	64
4	4	39	67
5	5	40	70
6	6	41	73
7	7	42	76
8	8	43	79
9	9	44	82
10	10	45	85
11	11	46	88
12	12	47	91
13	13	48	94
14	14	49	97
15	15	50	100
16	16	51	105
17	17	52	110
18	18	53	115
19	19	54	120
20	20	55	125
21	21	56	130
22	22	57	135
23	23	58	140
24	24	59	145
25	25	60	150
26	28	61	155
27	31	62	160
28	34	63	165
29	37	64	170
30	40	65	175
31	43	66	180
32	46	67	185
33	49	68	190
34	52	69	195
35	55	70	200

Degree of disability (%)	Compensation sum insured (%)	Degree of disability (%)	Compensation sum insured (%)
71	205	86	280
72	210	87	285
73	215	88	290
74	220	89	295
75	225	90	300
76	230	91	305
77	235	92	310
78	240	93	315
79	245	94	320
80	250	95	325
81	255	96	330
82	260	97	335
83	265	98	340
84	270	99	345
85	275	100	350

10. Benefit limitations

10.1. Principle

The rules on benefit limitations according to the common provisions do not apply.

10.2. Benefit exclusions

No entitlement to insurance benefits exists:

- as a consequence of war, civil war or circumstances similar to war
 - in Switzerland, in the principality of Liechtenstein or in neighbouring countries,
 - in the remaining foreign countries 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 if he/she was taken by surprise by the outbreak of the war-like events,
- as a result of an earthquake in Switzerland or in the principality of Liechtenstein,
- as a result of exceptional risks which include:
 - foreign military service,
 - participation in warlike actions, terrorist acts, perpetration of crimes,
 - participation in scuffles and fights, unless the insured person is harmed by the fighting parties as an uninvolved bystander or while helping a defenceless person,
 - risks taken by the insured person by strongly provoking others,
 - the consequences of unrest of all kinds, unless the insured person proves that he or she did not play an active part on the side of the persons causing the unrest and did not provoke them to further unrest,
- as a result of the deliberate perpetration of or participation in crimes or offences by the insured person or an attempt to do so, even if only by accepting such crime/offence,
- as a result of the effect of ionising radiation and damage caused by nuclear energy,
- in the case of accidents in which the insured person has a blood alcohol content of two parts per 1,000 by weight or more, unless there is manifestly no causal relationship between drunkenness and the accident,

- as a result of acts of daring (actions in which the insured person exposes himself/herself to a particularly great 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 which the insured person has caused deliberately or in a state in which he or she was not in full or partial possession of his or her faculty of judgement,
- as a result of the deliberate administration or injection of medicines, drugs or chemical products,
- as a result of medical or surgical interventions, which were not necessitated by an insured accident,
- during the use of aircrafts as a military pilot, other military crew member and parachutist,
- in military parachute jumps,
- in aviation if the insured person has deliberately infringed official requirements or is not in possession of the appropriate official licences and permits,
- for the statutory and regulatory cost contributions by the insured person to the compulsory health insurance.

10.3. Reductions of benefits

10.3.1. Gross negligence

The insurer waives the right to reduce the benefits if the insured accident was caused by gross negligence.

10.3.2. External factors in an accident

If external factors influence the course of an insured accident, the insurer will only provide part of the agreed benefits determined on the basis of a medical examination. The external factors will already be deducted when determining the degree of disability and not when determining the disability capital.

10.3.3. Breach of obligations in the event of a claim

In the event of deliberate infringement by the insured person of his or her obligations, the benefits may be reduced.

10.3.4. Further benefit reductions

Further benefit reductions depend on the provisions of UVG (Art. 37 - 39) applicable at the time of the accident or the time when the occupational illness occurred.

10.4. Death caused by a person entitled to benefits

If a beneficiary deliberately caused the death of the insured person by the perpetration of a crime or offence, he or she shall have no entitlement to pecuniary benefits. If the beneficiary person has caused the death of the insured person by gross negligence, the benefits due to him or her shall be reduced. In particularly severe cases benefits may be refused.

11. Retraining costs

If professional retraining is necessary due to an accident for which the insurer has provided benefits, the insurer will pay appropriate costs subject to a maximum of 10 % of the insured disability sum.

12. Premiums

The conditions on premiums and payments according to the common provisions shall apply.

13. Conduct in the event of a claim

Any accident which may make the insurer liable for benefits shall be reported to ÖKK without delay. Death must be notified immediately and at the latest within ten days.

The insured person must undergo the examinations and follow the orders of any medical practitioner retained by the insurer at his ex-pense.

In case of loss of all entitlements due to omission, the insured person shall give the insurer all desired information about the present and previous state of health and about the course of the accident and recovery within 30 days from the corresponding written request. The insured person and 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 or she is treated in consequence of the accident or illness from the obligation of confidentiality to provide information requested by the insurer.

If the insured person or persons entitled to claim fail, through their own negligence, to comply with these obligations, the insurer shall be authorized to reduce the benefits by the amount by which it would have been reduced in the event of notification in due time, unless the insured persons or the persons entitled to benefits can prove that the conduct in breach of the contractual obligations had no influence on the consequences of the accident and on the determination thereof.

14. Notification to the insurer

All notifications and communications must be sent to ÖKK. The insurer acknowledges such notifications and communications as being made to him. All notifications by the insurer are made with valid legal effect to the person insured or entitled to claim at their last indicated address in Switzerland.

15. Place of performance and jurisdiction

In addition to the place of jurisdiction of Zurich, the insurer likewise recognizes the jurisdiction at the place of residence of the insured or entitled person in Switzerland for disputes arising from this contract. The insurer performs his liabilities at the domicile of the insured or entitled person.

16. Applicable law

This insurance shall be governed by the provisions of the Federal Law of 2 April 1908 on insurance contracts (Ger. VVG).

ÖKK Risk capital in the event of death or disability caused by illness

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1. Basis of the insurance

1.1. Basis

The insurance contract shall be based on the individual insurance application, the insurance policy, the Common Provisions (ÖKK CP), the General Conditions of Insurance for risk capital insurance upon death or disability as a result of illness (GCI IDD) and, subsidiarily, the provisions of the Swiss Federal Insurance Contracts Act of 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 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 IDD) 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 (ÖKK CP) form an integral part of this risk capital insurance policy. In the event of any discrepancies, the General Conditions of Insurance (GCI IDD) shall take precedence over the Common Provisions (ÖKK CP).

1.4. Insurance carrier

The insurance carrier is Swiss National Life Insurance Ltd, Bottmingen (hereinafter "Insurer"). Claims arising from this insurance contract 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 IDD) are insurable under this policy.

The insurance is available to individuals who are insured under an ÖKK health or supplementary health insurance policy at the time of application or who have applied for such a policy and will become ÖKK insureds.

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 insured ("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

ÖKK 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 peace-keeping 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 insurance 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).
- A capital disability benefit is paid.
- The policy is cancelled in accordance with the Common Provisions (ÖKK 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 2 1/2 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	Maximum sum insured for death (CHF)	Maximum sum insured for disability (CHF)
Infants up to 0-3 years	20,000.- *	150,000.-
Children up to 4-15 years	20,000.-	150,000.-
Adults up to 16-50 years	300,000.-	300,000.-
Adults up to 51-55 years	200,000.-	200,000.-
Adults up to 56-65 ** years	100,000.-	100,000.-

* The maximum statutory lump-sum death benefit shall be CHF 2,500 for children under the age of 2 1/2 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.

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 for the calculation of the 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 the capital disability benefit

The capital disability benefit shall be graded and determined in accordance with the degree of occupational disability of the insured.

- 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 parttime 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. Basis for the calculation of the 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 (ÖKK CP).

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 (ÖKK 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 IDD) 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.

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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 ÖKK. In the event of a claim, benefits due from the Insurer shall be paid out via ÖKK.

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 ÖKK.

5.7. Jurisdiction and applicable law

In the event of a dispute arising from this 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 IDD) above are effective as of 1 January 2010.

The insured shall be notified of any amendments to the General Conditions of Insurance (GCI IDD) at least three months prior to their entry into force.

5.9. Governing language version of the General Conditions of Insurance (GCI IDD)

In the event of a dispute concerning or arising from this contract, the German language version of the General Conditions of Insur-

ance (GCI IDD), of which this is a translation of, shall in all cases govern and be the policy document to which reference shall be made by the relevant tribunal.

ÖKK COMPENSA

ÖKK Versicherungen AG, Edition 1.1.2010

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1. Fundamentals of the insurance

1.1. Purpose

ÖKK COMPENSA (insurance against loss of earnings for individuals under VVG) is provided in compliance with the provisions of the Swiss Federal Law on insurance contracts.

It is used to cover the loss of earnings caused by incapacitation from work through illness, accident or birth.

ÖKK COMPENSA is also offered to persons who are not in active employment.

1.2. General terms and conditions of insurance (GTC) and common provisions

The common provisions of ÖKK Versicherungen AG are an integral part of the general insurance conditions for ÖKK COMPENSA. In the event of any differences, the general terms and conditions of insurance take precedence over the common provisions.

2. Affiliation conditions

Self-employed, employed and non-active persons (i.e. housewives and househusbands, persons following training and members of family working in a family concern without cash payments) can be affiliated to ÖKK COMPENSA provided that:

- they are at least 15 and not more than 60 years old
- they are fully capable of working when the affiliation application is made
- they reside in Switzerland or in a neighbouring foreign country.

3. Geographical validity

3.1. General

The insurance applies worldwide.

3.2. Incapacitation from work abroad

In the event of private holiday travel abroad the insured daily allowances are paid only during hospital stays. These rules likewise apply to frontier workers outside Switzerland and away from their place of residence. Presence abroad for professional reasons is reserved.

3.3. Presence abroad during incapacitation from work

If an insured person who is incapacitated and entitled to benefits travels abroad without the consent of the Fund, no entitlement to benefits exists during the stay abroad. This limitation does not apply to frontier workers when they are present in Switzerland.

4. Insurance variants

The following insurance variants may be chosen:

- daily allowance for illness
- daily allowance for accident
- daily allowance for illness and accident

These insurance variants can be taken out with different benefit durations.

5. Procedure for taking out the insurance

5.1. Medical certificate

The Fund may require a medical certificate or an examination by the consultant medical officer. It may designate the doctor and bears the costs.

5.2. Transfer from group insurance

The general terms and conditions of the loss of earnings insurance for businesses (Ger. VVG) apply to transfer from the group to individual insurance.

5.3. AHV retirement age

Insured persons who remain in active employment after reaching the AHV retirement age may apply for insurance to continue. However, this arrangement cannot continue beyond their 70th birthday.

6. Notice of termination

6.1. Extraordinary termination

If the insured person has equivalent insurance against loss of earnings with a new employer under a new situation in employment law, termination is possible, by derogation from ordinary notice, with the approval of the Fund by giving one month's notice to the end of a month.

6.2. Other reasons for termination

Apart from the reasons for termination mentioned in the common provisions, the insurance lapses in the following cases:

- a) if a self-employed insured person gives up his business activity
- b) in the event of transfer of the place of business abroad except to a neighbouring foreign place
- c) if bankruptcy proceedings are opened in respect of the self-employed insured person
- d) on retirement. However, an application may be made for insurance to continue until the 70th birthday
- e) in the event of removal abroad, except to take up residence at a place in a neighbouring country

The insurer may withdraw from the contract within 30 days.

- f) if the insured person repeatedly and seriously infringes rulings of the Fund or instructions given by a doctor
- g) in the event of willful breach of the general terms and conditions of insurance.

7. Scope of insurance

7.1. Amount of the insured daily allowance

The amount of the insured daily allowance is agreed between the insured person and the Fund.

7.2. Basis of assessment of the daily allowances

7.2.1. General

The daily allowance is calculated as one 365th part of the insured loss of income in any one year. The calculated daily allowances are paid for every calendar day.

7.3. Maximum cover

7.3.1 Insurable daily allowance

The amount of the insurable daily allowance per person is limited to CHF 200,000.- per year. For persons who transfer from a group insurance contract by ÖKK, daily allowance is limited to CHF 250,000.- per year.

7.3.2. Self-employed persons

Insured persons whose income is derived from self-employment may, over and above their income liable for AHV payments, additionally insure provable ancillary expenses according to the last contribution ruling. These expenses are costs which relate directly to the insured person, are directly connected to earnings and continue to exist during incapacitation from work, in particular fixed costs for business rental, motor vehicle, insurance, machine depreciation etc.

7.3.3. Employees

Insured persons whose income is derived from gainful employment by a third party may take out insurance in an amount equivalent to the gross salary liable for AHV contributions.

7.3.4. Non-active persons

Housewives and househusbands, persons in education and members of family working in family businesses without a cash salary may take out insurance up to the amount of the simple AHV maximum pension.

7.3.5. Unemployed persons

The maximum cover for unemployed persons corresponds to the loss of unemployment compensation.

7.4. Accident cover

Accident cover can be included in the insurance or insured separately.

7.5. Birth

The daily allowance includes cover for loss of earning on the occasion of childbirth.

7.6. Commencement of benefits and waiting periods

The insurer offers daily allowance insurance with different benefit starting dates.

The entitlement to benefit begins after the expiry of the waiting period. The waiting period begins on the first day of incapacitation from work according to the medical certificate, but not earlier than three days before the first medical treatment. Waiting periods for up to 21 days inclusive are recalculated for each case of illness or accident. Longer waiting periods apply once each calendar year only.

Waiting days are days on which incapacitation of at least 25% exists.

The insurer pays the daily allowance according to the chosen start of benefits after entitlement to draw benefits begins for the days on which medically certified incapacitation from work exists.

On reaching the AHV retirement age, an agreed waiting period of 60 days or more is converted into a waiting period of 30 days.

7.7. Adjustment of the insurance

7.7.1. Adjustment to inflation

The insured person may ask for his insurance to be adjusted to the annual rate of inflation according to the national consumer price index. ÖKK grants this adjustment without any risk screening provided that no incapacitation from work has existed in the past two years and no daily allowance is drawn. Adjustment is possible for the last two completed calendar years.

The insured person may also apply at any time for his insurance to be adjusted to the real trend of salaries on the conditions applicable to higher insurance.

7.7.2. Unemployed persons

Unemployed persons may convert their insurance with an appropriate premium adjustment, regardless of their state of health, into insurance with a 30 day waiting period. The amount of the insured daily allowance is reduced to the level of unemployment compensation at the beginning of unemployment.

8. Benefits

8.1. Conditions for benefits

8.1.1. Incapacitation from work

Incapacitation from work exists if the insured person is wholly or partially unable by reason of illness, accident or childbirth to exercise his previous or other reasonable employment activity.

Partial incapacitation exists if incapacitation from work of at least 25% is present.

8.1.2. Medical certificate

Daily allowances are based on a medical certificate of incapacitation from work for the insured person.

ÖKK may choose the doctor.

8.2. Scope of benefits

8.2.1. General

The benefits are determined according to the agreed scope of insurance and the existing insurance conditions.

8.2.2. Self-employed and inactive persons

In the case of self-employed persons and persons not in active employment the insurer pays the agreed daily allowances.

8.2.3. Employed persons

In the case of persons in gainful employment, the total daily allowances paid out must not exceed the loss of earnings of the insured person.

8.2.4. Partial incapacitation from work

In the event of partial incapacitation from work of at least 25% the daily allowance is correspondingly reduced.

For unemployed persons who are incapacitated from work by a percentage of more than 25% and a maximum of 50%, one half of the daily allowance is paid, and the full daily allowance in the case of incapacitation of more than 50%.

8.2.5. Accident

If the accident risk is insured, the benefits in the event of accident are paid on the same scale as in the event of illness.

8.2.6. Birth

Daily allowances on childbirth are paid on condition that prior to the birth equivalent cover for an uninterrupted period of at least 270 days existed with ÖKK or a different insurer (waiting period in case of maternity).

Insured persons who gave up their gainful activity more than 8 weeks before birth or who do not receive maternity benefits pursuant to the income compensation act (Ger. EOG) are not considered as gainfully active.

In the event of birth, COMPENSA will pay benefits in addition to the maternity benefits according to the income compensation act (Ger. EOG), limited to the agreed daily allowance sum.

8.3. Duration of benefits

8.3.1. Principle

For illness and accident combined, the insured daily allowance is paid out for a maximum of 730 or 365 days. The duration of benefits is listed in the insurance policy and measured according to the particular insurance claim.

Illness or the sequels of accidents are treated as a new insurance claim if the insured person has been fit for work for an uninterrupted period of 12 months since the end of the last benefit payments.

The agreed waiting period is imputed against the maximum duration of benefits. Days of partial incapacitation from work count as full days for determination of the duration of benefits.

8.3.2. Childbirth

Entitlement to insurance benefits starts on the day of birth.

If a daily allowance was insured in the same amount for at least three full insurance years prior to the childbirth, the maximum duration of benefits is 16 weeks, i.e. in addition to maternity compensation 2 additional weeks at the rate of the insured daily allowance in the event of birth. The duration of benefits for a shorter insurance period is 8 weeks.

In the case of childbirth, the same waiting period applies as in the case of illness. The waiting period is imputed against the duration of benefits on childbirth regardless of the illness or accident. If the waiting period was imputed against the duration of benefits because of complications during pregnancy, a new imputation of the waiting period is waived in respect of the childbirth allowance.

Childbirth allowances are imputed against the maximum duration of an insurance claim.

8.3.3. AHV retirement age

In the event of further insurance at AHV retirement age, an entitlement to the insured daily allowance exists for 90 days, for persons transferring from a collective insurance by ÖKK for 180 days, but no later than until the 70th birthday.

8.3.4. Unemployed persons

Unemployed persons receive the insured daily allowance at the latest until the end of a maximum period of payment pursuant to the provisions of the Swiss Federal Act on Compulsory Unemployment Insurance and Insolvency Compensation.

8.3.5. Transfer from group insurance

For insured persons who have left the circle of insured persons under a group insurance and were insured under the scaled cover according to the general insurance conditions for insurance against loss of earnings for businesses (VVG), the maximum duration of benefits is 365 days.

8.4. Limitation of benefits

8.4.1. Exclusion of benefits

Apart from the benefit exclusions mentioned in the common provisions, there is no entitlement to insurance benefits:

- a) for the consequences of accidents and occupational illnesses which are to be covered by a different insurer;
- b) if a certificate of incapacitation from work was issued by a doctor or chiropractor who is not recognized by the insurer;
- c) if the insured person deliberately receives or seeks to receive unlawful benefits;
- d) if the degree of incapacitation from work of the insured person is less than 25%;
- e) for employees for the duration of unpaid leave;
- f) after the expiry of the insurance contract.

8.4.2. Limitation of benefits

Apart from the benefit limitations mentioned in the common provisions, benefits may be reduced:

- a) if the illness or sequels of accident are only partially the cause of the incapacitation;
- b) if the insured person repeatedly and seriously fails to comply with rulings of the Fund or instructions given by a doctor;
- c) if the insured person declines a medical examination by the consultant medical officer required by the Fund;
- d) if the insured person refuses to exercise another reasonable employment activity.

8.4.3. Compulsory reimbursement

Benefits paid erroneously or unjustifiably must be refunded by the insured person to the insurer.

9. Obligation to participate in the event of illness or accident

9.1. Compulsory notification

The insured person must inform the Fund within five days of every incapacitation from work which might give entitlement to a daily allowance and state whether this is due to an accident or illness. In the case of agreed waiting periods of more than 21 days, the notification of incapacitation from work must be given no later than one week before any claim is made to benefits.

The certificate issued by the doctor or chiropractor must be presented to the Fund at the latest ten days after the beginning of the incapacitation from work, or in the case of waiting periods exceeding 21 days with the notification of incapacitation from work.

In the event of failure to comply without sufficient reason, the insurer only grants benefits from the date on which the report is received. Medical certificate and illness or accident reports may not be backdated by more than 3 days.

Employees must provide evidence of a loss of earnings which is not otherwise covered.

If the degree of incapacitation from work is reduced this fact must be notified to the Fund without delay.

9.2. Compulsory information

The insured person must make available to the Fund in the event of an accident all the necessary information on the reasons for the accident with particulars of third parties involved in the accident.

In the event of frequent short absences within a relatively short period of time, the Fund is entitled to require the insured person to visit a doctor on the first day of incapacitation from work.

The Fund may verify the incapacitation from work and the uncovered loss of earnings in every case and make appropriate checks if necessary.

The obligations to provide information pursuant to the common provisions likewise apply.

10. Premiums and payments

10.1. Amount of premiums

The amount of the premium is calculated as a function of the risk having regard e.g. to age, place of residence, benefits drawn or branch of the insured person. Persons who are transferred from the loss of earnings insurance for businesses to an individual insurance form a separate risk group.

The common provisions likewise apply to the fixing of the premium, payment of the premium, premium arrears and premium adjustments.

10.2. No claims discount (NCD)

10.2.1. Principle

A premium discount is granted if no claims are made.

10.2.2. Observation period

The observation period is the period between 1 September or the start of insurance and the subsequent 31 August. The date of processing of a daily allowance account is the determining factor for calculation of benefits in the observation period.

10.2.3. Bonus stages

The following bonus stages or premiums are applicable:

Bonus stage	Premium
0	100%
1	64%

The fixing of the bonus stages may be adjusted to the trend of costs.

10.2.4. Adjustment of stage if benefits are drawn

If the insured person has claimed benefits during an observation period, adjustment to bonus stage 0 will take place on 1 January of the following year unless the insured person is already in this stage.

10.2.5. Adjustment of stage if no benefits are drawn

If the insured person has not claimed any benefits during three successive observation periods in bonus stage 0, adjustment to bonus stage 1 will take place on 1 January of the fourth year.

10.2.6. Change of insurance cover

The bonus stage is maintained in the event of any change of insurance cover within ÖKK COMPENSA.

10.3. Payment of benefits

10.3.1. Payment of daily allowances

The daily allowance is paid out on the basis of a medical certificate when the person concerned becomes fit for work again. If the incapacitation from work lasts for more than one month, the daily allowance is generally paid out monthly.

10.3.2. Childbirth allowances

Childbirth allowances for employed and self-employed women are only payable after the settlement of the maternity compensation pursuant to EOG has been submitted to the fund.

11. Third party benefits

11.1. Employees and persons not in active employment

Days with partial benefits due to a reduction because benefits are payable by a third party count as whole days for the calculation of the period of benefits in the waiting period.

The rules of the common provisions likewise apply.

11.2. Self-employed persons

For self-employed persons, the scope of benefit corresponds to the agreed daily allowance total. The rules on over-insurance pursuant to the common provisions do not apply.

On the other hand, no benefits charged to social insurance schemes (KV, UV, IV, MV, AHV, AVI, EO, BV, FL etc) are accepted.

Benefit claims must be registered with the insured's social security scheme.

The insured shall assign to the insurer any claims on the social security scheme for additional payments, in the event that the insurer has made advance payments.