General Insurance Conditions (GIC)

ÖKK UNO product line

Edition 2023

General Insurance Conditions ÖKK UNO product line

Edition 2023

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This text is a translation. In the event of any discrepancy between the English and the German version, the original German version shall prevail.

You can find the latest versions of the Insurance Conditions under www.oekk.ch/gic or in your ÖKK agency.

ÖKK BASIS

ÖKK Kranken- und Unfallversicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurer

The insurer is ÖKK Kranken- und Unfallversicherungen AG, Landquart. The insurer is specified on the policy.

1.2 Legal basis

The Swiss Health Insurance Act (KVG) and the Swiss Federal Act on the General Aspects of Social Security Law (ATSG) shall take precedence over these General Insurance Conditions.

1.3 Purpose

ÖKK BASIS is compulsory health care insurance in accordance with the KVG. It provides benefits in the case of illness, accident and maternity.

2. Insurance

2.1 Insured persons

In particular, persons who are resident in the insurer's area of activity are insured. The group of insured persons conforms to Art. 3 KVG.

2.2 Acceptance process

2.2.1 Application

Applications are made using the pre-printed form. The questions listed on the form must be answered completely and truthfully.

2.2.2 Insurance policy and GIC

After being accepted, the insured person receives an insurance policy and these GIC.

2.3 Duration of insurance

The start and end of the insurance is based on Art. 5 KVG.

2.4 Change of residence

2.4.1 General provisions

The insurer must be notified of any changes of address or residence within 30 days. A change of residence is considered to be a change of a person's civil law domicile.

2.4.2 Moving abroad

Employees who are posted abroad by their company domiciled in Switzerland remain insured for two years and on request, up to six years. People who live in an EU member state in accordance with an agreement on the free movement of persons and continue to require insurance in Switzerland, as well as people in the public service who are working abroad, are required to have insurance indefinitely. Family members can remain insured to the same degree.

When moving abroad from Switzerland, a contact address in Switzerland must be given.

If treatment is received in an EU member state, ÖKK BASIS provides benefits in accordance with the social insurance tariff and cost-sharing rules that apply in the corresponding country.

In other foreign countries, in case of emergency ÖKK BASIS pays up to twice the amount of the tariff applicable at the person's most recent place of residence in Switzerland.

2.5 Accident cover

2.5.1 Suspension of accident cover

Insured persons who have compulsory occupational and non-occupational accident insurance may request that their accident cover be suspended. The premium is adjusted as of the beginning of the month after the request is made.

2.5.2 Withdrawal from accident insurance

If insured persons withdraw from the accident insurance in accordance with the UVG, they shall notify the insurer of this within one month.

2.6 Change to forms of insurance

Deductibles may be changed as of the beginning of a calendar year. When changing to a lower deductible, the notice period is three months as of the end of the calendar year.

It is possible to change from ÖKK BASIS to ÖKK BASIS CASAMED or ÖKK BASIS ECOPLAN as of the beginning of a calendar year. When changing from ÖKK BASIS CASAMED or ÖKK BASIS ECOPLAN to ÖKK BASIS, the notice period is three months as of the end of the calendar year.

2.7 End of insurance

2.7.1 General provisions

Insurance shall end upon

- termination of the policy;
- moving abroad, except where the person is still required to have insurance;
- death.

2.7.2 Termination

The insured person may terminate the policy subject to three months' notice as of the end of a calendar half-year.

After new premiums are announced, the insured person may terminate the policy subject to one month's notice as of the end of the month before the new premiums enter into effect.

In both cases, the key date in this regard is the date the insurer receives the notice of termination (not the date of the postmark).

The insurance policy does not end until the new insurer has confirmed that the insured person is insured with it without any interruption of insurance cover.

2.7.3 Consequences of insurance ending

After the insurance has ended, apart from any outstanding insurance benefits, no legal claims whatsoever exist against the insurer.

Insured persons shall meet their financial obligations to the insurer.

3. Benefits

3.1 General conditions relating to insurance benefits

3.1.1 Eligibility to claim benefits

The insured person is eligible to claim benefits for the duration of the insurance cover.

3.1.2 Benefits in the case of illness, accident, birth defects, maternity

ÖKK BASIS provides benefits for the diagnosis and treatment of illnesses, accidents, birth defects and in case of maternity.

In particular, the benefits cover

- examinations, treatment and care measures by doctors and chiropractors;
- medically prescribed medication, analyses and aids;
- medical or medically prescribed preventative measures;
- hospital stays corresponding to the standard on a general ward;
- medical rehabilitation measures;
- care measures in a care home;
- care services outside of hospitals;
- medically prescribed balneotherapy treatments;
- rescue costs and costs for medically required transport;
- dental treatments; and
- maternity benefits.

3.1.3 Benefits abroad

If medically required treatment is received in an EU/EFTA member state, ÖKK BASIS provides benefits in accordance with the social insurance tariff and cost-sharing rules that apply in that country. In other foreign countries, in case of emergency ÖKK BASIS pays up to twice the amount of the tariff applicable at the person's place of residence in Switzerland.

No benefits abroad are provided if the purpose of the trip abroad is to receive treatment, subject to Art. 34, para. 2 KVG.

In accordance with the provisions of the agreement on the free movement of persons, persons resident in an EU member state who are required to have insurance may receive treatment in their country of residence.

3.1.4 Conditions for receiving benefits

ÖKK BASIS covers costs for benefits that are effective, expedient and economical. Benefits are considered economical if they are limited to the extent that they are in the interests of the insured person and are necessary for the purpose of treatment.

The insurer reimburses benefits from recognised service providers in accordance with the KVG.

3.1.5 Invoicing, reimbursement

The insured person owes the service provider for the benefits invoiced if the benefits are not settled directly between the insurer and the service provider.

If the insured person requests a reimbursement from the insurer, they must submit the relevant invoices and prescriptions. After checking the entitlement to benefits, the insurer reimburses the insured person for the amount invoiced less the cost-sharing amount.

The insured person may have invoices checked by the insurer before paying them.

3.1.6 Loss mitigation and duty of cooperation

Insured persons must do everything which is conducive to curing their condition and desist from any action which may delay this. In particular, they must follow the instructions of medical professionals.

Where medical or professional examinations are necessary and reasonable, the insured person must undergo such examinations.

Insured persons must provide the insurer with all information required to assess their claim and determine the insurance benefits at their own cost. In particular, the insured person shall report all benefits received from third parties in the case of illness, accident or disability.

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

On request, the insured person must agree to an examination by a second doctor or by the insurer's independent medical examiner. The insurer shall bear the costs for this.

Insured persons must inform the insurer about an accident at the latest within ten days. They must provide the insurer with all the necessary information.

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

3.2 Outpatient treatment

3.2.1 Duration of benefits

In the event of outpatient treatment, benefits are paid out in accordance with the KVG with no time limit.

3.2.2 Service providers

In particular, service providers include:

- doctors;
- pharmacies;
- chiropractors;
- midwives;
- laboratories;
- dispensation points for resources and objects;
- physiotherapists;
- ergotherapists;
- nurses; and
- speech therapists.

3.2.3 Scope of benefits

In the event of outpatient treatment, ÖKK BASIS provides benefits in Switzerland.

3.2.4 Choice of service provider

The insured person may choose from the service providers approved to provide treatment in accordance with the KVG.

Benefits are calculated on the basis of the agreements and tariffs concluded between the service providers and the insurer.

3.2.5 Medications

ÖKK BASIS provides benefits for medically prescribed medications in accordance with the List of Medications with Tariff (LMT) and the List of Specialities (LS) of the Federal Department of Home Affairs (FDHA).

3.2.6 Analyses

ÖKK BASIS provides benefits for medically prescribed analyses for diagnostic purposes or therapeutic control, provided they are included on the List of Analyses (LA) of the FDHA and are carried out by a pharmacist or laboratory.

3.2.7 Aids

ÖKK BASIS provides benefits for resources and objects in accordance with the List of Objects and Resources (MiGeL).

3.2.8 Alternative medicine

ÖKK BASIS provides benefits for medically prescribed alternative medical treatments in accordance with the Health Care Benefits Ordinance (KLV).

3.2.9 Medical prevention

ÖKK BASIS provides benefits for medically prescribed preventative examinations or measures in accordance with the KLV, in particular for childhood inoculations and gynaecological preventative examinations.

3.3 Inpatient treatment

3.3.1 Hospital

ÖKK BASIS provides benefits for acute inpatient treatment and medical rehabilitation corresponding to the standard on a general ward.

The insured person may select a hospital in Switzerland from a cantonal hospital list (list hospital).

ÖKK BASIS provides benefits up to the amount of the tariff applicable in a list hospital in the canton of residence.

ÖKK BASIS provides benefits for medically required treatment and emer-

gencies up to the amount of the tariff applicable in the list hospital of the respective canton.

ÖKK BASIS provides benefits for treatment on a semi-private or private ward of a list hospital up to the amount of the tariff applicable for the general ward of a list hospital in the canton of residence.

3.3.2 Cost guarantee, invoicing
If a referral diagnosis has been issued, the insurer provides the insured person with a cost guarantee covering their entitlement to benefits.

3.4 Care services
ÖKK BASIS provides benefits for medically prescribed outpatient care services provided by recognised organisations or nurses outside of a hospital at the insured person's home.

ÖKK BASIS provides benefits for medically prescribed care services in recognised care homes in accordance with Art. 39 para. 3 KVG.

3.5 Balneotherapy treatments
ÖKK BASIS provides up to CHF 10 per day, up to 21 days per calendar year for medically prescribed balneotherapy treatments.

The insured person may select the medically guided, recognised spa in Switzerland.

ÖKK BASIS also provides benefits if the insured person does not stay at the spa on an inpatient basis.

The medical prescription with diagnosis must be submitted to the insurer two weeks before entering the spa.

If the stay in the convalescent facility is interrupted, ÖKK BASIS provides benefits for partial treatment costs if the interruption was a result of illness or other compelling reasons and a medical certificate was obtained from the convalescent facility.

3.6 Transport and rescue costs
ÖKK BASIS provides benefits totalling 50%, up to CHF 500 per calendar year, of the costs of any medically required transport.

ÖKK BASIS provides benefits totalling 50%, up to CHF 5,000 per calendar year, of the costs of any rescue carried out in Switzerland.

3.7 Dental treatment
ÖKK BASIS provides benefits for major dental treatment resulting from an accident or illness in accordance with the KLV.

ÖKK BASIS provides benefits in accordance with the contractual and tariff agreements provided the dentist is authorised to carry out treatment in accordance with the KLV and a diagnosis, treatment plan and quote have been issued.

3.8 Maternity
3.8.1 Scope of benefits
ÖKK BASIS provides benefits for check-ups carried out by doctors or midwives or that are medically required during pregnancy and for up to 10 weeks after the birth. If there is no special medical indication, the costs of up to seven examinations during pregnancy and one check-up after the birth are reimbursed.

ÖKK BASIS provides benefits for births at home, in hospitals or in birth houses in accordance with the contractual and tariff agreements.

3.8.2 Care costs for child
The ÖKK BASIS policy of the mother provides benefits for the care costs for the child, provided the child stays with the mother in hospital and is insured with the insurer.

3.8.3 Antenatal courses and breastfeeding consultations
ÖKK BASIS provides up to CHF 150 towards antenatal courses and reimburses the costs of up to three breastfeeding consultations.

3.9 Benefit restrictions
3.9.1 Reduction and suspension of benefits
There is no entitlement to benefits for the treatment of illnesses of consequences of accidents that are to be covered by another insurer or third party.

Benefits may be temporarily or permanently reduced or, in serious cases, refused if the insured person withdraws from or refuses to undergo reasonable treatment or if they do not make reasonable efforts of their own to ensure their recovery. In such cases, the insured person receives a written reminder and is warned that the benefits will be reduced or refused.

3.9.2 Excessive invoices and uneconomical treatment
If an invoice is for an excessive amount or the treatment is uneconomical, the insurer may refuse to reimburse or reduce the amount of the benefits. It may make any payment of such benefits contingent on the claim for reduction being ceded. Any amounts already reimbursed may be reclaimed from the service provider by the insurer or the insured person.

3.9.3 Reimbursement obligation
Any benefits obtained in error or wrongfully may be reclaimed by the insurer.

3.10 Third-party benefits, over-compensation
3.10.1 Third-party benefits
If a third party is liable for an illness or accident for legal or contractual reasons or due to negligence, the claims of the insured person against the third party are transferred to the insurer to the extent of the benefits already provided. If there is more than one liable party, they shall be liable for the recourse claims of the insurer on a joint basis.

If other social insurers are obliged to provide benefits, the insurer is required to provide benefits first.

3.10.2 Over-compensation
Benefits from social insurers and other parties obliged to provide benefits may not exceed the costs incurred by the insured person as a result of the insurance event.

In the event of over-compensation the insurer reduces the benefits.

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4. ÖKK BASIS CASAMED
4.1 Purpose
ÖKK BASIS CASAMED is a special form of ÖKK BASIS. The choice of service providers is restricted.

4.2 Principle
The insured persons may, in agreement with the insurer, restrict their right to freely choose the service provider.

There are various insurance models available within ÖKK BASIS CASAMED for this purpose.

Under these insurance models, the insurer can restrict the choice of doctors, therapists or other service providers such as hospitals, pharmacies or medical supply stores.

ÖKK BASIS CASAMED only provides the statutory compulsory benefits if they are provided or prescribed by a service provider approved under the se-

lected insurance model (depending on the insurance model selected: general practitioner, HMO doctor, telemedical institution, pharmacy, hospital etc.).

The approved service provider may refer the insured person to a further provider. Referrals by service providers to whom insured persons were referred by their general practitioner require the latter's consent. If the insured person is not referred, the benefits may be reduced.

If the benefit is provided by a service provider that is not available under the selected insurance model, the insured person is liable for these costs.

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

In the case of a stay abroad of more than six months, the insurer, after receiving notification from the insured person, may transfer them to ÖKK BASIS as of the end of the current month, because there is no guarantee that any treatment will be carried out by service providers approved under the selected insurance model.

For insurance models with a fixed selection of service providers (general practitioner or HMO practices), it is possible to change the doctor selected. The insurer must be notified of any changes. The change takes effect as of the first day of the following month. The documents required for treatment are forwarded to the new general practitioner or HMO practice.

The insurer may stipulate an age limit of 18 for treatment by paediatricians.

4.3 Exceptions

ÖKK BASIS CASAMED provides benefits for routine treatments carried out by ophthalmologists, gynaecologists and paediatricians without prior consultation with the service provider approved under the selected insurance model. If these doctors perform more extensive treatment, the insured person must notify their general practitioner or HMO practice (depending on the model selected).

In the event of emergency, ÖKK BASIS CASAMED provides benefits without any restrictions on choosing doctors or other service providers. The insured person must notify their general practitioner or HMO practice (depending on the model selected) within 20 days of the emergency.

The insurer reserves the right to have its independent medical examiner verify the medical indication.

5. ÖKK BASIS ECOPLAN

5.1 Purpose

ÖKK BASIS ECOPLAN is a special form of ÖKK BASIS. The choice of hospitals is restricted.

5.2 Principle

The insurer specifies the hospitals which are generally entrusted with the treatment of the insured person.

ÖKK BASIS ECOPLAN does not provide benefits if the service is provided by a hospital which is not eligible to be selected. The insured person is liable for these costs.

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

In the case of a stay abroad of more than six months, the insurer, after receiving notification from the insured person, may transfer them to ÖKK BASIS as of the end of the current month, because there is no guarantee that any treatment will be carried out by the responsible hospital.

5.3 Exceptions

ÖKK BASIS ECOPLAN provides benefits for treatments that cannot be carried out in an ECOPLAN hospital.

In the event of emergency, ÖKK BASIS ECOPLAN provides benefits without any restrictions on choosing the hospital.

The insurer reserves the right to have its independent medical examiner verify the medical indication.

6. Cost sharing

6.1 Standard cost sharing

6.1.1 Deductible and excess

The insured person contributes towards the costs of the benefits provided to them via a deductible and an excess.

The minimum deductible is CHF 300 per calendar year for adults. There is no deductible for children.

The excess amounts to 10% of the benefits in excess of the deductible, up to CHF 700 for adults and CHF 350 for children per calendar year.

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

No cost-sharing amounts are charged for healthcare benefits from the 13th week of pregnancy, during birth and for up to 8 weeks after birth. Please refer to the Swiss Health Insurance Act (KVG) and the Federal Health Insurance Ordinance (KVV) for details in this regard.

6.1.2 Excess for medications

In principle, the insured person contributes 10% towards the cost of medications. For originator products, which are significantly more expensive than medications containing the same active ingredients, an excess of 20% applies. The Health Care Benefits Ordinance (KLV) governs the details in this regard.

6.1.3 Hospital contribution

The insured person contributes towards the cost of stays in hospital at a rate of CHF 15 per day.

Children up to 18 years of age, young adults up to 25 years of age, if they are in education, and women from the 13th week of pregnancy, during birth and for 8 weeks after birth are exempt from paying this contribution. Please refer to the Swiss Health Insurance Act (KVG) and the Federal Health Insurance Ordinance (KVV) for details in this regard.

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

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

If children have different optional deductibles, the cost-sharing amount is determined based on the highest deductible for all children of one family insured with ÖKK BASIS.

7. Premiums

7.1 Determining the premium

The insurer determines the applicable premiums. They may be graduated by canton and region according to differences in costs.

7.2 Premium reductions

Reduced premiums apply for insured persons

- up to 18 years of age;
- up to 25 years of age;
- who have cancelled their accident insurance;
- with optional deductibles;
- in ÖKK BASIS CASAMED; and
- in ÖKK BASIS ECOPLAN.

7.3 Reduced premiums

The individual reduced premiums comply with Art. 65 KVG.

7.4 Premium exemptions during military and civilian service

Insured persons who are covered by military insurance (MV) for more than 60 consecutive days are exempt from paying premiums.

7.5 Premium payment

7.5.1 Due date and payment period

Premiums are to be paid in advance. The shortest payment period is the calendar month. Premiums are to be paid without interruption, even in the event of illness, accident, or inability to work or if the entitlement to benefits is suspended.

7.5.2 Payment fees

The insured person has various options for paying their premiums and cost-sharing amounts without any additional fees. The insurer may pass on any fees, such as those incurred when making a payment at the post office, to the insured person.

7.5.3 Default of payment

If insured persons do not pay outstanding premiums or cost-sharing amounts, the insurer sends them a request for payment after at least one written reminder. In this reminder, the insurer stipulates an extension to the due date of thirty days and informs the insured person of the consequences of delayed payments. If, despite this request for payment, the insured person does not pay the premiums, cost-sharing amounts and interest on arrears within the deadline stipulated, the insurer will initiate debt collection proceedings.

Any expenses relating to reminders or collection proceedings resulting from defaults of payment are borne by the insured person.

The insured person may not change insurer for as long as the outstanding premiums, cost-sharing amounts, interest on arrears and debt collection costs have not been paid in full.

7.5.4 Pledging and assignment

Claims against the insurer may not be pledged and may only be assigned in the cases provided for in the KVG.

8. Administrative contract

8.1 General provisions

The insurer can conclude administrative contracts for specific groups of persons.

8.2 Alternative conditions

Persons covered by administrative contracts are in principle subject to the same benefits and premiums as other insured persons.

The insurance conditions can differ from these GIC. The conditions of the administrative contract take precedence over these GIC.

In particular, alternative conditions relate to

- a simplified acceptance process;
- a different method of premium payment;
- the administrative contract partner as a third-party payer;
- the transfer to the administrative contract partner of the obligation to provide information;
- a different procedure for processing benefits and cost-sharing; and
- a simplified procedure for accident exclusion.

9. Administration of justice

9.1 Decision

If an insured person or applicant does not agree with a decision, the insurer will, on request, issue a written, reasoned decision including an explanation of the right of appeal within 30 days.

9.2 Appeal

An appeal against this decision can be lodged with the insurer within 30 days of the decision being issued. The insurer reviews the appeal and issues a written, reasoned appeal decision including an explanation of the further right of appeal.

9.3 Cantonal insurance tribunal

An objection to the appeal decision can be lodged with the cantonal insurance tribunal within 30 days of the appeal decision being issued.

To be entitled to lodge an objection, the person must be impacted by the contested decision or appeal decision and have a legitimate interest in having it annulled or amended

The responsible body is the insurance tribunal in the canton in which the insured person or the third party lodging the objection resides. An objection can also be lodged with the insurance tribunal if the insurer does not issue an order or appeal decision by the specified deadline.

If the insured person or third party lodging the objection resides abroad, the insurance tribunal of the canton in which they were last resident or in which their last employer is domiciled shall be responsible. If none of these locations can be determined, the insurance tribunal at the insurer's place of domicile is responsible.

9.4 Legal force

If no appeal or objection is lodged within the relevant deadline, or if the objection is legally rejected, the order or appeal decision of the insurer enters into legal force. Legally binding pecuniary orders are equal to enforceable judicial decisions within the meaning of Art. 80 of the Swiss Federal Act on Debt Enforcement and Bankruptcy (DEBA).

9.5 Legal protection

If the insured person is in a dispute with service providers in relation to treatment costs, according to the KVG, the insurer can, at the request and expense of the insured person, take responsibility for pleading the case before the responsible court, provided the legal challenge has some hope of success.

10. Final provisions

10.1 Changes

Any changes to these GIC shall be communicated to the insured person in a written notification, in the customer magazine or in an official publication.

10.2 Entry into force

These GIC enter into force on 1 January 2023 and replace all previous versions.

ÖKK

Common Provisions

ÖKK Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Principle

In accordance with these General Insurance Conditions (hereinafter referred to as ÖKK UNO GIC), supplementary insurance policies and further insurance policies are offered in addition to health care insurance under KVG.

1.2 Insurance providers

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

The insurer for the ÖKK PROTECT health-legal protection and the ÖKK TOURIST travel legal protection insurance is Coop Rechtsschutz AG, Aarau. ÖKK Versicherungen AG, as the policyholder, has concluded a collective insurance contract with Coop Rechtsschutz AG as the insurer.

The insurer for the ÖKK TOURIST cancellation costs insurance as well as the ÖKK TOURIST luggage insurance is Helvetia Swiss Insurance Company Ltd, St. Gallen. These insurance policies are the responsibility of European Travel Insurance, branch office of Helvetia Swiss Insurance Company Ltd, domiciled in Basel. ÖKK Versicherungen AG, as the policyholder, has concluded a collective insurance contract with European Travel Insurance as the insurer.

The insurer for ÖKK RISK CAPITAL INSURANCE IN THE EVENT OF DISABILITY OR DEATH CAUSED BY AN ACCIDENT is SOLIDA Versicherungen AG, Zurich. ÖKK Versicherungen AG, as the policyholder, has concluded a collective insurance contract with SOLIDA Versicherungen AG as the insurer.

The insurer for ÖKK RISK CAPITAL INSURANCE IN THE EVENT OF DISABILITY OR DEATH CAUSED BY ILLNESS is Squarelife Insurance AG, Ruggell, Liechtenstein. ÖKK Versicherungen AG, as the policyholder, has concluded a collective insurance contract with Squarelife Insurance AG as the insurer.

1.3 Scope of insurance

The insurance covers the financial consequences of illness, accident and maternity as well as in relation to travel incidents, personal assistance, cancellation costs, luggage and travel legal protection for the duration for which the insurance is concluded.

Provided it is stipulated in the provisions of the individual insurance products, accident insurance can be excluded.

Risk capital insurance policies covering death and disability resulting from an accident or illness are fixed-sum insurance policies. All other supplementary and additional insurance policies are indemnity insurance policies.

1.4 General Insurance Conditions

Unless special conditions have been agreed in an individual contract, the ÖKK UNO GIC govern the insurance relationship.

The Common Provisions of the ÖKK UNO GIC (hereinafter referred to as ÖKK UNO CP) apply for all the insurance products listed below. Details concerning the benefits can be found in the provisions of the individual insurance products. If the provisions of the individual insurance products differ from the ÖKK UNO CP, the provisions of the individual insurance product take precedence over the ÖKK UNO CP.

1.5 Conditions for framework contracts/collective insurance policies

The ÖKK UNO GIC also apply for framework contracts/collective insurance policies in the area of treatment costs. Alternative conditions may be agreed in the individual framework/collective contracts.

The provisions in framework/collective contracts take precedence over the ÖKK UNO GIC.

The policyholders covered by the framework contract can obtain the terms and conditions that apply to them from the insurer.

Policyholders in collective contracts (in particular employers) must notify the insured persons of the key content of the collective contract as well as any changes or annulments in writing. The insurer shall provide the policyholder with the documentation required for this purpose.

1.6 Insurance Contract Act

Unless these terms and conditions contain regulations to the contrary, the provisions of the Federal Act on Insurance Contracts (VVG) of 2 April 1908, as updated on 1 January 2022, shall apply (also for contracts concluded before 1 January 2022).

2. Insurance departments

2.1 Insurance possibilities

The insurance products covered by these ÖKK UNO GIC are as follows:

- ÖKK GENERAL SUPPLEMENT and ÖKK PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- ÖKK COMBI: GENERAL, SEMI-PRIVATE, PRIVATE, GLOBAL, FLEX, COMFORT
- ÖKK PRIVATE ACCIDENT
- 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 products are managed with CASAMED and/or ECOPLAN variants.

2.2 Selected insurance departments

The insurance policy specifies the insurance products that have been concluded. Any special provisions or agreements that differ from those in the ÖKK UNO GIC are also noted in the insurance policy.

3. Insured persons

3.1 Individual insurance

The persons listed in the insurance policy are insured.

3.2 Framework contract/collective insurance

The framework contract specifies the group of people to whom the terms and conditions of said framework contract shall apply.

The collective contract specifies the group of insured persons.

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

4. Start and duration of insurance

4.1 Process for concluding insurance

4.1.1 Application

Applications to conclude the insurance must be made in writing. The questions listed on the form must be answered by the person making the application completely and truthfully.

Persons who are not authorised 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.

If the contract is dissolved, the insurer's obligation to provide benefits shall also expire in respect of claims already made, the occurrence or extent of which were related to the non-disclosed/incorrectly disclosed material risk factors. The insurer has a right to be reimbursed to the extent that benefits have already been paid out.

By submitting an application to conclude insurance policies, the applicant authorises the insurer to obtain the information from medical personnel and other insurers that is necessary to conclude the insurance and clarify any subsequent obligation to provide benefits.

The insurer may require a medical certificate or order a medical examination at its own expense.

Policyholders shall ensure that they can provide all necessary information concerning the insured persons.

4.1.3 Documentation

Upon concluding the insurance policies, the policyholder receives:

- the insurance policy
- the General Insurance Conditions (the latest version of the General Insurance Conditions can be found at www.oekk.ch/gic. A printed copy can be requested from any ÖKK Agency).

4.1.4 Right of revocation

The application to conclude insurance policies may be revoked within 14 days of it being made. In providing notice of revocation, all obligations of the insurer lapse.

This deadline is deemed to have been met if the policyholder notifies the insurer of the revocation or sends its revocation declaration by post on the last day of the revocation period.

4.2 Start of insurance

The insurance starts on the date specified on the insurance policy.

4.3 Duration of insurance

4.3.1 General provisions

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

4.3.2 Longer duration of insurance

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

4.3.3 Timing of conclusion of insurance

Insurance may be concluded at any time, even 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 automatically extended by one year at the end of every year, unless it is terminated by the policyholder subject to the standard notice period.

4.4 Changes to the insurance

4.4.1 Changes on the part of the policyholder

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 on the part of 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, the insurer is authorised to amend the GIC. These far-reaching changes include an increase in the number of medical service providers or new categories of medical service providers, an expansion of the medical benefits offered, the introduction of new, cost-intensive forms of therapy or medication, as well as similar developments or amendments to social insurance legislation.

These new GIC will be communicated to the policyholder 30 days in advance. The policyholder has the right to withdraw from the affected insurance products as of the date the changes enter into force within 30 days of being informed of such changes. If policyholders do not provide notice of termination within this period, they are deemed to have agreed to the new GIC.

4.5 Suspension of insurance

4.5.1 Requirements

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 notice.

5. End of insurance

5.1 Termination by the policyholder

5.1.1 Standard 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 each claim for which the insurer has provided benefits, the policyholder may terminate the corresponding part of the contract in writing within 14 days of receiving payment or becoming aware that the insurer has taken responsibility for covering said benefits. The premium is payable until the termination of the contract.

5.1.3 Receipt of notice of termination
The key date in this regard is the date the insurer receives the notice of termination and not the date of the postmark.

5.1.4 Collective contract
If a collective contract is terminated, the insurance contracts with the insured persons are individually continued as individual policies without any health check necessary.

When leaving a collective contract, the insured persons have the right to transfer to individual insurance with the same level of cover and without any health check necessary. This right of transfer must be exercised within 30 days of leaving the collective contract. After the conditions for the individual insurance are subsequently announced, the insured person must notify the insurer of their decision whether to continue the individual insurance within 30 days. The key date in this regard is the date the insurer receives such notification.

5.1.5 Framework contract
If a framework contract is terminated, the existing insurance contracts with the policyholders are continued outside of the framework contract. There is a right to terminate the contract in accordance with section 8.2 (Changes to discount conditions).

When the policyholder leaves the framework contract, their existing insurance contract is continued outside of the framework contract. They are no longer eligible for the special conditions under the framework contract. This does not give rise to an extraordinary right to terminate the contract.

5.2 Termination by the insurer
Only the policyholder has an ordinary right to terminate the contract and a right to terminate the contract in the event of a claim.

The insurer has a right to terminate the insurance in the following cases in particular:

a) Collective daily allowance insurance
b) Breaches of disclosure obligation when submitting an application
c) Attempted or successful insurance fraud
d) For good cause (in accordance with Art. 35b VVG)

The policyholder also has a right to terminate the contract for good cause (in accordance with Art. 35b VVG).

5.3 Other grounds for termination
The insurance likewise expires in the following cases:

a) on the death of the insured person;
b) on moving abroad (unless the insurance has been suspended);
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; and
f) in the cases stipulated by law, in particular if there are outstanding premiums or cost-sharing amounts (see also section 8.3.2).
g) upon dissolution of the collective contract between ÖKK and the insurer (see also section 1.2). In such a case, only the respective cover will be cancelled and not the whole insurance contract as such. For claims that occurred during the duration of the contract, cover will still be in place. If the collective contract is dissolved, ÖKK may conclude a new collective contract with a subsequent insurer in order to continue the previous coverage. The policyholder reserves the right to refuse any questionable continuation of coverage.

6. Benefits
6.1 Definition of terms
6.1.1 Illness
Illness is any impairment of physical, mental or psychiatric health that is not the result of an accident and results in a medical examination or treatment, or an inability to work.

6.1.2 Chronic illness
A chronic illness is any permanent, constant health impairment, which requires care, but not constant medical attention.

6.1.3 Accident
An accident is the sudden, unintended injurious impact of an exceptional external factor on the human body, which results in an impairment of the person's physical, mental or psychological health, or death.

The following conclusive list of physical injuries are considered equivalent to accidents, provided they were not primarily caused by illness or attrition:
a) Bone fractures
b) Dislocations of joints
c) Meniscal tears
d) Muscle tears
e) Pulled muscles
f) Tendon tears
g) Ligament lesions
h) Injuries to the ear-drum.

Physical injuries within the meaning of the above paragraph do not include non-accident-related damages to objects which were used as a result of an illness and replace a body art or bodily function.

Accidents also include occupational illnesses which are recognised as accidents in accordance with the UVG.

6.1.4 Maternity
Maternity includes pregnancy and birth, as well as the recovery period for the mother. Benefits relating to pregnancy and birth are insured the same as for illness, provided the mother has been insured with the insurer for at least 270 days (qualifying period) at the time of the birth or, if she previously had equivalent insurance with another insurer, provided there is confirmation that this insurance was concluded at least 270 days before the birth (and there is confirmation of this).

6.1.5 Birth defects
Birth defects are those illnesses that exist following birth.

6.1.6 Acute-care hospitals
Acute-care hospitals are those treatment facilities that can provide the medical and nursing services and have the technical infrastructure in place required to treat acute illnesses, accidents and for births that require continuous medical monitoring.

6.1.7 Acute treatments
Acute treatments refer exclusively to inpatient treatments in acute-care hospitals (excl. psychiatric clinics and rehabilitation clinics).

6.1.8 Psychiatric clinics
A psychiatric clinic (also referred to as a neurological clinic) is a specialist hospital that treats mental disorders and psychiatric illnesses.

6.1.9 Rehabilitation clinic
Rehabilitation clinics are those institutions that meet the necessary med-

ical-technical and infrastructure requirements and have sufficiently qualified medical nursing and therapeutic staff in order to carry out specific and targeted inpatient rehabilitation measures.

6.1.10 Types of acute-care hospitals, psychiatric clinics and rehabilitation clinics

6.1.10.1 List hospitals

An institution that is on a cantonal hospital list in accordance with Art. 39 KVG. These institutions are recognised by the insurer.

6.1.10.2 Contractual hospitals

An institution with which the insurer has entered into an agreement concerning the determination of tariffs or whose tariffs are recognised by the insurer.

A list of these recognised institutions is available from the insurer on request.

6.1.10.3 Other hospital

An institution that does not appear on a cantonal hospital list and whose tariffs are not recognised by the insurer.

6.1.11 KVG doctor

Doctors are deemed to be a KVG doctor if they fulfil the eligibility requirements to charge compulsory health care insurance for their services (as per KVG). Doctors are eligible if they have a federal diploma and further training recognised by the Federal Council.

6.1.12 Dentist

Dentists are professionals who have the corresponding federal diploma (or equivalent) or have been granted approval by the canton to exercise their profession based on a scientific certificate of proficiency.

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 cross-border workers, the insurance also covers benefits in their place of residence.

6.2.2 Period of benefits

The entitlement to benefits exists for the duration of the insurance. There is no entitlement to benefits for costs incurred after the end of the insurance, with the exception of periodic benefit obligations within the meaning of Art. 35c VVG.

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 order to provide optimum treatment for insured persons, the insurer may agree accompanying measures with the approved service providers with the aim of ensuring the insured persons receive the most effective, expedient and economic treatment through improved cooperation and coordination between the service providers and the insurer. The insurer may mandate a health advisor to carry out 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 recognised 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 Benefit restrictions

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

There is no entitlement to insurance benefits:

a) for illnesses and consequences of accidents which already existed at the time the insurance was concluded and have been excluded from the insurance by the insurer;
b) for illnesses and consequences of accidents which already existed at the time the application was made and about which insufficient/no information was provided;
c) during a qualifying period;
d) if a treatment does not serve to remedy a health problem or its consequences. This does not apply to measures carried out to prevent the impending onset or deterioration of a health problem if the person is already sick;
e) for treatments carried out by service providers not recognised by the insurer;
f) for dental treatments if the cover is not specifically regulated in the insurance product concluded;
g) if the insurance has been suspended;
h) in the event of payment defaults, from the expiry of the reminder period until all obligations have been paid in full;
i) in the case of participation in warlike actions, unrest, and similar events, and during military service abroad;
j) in the case of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
k) in the case of illnesses and accidents resulting from active participation in punishable actions, fights or other acts of violence;
l) for the consequences of earthquakes and other natural catastrophes;
m) in the event of health impairments resulting from large-scale industrial emergencies or impairments caused by nuclear energy;
n) for organ transplants in accordance with the Health Care Benefits Ordinance (KLV), Appendix 1 on transplant surgery, irrespective of where the transplant is carried out;
o) for statutory and agreed cost-sharing amounts from compulsory health care insurance; and
p) in the event of epidemic diseases.

Any further benefit exclusions can be found in the provisions of the individual insurance products.

6.4.3 Limitations of benefits

Benefits can be reduced:

a) in the case of grossly negligent causation of the illness or accident, in particular as a result of misusing alcohol, medication or other drugs;
b) 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 operations for persons are an exemption. In terms of this provision, recklessness includes in particular the participation in races or training with motor vehicles;
c) if the insured person's health is damaged intentionally, also as a suicide attempt or self-harm; and
d) if the documents needed to ascertain the insurance claim are not produced within four weeks despite a written reminder to do so. The provisions under Art. 45 VVG shall apply (absence of fault or no influence on scope of benefit).

7. Duty of cooperation in the event of illness and accident

7.1 Notification obligation

The insured person must notify the insurer of their benefits claims in due time in accordance with the provisions of the individual insurance products. 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 insurer with the necessary medical and administrative particulars. Only detailed original bills will be accepted.

7.2 Reduction of damage

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.

As part of the accompanying measures carried out by the insurer, insured persons must support the case managers' work, providing them with the necessary information.

7.3 Obligation to provide information

The insured person releases the treating doctors, other medical service providers and other insurers from the duty of non-disclosure to the insurer. The insurer may seek such information as is necessary.

On request, the insured person must agree to an examination by a second doctor or by the insurer's independent medical examiner. The insurer will pay the costs.

The insured person must give information to the insurer 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 insurer.

For incapacitated persons, the policyholder is responsible for fulfilling the obligation to provide information.

8. Premiums and payments

8.1 Determining the premium

8.1.1 General provisions

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

8.1.2 Level of premiums

The level of the premiums is determined in line with the risk entailed, for example based on the insured person's age.

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

Insured persons must provide notification of any changes in personal circumstances that may impact the calculation of the premium. If they fail to do so, any potential difference in premiums are payable retroactively.

A reduced premium is charged for suspended insurance.

8.1.3 Premium discounts and premium waivers

The insurer may grant family discounts and premium waivers for children and young adults up to 25 years of age.

Family discount

Children who have their basic and supplementary insurance with the insurer on the same family policy as at least one parent are eligible for the 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.

If the requirements are permanently met, the family discount is guaranteed for the minimum contract length; adjustments are possible thereafter (section 8.2).

Waiving the premium

The insurer may grant supplementary insurance premium exemptions from the third child if:

– the child lives in the same household with one parent and both older siblings;
– the child is insured on the same family policy with the insurer;
– the child has its basic insurance with the insurer;
– both older siblings have their basic insurance and, as a minimum, equal supplementary insurance cover with the insurer; and
– the parent has their basic insurance with the insurer and has supplementary outpatient or inpatient treatment costs insurance with the insurer.

8.2 Adjustment of premium tariffs and cost-sharing amounts

The premium tariffs and cost-sharing amounts may be adjusted in line with changes in costs and the claims history.

The premiums are also adjusted when insured persons move into the next-highest age group. The adjustment may result in a premium increase.

The age groups are usually 0 to 10, 11 to 18, 19 to 25, 26-30 and then age groups spanning five years up to the age of 60, then in ten-year steps up to the age group 81+.

For ÖKK COMBI, the first age group is 0 to 18; for ÖKK DENTAL, the first three age groups are as follows: 0 to 3, 4 to 5 and 6 to 10.

The first age group for ÖKK COMPENSA is 15 to 18 and the last is 61 to 70.

Age groups for ÖKK BLV DAILY ALLOWANCE (entry age tariff): 16 to 30, 31 to 40, 41 to 50, 51 to 65.

The premium adjustments will be communicated to the policyholder 30 days in advance. Policyholders have the right to withdraw from the affected insurance product as of the date the premium adjustment enters into force within 30 days of being informed of this adjustment.

If policyholders do not provide notice of termination within this period, they are deemed to have agreed to the premium adjustment.

If insured persons lose their entitlement to a discount when the discount conditions remain in place, this is not deemed to be a premium adjustment and does not give rise to a right to terminate the contract. By contrast, if the level of the discount changes and this was not made known when the

contract was concluded, or the discount conditions are changed, this does give rise to a right to terminate the contract.

An adjustment of the premium scale due to a change in the place of residence is not considered a premium adjustment.

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

8.3.2 Reminders and consequences of default

If premiums or cost-sharing amounts that are due are not paid within 30 days, the insurer sends the policyholder a reminder, which sets out the legal consequences of default and requests the payment of the outstanding amounts, including any reminder fees, within 14 days of the reminder being sent.

If these amounts are still not paid, the insurer's obligation to provide benefits is suspended from the expiry of the reminder deadline.

If the insurer does not demand payment of the overdue premiums within two months of the expiry of the reminder deadline, the insurer is deemed to have withdrawn from the contract. In this case, the insurer waives its rights to the payment of the overdue premiums.

If the insurer demands payment of the premiums or if the insurer subsequently takes payment of the premiums, the insurance cover is reactivated as soon as the outstanding premiums, including interest amounts and costs, are paid.

The costs of reminders and any additional administrative costs incurred as a result payment arrears are borne by the insured person.

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 insurer. 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 discount

In the COMBI Departments, excluding those with a discretionary excess, a variant with a no-claims discount can be made 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 Discount levels

For the ÖKK COMBI and ÖKK SALTO insurance products with no-claims discount, the following discount levels/premiums apply:

Discount level NCD ÖKK COMBI/ ÖKK SALTO	Premium NCD ÖKK COMBI/ÖKK SALTO
0	Ordinary premium ÖKK COMBI/ÖKK SALTO +20%
1	Ordinary premium ÖKK COMBI/ÖKK SALTO
2	Ordinary premium ÖKK COMBI/ÖKK SALTO –30% In HMO variant: Ordinary premium ÖKK COMBI/ÖKK SALTO –20% up to –30%

The premiums for ÖKK COMBI and ÖKK SALTO with no-claims discount are listed on the insurance policy. The fixing of the three discount levels 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 discount level in the case of ÖKK COMBI 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 discount level 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 domestic assistance 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 discount level 0 or discount level 1 and a simultaneous outstanding benefit claim, the change from COMBI with no-claims bonus to ordinary COMBI is possible only with a health declaration. This also applies to the change to ordinary COMBI and simultaneous reduction to a lower benefit stage.

8.6 Other payment provisions

8.6.1 Offsetting

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

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

8.6.2 Pledging and assignment

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

8.6.3 Payment 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 tariffs exist between the insurer and the benefit provider, direct payment will be made by the insurer to said providers. In the event of direct payment to the benefit providers by the insurer, the insured

person is required to reimburse to the insurer 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 Statute of limitations

The insured person's entitlement to benefits from the insurer expires five years after the event upon which the obligation to provide benefits is based.

For contracts concluded before 1 January 2022, a period of two years applies for claims of the insurer against the insured person.

9. Third-party benefits

9.1 Subsidiarity

9.1.1 General provisions

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.

Within the scope of the benefit claims against third parties, there is no obligation to provide benefits in accordance with these ÖKK UNO GIC.

9.1.2 Benefits covered by public authorities

Within the scope of the claims for benefits or reductions against cantons and municipalities, there is no obligation to provide benefits in accordance with these ÖKK UNO GIC.

9.1.3 Multiple insurance policies

Where several private insurers are liable to provide benefits, a calculation will be made to determine how much each private insurer would have had to pay had they been solely responsible. This provision likewise applies if the obligation to provide benefits of the other private insurer only exists subsidiarily.

The payment to be made under these ÖKK UNO GIC is limited to the proportion of the total insurance amount corresponding to this cover.

9.1.4 Waiver of benefits

If the insured person wholly or partially waives their right to benefits vis-à-vis third parties without the consent of the insurer, the obligation to provide benefits under these ÖKK UNO GIC no longer applies. 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 recourse

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 Overinsurance

Under indemnity insurance policies, insured persons may not make any profit from the benefits provided under these ÖKK UNO GIC taking into consideration the benefits provided by third parties. In the event of overinsurance, the benefits are reduced accordingly.

10. Data protection

10.1 Legal basis

Processing of data about insured persons shall be governed by the provisions of the Insurance Contract Act (Swiss VVG) and the Federal data protection law.

10.2 Purpose of processing data

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 Forwarding of 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 Data storage

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 insurer within 30 days in writing.

When spending time outside Switzerland, a contact address in Switzerland must be given.

All notifications provided by policyholders or insured persons must be sent to the responsible branch of the insurer.

Notifications from the insurer are duly sent in writing to insured persons or policyholders at their last known address or the contact address in Switzerland.

Further information is communicated to insured persons or policyholders in the customer magazine or is published on the insurer's website.

12. Formal requirements

Where these GIC require notification in writing, it is sufficient to provide notification in another form that also provides evidence in text form.

13. Place of jurisdiction

In the event of any disputes arising out of insurance policies in accordance with these ÖKK UNO GIC and the provisions of the individual insurance products, claimants may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (ÖKK Versicherungen AG, Landquart).

ÖKK

ÖKK GENERAL SUPPLEMENT and ÖKK PRIVATE SUPPLEMENT

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Purpose

GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT provide benefits towards preventative measures, aids, dental treatments, alternative treatment methods, convalescent treatments, transport, search, rescue and recovery operations, optional medications and pay a breastfeeding allowance.

PRIVATE SUPPLEMENT also insures the costs not covered under KVG for treatments by doctors not subject to KVG. It also makes contributions to alternative medical care abroad and travel costs.

The benefits are usually provided over and above the other insurance products of these ÖKK UNO GIC.

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 person turns 60 years of age.

1.3 Condition for receiving benefits

Benefits are paid only if the treatment is necessary for medical reasons and performed by persons who are recognised for this purpose by the insurer. Information must be sought from the insurer 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 by doctors not subject to KVG

PRIVATE SUPPLEMENT also provides benefits in accordance with the KVG tariff towards treatments by doctors not subject to KVG.

Psychotherapeutic treatments are reimbursed up to a maximum of 50 hours.

2.2 Private consultations with hospital doctors not subject to KVG

PRIVATE SUPPLEMENT also provides benefits in accordance with the recognised tariff towards private outpatient consultations with senior university hospital consultants not subject to KVG.

PRIVATE SUPPLEMENT also provides a maximum of 50 hours of psychotherapeutic treatments in accordance with the KVG tariff.

2.3 Medical treatment abroad

2.3.1 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 benefiting from global insurance, full cost cover is provided according to the normal local rate.

A maximum of 50 hours psychotherapeutic treatment will be reimbursed.

2.3.2 Emergency treatment

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

2.4 Duration of benefits

Unless the provisions of GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT specify otherwise, benefits are paid out with no time limit.

3. Prevention

3.1 Vaccination

Up to 90% of the actual costs, but no more than CHF 200 per calendar year, is reimbursed towards the costs of vaccinations to protect against infections. 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-up examinations

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, up to CHF 300
PRIVATE SUPPLEMENT: 90% of costs, up to CHF 600

The description of a check-up is available from the insurer on request.

3.3 Gynaecological preventative examinations

The costs of a precautionary gynaecological 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 Antenatal courses

Up to CHF 200 per pregnancy is reimbursed towards the costs of an antenatal course (incl. postnatal course) with a qualified professional.

3.4.2 Nursing allowance

There is an entitlement to a breastfeeding allowance of CHF 250. This allowance is paid out if the insured mother breast feeds her child for ten weeks, either in whole or in part. This must be documented on the insurer's breastfeeding 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, up to CHF 300
PRIVATE SUPPLEMENT: 90% of costs, up to CHF 500

The insurer designates the recognised courses to learn forms of behaviour conducive to good health. The list of recognised courses is available from the insurer on request.

3.6 Other preventive measures

Contributions are payable to further preventive measures.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

4. 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

If there is a medical indication, up to 50% of the costs, up to a maximum amount of CHF 250 per calendar year, can be reimbursed towards the rental or purchase costs of recognised aids for which BASIS does not provide any benefits. The insurer designates the recognised remedial aids. The list of recognised aids is available from the insurer on request.

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

5. Dental treatment

5.1 Wisdom teeth

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital inpatient, the costs are covered up to the amount of the contractually fixed 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, incl. x-rays up to CHF 60 per calendar year, provided dental treatment (conservative, prosthetic etc.) does not have to be carried out at the same time.
- Costs of orthodontic treatment at the acknowledged scale:

GENERAL SUPPLEMENT: 70% of costs, up to CHF 5,000
PRIVATE SUPPLEMENT: 70% of costs, up to 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 there is equivalent previous insurance in place upon concluding the contract, the insurer does not stipulate a qualifying period provided at least one parent is also insured with the insurer. 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 Service providers and tariffs

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the “KVG tariff” and the “revised UVG/MV/IV dental tariff”.

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

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

If and to the extent not covered by mandatory health care insurance, under GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT, the insurer pays 90% of the costs of dental treatment for the alternative medicine methods stated below:

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

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

6.2 Empiric medical methods

If there is a medical indication, 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

The insurer contributes towards alternative medical treatment provided both the method of therapy as well as the administering therapist or naturopath are recognised by the insurer. Contributions are paid as follows:

GENERAL SUPPLEMENT: up to CHF 70 per hour of therapy (60 minutes)
PRIVATE SUPPLEMENT: up to CHF 100 per hour of therapy (60 minutes)

The insurer designates the acknowledged forms of therapy and the therapists. The list of acknowledged forms of therapy and therapists is available from the insurer on request.

No costs are paid for forms of therapy and treatments carried out by therapists included on the insurer’s negative list (NL).

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

6.4 Additional benefits PRIVATE SUPPLEMENT

Under 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 provided 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 remedies

The insurer pays 90% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and Oligosol, provided that they are not covered by BASIS and are not included 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 recognised alternative therapy methods recognised by the insurer;
- list of therapists or naturopaths recognised by the insurer;
- 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 receiving benefits

The benefits are payable after prior application has been submitted to the insurer. The right to have a medical consultant of the insurer 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. Optional medications

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%, up to CHF 2,500
PRIVATE SUPPLEMENT: 90%, up to 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 psychotherapists who are not medical practitioners but who have a cantonal license to practise independently. For the first 50 hours, the insurance pays a maximum share of CHF 60, and CHF 50 for subsequent hours.

9.2 Condition for receiving benefits

The benefits are paid after the cost guarantee request has been approved by the insurer's independent medical examiner. After the number of hours of treatment approved by the insurer has been exhausted, but at the latest at the end of the first 50 hours of therapy, the therapist must again report to the independent medical examiner about 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 psychiatrist.

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 operations, travel expenses

10.1 Transport costs, search, rescue and recovery operations 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 inpatient;
- for search and rescue operations.

Transport by aircraft is only authorised 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 operations

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

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 covered 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 covered per calendar year.

11. CASAMED variant

11.1 General provisions

The following additional provisions apply to insured persons who are insured with the insurer under BASIS with the CASAMED option.

11.2 General condition for receiving benefits

The benefits of the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT are paid if the services are provided according to the medical practitioner principle. These benefits must be provided, prescribed or organised by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED general practitioners.

11.3 Doctors not subject to KVG

The CASAMED option of 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 carried out by ophthalmologists, gynaecologists and paediatricians without prior consultation with the CASAMED general practitioner. If these doctors perform more extensive treatment, the CASAMED general practitioner must be consulted.

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

11.5 Other specialists

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

11.6 Preventive measures, alternative medicine, non-compulsory pharmaceuticals

The insurer may authorise the CASAMED general practitioner or the designated specialists to provide other preventative measures, alternative medical benefits or optional medications, or to prescribe or arrange such treatment other than those listed in the GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT policies.

11.7 Other service providers

With a view to the provision of care at a reasonable cost, the insurer may designate other service providers such as chemists, therapists, medical supply stores or similar service providers to which medical treatment or supplies for CASAMED insured persons are exclusively entrusted.

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 authorised list, except in an emergency, all costs will be charged to him.

11.10 Benefit processing

11.10.1 Flat-rate payment

The insurer may agree with CASAMED general practitioners that the benefits from GENERAL SUPPLEMENT and PRIVATE SUPPLEMENT are paid on a flat-rate basis.

11.10.2 Prescribed benefits

In the case of prescribed benefits, the insurer 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 insured person was referred by the CASAMED general practitioner intends to make a further referral, the responsible CASAMED general practitioner must give their consent.

The insurer or CASAMED cooperation partners may provide electronic aids to the service providers which will allow fast and safe communication between service providers as well as perfect coordination and control of services.

The insurer shall ensure compliance with the relevant data protection provisions.

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 deductible equivalent to the ordinary KVG deductible may be charged to insured persons from the age of 18.

ÖKK OPTIMA

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO 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 operations, 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 (Swiss KVG). Of the total costs, the maximum share payable is the portion which is not covered by a social insurance.

1.4 Conditions for receiving 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 can be concluded until the person turns 60 years of age.

2. Outpatient treatment

2.1 Medical treatment in case of an emergency abroad

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

2.2 Psychotherapy by non-medical practitioners

2.2.1 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.

2.2.2 Conditions for receiving 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.

2.3 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.

2.4 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 allowance

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

4. Prevention

4.1 Gynaecological preventative examinations

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.

The description of a check-up is available from the insurer on request.

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.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

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 inpatient treatment, the insurance will pay the costs up to the amount of the contractually fixed tariffs 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 Tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

The insurance 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 medical 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. sub-sections of traditional Chinese medicine, 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. Medications and remedies

8.1 Optional medications

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 operations in emergencies

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 inpatient treatment;
- rescue and recovery operations

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 Third-party benefits

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 operations

The insurance pays CHF 20,000 per calendar year for search operations 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 insured persons who have limited their choice of service providers for their health care insurance pursuant to the KVG, the following additional conditions apply.

10.2 General practitioner principle

The insurance will pay benefits pursuant to the general practitioner principle. Benefits must 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 designate hospitals which are exclusively responsible for the insured person's care.

10.5 Other specialists

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

10.6 Further service providers

The insurer may designate other service providers such as pharmacies, therapists, medical supply stores or similar service providers which are exclusively responsible for the insured person's medical treatment and supplies.

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 Exclusion of benefits, exclusion from general practitioner variant

10.8.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

10.8.2 Exclusion from general practitioner variant

The insurer can transfer the insured person from the general practitioner option to the ordinary insurance option in the case of repeated conduct in breach of the regulations.

10.9 Benefit processing

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 benefits

In the case of prescribed benefits, the insurer may require evidence from the insured person or the general practitioner that the service was in fact performed according to the general practitioner principle.

ÖKK PREMIUM

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO 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 operations, 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 (Swiss KVG). Of the total costs, the maximum share payable is the portion which is not covered by a social insurance.

1.4 Conditions for receiving 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 can be concluded until the person turns 60 years of age.

2. Outpatient treatment

2.1 Elective medical treatment abroad

The insurance pays 90% of the costs for outpatient conventional medical treatments by doctors abroad.

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 Conditions for receiving 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 allowance

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

4. Prevention

4.1 Gynaecological preventative examinations

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.

The description of a check-up is available from the insurer on request.

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.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

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 inpatient treatment, the insurance will pay the costs up to the amount of the contractually fixed tariffs 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 Tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the “KVG tariff” and the “revised UVG/MV/IV dental tariff”.

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

The insurance 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 medical 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. sub-sections of traditional Chinese medicine, 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. Medications and remedies

8.1 Optional medications

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 operations in emergencies

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 inpatient treatment;
- rescue and recovery operations

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 Third-party benefits

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 operations

The insurance pays CHF 20,000 per calendar year for search operations 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 insured persons who have limited their choice of service providers for their health care insurance pursuant to the KVG, the following additional conditions apply.

10.2 General practitioner principle

The insurance will pay benefits pursuant to the general practitioner principle. Benefits must 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 designate hospitals which are exclusively responsible for the insured person's care.

10.5 Other specialists

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

10.6 Further service providers

The insurer may designate other service providers such as pharmacies, therapists, medical supply stores or similar service providers which are exclusively responsible for the insured person's medical treatment and supplies.

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 Exclusion of benefits, exclusion from general practitioner variant

10.8.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

10.8.2 Exclusion from general practitioner variant

The insurer can transfer the insured person from the general practitioner option to the ordinary insurance option in the case of repeated conduct in breach of the regulations.

10.9 Benefit processing

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 benefits

In the case of prescribed benefits, the insurer may require evidence from the insured person or the general practitioner that the service was in fact performed according to the general practitioner principle.

ÖKK COMBI

ÖKK Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurer

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.3 Purpose

The insurance provides benefits for inpatient treatments in the event of illness, accident or maternity. It makes contributions to spa treatment, prolonged courses of treatment, domestic assistance outside the hospitals (SPITEX) and transport costs.

The 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 the insurer take priority over the COMBI benefits.

1.4 Conclusion of the insurance

The insurance can be concluded until the person turns 60 years of age.

1.5 Condition for receiving benefits

1.5.1 General provisions

The insurance provides benefits if the treatment is medically necessary and is carried out in a list or contractual hospital. The treatment must be provided by service providers who are acknowledged by KVG.

1.5.2 Treatment in other hospitals

In other hospitals, benefits are only insured in the event of acute treatments within the scope of sections 2.1.4 and 2.2.

1.6 Accident cover

Accident cover can be excluded.

1.7 Insurance possibilities

1.7.1 Levels of benefits

The insurance offers the following benefit levels:

COMBI GENERAL:	General ward in Switzerland (shared room); in accordance with tariff recognised by the insurer
COMBI SEMI-PRIVATE:	Semi-private ward in Switzerland (twin room); in accordance with tariff recognised by the insurer
COMBI PRIVATE:	Private ward in Switzerland (single room); in accordance with tariff recognised by the insurer
COMBI GLOBAL:	Private ward worldwide (single room)
COMBI FLEX:	General, semi-private or private ward in Switzerland; in accordance with tariff recognised by the insurer; with corresponding cost-sharing amount
COMBI COMFORT:	General ward in comfort contractual hospital in a one or two-bed room. This benefit level may be restricted to insured persons residing in a particular region.

Comfort contractual hospitals are those with which the insurer has entered into an agreement concerning the determination of tariffs. The list of contractual hospitals is available from the insurer on request.

1.7.2 Absence of criteria, maximum tariffs

If a hospital does not have any/has different classification criteria for hospital wards than those specified in these conditions, these are treated as private wards for insurance purposes. For the general and semi-private ward, the insurer can set maximum tariffs that are used as criteria for classifying the insured hospital wards.

These maximum tariffs are based on the tariffs and agreements of a comparable list or contractual hospital and/or hospitals that offer comparable additional benefits in the insured person's region of residence. When assessing the level of benefits, medical and clinical benefits as well as hotel/comfort benefits are included at the standard market tariffs.

The maximum tariffs defined by the insurer can be inspected at the insurer.

1.7.3 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 insurer. This list is available for inspection.

2. Inpatient treatment

2.1 Acute treatment

2.1.1 Condition for receiving benefits

The insurance provides benefits if the insured person is in need of hospital care within the meaning of BASIS insurance.

2.1.2 Scope of benefits

The insurance provides benefits to cover the costs of a stay on the insured ward in accordance with the chosen insurance level over and above the benefits provided by BASIS.

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

2.1.3 Treatment on a more expensive hospital ward

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

COMBI GENERAL:	The costs which would have been incurred in an insured hospital ward. In the event that such costs cannot be determined, the COMBI insurance shall pay a flat rate of CHF 30 per day.
COMBI 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 COMBI.
COMBI COMFORT:	In the comfort contractual hospital, the costs of the insured room.

2.1.4 Treatment in other hospitals

If the treatment is carried out in a hospital other than a list or contractual hospital, the following costs are covered:

COMBI GENERAL/ COMFORT:	Flat rate of CHF 30 per day.
COMBI SEMI-PRIVATE/ PRIVATE/FLEX:	The additional costs that would have been incurred in a list hospital in the canton of residence compared to the general and the insured and chosen hospital ward.
COMBI GLOBAL:	Full cost cover.

2.1.5 Treatment in a non-contractual hospital

Where treatment of the COMBI COMFORT insured person takes place in a hospital which does not appear on the list of comfort contractual hospitals kept by the insurer, the maximum benefits covered will be those equivalent to the cost of a general ward or the reference charge scale of the comfort contractual hospital in the canton of residence.

2.2 Long-term treatment

The insurance pays the following daily flat rates if

- care for a chronically ill person requires a stay in a suitable list or contractual 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
COMBI SEMI-PRIVATE/FLEX:	CHF 50	CHF 25
COMBI PRIVATE:	CHF 70	CHF 35
COMBI GLOBAL:	CHF 90	CHF 45

These benefits are provided for treatment on the insured ward once within a period of 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 COMBI variant for the ward in which the treatment took place.

2.3 Rehabilitation as an inpatient

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance covers the full costs for the first 60 days in accordance with the conditions for acute treatments. The benefits for long-term treatment are then paid after imputation of the previous duration.

Recognised rehabilitation clinics are specified on a list, which is available from the insurer at any time.

2.4 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic, the insurance covers the full costs for 90 days in accordance with the conditions for acute treatment.

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
COMBI GENERAL/COMFORT:	CHF 20
COMBI SEMI-PRIVATE/FLEX:	CHF 50
COMBI PRIVATE:	CHF 70
COMBI 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 COMBI variant for the ward in which the treatment took place.

2.5 Benefits abroad

2.5.1 Emergencies

The insurance covers the costs for emergency inpatient treatment in an acute-care hospital during temporary stays abroad up to the full costs incurred on the insured hospital ward over and above the benefits provided by BASIS. Benefits are only provided for as long as the insured person cannot reasonably be repatriated.

2.5.2 Elective treatments abroad

COMBI GLOBAL also provides benefits even if the insured person travels abroad with the intention of receiving treatment there.

For the other benefit levels, the same benefits are provided as in the case of treatment in other hospitals.

2.5.3 Procedure in the case of hospital stays

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

3. Balneotherapy and convalescent therapy

3.1 Convalescent therapy

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 the insurer.

The insurance provides the following benefits for medically prescribed convalescent treatments following acute treatments for a maximum of 21 days in each case:

COMBI GENERAL/COMFORT:	CHF 50/day
COMBI SEMI-PRIVATE/FLEX:	CHF 70/day
COMBI PRIVATE:	CHF 90/day
COMBI GLOBAL:	CHF 110/day

3.2 Balneotherapy

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

COMBI GENERAL/COMFORT:	CHF 30/day
COMBI SEMI-PRIVATE/FLEX:	CHF 30/day
COMBI PRIVATE:	CHF 50/day
COMBI GLOBAL:	CHF 50/day

The insured person may select any medically supervised thermal spa which is recognised by the insurer. The list of recognised spas is available from the insurer on request.

The contribution to the balneotherapy treatment is made irrespective of whether the insured person is treated in the spa on an inpatient basis, or stays in a hotel, guest house or in private rooms in the location of the spa.

The insurer 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 insurer, 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 in case of convalescent stays

The medical prescription for a spa treatment course must be submitted to the insurer 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

If a hospital stay can be avoided or shortened, the insurance makes contributions towards domestic assistance outside of the hospital (SPITEX), provided the insured person's domestic and family circumstances require this.

4.1.2 Scope of benefits

The insurance makes a contribution once a calendar year towards to the costs of recognised domestic assistance. Benefits are provided even if an agreement does not exist between the service provider and the insurer.

Benefits are paid as follows:

COMBI GENERAL/COMFORT:	up to CHF 40/day, max. CHF 400
COMBI SEMI-PRIVATE/FLEX:	up to CHF 50/day, max. CHF 500
COMBI PRIVATE:	up to CHF 60/day, max. CHF 630
COMBI GLOBAL:	up to CHF 60/day, max. CHF 800

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

COMBI GENERAL/COMFORT:	up to CHF 40/day, max. CHF 600
COMBI SEMI-PRIVATE/FLEX:	up to CHF 70/day, max. CHF 1,000
COMBI PRIVATE:	up to CHF 100/day, max. CHF 1,300
COMBI 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

A person who works in the insured person's household on a professional basis for their own account or for a SPITEX organisation contractually recognised by the insurer is recognised as a domestic assistance provider.

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

Instead of domestic assistance 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 operations in emergencies

Contributions from the insurance are made towards 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 insured person's canton of residence for inpatient treatment; and
- for rescue and recovery operations

as follows:

COMBI GENERAL/COMFORT:	CHF 10,000 per calendar year towards the uncovered amount exceeding CHF 100 per case
COMBI SEMI-PRIVATE/FLEX:	CHF 20,000 per calendar year
COMBI PRIVATE:	CHF 30,000 per calendar year
COMBI 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

The insurance 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 Childcare service

4.4.1 Principle

The insurance provides benefits towards childcare and nursing services for children up to the age of twelve organised by a section of the Swiss Red Cross (SRC).

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

4.4.2 Conditions receiving benefits

The insurance provides benefits if the child, in the opinion of the SRC, requires childcare or nursing as a result of 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 insurance provides benefits of up to CHF 30 per hour, up to CHF 600 per calendar year.

4.5 Rooming-in

If a child up to the age of twelve requires inpatient treatment, the insurance pays up to CHF 50 per day for the stay of one parent in the child's room.

If a parent requires inpatient treatment, the insurance pays up to CHF 50 per day for the stay of one child up to the age of twelve in the parent's room.

4.6 Daily hospital allowance

COMBI 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 inpatient treatment

The insurance covers the uncovered costs of a hospital birth for the mother and the newborn child in accordance with the insurance level concluded by the mother.

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

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

5.2 Birth in a birth house

In the event of birth in a birth house recognised by the insurer which does not appear on the cantonal list of hospitals, the following benefits will be provided:

COMBI GENERAL/COMFORT:	up to CHF 1,000 per birth
COMBI SEMI-PRIVATE/FLEX:	up to CHF 2,000 per birth
COMBI PRIVATE/GLOBAL:	full cost cover

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

5.3 Domestic assistance after childbirth

5.3.1 Principle

The insurance pays contributions to the costs of medically prescribed domestic assistance by personnel acknowledged by the insurer.

They are paid instead of the ordinary SPITEX benefits from the insurance.

Contributions are also paid if this assistance is provided by family members

of the insured person and the family members suffer a demonstrable loss of earnings as a result.

5.3.2 Birth in a hospital
Following a hospital birth the following rates are payable:

COMBI GENERAL/COMFORT:	up to CHF 60/day, max. CHF 600
COMBI SEMI-PRIVATE/FLEX:	up to CHF 100/day, max. CHF 1,000
COMBI PRIVATE:	up to CHF 100/day, max. CHF 1,300
COMBI 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 outpatient, the following rates are paid:

COMBI GENERAL/COMFORT:	up to CHF 60/day, max. CHF 840
COMBI SEMI-PRIVATE/FLEX:	up to CHF 105/day, max. CHF 1,500
COMBI PRIVATE:	up to CHF 135/day, max. CHF 1,900
COMBI GLOBAL:	up to CHF 165/day, max. CHF 2,310

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.

7. CASAMED variant

7.1 General provisions

The following additional provisions apply to insured persons who are insured with the insurer under BASIS with the CASAMED option.

7.2 Benefit levels

All the benefit levels under the insurance apply.

7.3 General condition for receiving benefits

Benefits are provided if they were performed according to the medical practitioner principle. These benefits must be provided, prescribed or organised by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED medical practitioners.

7.4 Choice of hospital

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

7.5 Ophthalmologists, gynaecologists and paediatricians

For CASAMED policyholders who undergo routine treatment by ophthalmologists, gynaecologists and paediatricians, the operations performed by such medical specialists on an outpatients or inpatients basis are paid after consultation of the CASAMED practitioner.

7.6 Emergencies

Emergencies are covered regardless of the chosen service provider. A review of the medical indication by the medical consultant may be ordered.

7.7 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

8. ECOPLAN variant with limited choice of hospital

8.1 General provisions

The ECOPLAN variant with limited choice of hospital exists under COMBI SEMI-PRIVATE and PRIVATE.

ECOPLAN may be restricted to insured persons residing in a particular region.

8.2 Choice / termination of ECOPLAN

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

It is possible to change from ECOPLAN to the ordinary insurance at any time as at the end of a calendar year by giving three months' prior notice.

8.3 Scope of benefits

The insurance benefits are provided under 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 recognised for this cover variant. The list of ECOPLAN hospitals is available from the insurer on request.

8.4 Treatment in a different hospital

If the insured person seeks treatment from a non-ECOPLAN hospital, all costs are to be borne by the insured person, except in the definitively listed exceptions.

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

9. Deductible and reimbursement in COMBI SEMI-PRIVATE, PRIVATE and GLOBAL

9.1 Deductible

9.1.1 General provisions
Adults may opt for an excess with a corresponding reduction of the premiums in the event of hospital treatment.

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

The deductible does not apply if the insured person is admitted to the general ward (shared room) of a list or contractual hospital.

Half of the deductible is not payable if the person holding COMBI PRIVATE or GLOBAL insurance is treated in the semi-private ward (twin room) of a list or contractual hospital.

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

9.1.2 Change / termination of the deductible
The change from a lower to a higher deductible can only be made at the beginning of a calendar year.

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

9.1.3 Amount of the deductible
The following deductibles are available:
CHF 2,000 per calendar year
CHF 5,000 per calendar year

The deductible may be adjusted to inflation. The statutory BASIS cost share is additional to this deductible.

9.2 Reimbursement

COMBI SEMI-PRIVATE, PRIVATE and GLOBAL provide a reimbursement to insured persons aged 16 and over if they choose a cheaper hospital ward in an acute-care hospital in Switzerland.

COMBI SEMI-PRIVATE:	General ward up to CHF 300 a day General ward comfort single and twin rooms up to CHF 200 a day
COMBI PRIVATE/ COMBI 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. If the amounts are reduced, the right to withdraw in accordance with Art. 8.2 ÖKK UNO CP applies.

The reimbursement is paid if no deductible has been agreed.

10. Cost-sharing under COMBI FLEX

10.1 Scope of cost share

The insured person chooses the ward before admission; this choice determines the cost share.

The following cost shares are required:

Treatment on:	Cost-sharing amount per calendar year:
General ward	None
General ward with comfort twin-bedded room	10% up to a max. of CHF 200
General ward with comfort single room	10% up to a max. of CHF 200
Semi-private ward	15% up to a max. of CHF 1,500
Private ward	25% max. CHF 4,500

This cost share likewise applies in the case of maternity.

The cost share is not payable if flat-rate reimbursements are made pursuant to these insurance conditions. 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 COMBI FLEX, cost shares which exceed the amount of CHF 4,500 per calendar year may be claimed.

ÖKK PRIVATE ACCIDENT

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.3 Purpose

The insurance pays out benefits in the event of an accident. It provides benefits with respect to inpatient treatments, spas, long-term treatments, household help outside the hospital and transport costs.

The insurance provides benefits as a supplement to health insurance in accordance with the Swiss Health Insurance Act (KVG). Of the total costs, the maximum share payable is the proportion which is not covered by a social insurance. If other insurance policies are held with the insurer with benefits for outpatient or inpatient treatment, the benefits from these policies shall take precedence over those under ÖKK PRIVATE ACCIDENT.

1.4 Conditions for receiving benefits

The insurance pays out benefits if the treatment is required for medical reasons and is carried out by persons acknowledged by the insurer to do so.

The insurance provides benefits for inpatient treatment if it is carried out in a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so in accordance with KVG.

Under no circumstances are benefits paid out for psychiatric treatment.

The insurance provides benefits up to the amount of the additional costs incurred on a private ward compared to the general ward of a list hospital in the insured person's canton of residence if the treatment is carried out in a hospital without a recognised tariff. In cases of emergency, all costs are covered.

An accident and the consequences thereof are insured if the accident occurs during the term of the insurance cover.

1.5 Geographical scope

The insurance pays out benefits in Switzerland, and in case of emergency, worldwide.

1.6 Conclusion of the insurance

The insurance can be concluded until the person turns 60 years of age.

It may only be concluded/held together with one of the following insurance policies of the insurer:

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

2. Inpatient treatment

2.1 Acute treatment

In the event of a hospital stay, the insurance covers the cost of a private ward. The cost sharing amounts for health insurance under KVG are not covered.

2.2 Long-term treatment

The insurance pays flat-rate daily allowances of CHF 70 from the first to 90th day and CHF 35 from the 91st to 180th day once within three calendar years if

- care for a chronically ill person requires a stay in a suitable list or contractual 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 its benefits after giving one month's notice. The hospital days are calculated from the initial application date against the duration of benefits.

If treatment is carried out on a ward that is of a lower category than a private ward, the insurance pays flat-rate daily allowances of CHF 50 from the first to the 90th day and CHF 25 from the 91st to the 180th day.

2.3 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance covers the full costs for the first 60 days in accordance with the conditions for hospital treatment (section 2.1).

The insurance pays benefits from the 61st day taking into account the previous length of stay in accordance with the conditions for long-term treatment (section 2.2).

2.4 Benefits abroad

2.4.1 Emergencies

For emergency inpatient treatments in an acute hospital during a temporary stay abroad, the insurance covers up to all the costs in a private ward provided that transporting the patient home is not possible on medical grounds.

2.4.2 Application for undertaking to cover costs

An application for an undertaking to cover costs is to be submitted to the insurer immediately, and no later than within ten days of entering hospital.

2.5 Balneotherapy and convalescent therapy

2.5.1 Convalescent therapy

The insurance pays CHF 90 per day, for up to 21 days in each case, towards medically prescribed convalescent therapy following a stay in hospital.

A free choice may be made from the medically managed spa establishments acknowledged by the insurer. The acknowledged spa establishments are shown on a list, which can be viewed at the insurer.

2.5.2 Balneotherapy

The insurance pays CHF 50 per day, up to 21 days per calendar year.

A free choice may be made from the medically managed spas acknowledged by the insurer. The acknowledged spa establishments are shown on a list, which can be viewed at the insurer.

The insurance makes this payment irrespective of whether the insured person is treated on an inpatient basis or in a hotel or privately on location at the spa.

The insurer may demand an examination on admission by the spa doctor and a final check-up with a closing report to the prescribing doctor.

2.5.3 Other treatment

At the request of the independent medical examiner, 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.

2.5.4 Procedure in case of convalescent stays

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

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.

2.6 Rooming-in

If a child up to twelve years of age is treated on an inpatient basis, PRIVATE ACCIDENT pays CHF 50 per day from the child's insurance for one parent to stay in the room of the child.

If a parent is treated on an inpatient basis, PRIVATE ACCIDENT pays CHF 50 per day from the parent's insurance for one child up to twelve years of age to stay in the room of the parent.

3. Special benefits

3.1 Domestic assistance

3.1.1 General provisions

If a stay in hospital can be avoided or shortened, the insurance makes contributions, where medically prescribed, towards household help outside the hospital, provided that domestic and family circumstances necessitate this.

3.1.2 Scope of benefits

The insurance pays up to CHF 60 per day, up to a maximum of CHF 630 per calendar year, towards the costs of recognised household help. This benefit is also paid even if there is no contract in place between the service provider and the insurer.

If the insured person is responsible for the care of a child up to twelve years of age, the insurance pays up to CHF 100 per day, up to a maximum of CHF 1,300 per calendar year.

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

3.1.3 Service provider

A person who works in the insured person's household on a professional basis or for an organisation contractually recognised by the insurer is recognised as a domestic assistance provider.

Assistance provided by relatives of the insured person is recognised if the relative can provide evidence of a loss of earnings or travel expenses incurred.

Instead of household help benefits, the same contributions can be provided for care services of commercial SPITEX companies if no remuneration is received by them from health insurance under KVG.

3.2 Transport costs, search and rescue activities in emergencies

The insurance contributes towards the costs of

- medically required emergency transport to the nearest suitable hospital by an appropriate means of transport;
- repatriation to a suitable hospital in the insured person's canton of residence for inpatient treatment; and
- for search and rescue activities

for a total of up to CHF 30,000 per calendar year.

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.

3.3 Childcare service

3.3.1 General provisions

The insurance of the insured child pays a contribution towards the care and nursing service for children up to the age of twelve carried out by a section of the Swiss Red Cross (SRC).

A requirement for this is a contractual arrangement between the insurer and the SRC.

3.3.2 Conditions for receiving benefits

The benefits are provided if, in the opinion of the Swiss Red Cross, the child is in need of care or nursing following an accident. The provision of these services is confined exclusively to 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 for the duration of the care period.

3.3.3 Scope of benefits

The insurance pays up to CHF 30 per hour, up to a maximum of CHF 600 per calendar year, towards the costs of the care and nursing service.

3.4 Medical treatment for the consequences of accidents

3.4.1 Treatment by physicians not under KVG contract

The insurance provides benefits in line with the KVG tariff for treatment by physicians who are not under KVG contract.

3.4.2 Private consultations with hospital physicians not under KVG contract

The insurance provides benefits in line with the approved tariff for outpatient consultations with senior university hospital physicians who are not under KVG contract.

3.4.3 Emergency medical treatment abroad

If the insured person is not covered under ÖKK PRIVATE SUPPLEMENT, ÖKK OPTIMA or ÖKK PREMIUM insurance or an equivalent insurance policy with the insurer, the insurance covers the full costs over and above the benefits provided by health insurance under KVG for emergency medical treatment abroad.

3.5 Aids

Following a stay in hospital resulting from an accident, the costs of any auxiliary aids required to treat the consequences of the accident are covered in accordance with the practice under compulsory accident insurance.

The costs of auxiliary aids that replace a body part or bodily function are covered to the same extent if these were damaged as a result of an accident requiring hospital treatment.

4. CASAMED variant

4.1 Additional conditions

For insured persons who have limited their choice of service providers for their health care insurance pursuant to the KVG, the following additional conditions apply.

4.2 General practitioner principle

The insurance pays benefits in accordance with the general practitioner principle. Benefits must be provided, prescribed or initiated by the general practitioner chosen by the insured person.

The insurance may also recognise telemedical institutions as general practitioners.

4.3 Exceptions to the general practitioner principle

The insurance pays benefits for routine treatments by ophthalmologists, gynaecologists and paediatricians without having consulted the general practitioner in advance. If further treatment is required, the general practitioner must be consulted.

4.4 Hospitals

The insurer may designate hospitals which are exclusively responsible for the insured person's care.

4.5 Emergencies

The insurance pays benefits in the event of an emergency irrespective of the general practitioner principle.

This is subject to the independent medical examiner checking the medical indication.

4.6 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

ÖKK

ÖKK FAMILY

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.3 Purpose

The insurance provides benefits for inpatient or outpatient treatment in the case of illness, accident and maternity as well as emergencies abroad.

The insurance provides benefits for preventative measures, aids, dental treatments, alternative treatment methods, transport costs, search, rescue and recovery operations, optional medications, natural remedies, spa treatments, domestic assistance outside the hospital and pays a breastfeeding allowance.

The insurance pays benefits further to 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).

The insurance provides benefits before any other insurance policies concluded with the insurer in accordance with the VVG. Retentions are deducted for every insurance.

1.4 Conditions for receiving benefits

The insurance provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer.

The insurance provides benefits for inpatient treatment if it is carried out in a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so in accordance with KVG.

1.5 Geographical scope

Unless otherwise specified, the insurance provides benefits in Switzerland.

1.6 Conclusion of insurance

The insurance can be concluded until the person turns 60 years of age.

2. Outpatient treatment

2.1 Medical treatment in the case of an emergency abroad

The insurance provides benefits for medical treatment in the event of emergencies abroad during temporary stays abroad.

2.2 Non-medical psychotherapy

2.2.1 Scope of benefits

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

2.2.2 Conditions for receiving benefits

The insurance provides benefits after the cost guarantee request has been approved by the independent medical examiner.

The insurance does not pay benefits in case of psychotherapy treatment which is 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.

2.3 Thermal bath

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

2.4 Sterilisation

The insurance provides benefits totalling 50%, up to CHF 1,000, for vasectomies and the sterilisation of adults.

3. Inpatient treatment

3.1 Acute treatment

3.1.1 Conditions for receiving benefits

The insurance provides benefits if the insured person is in need of hospital care within the meaning of BASIS insurance.

3.1.2 Scope of benefits

The insurance provides benefits to cover the costs of a stay on a general ward over and above the benefits provided by BASIS.

3.1.3 Treatment on a more expensive 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 these costs cannot be determined, the insurance provides a flat rate of CHF 30 per day.

3.1.4 Treatment in other hospitals

If the treatment is carried out in a hospital other than a list or contractual hospital, the insurance pays an amount of up to CHF 30 per day.

3.2 Inpatient rehabilitation

Where the medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance pays for up to 60 days per calendar year on the general ward.

3.3 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic, the insurance pays for up to 90 days every three calendar years on the general ward.

3.4 Emergency abroad

The insurance provides benefits in the event of emergencies abroad for inpatient treatment on the general ward of an acute-care hospital during temporary stays abroad, provided a return journey to Switzerland is not possible for medical reasons.

A cost guarantee request must be submitted to the insurer immediately, at the latest within 10 days of being admitted to hospital.

3.5 Balneotherapy and convalescent therapy

3.5.1 Convalescent therapy

The insurance provides benefits for medically prescribed convalescent treatments following hospital stays of CHF 50 per day, for up to 21 days per calendar year.

The insured person is free to choose from the medically run convalescent facilities recognised by the insurer.

3.5.2 Balneotherapy

The insurance provides benefits of CHF 30 per day, up to 21 days per calendar year.

The insured person is free to choose from the medically run spas recognised by the insurer.

The insurer may require an examination be carried out on admission by the doctor at the convalescent facility as well as a final check-up with a final report from the referring doctor.

3.5.3 Other cures
At the request of the independent medical examiner, the insurance may pay a flat rate up to the amount of the balneotherapy contribution for other medically prescribed convalescent treatments if there is a special medical indication.

3.5.4 Procedure in case of convalescent stays
The medical prescription (together with the diagnosis) for a convalescent stay must be submitted to the insurer two weeks before entering the convalescent facility.

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 assistance
3.6.1 General provisions
If, in the event of accident or illness, a hospital stay can be avoided or shortened, the insurance makes contributions towards domestic assistance outside of the hospital, provided the insured person's domestic and family circumstances require this.

3.6.2 Scope of benefits
The insurance provides up to CHF 50 per day, max. CHF 1,000 per calendar year, towards the costs of a recognised domestic assistance provider. Benefits are provided even if an agreement does not exist between the service provider and the insurer.

If the insured person is responsible for the care of a child up to twelve years of age, the insurance pays up to CHF 100 per day, up to 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 person who works in the insured person's household on a professional basis or for an organisation contractually recognised by the insurer is recognised as a domestic assistance provider.

Assistance provided by relatives of the insured person is recognised if the relative can provide evidence of a loss of earnings.

3.7 Childcare service
3.7.1 General provisions
The insurance provides contributions towards childcare and nursing services for children up to the age of twelve. This requires a contractual agreement between the insurer and a childcare service recognised by the insurer.

3.7.2 Conditions for receiving 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 recognised by the insurer.

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
The insurance provides up to CHF 30 per day, max. CHF 600 per calendar year, towards the costs of childcare and nursing services.

3.8 Rooming-In
If a child up to the age of twelve requires inpatient treatment, the insurance pays up to CHF 100 per day for the stay of one parent in the child's room.

If a parent requires inpatient treatment, the insurance pays up to CHF 100 per day for the stay of one child up to the age of twelve in the parent's room.

4. Maternity

4.1 Costs of inpatient treatment
The insurance covers the costs of a childbirth in the hospital, general ward, which are not covered by BASIS.

If the newborn child does not have their own insurance, the insurance of the mother will cover the uncovered costs of the child in the hospital, general ward.

4.2 Twin-bedded room or family room
The insurance provides benefits of up to CHF 200 per day for the additional costs of a twin or family room for childbirth in a list or contractual hospital.

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

4.3 Birth in a birth house
The insurance pays benefits of up to CHF 2,000 per birth in the case of childbirth in a birth house approved by the insurer, which is not listed on a cantonal hospital list.

4.4 Domestic assistance after childbirth
4.4.1 General provisions
The insurance pays contributions towards the costs of medically prescribed domestic assistance by personnel acknowledged by the insurer.

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

Contributions are also paid if this assistance is provided by family members of the insured person and the family members suffer a demonstrable loss of earnings as a result.

4.4.2 Scope of benefits in case of childbirth in hospital
The insurance provides up to CHF 100 per day, max. CHF 700 per calendar year, after childbirth in a hospital.

4.4.3 Scope of benefits in case of homebirth or outpatient childbirth
The insurance provides up to CHF 100 per day, max. CHF 1,200 per calendar year, after a home birth or outpatient birth.

4.5 Antenatal courses
The insurance will pay benefits of CHF 200 per pregnancy towards the costs of an antenatal course (incl. pregnancy and post-natal courses) if the class is held by a skilled specialist.

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

The description of a check-up is available from the insurer on request.

5.2 Gynaecological preventative examinations

The insurance covers 90% of the costs of a gynaecological preventative examination under the KVG at the KVG tariff per calendar year, provided no benefits have been paid from BASIS for a corresponding preventative examination in the current calendar year.

5.3 Health account

5.3.1 Scope of benefits

The insurance pays 50%, up to CHF 200 per calendar year per area, for the costs of selected preventative measures in the areas designated by the insurer of family, nutrition, movement and other prevention.

The contribution paid by the insurance for individual approved preventative measures may be limited.

If, in one year, several preventative measures from different areas are used, the insurance will pay up to CHF 500 per calendar year.

5.3.2 Conditions for receiving benefits

The preventative measures and courses must be recognised by the insurer.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

5.4 Vaccination

The insurance provides benefits totalling 90% of the costs, up to CHF 200 per calendar year, for medically recognised inoculations.

6. Aids

6.1 Visual aids

The insurance pays up to CHF 200 per calendar year towards the costs of glasses lenses and contact lenses required for vision correction.

6.2 Other aids

Upon medical prescription, the insurance may pay 50% of the costs of a necessary aid appropriate to insured person's 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. The insurer denotes the approved aids. The insurer designates the recognised 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

The insurance provides benefits totalling 90% for the extraction of wisdom teeth. If this is effected as inpatient treatment, the costs will be taken over up to the amount of the contractually fixed tariffs of the general ward in the canton of residence.

7.2 Additional benefits for children and young adults

The insurance also provides the following benefits for children and young people up to 25:

- 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.

The insurer does not stipulate a qualifying period provided at least one parent is also insured under an equivalent previous insurance policy with the insurer.

7.3 Community benefits

The insurance offsets its benefits against benefits provided by the cantons and municipalities. The insurance subsequently provides the relevant benefits.

7.4 Service providers and tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

7.5 Treatment abroad

The insurance also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are countries which have a joint border with Switzerland.

8. Alternative medicine

The insurance provides benefits for alternative medical treatments.

The insurance provides benefits totalling 70% of the costs, up to CHF 10,000 per calendar year, provided the therapy method (e.g. sub-sections of traditional Chinese medicine, naturopathic practices) and the therapist or doctor are recognised by the insurer.

The insurer designates the recognised forms of therapy as well as the therapists and doctors. The insurer maintains a list of recognised therapy methods.

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

The insurance does not provide benefits for therapy methods, treatments and therapists that are listed on the insurer's negative list.

If the alternative medicine treatment is carried out 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.

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

9. Medications and remedies

9.1 Optional medications

The insurance provides benefits totalling 90% of the costs of medically prescribed medication that does not appear on the List of Medications with Tariff (LMT), the List of Specialities (LS) in accordance with KVG or the insurer's negative list.

9.2 Natural remedies

The insurance provides benefits totalling 90% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and Oligosol, provided that they are not covered by BASIS and are not included on the insurer's negative list (NL).

10. Transport costs, rescue and recovery costs

10.1 Transport costs, rescue and recovery operations in emergencies

10.1.1 Scope of benefits

The insurance provides benefits towards the following costs:

- of medically required emergency transports to the nearest appropriate hospital in useful means of transport,
- repatriation to a suitable hospital in the insured person's canton of residence for inpatient treatment;
- of rescue and recovery operations

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 case.

10.1.3 Third-party benefits

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 operations

In the case of search operations, in addition to the costs of the rescue or recovery, the insurance pays 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, the insurance reimburses 90% of the costs of public transport, up to CHF 100 per year .

The insurance also provides benefits totalling 90%, up to CHF 300 per calendar year, for insured persons undergoing dialysis, radiation or chemotherapy.

11. CASAMED variant

11.1 General provisions

The following additional provisions apply to persons who are insured with the insurer under BASIS with the CASAMED option.

11.2 General practitioner principle

The insurance provides benefits pursuant to the general practitioner principle. These benefits must be provided, prescribed or organised by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED general practitioners.

11.3 Exceptions from the general practitioner principle

The insurance pays contributions to the costs of routine treatments carried out by ophthalmologists, gynaecologists and paediatricians without consulting the CASAMED general practitioner. If these physicians prescribe further treatments or operations or carry them out, the CASAMED general practitioner is to be consulted.

The insurance pays contributions to the costs of alternative medicine treatments, preventative measures within the scope of the health account, birth preparation, breastfeeding allowance, transport, search, rescue and recovery, and dental check-ups without consulting the CASAMED general practitioner.

11.4 Hospitals

The insurer may designate hospitals which are exclusively entrusted with the care of persons insured with CASAMED.

11.5 Other specialists

The insurer may designate other specialists instead of the CASAMED general practitioner who may provide, prescribe or arrange the benefits.

11.6 Preventative measures, alternative medicine, optional medications, cures

The insurer may authorise the CASAMED general practitioner or the designated specialists to provide other preventative measures, alternative medical treatments, optional medications or natural remedies, or to prescribe or arrange such treatments.

11.7 Further service providers

The insurer may designate other service providers such as chemists, therapists, medical supply stores or similar service providers to which medical treatment or supplies for CASAMED insured persons are exclusively entrusted.

11.8 Emergencies

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

11.9 Exclusion of benefits, exclusion from CASAMED variant

11.9.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

11.9.2 Exclusion from CASAMED variant

The insurer can transfer the insured person from the CASAMED option to the ordinary insurance option in the case of repeated conduct in breach of the regulations.

11.10 Benefits processing

11.10.1 Flat-rate payment

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

11.10.2 Prescribed benefits

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

ÖKK FAMILY FLEX

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.3 Purpose

The insurance provides benefits for inpatient or outpatient treatment in the case of illness, accident and maternity as well as emergencies abroad.

The insurance provides benefits for preventative measures, aids, dental treatments, alternative treatment methods, transport costs, search, rescue and recovery operations, optional medications, natural remedies, spa treatments, domestic assistance outside the hospital and pays a breastfeeding allowance.

The insurance pays benefits further to 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).

The insurance provides benefits before any other insurance policies concluded with the insurer in accordance with the VVG. Retentions are deducted for every insurance.

1.4 Conditions for receiving benefits

The insurance provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer.

The insurance provides benefits for inpatient treatment if it is carried out in a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so in accordance with KVG.

1.5 Geographical scope

Unless otherwise specified, the insurance provides benefits in Switzerland.

1.6 Conclusion of insurance

The insurance can be concluded until the person turns 60 years of age.

2. Outpatient treatment

2.1 Medical treatment in the case of an emergency abroad

The insurance provides benefits for medical treatment in the event of emergencies abroad during temporary stays abroad.

2.2 Non-medical psychotherapy

2.2.1 Scope of benefits

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

2.2.2 Conditions for receiving benefits

The insurance provides benefits after the cost guarantee request has been approved by the independent medical examiner.

The insurance does not pay benefits in case of psychotherapy treatment which is 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.

2.3 Thermal bath

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

2.4 Sterilisation

The insurance provides benefits totalling 50%, up to CHF 1,000, for vasectomies and the sterilisation of adults.

3. Inpatient treatment

3.1 Acute treatment

3.1.1 Conditions for receiving benefits

The insurance provides benefits if the insured person is in need of hospital care within the meaning of BASIS insurance.

3.1.2 Scope of benefits

The insurance provides benefits to cover the costs of a hospital stay over and above the benefits provided by BASIS. The deductible for BASIS applies.

The insured person chooses the hospital ward with the corresponding cost sharing amount before being admitted to hospital.

3.1.3 Insured hospital ward and deductibles

The insured person can choose from the following wards:

Treatment on:	Cost-sharing amount per calendar year:
General ward	nil
General ward with comfort twin-bedded room	10%, up to CHF 200
General ward with comfort single-bedded room	10%, up to CHF 200
General ward comfort family room (only for childbirth)	10%, up to CHF 200
Semi-private ward	15%, up to CHF 1,500
Semi-private ward family room (only for childbirth)	15%, up to CHF 1,500

For childbirth in a list or contractual hospital, the cost-sharing amount does not apply for a 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.

The insurance provides benefits up to CHF 200 per day for 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 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance provides benefits for up to 60 days per calendar year in accordance with the conditions for hospital treatment (section 3.1.3).

3.3 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic, the insurance pays for up to 90 days every three calendar years on the insured ward in accordance with the conditions for hospital treatment (section 3.1.3).

3.4 Emergencies abroad

The insurance provides benefits in the event of emergencies abroad for inpatient treatment on the general ward of an acute-care hospital during temporary stays abroad in accordance with the conditions for hospital treatment (section 3.1.3), provided a return journey to Switzerland is not possible for

medical reasons. A cost guarantee request must be submitted to the insurer immediately, at the latest within 10 days of being admitted to hospital.

3.5 Balneotherapy and convalescent therapy

3.5.1 Convalescent therapy

The insurance provides benefits for medically prescribed convalescent treatments following hospital stays of CHF 50 per day, for up to 21 days per calendar year.

The insured person is free to choose from the medically run convalescent facilities recognised by the insurer.

3.5.2 Balneotherapy

The insurance provides benefits of CHF 30 per day, up to 21 days per calendar year.

The insured person is free to choose from the medically run spas recognised by the insurer.

The insurer may require an examination be carried out on admission by the doctor at the convalescent facility as well as a final check-up with a final report from the referring doctor.

3.5.3 Other cures

At the request of the independent medical examiner, the insurance may pay a flat rate up to the amount of the balneotherapy contribution for other medically prescribed convalescent treatments if there is a special medical indication.

3.5.4 Procedure in case of convalescent stays

The medical prescription (together with the diagnosis) for a convalescent stay must be submitted to the insurer two weeks before entering the convalescent facility.

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 assistance

3.6.1 General provisions

If, in the event of accident or illness, a hospital stay can be avoided or shortened, the insurance makes contributions towards domestic assistance outside of the hospital, provided the insured person's domestic and family circumstances require this.

3.6.2 Scope of benefits

The insurance provides up to CHF 50 per day, max. CHF 1,000 per calendar year, towards the costs of a recognised domestic assistance provider. Benefits are provided even if an agreement does not exist between the service provider and the insurer.

If the insured person is responsible for the care of a child up to twelve years of age, the insurance pays up to CHF 100 per day, up to 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 person who works in the insured person's household on a professional basis or for an organisation contractually recognised by the insurer is recognised as a domestic assistance provider.

Assistance provided by relatives of the insured person is recognised if the relative can provide evidence of a loss of earnings.

3.7 Childcare service

3.7.1 General provisions

The insurance provides contributions towards childcare and nursing services for children up to the age of twelve.

This requires a contractual agreement between the insurer and a childcare service recognised by the insurer.

3.7.2 Conditions for receiving 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 recognised by the insurer.

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

The insurance provides up to CHF 30 per day, max. CHF 600 per calendar year, towards the costs of childcare and nursing services.

3.8 Rooming-in

If a child up to twelve years of age receives inpatient treatment, the insurance provides benefits from the child's insurance for one parent to stay in the child's room.

If a parent receives inpatient treatment, the insurance provides benefits from the parent's insurance for one child up to twelve years of age to stay in the parent's room.

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4. Maternity

4.1 Costs of inpatient treatment

If the newborn child does not have their own insurance, the insurance of the mother will cover the uncovered costs of the child in the hospital on the insured ward in accordance with the conditions for hospital treatment (section 3.1.3).

4.2 Birth in a birth house

The insurance pays benefits of up to CHF 2,000 per birth in the case of childbirth in a birth house approved by the insurer, which is not listed on a cantonal hospital list.

4.3 Domestic assistance after childbirth

4.3.1 General provisions

The insurance pays contributions towards the costs of medically prescribed domestic assistance by personnel acknowledged by the insurer.

The contributions shall be paid in lieu of the benefits pursuant to section 3.6.

Contributions are also paid if this assistance is provided by family members of the insured person and the family members suffer a demonstrable loss of earnings as a result.

4.3.2 Scope of benefits in case of childbirth in hospital

The insurance provides up to CHF 100 per day, max. CHF 700 per calendar year, after childbirth in a hospital.

4.3.3 Scope of benefits in case of homebirth or outpatient childbirth

The insurance provides up to CHF 100 per day, max. CHF 1,200 per calendar year, after a home birth or outpatient birth.

4.4 Antenatal courses

The insurance will pay benefits of CHF 200 per pregnancy towards the costs of an antenatal course (incl. pregnancy and post-natal courses) if the class is held by a skilled specialist.

4.5 Nursing allowance

The insurance pays a breastfeeding allowance of 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

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

The description of a check-up is available from the insurer on request.

5.2 Gynaecological preventative examinations

The insurance covers 90% of the costs of a gynaecological preventative examination under the KVG at the KVG tariff per calendar year, provided no benefits have been paid from BASIS for a corresponding preventative examination in the current calendar year.

5.3 Health account

5.3.1 Scope of benefits

The insurance pays 50%, up to CHF 200 per calendar year per area, for the costs of selected preventative measures in the areas designated by the insurer of family, nutrition, movement and other prevention.

The contribution paid by the insurance for individual approved preventative measures may be limited.

If, in one year, several preventative measures from different areas are used, the insurance will pay up to CHF 500 per calendar year.

5.3.2 Conditions for receiving benefits

The preventative measures and courses must be recognised by the insurer.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

5.4 Vaccination

The insurance provides benefits totalling 90% of the costs, up to CHF 200 per calendar year, for medically recognised inoculations.

6. Aids

6.1 Visual aids

The insurance pays up to CHF 200 per calendar year towards the costs of glasses lenses and contact lenses required for vision correction.

6.2 Other aids

Upon medical prescription, the insurance may pay 50% of the costs of a necessary aid appropriate to insured person's 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. The insurer designates the recognised 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

The insurance provides benefits totalling 90% for the extraction of wisdom teeth.

If this is effected as inpatient treatment, the costs will be taken over up to the amount of the contractually fixed tariffs of the general ward in the canton of residence.

7.2 Additional benefits for children and young adults

The insurance also provides the following benefits for children and young people up to 25:

- 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.

The insurer does not stipulate qualifying period provided at least one parent is also insured under an equivalent previous insurance policy with the insurer

7.3 Community benefits

The insurance offsets its benefits against benefits provided by the cantons and municipalities. The insurance subsequently provides the relevant benefits.

7.4 Service providers and tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

7.5 Treatment abroad

The insurance also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are countries which have a joint border with Switzerland.

8. Alternative medicine

The insurance provides benefits for alternative medical treatments.

The insurance provides benefits totalling 70% of the costs, up to CHF 10,000 per calendar year, provided the therapy method (e. g. sub-sections of traditional Chinese medicine, naturopathic practices) and the therapist or doctor are recognised by the insurer.

The insurer designates the approved forms of therapy as well as the therapists and physicians. The insurer keeps a list of recognised therapy methods.

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

The insurance does not provide benefits for therapy methods, treatments and therapists that are listed on the insurer's negative list.

If the alternative medicine treatment is carried out 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. Medications and remedies

9.1 Optional medications

The insurance provides benefits totalling 90% of the costs of medically prescribed medication that does not appear on the List of Medications with Tariff (LMT), the List of Specialities (LS) in accordance with KVG or the insurer's negative list.

9.2 Natural remedies

The insurance provides benefits totalling 90% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and Oligosol, provided that they are not covered by BASIS and are not included on the insurer's negative list (NL).

10. Transport costs, search, rescue and recovery costs

10.1 Transport costs, rescue and recovery operations in emergencies

10.1.1 Scope of benefits

The insurance provides benefits towards the following costs:

- of medically required emergency transports to the nearest appropriate hospital in useful means of transport,
- repatriation to a suitable hospital in the insured person's canton of residence for inpatient treatment; and
- of rescue and recovery operations

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 case.

10.1.3 Third-party benefits

If a membership (patronage) with an air rescue service or similar organisation is given, the insurance will pay benefits if no benefits are provided by these organisations. Differing contractual agreements remain reserved.

10.2 Search operations

In the case of search operations, in addition to the costs of the rescue or recovery, the insurance pays 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, the insurance reimburses 90% of the costs of public transport, up to CHF 100 per year.

The insurance also provides benefits totalling 90%, up to CHF 300 per calendar year, for insured persons undergoing dialysis, radiation or chemotherapy.

11. CASAMED variant

11.1 General provisions

The following additional provisions apply to persons who are insured with the insurer under BASIS with the CASAMED option.

11.2 General practitioner principle

The insurance provides benefits pursuant to the general practitioner principle. These benefits must be provided, prescribed or organised by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED general practitioners.

11.3 Exceptions from the general practitioner principle

The insurance pays contributions to the costs of routine treatments carried out by ophthalmologists, gynaecologists and paediatricians without consulting the CASAMED general practitioner. If these physicians prescribe further treatments or operations or carry them out, the CASAMED general practitioner is to be consulted.

The insurance pays contributions to the costs of alternative medicine treatments, preventative measures within the scope of the health account, birth preparation, breastfeeding allowance, transport, search, rescue and recovery, and dental check-ups without consulting the CASAMED general practitioner.

11.4 Hospitals

The insurer may designate hospitals which are exclusively entrusted with the care of persons insured with CASAMED.

11.5 Other specialists

The insurer may designate other specialists instead of the CASAMED general practitioner who may provide, prescribe or arrange the benefits.

11.6 Preventative measures, alternative medicine, non-compulsory pharmaceuticals

The insurer may authorise the CASAMED general practitioner or the designated specialists to provide other preventative measures, alternative medical treatments, optional medications or natural remedies, or to prescribe or arrange such treatments.

11.7 Further service providers

The insurer may designate other service providers such as chemists, therapists, medical supply stores or similar service providers to which medical treatment or supplies for CASAMED insured persons are exclusively entrusted.

11.8 Emergencies

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

11.9 Exclusion of benefits, exclusion from CASAMED variant

11.9.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

11.9.2 Exclusion CASAMED variant

The insurer can transfer the insured person from the CASAMED option to the ordinary insurance option in the case of repeated conduct in breach of the regulations.

11.10 Benefits processing

11.10.1 Flat-rate payment

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

11.10.2 Prescribed benefits

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

ÖKK

ÖKK SALTO

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.2 Purpose

The insurance provides benefits for inpatient or outpatient treatment as well as emergencies abroad.

The insurance provides benefits for inoculations, aids, wisdom teeth extractions, transport costs, search, rescue and recovery operations and for courses aimed at promoting good health.

The purpose of the insurance is also to pay uncovered costs for treatment in the case of illness, accident or maternity in acute-care hospitals.

The insurance provides also benefits towards the uncovered costs of emergency treatment abroad in the event of illness, accident or premature birth as well as other services during vacations, business travel or stays abroad.

The insurance benefits are provided over and above all the other insurance products concluded with the insurer in accordance with the VVG.

The insurance pays benefits further to 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).

1.3 Insured persons

The insurance can be concluded from when the person turns 18 until the person turns 30 years of age.

1.4 Automatic transfer to ÖKK GENERAL SUPPLEMENT or ÖKK OPTIMA, ÖKK COMBI GENERAL and ÖKK TOURIST

The insurance lapses on 31 December of the year in which the insured person turns 32 years of age. The insured person is automatically transferred into the ÖKK GENERAL SUPPLEMENT (for contracts beginning up to 31.12.2009) or ÖKK OPTIMA (for contracts beginning from 1.1.2010), ÖKK COMBI GENERAL and ÖKK TOURIST insurance products as of 1 January of the following year. With an automatic transfer, there is no need for a new health declaration; however, any existing restrictions in cover in accordance with the ÖKK UNO CP will remain unchanged.

1.5 Early transfer to ÖKK GENERAL SUPPLEMENT or ÖKK OPTIMA, ÖKK COMBI GENERAL and ÖKK TOURIST

The insured person can be prematurely transferred into the ÖKK GENERAL SUPPLEMENT (for contracts beginning up to 31.12.2009) or ÖKK OPTIMA (for contracts beginning from 1.1.2010), ÖKK COMBI GENERAL and ÖKK TOURIST insurance products as of 1 January of any given year without a health declaration. 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. Any existing restrictions in cover in accordance with the ÖKK UNO CP will remain unchanged.

1.6 Condition for receiving benefits

1.6.1 General provisions

Benefits are only payable, if the treatment is medically indicated and if it is given by persons who are recognised by the insurer. The insurer may give information about the acknowledgement of the relevant persons.

The treatment must be carried out by service providers who are recognised to do so in accordance with KVG. The treatment must be carried out by service providers who are recognised to do so in accordance with KVG.

1.6.2 Treatment in other hospitals

For treatment in other hospitals benefits are payable according to section 3.1.4.

1.6.3 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 Inpatient benefit level and hospital tariffs

1.7.1 Benefit levels

The following benefit levels apply for the insurance:

– General ward (shared room) of a hospital with approved tariff in the whole of Switzerland.

1.7.2 Absence of criteria, maximum tariffs

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 tariffs for general and semi-private wards, which are used as a criterion for allocation to the insured hospital wards.

These maximum tariffs are based on the tariffs and agreements of a comparable list or contractual hospital in the insured person's region of residence.

The maximum tariffs defined by the insurer can be inspected at the insurer.

1.7.3 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 insurer. This list is available for inspection.

2. Outpatient treatment

2.1 Emergency medical treatment abroad

In the case of emergency medical treatment abroad, the insurance covers the costs over and above the benefits provided by BASIS.

2.2 Duration of benefits

Unless the provisions of the insurance specify otherwise, benefits are paid out with no time limit.

3. Inpatient treatment

3.1 Acute treatment

3.1.1 Condition for receiving benefits

The insurance provides inpatient benefits to the extent and for as long as the insured person is in need of hospital care within the meaning of BASIS insurance.

3.1.2 Scope of benefits

The insurance provides benefits to cover the costs of a hospital stay in accordance with the insured benefit level over and above the benefits provided by BASIS.

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

3.1.3 Treatment on a more expensive hospital ward

If the treatment is carried out on a more expensive ward than the one insured, the insurance provides at the most the following benefits:

– The costs which would have been incurred in an insured hospital ward. If these costs cannot be determined, a flat rate of CHF 30 per day is paid.

3.1.4 Treatment in other hospitals

If the treatment is carried out in a hospital other than a list or contractual hospital, the insurance provides at the most a flat rate of CHF 30 per day.

3.2 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance covers the full costs for the first 60 days in accordance with the conditions for acute treatments.

The rehabilitation clinics are specified on a list, which is available from the insurer.

3.3 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic, the insurance covers the full costs for 90 days in accordance with the conditions for acute treatment.

These benefits are paid once in three calendar years.

3.4 Benefits abroad in emergencies

The insurance covers the costs for emergency inpatient treatment in an acute-care hospital during temporary stays abroad up to the full costs incurred on the insured hospital ward over and above the benefits provided by BASIS.

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 inpatient, a cost reimbursement application must be submitted to the insurer immediately, but at the latest within 10 days of admission to the hospital.

4. Maternity

4.1 Costs of inpatient treatment

The insurance covers the costs of a childbirth anywhere in Switzerland for the mother in a hospital, general ward, which are not covered by BASIS.

If the newborn child does not have their own insurance, the insurance of the mother will cover the uncovered costs of the child in the hospital, general ward, anywhere in Switzerland.

4.2 Birth in a birth house

In the case of childbirth in a birth house approved by the insurer, which is not listed on a cantonal hospital list, the insurance pays 90%, up to CHF 1,000 per birth.

5. Additional services abroad

5.1 Maximum cover

For trips lasting up to 100 days per calendar year, uncovered costs of up to CHF 50,000 are also insured in case of emergencies.

5.2 Trip for visiting purposes 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, in the event of medical necessity, an insured person has to be transported back from abroad to a suitable hospital in the canton of residence for inpatient treatment, the ÖKK emergency call centre organises the additional return trips for insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

If an insured person suffers an illness or accident and cannot undertake their journey home because they have to stay in hospital, the ÖKK emergency call centre organises the additional return trip for the insured person, insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

5.3 Advance towards hospital costs

If an insured person has to be hospitalised abroad, if necessary the insurer provides a payment advance to cover hospital costs of up to CHF 20,000. 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 are organised by the ÖKK emergency call centre, the latter notifies relatives of the insured person of the relevant facts and the measures taken.

5.5 Arranging hospitals and medical contacts abroad

If required, the ÖKK emergency call centre refers its insured persons to a doctor or hospital close to where they are staying. If there are communication problems, the ÖKK emergency call centre will provide translation assistance.

5.6 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be obtained at the place they are staying, the doctors at the ÖKK emergency call centre provide medical advice. This advice is only a suggestion and must not, under any circumstances, be regarded as a diagnosis.

5.7 Exclusion of benefits

In addition to the benefit restrictions from the ÖKK UNO CP, there is no entitlement to insurance benefits:

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 prior approval for search operations, repatriation, visitation or additional return trips.

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 ÖKK emergency call centre

In the event of sudden illness, accident or premature birth in Switzerland or abroad necessitating a period of hospitalisation, the ÖKK emergency call centre must be notified immediately in all cases.

5.8.2 Release from the obligation of secrecy

The insured person releases the doctor treating them and other medical personnel as well as insurers from their duty of professional secrecy vis-à-vis the ÖKK emergency call centre/insurer.

5.8.3 Notification of claim

The insured person must notify the claim immediately to the insurer and make available all information with the necessary medical and administra-

tive 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 insurer 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. If this obligation is not met, the insurer may reclaim an amount determined at its discretion from the insured person 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 Vaccination

Up to 90% of the actual costs, but no more than CHF 200 per calendar year, is reimbursed towards the costs of vaccinations to protect against infections. 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 Gynaecological preventative 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

The insurance pays 90% of costs, up to CHF 300, within two calendar years towards the proven costs of a medically prescribed course run by qualified persons aimed at promoting good health (e. g. stopping smoking).

The insurer designates the recognised courses to learn forms of behaviour conducive to good health. The list of recognised courses is available from the insurer on request.

7.4 Further preventative measures

Contributions may be paid to further recognised preventive measures.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

8. Aids

8.1 Visual aids

Insured persons receive a contribution of CHF 420 towards the costs of glasses lenses and contact lenses required for vision correction within five calendar years.

8.2 Other aids

Upon medical prescription, up to 50% of the costs, up to a maximum amount of CHF 250 per calendar year, can be reimbursed towards the rental or purchase costs of recognised aids appropriate to insured person's state of health, for which BASIS does not provide any benefits. The insurer designates the recognised remedial aids. The list of recognised aids is available from the insurer on request.

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

9. Dental treatment / wisdom teeth

9.1 General provisions

The insurance covers the costs of extraction of wisdom teeth. If the treatment takes place as a hospital inpatient, the costs are covered up to the amount of the contractually fixed 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 Service providers and tariffs

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

9.3 Treatments 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 insured person's canton of residence for inpatient treatment; and
- search and rescue operations.

Transport by aircraft is only authorised 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 operations up to a maximum of CHF 20,000 per calendar year are covered.

11. CASAMED variant

11.1 General provisions

The following additional provisions apply to insured persons who are insured with the insurer under BASIS with the CASAMED option.

11.2 General benefit conditions

The insurance benefits are provided if the medical practitioner principle was applied. The benefits must be supplied, prescribed or arranged by the CASAMED medical practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED general practitioners.

11.3 Exceptions to the medical practitioner principle

The insurance provides benefits for routine treatments by ophthalmologists, gynaecologists and paediatricians without prior consultation from CASAMED medical practitioners. The CASAMED medical practitioner is to be consulted if the treatment continues.

The insurance provides benefits for preventative treatments as part of a course aimed at promoting good health, 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 insurer may designate the hospitals to which medical care for CASAMED policy holders is entrusted on an exclusive basis.

11.5 Other specialists

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

11.6 Other service providers

With view to the provision of services at reasonable cost, the insurer 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

Irrespective of the chosen service provider, emergencies are covered by the insurance. 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 payment

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

11.9.2 Prescribed benefits

In the case of prescribed benefits and prior to reimbursement of the costs, the insurer 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 1.1.2019

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1. Insurance fundamentals

1.1 Purpose

The insurance provides benefits for dental treatment and prophylactic measures.

1.2 Conclusion of the insurance

The insurance can be concluded until the person turns 60 years of age.

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. This benefit restriction is communicated to the insured person in writing.

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 Conditions for receiving benefits

Measures of a diagnostic and therapeutic nature which are dentally necessary and scientifically acknowledged are insured, as long as the treatment is also economical.

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

The insurance provides its benefits on a subsidiary basis, i.e. over and above 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 Benefits abroad

The insurance also provides benefits if the treatment is carried out in a country neighbouring 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 turning 15 years of age, the insured person is automatically transferred from ÖKK DENTAL PICCOLO into ÖKK DENTAL A with no benefit restrictions as of the start of the following year. The insured person has the right to withdraw within three months of being notified of this transfer.

2.2 ÖKK DENTAL

2.2.1 Benefit variants

Variant	Maximum benefit claim per calendar year
ÖKK DENTAL A	75%, up to CHF 1,000, excess CHF 500
ÖKK DENTAL B	50%, up to CHF 500
ÖKK DENTAL C	50%, up to CHF 1,000
ÖKK DENTAL D	75%, up to CHF 1,000
ÖKK DENTAL E	75%, up to CHF 1,500
ÖKK DENTAL F	75%, up to CHF 3,000
ÖKK DENTAL G	75%, up to CHF 5,000, excess CHF 500
ÖKK DENTAL H	75%, up to 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 Check-ups and prophylaxes

The insurance provides benefits for a check-up incl. x-ray and for prophylaxes of up to 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. The insurer pays the insured benefits per calendar year.

The insurer will pay the insured benefits per calendar year.

2.2.4 Qualifying period

Insured persons are entitled to benefits from the insurance

- after a qualifying period of 12 months for prosthetic preventative measures (such as crowns, bridges, prostheses, dentures, core build-ups, dentures and apparatus for orthodontic treatment incl. the relevant temporary apparatus, repair work and the associated dental treatment and check-ups); and
- after a qualifying period of 6 months for all other treatment.

The qualifying period also applies for increases in insurance. Benefits for prophylaxes and check-ups are not subject to a qualifying period.

2.2.5 Procedure after dental treatment

To make a 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 provisions

To conclude any of the CASAMED options, the insured person must have concluded a BASIS CASAMED policy.

The following additional conditions apply for the CASAMED variant .

3.2 Benefit condition

The benefits are reimbursed if care has been provided, prescribed or arranged by a CASAMED dentist approved by the insurer, with whom the insured person is registered.

3.3 Emergencies

Irrespective of the chosen service provider, emergencies are covered by the insurance. However, a verification of the medical indication by the consultant medical officer may be required.

3.4 Exclusion of benefits, exclusion from CASAMED variant

3.4.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

3.4.2 Exclusion from CASAMED variant

The insurer is entitled to transfer the insured person from the CASAMED option to the ordinary insurance option in the 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
Coop Rechtsschutz AG
Helvetia Swiss Insurance Company Ltd
Edition 1.1.2022

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INSURANCE FUNDAMENTALS

1. Insurance providers

The insurer is the health insurer listed in the insurance policy. The insurer is the point of contact for any issues the insured persons may have, unless another company is expressly stipulated in these provisions.

The insurance provider for the treatment costs & personal assistance is ÖKK Versicherungen AG, Landquart (hereinafter referred to as ÖKK).

The insurer for the travel legal protection insurance is Coop Rechtsschutz AG, Aarau (hereinafter referred to as Coop Rechtsschutz). ÖKK has concluded a collective insurance contract with Coop Rechtsschutz as insurance provider in favour of the insured persons; this contract grants the insured persons a direct right of claim against Coop Rechtsschutz for travel legal protection insurance.

The insurer for the cancellation costs insurance as well as the luggage insurance is Helvetia Swiss Insurance Company Ltd, St. Gallen. These insurance policies are the responsibility of European travel insurance, branch office of Helvetia Swiss Insurance Company Ltd, domiciled in Basel (hereinafter referred to as ETI). ÖKK has concluded a collective insurance contract with ETI as the insurance provider in favour of the insured persons; this contract grants the insured persons a direct right of claim against ETI for cancellation cost and luggage insurance.

2. Common Provisions

Unless expressly excluded, the Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance policy shall apply. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

The regulations governing benefit restrictions in accordance with the CP applicable as per the policy do not apply for ÖKK TOURIST.

3. Purpose

Depending on the module selected, the insurance provides the following benefits for claims that arose during a holiday, business trip or stay abroad:

- Benefits to cover the uncovered costs of emergency treatment in the event of illness, accident or premature birth;
- Benefits to cover transport, search, rescue and recovery operations;
- Services;
- Contributions towards lawyer, expert and court costs (legal protection abroad);
- Cancellation costs if the insured person cannot embark upon the travel services booked,
- Benefits for the delayed start, premature cancellation or extension of the trip; and
- Benefits in the event of theft, loss during transportation and damage to personal luggage.

The following conditions apply with regard to the insurance cover.

4. Insurance options

The following modules can be concluded within ÖKK TOURIST:

- Treatment costs & personal assistance
- Travel legal protection
- Cancellation costs
- Luggage

5. Conclusion of the insurance

This insurance may be concluded by all persons, without any age restrictions, who have compulsory health care insurance under the Swiss Health Insurance Act (KVG) and their legal place of residence in Switzerland.

In addition, the insurance may be concluded by people who have the relevant compulsory health care insurance in the Principality of Liechtenstein and also have the legal place of residence there.

6. Insured persons

The policyholder is the person with whom the insurer has concluded an insurance contract.

6.1 Individual insurance

The person listed in the insurance policy is insured.

6.2 Family insurance

The policyholder listed in the insurance policy as well as their spouse/partner and children are insured, provided they live in the same household as the policyholder.

7. Start, duration and end of insurance

The start, duration and end of the insurance are guided by the CP that apply as per the policy.

8. Dissolution of the collective contract

The insurance expires if the collective contract between Coop Rechtsschutz / ETI and ÖKK Versicherungen AG is dissolved. The insured person must be notified in writing of the dissolution of this contact by no later than one month before the expiry of the insurance cover.

9. Cost sharing

No cost sharing applies to benefits provided under ÖKK TOURIST.

TREATMENT COSTS & PERSONAL ASSISTANCE

1. Conditions for receiving benefits

Benefits shall only be provided if the treatment is appropriate and medically necessary and is performed by people with the required authorisation to do so.

2. Geographical scope

The insurance applies for emergency treatments outside of the canton of residence in Switzerland and worldwide.

The Principality of Liechtenstein is considered equivalent to a canton of residence, provided the insured person has their place of residence there.

3. Period of benefits

Benefits are only provided for as long as it is not medically viable for the insured person to be repatriated.

The obligation to provide benefits for illnesses and accidents that occurred during the duration of the insurance shall in any case lapse no later than 91 days after expiry of the insurance.

4. Insurance benefits

4.1 Treatment costs

Over and above the compulsory health care insurance under KVG, accident insurance under UVG and any additional insurance cover existing with the insurer or other insurance companies, the insurance pays benefits to cover treatment costs in the case of emergency treatment as an outpatient or inpatient.

With respect to other insurance companies, please refer to section 9.1.3 of the CP applicable as per the insurance policy on multiple insurance policies.

The cover extends to illness, accident or premature birth at the habitual local tariffs or the contractually agreed tariffs. 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.

4.2 Transport, search, rescue and recovery operations

If an insured person suffers a serious illness or accident or dies, the insurer – based on the medical findings – provides the following benefits as organised by the ÖKK emergency call centre and pays the costs for:

a) medically necessary rescue operations and emergency transport in an appropriate means of transport to the nearest suitable place of treatment;
b) search operations undertaken with regard to rescuing or recovering the insured person as well as recovery operations up to a total of CHF 20,000 per insured person;
c) medically necessary repatriation of the insured person who has suffered an illness or accident to a suitable hospital in the canton of residence for inpatient treatment; and
d) repatriation of the deceased person to their place of residence.

4.3 Trips for visiting purposes and additional travel costs

4.3.1 Trips for visiting purposes

If an insured person suffers a serious illness or accident abroad and has to be hospitalised for more than 7 days, the ÖKK emergency call centre organises a trip for visiting purposes to the hospital for one person close to the insured person (first-class rail ticket, economy-class airfare). The costs for this are covered by the insurer.

4.3.2 Additional return trip

If, in the event of medical necessity, an insured person has to be transported back from abroad to a suitable hospital in the canton of residence for inpatient treatment, the ÖKK emergency call centre organises the additional return trips for insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

If an insured person suffers an illness or accident and cannot undertake their journey home because they have to stay in hospital, the ÖKK emergency call centre organises the additional return trip for the insured person, insured family members travelling with the insured person or a close person. The additional costs incurred are covered.

4.4 Amount of coverage

4.4.1 ÖKK TOURIST 50/100

The amount of coverage for all benefits amounts to CHF 50,000 per insured person, up to a maximum of CHF 100,000 per insured family.

Insurance options duration of stay abroad:
– up to 17 days
– up to 40 days.

4.4.2 ÖKK TOURIST 250/500

The amount of coverage for all benefits amounts to CHF 250,000 per insured person, up to a maximum of CHF 500,000 per insured family.

Insurance options duration of stay abroad:
– up to 17 days
– up to 40 days
– up to 365 days.

4.5 Services

4.5.1 Payment advances to hospitals

If an insured person has to be hospitalised abroad, if necessary the insurer provides a payment advance to cover hospital costs of up to CHF 20,000. If some of this prepaid amount is not covered by the existing insurance, the difference will be invoiced to the insured person. The requested amount must be repaid within 30 days.

4.5.2 Notification of people at home

If measures are organised by the ÖKK emergency call centre, the latter notifies relatives of the insured person of the relevant facts and the measures taken.

4.5.3 Referral to hospitals and doctors abroad

If required, the ÖKK emergency call centre refers its insured persons to a doctor or hospital close to where they are staying. If there are communication problems, the ÖKK emergency call centre will provide translation assistance.

4.5.4 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be obtained at the place they are staying, the doctors at the ÖKK emergency call centre provide medical advice. This advice only represents a recommendation, and in no way should be considered a diagnosis.

4.6 Exclusion of benefits

There is no entitlement to insurance benefits:

a) for illnesses and consequences of accidents that existed before embarking on the journey;
b) if the insured person travelled abroad for the purposes of receiving treatment or care, or giving birth;
c) if the ÖKK emergency call centre has not given its prior approval for search operations, repatriation, visitation or additional return trips; the provisions under Art. 45 VVG shall apply (absence of fault or no influence on scope of benefit);
d) in the case of participation in warlike actions, unrest, and similar events, and during military service abroad;
e) in the case of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
f) in the case of illnesses and accidents resulting from active participation in punishable actions, fights or other acts of violence;
g) in the case of grossly negligent causation of the illness or accident, in particular as a result of misusing alcohol, medication or other drugs;
h) in the case of health impairments resulting from recklessness, i.e. if the insured person exposes themselves to a risk without taking or being able to take any measures that could reduce this risk to a reasonable level. This does not include rescue operations in aid of persons. In terms of these provisions, recklessness includes in particular the participation in races or training with motor vehicles; and
i) if the insured person's health is damaged intentionally, also as a consequence of suicide, a suicide attempt or self-harm.

If the emergency transportation or repatriation is not possible as a result of external factors, such as strike action, turmoil, acts of violence, large-scale industrial emergencies, radioactivity, natural disasters, epidemic illnesses or force majeure, there is no right to demand that these be organised or performed.

5. Obligations in the event of a claim

5.1 Notification of ÖKK emergency call centre

In the event of sudden illness, accident or premature birth in Switzerland or abroad necessitating a period of hospitalisation, the ÖKK emergency call centre must be notified immediately in all cases.

5.2 Release from duty of professional secrecy

The insured person releases the doctors treating them and other medical personnel as well as insurers from their duty of professional secrecy vis-à-vis the ÖKK emergency call centre/insurer.

5.3 Making a claim

The insured person must submit their claim for benefits to the insurer immediately and make available all information that contains the required medical and administrative details. Only detailed original invoices are accepted. If the invoice details are insufficient and additional information is not provided upon request, the level of benefits to be provided is determined at the insurer's discretion.

5.4 Deduction of rail or flight tickets

Unused rail or flight tickets must be automatically returned to the insurer. If useless tickets are sold or reimbursed by a third party, the amounts received in this respect will be deducted from the insurance benefits. If this obligation is not met, the insurer may reclaim an amount determined at its discretion from the insured person or offset this amount against the claim for benefits.

6. Third-party benefits

6.1 Social insurance

No benefits are covered that are paid out under social insurance (KV, UV, IV, MV, AHV, AVI etc.). Any claim to benefits must be reported to the relevant social insurance office.

If an insured person does not have compulsory health care insurance under KVG or equivalent coverage in the Principality of Liechtenstein, benefits are provided by the insurer as if this cover were in place.

6.2 Existing insurance policies with the insurer

Other existing supplementary insurance with the insurer shall take precedence over the benefits under ÖKK TOURIST.

6.3 Air rescue service and similar organisations

If the insured person is a member (donor) of an air rescue service or similar organisations, costs are only covered to the extent that these organisations have not provided benefits. This remains subject to other contractual agreements in place.

TRAVEL LEGAL PROTECTION

1. Geographical scope

The insurance cover applies worldwide outside of Switzerland and the Principality of Liechtenstein.

2. Period of benefits

The insurance cover applies for the duration of the insurance specified in the insurance policy.

Legal protection is provided for disputes arising during the duration of the insurance specified in the insurance policy. Cases are deemed to have occurred at the time of the breach of the law; for insurance-law-related cases, at the time of the insured event.

3. Insured capacities

The insured person has legal protection in their capacity as

a) the owner, driver or renter of a motor vehicle;
b) a sportsperson, pedestrian, cyclist, motorist or passenger in any form of transport;
c) the renter of a holiday property;
d) an attendee of a course at a foreign school;
e) the contractual party to a travel contract;
f) the victim of a violent crime; and
g) the holder of a credit card.

4. Insured travel legal protection claims

The following legal protection claims are insured:

a) claims for extra-contractual compensation for damage against the perpetrator/the perpetrator's liability insurance due to a physical injury or damage to property caused;
b) legal disputes with an insurer, health insurer or pension fund in relation to an event abroad;
c) representation in proceedings brought by criminal or administrative authorities resulting from a negligent breach of foreign legislation. In the event of an official investigation due to a premeditated crime, the costs will only be covered if the insured person is acquitted or the proceedings are suspended; and
d) legal disputes arising from the following contracts under the Swiss Code of Obligations (exhaustive list), provided the insured person is affected in a capacity in accordance with section 3 above:
   – Tenancy contract
   – Repair contract
   – Freight contract
   – Contract of carriage
   – Travel contract
   – School contract
   – Credit card contract.

5. Insurance benefits

The following benefits are provided in the insured legal protection cases:

a) protection of the insured person's legal interests by the legal service of Coop Rechtsschutz;
b) payment of up to CHF 300,000 (CHF 100,000 outside Europe) per case unless a specific benefit restriction applies, in particular the
   – costs of appointed lawyers and mediators;
   – costs of appointed experts;
   – costs of legal proceedings and court costs charged to the insured person;
   – procedural costs payable to the other party;
   – travel expenses for necessary appearances before a foreign court of up to CHF 5,000;
   – translation costs of up to CHF 5,000; and
   – bail money in order to avoid custodial remand of up to CHF 100,000. This benefit is only provided in advance and must be reimbursed to Coop Rechtsschutz.

No benefits are paid for:

a) fines;
b) compensation for damage and settlements;
c) costs which a liable third party is required to cover;
d) costs for public notarisations and register entries; and
e) costs for official authorisations, permits and inspections.

The insured person must reimburse to Coop Rechtsschutz the procedural and party compensation granted to them in the amount of the benefits they receive.

6. Exclusions

No legal protection is provided:

a) in legal protection cases for insured persons in the same family policy;
b) in direct or indirect relation to a crime being intentionally committed;
c) in legal protection cases that were intentionally caused as well as any resulting disputes/proceedings under civil or administrative law;
d) in relation to lawyers, mediators, appraisers and experts who are acting or acted for an insured person in an insured legal protection case;
e) in relation to claims assigned to an insured person as well as claims transferred to insured persons as heirs; and
f) in claims against Coop Rechtsschutz or any of its executive bodies.

7. Reporting a legal protection case

The occurrence of a legal protection case must be reported to the insurer immediately, and on its request, in writing. The insurer immediately forwards the case to Coop Rechtsschutz to be processed.

The insured person must assist Coop Rechtsschutz in processing the legal protection case, provide it with the necessary powers of attorney and information, and forward any notifications they receive, in particular from authorities, with no delay.

In the case of a culpable breach of these obligations, Coop Rechtsschutz may reduce the benefits it provides by the amount of the additional costs it incurs as a result. In the case of a serious breach, the insurer may refuse to pay any benefits.

8. Processing a legal protection case

Having consulted the insured person, Coop Rechtsschutz takes the measures required to safeguard its interests.

If it is necessary to involve a lawyer, in particular in court or administrative proceedings or in the case of conflicts of interest, the insured person is free to choose a lawyer. If Coop Rechtsschutz disagrees with the insured person's choice, the latter may propose three further lawyers, which may not belong to the same law firm. Coop Rechtsschutz must accept one of these three lawyers.

Before appointing the lawyer, the insured person must obtain consent from Coop Rechtsschutz as well as a cost guarantee.

If there is no valid reason for changing lawyers, the insured person must bear any costs resulting from this change.

9. Process in the case of differences of opinion

In the case of differences of opinion, particularly in cases Coop Rechtsschutz believes have no chance of success, the insured person may request that arbitration proceedings be initiated. Both parties jointly appoint a person as the arbitrator. Furthermore, this process is based on the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO).

If an insured person takes legal action at their own cost, contractual benefits will be provided if the result in the main proceedings is more favourable than the assessment of Coop Rechtsschutz.

10. Place of jurisdiction

In the event of any disputes arising out of this travel legal protection insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (Coop Rechtsschutz AG, Aarau).

CANCELLATION COSTS

1. Geographical scope

The insurance cover applies worldwide.

2. Period of benefits

The insurance cover applies for the period specified in the insurance policy.

The cover begins when the insurance is concluded or, in the case of existing insurance cover, when the travel service is booked and ends when the insured travel service ends (check-in, boarding the booked means of transport etc.).

3. Insured events

Insurance cover is provided if the insured person cannot make use of, has to prematurely cancel or has to extend a booked travel service as a result of one of the events listed below, provided the event occurs after the insurance is concluded/the travel service is booked:

a) unforeseen serious illnesses, injuries, pregnancy complications or death of
   - an insured person;
   - a person travelling with the insured person;
   - a person not travelling with the insured person, but to whom the latter is extremely close;
   - the insured person's deputy at their place of work, meaning that the insured person must be present there;

b) strikes (except in the case of active participation) on the planned route of travel abroad;

c) unrest of any kind or force majeure at the destination of travel if this could specifically endanger the life and/or property of the insured person and there is an official travel warning in place issued by the Swiss authorities for the destination of travel and if it is therefore impossible or unreasonable to continue the trip or stay;

d) serious damage to the property of the insured person at their place of residence as a result of fire, natural hazards, theft or water damage, meaning that they must be present in their homes;

e) the outage or delay – both as a result of technical defects or personal accidents – of the means of public transport to be used to travel to the official point of departure (airport, train station, port or coach terminal) in the country of residence;

f) if, within 30 days before departure,
   - the insured person unexpectedly starts a new permanent job with a new employer (promotions etc. are excluded); or
   - the employment contract of the insured person is terminated by the employer through no fault of their own; and

g) theft of tickets, passport or identity cards.

If the person who triggers the cancellation because of an insured event is neither related to nor related by marriage to the insured person, there is only an entitlement to benefits if the insured person would be obliged to embark upon the trip alone.

4. Insurance benefits

4.1 Principle

The entitlement to benefits is determined based on the event that triggered the cancellation, premature disruption or extension of the travel services. Neither previous nor subsequent events are taken into account.

4.2 Cancellation costs

Upon occurrence of the insured event, the insurance covers the cancellation costs actually incurred (excl. security and airport taxes). In total, this benefit is restricted to the price of the travel service/the insured amount.

Excessive or repeated processing fees are not insured.

4.3 Additional costs

The insurance reimburses the additional costs for any delayed start, premature cancellation or extension of travel if the travel service cannot be made use of, has to be prematurely cancelled or has to be extended as at the scheduled time as a result of the insured event.

Additional costs to extend the trip are reimbursed for a maximum of seven days.

If a claim is made for additional costs, there is no entitlement to any cancellation costs.

4.4 Unused travel services

The insurance reimburses the pro rata costs of unused travel services (excl. costs of the originally booked return journey) if the travel has to be interrupted prematurely. This benefit is restricted to the price of the travel service/the insurance amount specified in the insurance policy.

4.5 Amount of coverage

The benefits for cancellation costs or additional costs for any delayed start or premature cancellation of travel are limited to CHF 20,000 per event and person / CHF 50,000 per event and family.

Additional costs to extend the trip are limited to a maximum of CHF 700 per person, or up to CHF 1,000 if using a hire car, irrespective of how many people use the car.

Benefits included in the leisure cover (day trips, training courses, concert tickets, ski passes, entry fees for runs etc.) are limited to CHF 500 per person and event.

4.6 Exclusion of benefits

Benefits are excluded:

a) if the service provider (travel company, lessor, organiser etc.) cancels the agreed service or would have to have cancelled them for objective reasons (this particularly applies for package holidays);

b) if the event had already occurred or was foreseeable at the time the insurance was concluded or the travel service booked;

c) if the complaint giving rise to the cancellation, disruption or extension of the trip was a complication or consequence of a medical operation or treatment that was already planned at the time the insurance began/the travel service was booked;

d) if an illness or the consequences of an accident, an operation or a medical procedure already existed at the time the travel was booked and had not healed by the date of travel;

e) in the event of cancellation, disruption or extension of the trip without medical indication or if the certificate of incapacity to work had not been issued at the time the inability to travel could first possibly be identified or if it was obtained on the basis of a telephone consultation;

f) if a cancellation as a result of an psychological or psychosomatic complaint:
   – cannot be justified on the basis of a psychiatrist's findings and a certificate issued by said psychiatrist on the day of the cancellation; and
   – cannot additionally be justified by people in employment relationship by providing a 100% absence confirmation from their employer for the duration of the medically certified inability to travel;
g) if the appraiser (expert, doctor etc.) who makes the findings is a direct beneficiary or is related/married to the insured person;
h) for events resulting from orders by public authorities (arrest, entry or exit bans, closure of borders and/or airspace, quarantine etc.);
i) which the insured person brings about in relation to suicide, self-mutilation or attempts thereof;
j) in the case of cancellation, travel disruption or travel extension resulting from warlike events or terrorism;
k) in the case of cancellation, travel disruption or travel extension due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
l) if the event that gave rise to the cancellation, travel disruption or travel extension is a result of deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
m) if an event that gave rise to the cancellation, travel disruption or travel extension was caused when under the influence of alcohol, drugs, narcotics or medication;
n) if the event that gave rise to the cancellation, travel disruption or travel extension arose while intentionally committing criminal acts or attempting to do so;
o) if additional costs are claimed for the premature cancellation or extension of a trip without these costs having first been approved by the ÖKK emergency call centre; and
p) in the case of epidemics and pandemics as well as the consequences of those. This has no impact on the benefits covered for the insured events as definitely listed in this document.

4.7 Chronically ill persons

The chronically ill must obtain confirmation in the form of a medical certificate that they are able to travel immediately prior to booking a travel service.

If an insured person suffers from a chronic illness, but there appears to be no concern regarding the travel service upon conclusion of the insurance/booking of the travel service because of said illness, the insurance pays the insured costs incurred if the travel service has to be cancelled due to an unforeseeable, serious acute deterioration of this illness or if the insured person dies as a result of the chronic illness.

4.8 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

4.9 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

5. Obligations regarding conduct while travelling

When assessing whether a journey to a country is feasible or not due to a strike, unrest, war, terror attacks etc., only the applicable recommendations and travel warnings issued by the Swiss authorities must be considered. First and foremost, this is the Federal Department of Foreign Affairs (FDFA) and the Federal Office of Public Health (FOPH).

6. Obligations in the event of a claim

The place of booking (travel agency, transport company, lessor etc.) must be notified immediately upon occurrence of the event.

Furthermore, in the event of a claim, the insurer must be notified immediately. The insurer immediately forwards the case to ETI to be processed.

The ÖKK emergency call centre must always be contacted before cancelling or extending a trip.

In the case of accident or illness, a doctor must be contacted immediately, who must be informed about the travel plans and whose instructions must be followed. The insured/entitled person must release the doctors treating them from their duty of professional secrecy to the insurer.

The following documents must be submitted to ETI, among others:
– the booking confirmation/invoice for the travel service as well as the invoices for the cancellation/additional travel costs (original copies);
– a detailed medical certificate/death certificate or any other official certificates; and
– a copy of the insurance policy.

7. Claims against third parties

If the insured/entitled person is reimbursed by a liable third party or their insurer, no reimbursement is due on the basis of this contract. If ETI is requested to make settlement instead of the liable third party, the insured person has to assign their liability claims to ETI up to the amount of the costs.

In the case of multiple insurance policies (voluntary or compulsory insurance), ETI provides its benefits on a subsidiary basis unless the insurance conditions of the other insurer also contain a subsidiarity clause. In this case, the statutory rules covering duplicate insurance cover shall apply. In the event of a claim, the insured/entitled person shall fully disclose and make accessible any existing insurance cover and authorise ETI to make any claims.

If there are multiple insurance policies in place with licensed companies, the costs shall only be reimbursed once overall.

8. Place of jurisdiction

In the event of any disputes arising out of this cancellation cost insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European travel insurance, Basel).

LUGGAGE

1. Geographical scope

The insurance cover applies worldwide.

2. Period of benefits

The insurance cover applies for the duration of the insurance specified in the insurance policy, and for as long and so often as the insured items are taken outside the insured person's permanent residence.

The insurance cover also applies for travel on public transport for as long as the insured items are in the custody of a transport operator.

3. Insured items

All items taken on the journey by the insured persons for their own person necessity are insured.

Sporting equipment, wheelchairs and prams/pushchairs are only covered by the insurance during travel on public transport and for as long as these items are in the custody of the transport operator.

4. Uninsured items

The insurance does not cover the following:

a) Cash and tickets (subject to section 6.1 d);
b) All types of securities, certificates and documents (subject to section 6.1 g);
c) Software;
d) Precious metals, precious stones and pearls;
e) Stamps;
f) Commercial goods and commercial samples;
g) Items of artistic or collector's value;
h) Musical instruments;
i) Surf boards;
j) Motor vehicles, trailers, caravans, boats and aircraft, including all accessories;
k) Items covered by special insurance;
l) Items bought or received as gifts during the period of travel (e.g. souvenirs) that are not personal travel necessities; and
m) Items that are taken on the journey that are not personal travel necessities (gifts, goods for third parties etc.).

5. Insured events

The following events are insured:

a) Theft and burglary
b) Robbery
c) Damage and destruction
d) Loss during travel on public transport; and
e) Delayed delivery (at least six hours) by public transport.

When camping, these events are only insured within official campsites.

6. Insurance benefits

6.1 Scope of benefits

The insurance reimburses the following:

a) in the case of total loss/write-off of insured items, the fair value; the fair value is the item's original purchase price less depreciation of at least 10% per year from the date of purchase; in total, however, a maximum of 60%;
b) in the case of partial damage, the costs of the repairs, up to a maximum of the fair value;
c) for all valuable items, up to 50% of the insurance amount;
d) cash and tickets only in the event of robbery; in such cases, up to 20% of the insurance amount, up to CHF 1,000; for replacement tickets, up to CHF 2,000;
e) breakages, up to 20% of the insurance amount;
f) glasses, contact lenses, prosthetics and wheelchairs, up to 20% of the insurance amount;
g) in the event of theft/loss of a passport, identity card, driving licence, vehicle registration documents and similar document as well as keys, the replacement costs;
h) in the event of theft/loss of credit cards and mobile telephones, the organisation (but not the costs) of having them blocked;
i) if luggage is delivered late via public transport, the costs of absolutely necessary purchases of up to CHF 1,000 per person and up to CHF 4,000 per family/per insurance confirmation and event. Insured persons are not entitled to any reimbursements when travelling back to their place of residence;
j) for non-valuable items left in a closed vehicle, boat or tent, up to 50% of the insurance amount, up to CHF 2,000 per insured journey under individual insurance policies and up to CHF 5,000 under family insurance policies.

6.2 Amount of coverage

Benefits are limited to the insured amount, up to CHF 4,000 per person and up to CHF 10,000 per family/insurance confirmation and event.

6.3 Exclusion of benefits

Benefits are excluded for loss/damage:

a) resulting from wear and tear, damage inflicted by the insured person, weather damage, insufficient or unsatisfactory quality or packaging of the items;
b) resulting from neglect, inattention, loss, dropping or negligence;
c) to items left in a publicly accessibly location outside the insured person's sphere of location, even if for just a short period of time;
d) to items whose value is not deemed sufficient for the item to be kept safe;
e) to valuable items left in a vehicle, boat or tent or handed over to a transport operator for transport, and for as long as these items are in the custody of the transport operator;
f) to items left in vehicles, boats or tents overnight (from 10 p.m. to 6 a.m.);
g) resulting from warlike events or terrorism;
h) due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
i) caused by deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
j) arising while intentionally committing criminal acts or attempting to do so.

6.4 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

6.5 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

7. Obligations regarding conduct while travelling

When they are not being used or worn, valuable items must:

- be handed over to the place of accommodation or a guarded cloakroom for safekeeping; or
- be stored in a locked room that is not accessible to the general public and kept under separate lock and key; bags of any kind, beauty and attaché cases, and jewellery boxes are not considered sufficient for this purpose.

Travel advice issued by the Federal Department of Foreign Affairs (FDFA) on the respective destination, in particular crime there and the associated precautionary measures to be taken, must be taken into consideration and followed.

8. Obligations in the event of a claim

In the event of a claim, the insurer must be notified immediately. The insurer forwards the case to ETI to be processed.

The insured person must

a) in the case of theft or robbery, request from the nearest police station that an official investigation be carried out and that the incident be recorded (police report, report of loss of air ticket etc.);
b) in the event of damage, delayed delivery or loss while the luggage is being transported by the responsible body (hotel management, tour leader, transport company etc.), immediately have the causes, circumstances and extent of the damage be confirmed in a report and request compensation from said body; and
c) after returning from the trip, immediately notify ETI in writing and provide justification for the claim.

The following documents must be submitted to ETI, among others:

a) the original copy of the relevant report (police report, report of loss of air ticket etc.);
b) the original confirmation, receipts purchase confirmations; and
c) a copy of the insurance policy.

Damaged goods must be made available to ETI.

9. Place of jurisdiction

In the event of any disputes arising out of this luggage insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European travel insurance, Basel).

ÖKK PROTECT

Coop Rechtsschutz AG, Edition 1.1.2022

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1. Insurance fundamentals

1.1 Insurance provider

The insurer is Coop Rechtsschutz AG, Entfelderstrasse 2, 5000 Aarau (hereinafter referred to as the insurer).

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract as a policyholder with Coop Rechtsschutz AG as the insurer to provide health-legal protection.

The insured person has a direct right of claim against Coop Rechtsschutz AG. ÖKK accepts no liability for any claims arising out of this legal protection insurance.

ÖKK Kranken- und Unfallversicherung AG, Landquart (hereinafter referred to as ÖKK KUV AG) shall be entitled to take all actions on behalf and for the account of ÖKK.

1.2 Common Provisions

The Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance policy shall apply. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

1.3 Geographical scope

The insurance cover applies worldwide.

1.4 Period of benefits

Legal protection is provided for disputes arising during the duration of the insurance. Cases are deemed to have occurred at the time of the breach of the law; for insurance-law-related cases, at the time of the insured event. If this insurance is dissolved, the entitlement to legal protection also expires for cases occurring after this time.

1.5 Insured persons

Persons who have concluded an ÖKK PROTECT policy with ÖKK are insured.

The following persons are also insured:

- all persons who are insured at ÖKK under a joint policy with the aforementioned person; and
- children and young persons up to the age of 18 who live in the same household as the aforementioned person and are insured at ÖKK.

If an insured person dies as a result of an insured event, their legal successors are insured for this case.

1.6 Start, duration and end of insurance

The start, duration and end of the insurance are guided by the CP that apply as per the policy.

The insurance can only be taken out or held in conjunction with at least one of the following insurance policies:

- ÖKK GENERAL SUPPLEMENT
- ÖKK PRIVATE SUPPLEMENT
- ÖKK OPTIMA
- ÖKK PREMIUM
- ÖKK COMBI
- ÖKK FAMILY
- ÖKK FAMILY FLEX
- ÖKK SALTO
- ÖKK DENTAL
- ÖKK MONDIAL

If a person fulfilling the conditions for ÖKK PROTECT leaves the joint policy, they remain insured with ÖKK PROTECT. However, the insured person has the right to withdraw within three months of being notified of this.

1.7 Dissolution of the collective contract

The insurance expires if the collective contract between the insurer and ÖKK Versicherungen AG is dissolved. The insured person must be notified in writing of the dissolution of this contact by no later than one month before the expiry of the insurance cover.

2. Scope of coverage

2.1 Contract fundamentals

The content of the contract is based on these ÖKK PROTECT General Insurance Conditions, the Federal Act on Insurance Contracts (VVG), the 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 relation to an insured person's health being damaged:

- disputes related to liability law (e. g. with medical service providers, with vehicle owners following traffic accidents), in particular:
  - enforcing claims for damages resulting from incorrect treatments;
  - the obligation to provide information to the insured person regarding the potential impact of medical treatment;
  - incorrect information being provided or the refusal to provide information, in particular concerning
    - the inspection of examination documents;
    - the surrender of x-ray images; and
  - a failure to carry out examinations.
- disputes related to insurance law (e. g. with liability, accident, health, disability insurance providers).

2.3 Subsidiarity

There is only an entitlement to legal protection if and to the extent that the benefits have to be provided by another insurer. The principle of subsidiarity does not apply to disputes with medical service providers and their liability insurers.

2.4 Non-insured disputes

The insurance does not cover the following:

- cases that are not expressly listed;
- cases that occurred before this insurance entered into force;
- disputes of the insured person with Coop Rechtsschutz AG and/or its executive bodies and representatives;
- cases related to:
  - psychiatric and psychotherapeutic treatments;
  - fees and invoices (excluding those related to the non-provision of benefits);
  - ÖKK premium calculations; and
  - defending claims for damages.

3. Insurance benefits

The insurer provides the following benefits:

- protection of the insured person's legal interests by the legal service of Coop Rechtsschutz;
- 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.

Court costs and legal fees promised to the insured person are to be assigned to the insurer.

4. Legal protection cases

4.1 Reporting a legal protection case

The occurrence of a legal protection case must be reported to the insurer/ÖKK immediately, and on their request, in writing. The insured person must assist the insurer in processing the legal protection case, provide them with the necessary powers of attorney and information, and forward to the insurer any notifications they receive, in particular from authorities, with no delay. In the case of a culpable breach of these obligations, the insurer may reduce the benefits it provides by the amount of the additional costs it incurs as a result. In the case of a serious breach, the insurer may refuse to pay any benefits.

4.2 Processing a legal protection case

Having consulted the insured person, the insurer takes the measures required to safeguard the latter's interests. If it is necessary to involve a lawyer, in particular in court or administrative proceedings or in the case of conflicts of interest, the insured person is free to choose a lawyer. If there is no valid reason for changing lawyers, the insured person shall bear any costs resulting from this change.

4.3 Process in the case of differences of opinion

In the event of a difference of opinion about the next steps to be taken, particularly in cases the insurer believes have no chance of success, arbitration proceedings will be initiated at the request of the insured person. Both parties jointly appoint a person as the arbitrator. Furthermore, this process is based on the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO). If an insured person takes legal action at their own cost, contractual benefits will be provided if the result in the main proceedings is more favourable than the assessment of the insurer.

5. Place of jurisdiction

The place of jurisdiction is agreed as the Swiss place of residence of the insured person or Aarau.

ÖKK

ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ACCIDENT

SOLIDA Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is SOLIDA Versicherungen AG, Zurich (hereinafter referred to as the insurer).

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract with SOLIDA as the insurer to provide insurance cover in the event of death or disability caused by accident.

Customers of ÖKK may submit an application to ÖKK to be insured with SOLIDA against the financial consequences of death or disability.

Customers of ÖKK do not have a contract in place with SOLIDA. Under the Insurance Contract Act, however, if an insured event occurs, insured persons have a direct claim against SOLIDA for the benefits it insures. ÖKK accepts no liability for claims resulting from this accident insurance policy.

ÖKK Kranken- und Unfallversicherung AG, Landquart (hereinafter referred to as ÖKK KUV AG) shall be entitled to take all actions on behalf and for the account of ÖKK.

1.2 Common Provisions

The Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance confirmation shall apply. The CP shall apply mutatis mutandi for this collective insurance. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

1.3 Geographical scope

The insurance cover applies worldwide. If the insured person moves abroad, the insurance ends with the calendar year in which they move (unless the insurance has been suspended).

1.4 Period of benefits

An accident and its consequences are insured if the accident occurred during the term of insurance cover.

1.5 Conclusion of the insurance

The insurance can be concluded until the person turns 65 years of age.

1.6 Age of insured person

The age of the insured person for the purpose of the insurance policy is the difference between the calendar year and their year of birth.

1.7 Insured persons

Individuals who have registered for the accident insurance in accordance with these GIC and have received the insurance confirmation are insured.

1.8 Start, duration and end of insurance

The start, duration and end of the insurance are guided by the CP that apply as per the insurance confirmation.

1.9 Changes to insurance

It is possible to increase the insurance amount until the insured person turns 65 years of age.

1.10 Dissolution of the collective contract

The insurance cover ends if the collective insurance contract between the insurer and ÖKK Versicherungen AG is dissolved. The insured person must be notified in writing of the dissolution of this contact by no later than one month before the termination of the insurance cover.

1.11 Contractual amendments

If the GIC are amended from the following calendar year, the new insurance conditions apply for the contractual partner of ÖKK. ÖKK shall provide notification of any amendments by no later than 30 days before the end of the calendar year. The contractual partner has the right to terminate the contract as of the end of the current calendar year. Due notice shall be deemed to have been given if it is received by ÖKK by no later than the last day of the calendar year. If the contractual partner fails to provide ÖKK with due notice of termination, they are deemed to have accepted the amendment(s).

2. Scope of coverage

The insurance covers all occupational and non-occupational accidents, including occupational diseases, provided there was an obligation to pay compensation for them at the time they occurred in accordance with the Swiss Federal Accident Insurance Act (UVG, Art. 6–9).

An accident is the sudden, unintended injurious impact of an exceptional external factor on the human body, which results in an impairment of the person's physical, mental or psychological health, or death.

The following conclusive list of physical injuries are considered equivalent to accidents, provided they were not primarily caused by illness or attrition: bone fractures, dislocations of joints, meniscal tears, muscle tears, pulled muscles, tendon tears, ligament lesions and eardrum injuries.

Physical injuries within the meaning of the above paragraph do not include non-accident-related damages to objects which were used as a result of an illness and replace a body art or bodily function.

The following are also considered to be accidents:
- health impairments caused by involuntarily breathing gases or vapours, or unintentionally consuming poisonous or corrosive substances;
- drowning; and
- the following health impairments, provided the insured person sustains them on an involuntarily basis and they are caused by an insured accident event: frostbite, heatstroke, sunstroke and health impairments caused by ultraviolet radiation, excluding sunburn.

The following are also not considered to be accidents: illnesses of all types, in particular infectious diseases, asbestos-related damage, effects of ionising radiation, damage caused by treatment or examination measures that were not required as a result of an insured accident and procedures carried out to the person's own body.

3. Insurance amounts

3.1 Level of insurance amounts

The insurance amounts listed in the insurance confirmation apply.

3.2 Maximum insurance amounts

3.2.1 Maximum insurance amounts for children

The maximum insurance amount for the death of a child up to the age of 15 is CHF 20,000.

The statutory death lump-sum payment from this and other insurance policies is a maximum of CHF 2,500 for children who are under two and a half years of age and a maximum of CHF 20,000 for children who are under twelve years of age.

3.2.2 Maximum insurance amounts in old age

The maximum insurance amounts for insured persons aged 66 (see section 1.6) and above are CHF 20,000 in the event of death and CHF 100,000 in the event of disability.

Higher insurance amounts are automatically reduced to the maximum insurance amounts as of the start of the next calendar year.

The progression for disability insurance does not apply.

4. Death endowment policy

4.1 Beneficiaries

If the accident causes the death of the insured person immediately or within five years of the date of the accident, the insurer shall pay the insured amount upon death provided accident insurance was in place at the time of the accident

- to the surviving spouse/registered partner;
- if there is no surviving spouse, to the children, adoptive children and step-children in equal amounts;
- if there are none of the above, to the parents in equal amounts;
- if there are none of the above, to the siblings in equal amounts.

Spouses and children from a marriage that took place after the accident have no entitlement to any benefits.

In amendment of the above regulation, the insured person may notify ÖKK in writing that they wish to designate a beneficiary/exclude persons entitled to the benefits. Such a declaration may be revoked or amended at any time in writing.

If there are none of the above-mentioned beneficiaries, the insurer reimburses the costs of the funeral, but no more than 10% of the insurance amount, up to CHF 10,000.

The insurance benefits are owed irrespective of whether the insured event caused a loss of assets (fixed-sum insurance policy).

4.2 Double death benefit

If the same accident results in the death of both parents or registered partners, the insurer pays double the death lump-sum benefit of each insured parent/registered partner in equal parts to the minor or long-term incapacitated children, step children or adoptive children who are in need of support.

4.3 Deduction of disability lump-sum payment

Any disability lump-sum payment already paid out for the same accident is deducted from the death lump-sum payment.

5. Disability endowment policy

5.1 Principle

If the accident results in an insured person suffering a disability that according to medical theory is likely to be of an enduring nature, the insurer pays the insurance amount agreed for the disability provided accident insurance was in place at the time of the accident:

- the full insurance amount for cases of full disability;
- part of the insurance amount corresponding to the degree of disability for cases of partial disability.

The final degree of disability is calculated based on the condition of the insured person that has been recognised as likely to persist. However, the insurer may have the degree of disability conclusively determined five years or more after the accident. This will determine the current degree of disability at the time the assessment is carried out. Any changes to the degree of disability that subsequently occur, i. e. relapses and long-term consequences, are no longer insured. When determining the degree of disability, any inability to work arising as a result of the event is not taken into consideration.

Only the insured person is entitled to the disability lump-sum payment.

5.2 Full disability

Full disability is considered to be:

- 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 hand and a leg or foot;
- full paralysis; and/or
- complete blindness.

5.3 Partial disability

In the case of partial disability, the proportion of the insurance amount for full disability is paid in line with the degree of disability. The degree of disability is calculated according to the following scale:

Loss of or complete inability to use the following:

– Upper arm	70%
– Lower arm	65%
– Hand	60%
– Thumbs with metacarpal joint	25%
– Thumbs, metacarpal joint intact	22%
– End joint of the thumb	10%
– Index finger	15%
– Middle finger	10%
– Ring finger	9%
– Little finger	7%
– Leg above the knee	60%
– Leg below the knee	50%
– Foot	45%
– Big toe	8%
– Toe	3%
– Sight of one eye	30%
– Sight of the second eye for people with one eye	50%
– Hearing in both ears	60%
– Hearing in one ear	15%
– Hearing in one ear if hearing in the other ear had already been completely lost prior to the accident occurring	30%
– Sense of smell	10%
– Sense of taste	10%
– Kidney	20%
– Spleen	5%
– Extremely painful, severe functional restrictions to spinal column	50%

In the event of a partial loss of or partial inability to use a body part, the degree of disability that applies shall be reduced accordingly.

If it is not possible to determine the degree of disability using the applicable scale, it shall be determined in line with the guidelines for determining the loss of bodily functions in accordance with the Federal Law on Accident Insurance (UVG) and the Swiss Federal Ordinance on Accident Insurance (UVV).

In the event of a simultaneous loss of or inability to use multiple body parts as a result of the same accident, the degree of disability is usually calculated by adding together the percentages. However, the degree of disability cannot exceed 100%. In the event of an insured person losing all the fingers on one hand, only the disability lump-sum payment for the loss of the corresponding hand is paid out.

5.4 Severe disfigurements

With respect to persisting, severe disfigurements of the human body resulting from an accident (aesthetic damage, e. g. scars) for which no disability lump-sum payment is due, but which however, make the insured person's social circumstances more difficult, the insurer pays up to the following percentages of the insurance amount agreed in the event of disability:

– 10% for facial disfigurement
– 5% for disfigurement of other body parts that are usually visible.

Benefits paid with respect to aesthetic damage shall also be limited to CHF 20,000.

There shall be no progressive payments.

5.5 Pre-existing physical defects

If pre-existing physical defects (with the exception of the loss of an insured person's second eye or the hearing in their second ear) aggravate the consequences of the accident, this shall not result in a higher benefit being paid. If, prior to the accident, the insured person had already completely or partially lost the limb / organ or use thereof, the pre-existing degree of disability, as calculated in line with the aforementioned principles, is subtracted from the final degree of disability.

If pre-existing illnesses or infirmities that were not initially sustained as a result of the accident significantly aggravate the consequences of the accident, the insurance benefits are proportionally reduced; this is done at the time the degree of disability is determined and not when the disability lump-sum payment is determined.

5.6 Reimbursement in the case of disability

In the case of a disability of more than 25%, the reimbursement increases progressively up to 350% of the insurance amount.

Degree of disability (%)	Reimbursement (%) insured amount	Degree of disability (%)	Reimbursement (%) insured amount
1	1	29	37
2	2	30	40
3	3	31	43
4	4	32	46
5	5	33	49
6	6	34	52
7	7	35	55
8	8	36	58
9	9	37	61
10	10	38	64
11	11	39	67
12	12	40	70
13	13	41	73
14	14	42	76
15	15	43	79
16	16	44	82
17	17	45	85
18	18	46	88
19	19	47	91
20	20	48	94
21	21	49	97
22	22	50	100
23	23	51	105
24	24	52	110
25	25	53	115
26	28	54	120
27	31	55	125
28	34	56	130
57	135	79	245
58	140	80	250
59	145	81	255
60	150	82	260
61	155	83	265
62	160	84	270
63	165	85	275
64	170	86	280
65	175	87	285
66	180	88	290
67	185	89	295
68	190	90	300
69	195	91	305
70	200	92	310
71	205	93	315
72	210	94	320
73	215	95	325
74	220	96	330
75	225	97	335
76	230	98	340
77	235	99	345
78	240	100	350

6. Benefit restrictions

6.1 Principle

The conditions regarding benefit restrictions in the CP as per the insurance confirmation do not apply.

6.2 Exclusion of benefits

There is no entitlement to insurance benefits:

a) as a result of war, civil war or war-like situations;
   – in Switzerland, the Principality of Liechtenstein or any neighbouring countries;
   – in other foreign countries unless the accident occurs within a period of 14 days of such events initially occurring in the country in which the insured person is staying and the outbreak of the hostilities is unexpected;
b) as a result of an earthquake in Switzerland and the Principality of Liechtenstein;
c) as a result of entering into extraordinary dangers. This includes the following:
   – foreign military service;
   – participating in acts of war or acts of terror;
   – involvement in fights and brawls unless the insured person was injured by those fighting as an innocent bystander or as a result of going to a defenceless person's aid;
   – risks the insured persons takes by seriously provoking others;
   – the consequences of disturbances of all kinds unless the insured person can prove that they did not actively participate in such acts on the side of the perpetrators or incite them to further violence;
d) as a result of intentionally or consciously committing criminal acts, attempting to do so, or participating in them;
e) as a result of the effects of ionising beams or damage caused by nuclear energy;
f) for accidents in which the insured person has a blood alcohol concentration of two parts per thousand or more unless there is clearly no causal relationship between the insured person's intoxication and the accident;

g) as a result of recklessness (actions by which the insured person exposes themselves to a considerable risk without taking or being able to take any measures that could reduce this risk to a reasonable level);
h) as a result of suicide or health impairments to the insured person's own body that the insured person caused to themselves intentionally or in a state of full or partial diminished responsibility;
i) as a result of intentionally consuming or injecting medications, drugs or chemical products;
j) as a result of medical or surgical procedures that were not necessitated by an insured accident;
k) when using aircraft as a military pilot, other military crew member or Parachute Reconnaissance Company member;
l) when undertaking military parachute jumps;
m) when undertaking air travel if the insured person intentionally breaches official regulations or is not in possession of official pieces of identification and authorisations; and
n) for the statutory and regulatory cost-sharing amounts of the insured person under compulsory health care insurance.

6.3 Benefit reductions

6.3.1 Gross negligence

The insurer waives its right to reduce the benefits in the case of the insured accident being caused as a result of gross negligence.

6.3.2 Non-accident-related factors

If non-accident-related factors impact the progression of an insured accident, the insurer only pays a part of the agreed benefits that is determined on the basis of a medical assessment. Here the non-accident-related factors are already deducted at the time the degree of disability is determined and not when the disability lump-sum payment is determined.

6.3.3 Breach of obligations in the event of a claim

In the case of a culpable breach of the obligations by the insured person, the benefits may be reduced.

6.3.4 Further benefit reductions

Any further benefit reductions are based on the UVG provisions (Art. 37–39) applicable at the time of the accident or the onset of the illness.

6.4 Death caused by beneficiary

If a person causes the death of the insured person as a result of intentionally or consciously committing criminal acts, attempting to do so, or participating in them, this person shall have no claim to any payments resulting from the death.

If a beneficiary causes the death of the insured person due to gross negligence, the benefits they receive will be reduced; in particularly serious cases, they may be refused.

7. Retraining costs

If professional retraining is required as a result of an accident for which the insurer has paid benefits, the insurer will cover the appropriate costs for this, up to 10% of the insured disability amount.

8. Fees

The conditions regarding premiums and payments in the CP as per the confirmation apply mutatis mutandi.

The fee for the cover is calculated according to the age group of the insured person and the level of the insurance amounts. In each case, the fee remains guaranteed for one calendar year. There is no tariff guarantee.

The age groups are 0 to 3 years, 4 to 15 years, 16 to 20 years and 21 to 65 years. The last age group contains older people.

9. Process for making a claim

An accident that is likely to trigger the insurer's obligation to provide benefits must be reported to ÖKK immediately.

A death must be reported immediately, within ten days at the latest.

The insured person must undergo the examinations and follow the instructions of the doctors appointed by the insurer at its cost.

If any entitlement is lost as a result of non-compliance, the insured person must provide the insurer with any information requested concerning previous and current medical conditions as well as the accident and how treatment is progressing within 30 days of such a written request being made. The insured person and the beneficiary must substantiate their claims to costs with doctor's certificates. These may also be obtained by the insurer.

The insured person must release any doctors who have treated them following an accident or illness from their duty of professional secrecy so that they can provide any information requested by the insurer.

If the insured person or beneficiary culpably fail to meet one of these obligations, the insurer may reduce the benefits by the amount by which they would have been reduced had this obligation been duly met in good time, unless the insured person or beneficiary proves that their conduct contrary to the contract had no impact on the consequences of the accident or the establishment thereof.

10. Notifications to the insurer

All notifications and disclosures are to be made to ÖKK. The insurer recognises these notifications and disclosures as if they had been made to it. All notifications on the part of the insurer are duly sent to the last known address in Switzerland of the insured person or beneficiary.

11. Place of performance and place of jurisdiction

Besides Zurich as the place of jurisdiction, for all disputes arising out of this contract, the insurer acknowledges the place of jurisdiction to be the Swiss place of residence of the insured person or beneficiary. The insurer fulfils its obligations at the domicile of the insured person or beneficiary.

12. Applicable law

Furthermore, the current provisions of the Federal Act on Insurance Contracts (VVG) apply to this insurance policy.

ÖKK

ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ILLNESS

Squarelife Insurance AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Principles

The principles of the contract "ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ILLNESS" comprise the individual application, the insurance confirmation, the Common Provisions (CP) and the General Insurance Conditions (KTI GIC) covering risk capital insurance in the event of death or disability caused by illness as well as, on a subsidiary basis, the provisions of the Federal Act on Insurance Contracts (VVG).

1.2 Purpose and content of the insurance policy

The purpose of this risk capital insurance is to protect the insured person against the financial consequences of death or disability caused by illness.
The content of this risk capital insurance policy comprises a one-time lump-sum benefit to cover the financial consequences of death or disability caused by illness.

1.3 Common Provisions

The Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance confirmation shall apply. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

1.4 Contractual parties and contractual relationship

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract as a policyholder with Squarelife Insurance AG, 9491 Ruggell, Liechtenstein (hereinafter referred to as Squarelife).

Under this contract, insured persons have a direct right of claim against ÖKK (Art. 95a VVG in conjunction with Art. 98 VVG).

1.5 Insured persons

Individuals who are residents of Switzerland may be insured.

1.6 Insurance year

The insurance year begins on 1 January and ends on 31 December.

1.7 Age of insured person

The age of the insured person for the purpose of the insurance policy (actual age) is the difference between the calendar year and their year of birth.

1.8 Acceptance into insurance

The applicant must complete and submit the application truthfully and in full. It is not possible to accept an applicant into the insurance in all cases.

If an application is made to be accepted into the insurance within 90 days of being born, no health check is required.

2. Application

2.1 Start of insurance cover

ÖKK shall give the contractual partner written notice of the day on which the insurance cover shall commence. This date shall be no earlier than the date specified on the insurance confirmation, provided the insured person is fully able to work at the time the insurance cover begins.

2.2 Application

The applicant must complete, sign and submit to ÖKK the application truthfully and in full. The insured person or their legal representative must answer the questions relating to health and other risk factors truthfully and in full.

2.3 No insurance cover

No insurance cover is provided if the claim stems from an illness, an infirmity or the consequences of an accident that existed before the insurance cover began.

In addition, no insurance cover is provided for small children during their first 90 days of life or for claims which are the result of an illness, an infirmity or the consequences of an accident during these first 90 days.

2.4 Discontinuation of insurance cover

The insurance cover is discontinued if the insured person engages in military service for peace-keeping purposes in areas of conflict (e.g. UN Blue Helmets or OSCE Yellow Caps).

2.5 Geographical scope of insurance cover

The insurance cover applies worldwide.

3. Start, duration and end of insurance

3.1 Start and duration of insurance

The insurance begins no earlier than the insured person's birth and no later than their 60th birthday (maximum entry age).

The term of the insurance contract ends no later than on the 65th birthday of the insured person (expiry age).

This insurance policy may be concluded at any time before the insured person reaches the maximum entry age and at any time during the calendar year. Cover can be applied for to commence on the first day of any month.

3.2 Changes to the insurance

The sum insured may be increased within the parameters of the predetermined age categories and sums insured at any time before the insured reaches the maximum entry age; ÖKK is under no obligation to accept an application to do so.

3.3 Suspension of insurance

It is not possible to suspend the insurance.

3.4 End of insurance

The insurance shall end
- upon the death of the insured person;
- upon payment of a death benefit in the event of a fatal illness as per section 4.5.3;
- if the insured person becomes fully disabled; or
- when the person reaches the expiry age on the day after their 65th birthday.

The insurance shall end prematurely
- upon the withdrawal or termination by the contractual partner of ÖKK;
- upon termination as a result of breaches of disclosure obligations (Art. 6 ff. VVG), withdrawal in the event of a partial claim (Art. 42 VVG) or termination for good cause (Art. 35b VVG);
- if the contractual partner of ÖKK or the insured person ceases to reside in Switzerland or spends a period of time abroad of more than 12 months; or
- in the cases stipulated by law, in particular if there are outstanding fees.

Furthermore, the insurance shall expire if the collective insurance contract between ÖKK and Squarelife is dissolved. The contractual partner must be notified in writing of the dissolution of this contact by no later than two months before the expiry of the insurance cover.

4. Benefits

4.1 Overview of benefits

Under the insurance cover, ÖKK pays beneficiaries the following benefits in the event of death or disability as a result of illness:

- In the event of death: death lump-sum payment
- In the event of occupational disability presumed permanent (disability): disability lump-sum payment

4.2 Definition of terms

4.2.1 Disability

Disability is the inability to work as a result of illness which is expected to be permanent. It is recognised by the insurer

- if, cumulatively, the insured person's inability to work is not expected to improve significantly from continued medical treatment; and
- if the insured person will still be unable to work despite rehabilitation measures being taken; and
- if it has existed for a period of at least 12 months.

If the disability has been established before 24 months have expired, the insurer may recognise it earlier.

4.2.2 Illness

Illness is any impairment of physical, mental or psychiatric health that is not the result of an accident and results in a medical examination or treatment, or an inability to work.

4.2.3 Inability to work

An inability to work is the full or partial inability to carry out reasonable work in a person's previous profession or area of work caused by an impairment of their physical, mental or psychological health.

4.2.4 Occupational disability

Occupational disability is the complete or partial loss of the insured person's ability to pursue gainful employment or self-employment in the relevant, balanced labour market as a result of an impairment of their physical, mental or psychological health that remains after reasonable treatment and rehabilitation.

The insured person is considered occupationally disabled if they are incapable of pursuing their 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 to be permanent if the insured person can prove that continued medical treatment cannot be expected to result in a significant improvement in their ability to work and that such occupational disability is likely to last throughout their life.

4.2.5 Reasonableness

An activity is deemed reasonable if it reflects the insured person's former permanent occupation and their previous position in life, even if they require retraining to obtain the necessary knowledge.

4.3 Insurance amounts

4.3.1 Level of insurance amounts

The insurance amounts listed in the insurance confirmation apply.

4.3.2 Minimum insurance amounts

The minimum insurance amount for a death lump-sum payment or disability lump-sum payment is CHF 10,000.

The maximum statutory death lump-sum payment is CHF 2,500 for children under the age of 2½ years.

4.3.3 Maximum insurance amounts

The maximum insurance amounts depend on the age of the insured person as per the following table.

Death

Age category	Maximum insurance amount Death (CHF)
0–12* years*	20,000*
13–20 years	300,000
21–65** years	500,000

* The maximum statutory death lump-sum payment is CHF 2,500 for children under the age of 2½ years.

** Up to expiry age as per sections 3.1 and 3.4

Disability

Age category	Maximum insurance amount Disability (CHF)
0–20 years	300,000
21–60 years	500,000
61–65** years	100,000

** Up to expiry age as per sections 3.1 and 3.4

If the insured person reaches a higher age category, the insurance amounts are automatically reduced to the maximum insurance amount in that new age category and the fees are adjusted accordingly. In all other cases, the insurance amounts remain unchanged.

4.3.4 Superseding causes

If the insured person dies before the disability lump-sum benefit is paid, only the insured death benefit is paid out.

4.4 Disability lump-sum payment

4.4.1 Entitlement to disability lump-sum payment

The insured person is entitled to the agreed disability lump-sum payment if they suffer an occupational disability that is likely to be permanent before reaching the expiry age.

4.4.2 Time of entitlement to disability lump-sum payment

The insurer pays out the disability lump-sum payment at the earliest after a waiting period of 24 months. The waiting period commences on the day on which the insured person first consults a doctor about the illness that led to their inability to work and the doctor confirmed that the insured person is at least 40% incapacitated.

In the event of a relapse or the insured person once again becoming unable to work within 12 months after the end of a period of an incapacity already reported and due to the same medical problem, no further waiting period applies.

If benefits have been paid under Swiss Federal Disability Insurance before the end of the waiting period or if the permanent inability to work is deemed to be permanent before the end of the waiting period or if a diagnosis has been received that will with absolute certainty result in disability in accordance with section 4.4.3, the insured disability lump-sum payment may be partially or completely paid out at an earlier date.

The insurer decides this on a case-by-case basis.

4.4.3 Diagnoses resulting with absolute certainty in disability

In the event of a diagnosis that will with absolute certainty result in disability, the insurer makes an immediate partial payment of up to CHF 20,000 as an advance payment of the disability lump-sum payment without having to observe the waiting period.

A diagnosis that will with absolute certainty result in disability is deemed to have been made when the medical specialists providing treatment determine that this is the case and the expert mandated by the insurer confirms the diagnosis.

Benefits from this insurance policy are only provided in the event of the below-listed diagnoses that will with absolute certainty result in disability (exhaustive list):
- Total loss of sight
- Total loss of hearing
- Multiple sclerosis from Expanded Disability Status Scale level 3.5
- Parkinson's disease from stage 3 on the Hoehn and Yahr scale
- Dementia
- Paraplegia
- Tetraplegia
- Amputation of at least one hand or both legs above the knee

4.4.4 Assessment basis for the calculation of the disability lump-sum benefit

The lump-sum benefit is determined on the basis of the insured disability lump-sum payment, the age of the insured person at the beginning of the waiting period, i.e. at the time their incapacity was first medically confirmed, and the insured person's degree of occupational disability determined by the insurer.

4.4.5 Grading of the disability lump-sum benefit

The disability lump-sum benefit is graded and determined in accordance with the degree of occupational disability of the insured person.
- If the degree of occupational disability is deemed to be between 70% and 100%, the insured person is entitled to the full disability lump-sum payment.
- If the degree of occupational disability is deemed to be at least 40% but less than 70%, the insured person is entitled to a disability lump-sum payment in proportion to the degree of disability determined.
- If the degree of occupational disability is deemed to be less than 40%, the insured person has no entitlement to a disability lump-sum payment.

4.4.6 Changes in the degree of occupational disability

If the degree of occupational disability changes after a disability lump-sum has been paid out, there is no adjustment in benefits to reflect the new degree of occupational disability.

4.4.7 Calculation of the degree of occupational disability for gainfully employed adults

For gainfully employed people, the degree of occupational disability is determined based on the loss of earnings suffered by the insured person. In principle, ÖKK recognises the degree of disability legally determined by the Swiss Federal Disability Insurance.

For gainfully employed people with a regular income, the degree of occupational disability is based on the income subject to state pension deductions (AHV) earned in the month preceding the start of the waiting period. For gainfully employed people with fluctuating or irregular income, the loss of earnings is based on the average income subject to state pension deductions (AHV) earned over the two calendar years preceding the start of the waiting period.

For self-employed people, the degree of occupational disability is based on either the average income subject to state pension deductions (AHV) earned in the two calendar years preceding the start of the waiting period or on the actual loss of earnings suffered by the insured person in the two preceding financial years. The income earned from gainful employment prior to the occurrence of the occupational disability is compared with that which the insured person has earned since the occurrence of occupational disability or that which they could have earned in a balanced labour market; the difference expressed as a percentage of the former income is deemed to be the degree of occupational disability.

4.4.8 Calculation of the degree of occupational disability for unemployed/partially employed adults

For people with no gainful employment and those who completely or partially stop working for reasons unrelated to health, the degree of occupational disability is determined on the basis of an activity comparison. The activity comparison measures, weights and compares the activities and tasks of the insured person before the illness occurred with those after its occurrence. The activities and tasks carried out prior to the occurrence of the occupational disability are set in proportion to those which can still be carried out following the occurrence of the occupational disability. An inability to be active in the former field of activity or work is treated as an occupational disability. The difference, expressed as a percentage of the former activities, is the degree of occupational disability. In principle, ÖKK recognises the degree of disability legally determined by the Disability Insurance (IV).

For people in part-time gainful employment, the degree of occupational disability is determined in accordance with the combined method of Swiss Disability Insurance (IV).

4.4.9 Calculation of the degree of occupational disability for infants and children

The occupational disability of infants and children is measured according to the degree to which the insured person will be incapable of taking on employment. For children who have not yet entered into any professional training, the occupational disability is measured according to whether and to what extent the insured person will later be able to carry out a professional activity. The degree of occupational disability reflects the presumed reduction in income attributed to the reduced capacity to work in relation to the income based on the annual median income ascertained in the Earnings Structure Survey conducted by the Swiss Federal Statistical Office.

For children currently in professional training, the assessment is based on the income that would have been earned in the relevant labour market following completion of the professional training. The degree of occupational disability reflects the presumed reduction in income attributed to the reduced capacity to work in relation to the income based on the annual median income ascertained in the salary structure survey conducted by the Swiss Federal Statistical Office and relevant for the profession for which the training has begun.

4.5 Death lump-sum payment

4.5.1 Entitlement to death lump-sum payment

If the insured person dies during the term of the insurance cover, there is an entitlement to a death lump-sum payment.

The insurer waives its legal right to reduce the death lump-sum benefit if the death of the insured person was a result of the latter's gross negligence.

4.5.2 Basis for the calculation of the death lump-sum benefit

The death lump-sum benefit is calculated on the basis of the insured death lump-sum payment and the age of the insured person at the time of death.

4.5.3 Fatal illness

If a serious illness with a likely life expectancy of up to 12 months is diagnosed for an insured person after the start of the insurance and at least 12 months before the end of the insurance, the insurer shall pay the insurance amount valid at the time of the diagnosis for the death while the insured person is still alive provided that the medical specialists providing treatment determine that this is the case and the expert mandated by the insurer confirms the diagnosis and provided there are no restrictions in these KTI GIC, CP or applicable legal regulations that would prevent this happening.

The insurance cover ends upon payment of the insurance amount for the serious illness with a likely life expectancy of up to 12 months. For the purpose of this contract, a "serious illness with a likely life expectancy of up to 12 months" is deemed to be an advanced, quickly developing, terminal illness, as a result of which the insured person has a likely life expectancy of up to 12 months as diagnosed by the medical specialists providing treatment and confirmed by the expert mandated by the insurer.

If the insured person culpably contracts a serious illness with a likely life expectancy of up to 12 months (irrespective of whether they were of sound mind at the time), the insurer is not obligated to provide insurance benefits.

4.5.4 Beneficiaries

Unless otherwise stipulated with regard to the payment of the death lump-sum benefit, the following persons, in descending order, shall be entitled to the benefits:

- in the case mentioned in section 4.5.3, the insured person;
- if they die, the spouse or registered partner of the insured person;
- if there are none of the above, the children of the insured person;
- if there are none of the above, the parents of the insured person;
- if there are none of the above, the other heirs of the insured person, to the exclusion of the community.

The contractual partner may change the order of beneficiaries at any time prior to the insured person's death, exclude beneficiaries or designate other beneficiaries, provided they have not previously put in place an irrevocable list of beneficiaries. Legal entities can also be named as a beneficiary. Any changes to the beneficiaries must be communicated in writing.

4.6 Exclusions of insurance benefits

4.6.1 In the event of an accident

There is no entitlement to benefits upon death or occupational disability as a result of illness if the insured event was a result of an accident as defined by the CP applicable as per the insurance confirmation. Occupational illnesses within the meaning of the UVG likewise do not give rise to any entitlement to benefits in the event of death or occupational disability as a result of illness.

4.6.2 Accident-like physical injuries

There is no entitlement to benefits in case of death or occupational disability as a result of illness in case of physical injuries deemed similar to accidents.
The following are considered accident-like physical injuries and not illnesses:

- health impairments and their consequences caused by involuntarily breathing gases or vapours, or unintentionally consuming poisonous or corrosive substances;
- the physical injuries considered equivalent to accidents that are listed in the CP and are applicable as per the insurance confirmation, provided they were not primarily caused by illness or attrition;
- frostbite, heatstroke, sunstroke and health impairments caused by ultraviolet radiation and their consequences, excluding sunburn, and involuntary drowning.

4.6.3 Intentional self-inflicted occupational disability

There is no entitlement to benefits for occupational disability if the insured person intentionally causes their occupational disability or illness (e.g. self-harm, attempted suicide). This also applies if the insured person takes the action leading to their occupational disability but was not mentally competent to judge their action.

The insurer waives its legal right to reduce the disability lump-sum benefit if the occupational disability of the insured person was a result of the latter's gross negligence.

4.6.4 Prenatal bodily injuries, birth defects and their consequences

There is no entitlement to disability or death benefits if the insured person's occupational disability or death is a result of prenatal bodily injuries, birth defects or their consequences.

4.6.5 Suicide and injury as a result of attempted suicide

There is no entitlement to death benefits if the insured person commits suicide within three years of the application or if the insured person dies of injuries as a result of attempted suicide committed within three years of the application. This also applies if the insured person is not competent to judge their actions or has a reduced capacity to make judgements at the time the action is taken which leads to their death.

4.6.6 Ionising beams and damage caused by nuclear energy

There is no entitlement to death or disability benefits if the insured person becomes ill as a result of exposure to the effects of ionising beams from nuclear energy.

4.6.7 Other benefit exclusions

Furthermore, there is no entitlement to insurance benefits in the cases listed in section 6.4.2 of the CP (benefit exclusions).

4.7 Reduced entitlement to insurance benefits

4.7.1 Concurrence of multiple causes

In the event that a number of different causes coincide, the insurer recognises partial claims that are not covered by accident or military insurance.

4.7.2 Concurrence of disability and death lump-sum benefits

In the event of death, the disability lump-sum payment already made to the insured person is deducted from the death lump-sum payment.

4.7.3 Other benefit restrictions

Furthermore, benefit restrictions apply in the cases listed in section 6.4.3 of the CP (benefit restrictions).

4.7.4 Verification of insurance claim

The standard documents to be submitted to verify the claim 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 decree/IV files/AHV statement/annual salary statement, payslips and accounts.

The insurer is entitled to demand further information and evidence and to make further enquiries of its own; it may also require that the insured person be examined by its independent medical examiner. The insured person's doctor is released from their duty of medical confidentiality in their dealings with ÖKK and the insurer.

4.7.5 Payment of insurance benefits

The insurance benefits are paid out when the beneficiaries have submitted all documents required for the verification and assessment of the claim and on the condition that the verification of the claim has a positive outcome.
Insurance benefits fall due after four weeks have passed from the time when the insurer received all documentation and information that were sufficient to prove to them the accuracy of the claim; in case of disability, this is no earlier than the end of the waiting period, however. The fee must be paid up until this time.

The insurance benefits are paid in Swiss francs (CHF) into an account designated by the beneficiary at a bank in Switzerland or the Swiss Post Office.

5. Obligations of the insured person

5.1 Disclosure obligation and health check

All facts material to the determination of risk must be listed truthfully and in full on the application to the extent and as they are known or should be known. If such facts are incorrectly listed or omitted, ÖKK may terminate the contract in writing within four weeks of becoming aware of the breach of the disclosure obligation. The notice of termination enters into effect on being received by the contractual partner.

If the contract is dissolved by means of termination, the obligation to provide benefits shall also expire in respect of claims already made, to the extent the occurrence or scope of which were related to the non-disclosed/incorrectly disclosed material risk factors. There is a right for any benefits that have already been paid out to be reimbursed. There is no right for fees paid for the cover to be reimbursed.

5.2 Process for making a claim

The insured person must immediately report any illness that is likely to trigger an obligation to pay benefits.

A death must be reported immediately, within ten days at the latest.

The documents required to verify and assess the claim must also be submitted without delay.

5.3 Duty of cooperation in the event of illness

The insured person has an obligation to cooperate and to mitigate loss. The insured person grants the insurer the authority to request files and information from hospitals, doctors, government offices, insurance companies, social security institutions and third parties, and to release these institutions from their duty of confidentiality.

The insured person shall without delay provide the insurer with all information requested regarding their previous and present state of health and the course of the illness.

The insurer reserves the right to require the insured person to undergo an examination by a physician designated by it. The insured person must undergo the examinations and follow the instructions of the doctors appointed by the insurer at its cost.

If the beneficiary fails to meet any of these obligations, there is no entitlement to benefits and the insurer is authorised to refuse to pay benefits unless the injury is considered to be non-culpable under the circumstances or the beneficiary can prove that the injury had no impact on the occurrence of the feared event and the extent of benefits owed by the insurer. In any case, the obligation to pay the fee for the cover continues to exist.

5.4 Notifications and disclosures

All notifications and disclosures are to be made to ÖKK and are only legally effective if they are sent in writing via e-mail or by post.

6. Fee

The fee for the cover is calculated according to the age group of the insured person and the level of the insurance amounts. In each case, fees remain guaranteed for one calendar year. There is no tariff guarantee.

The age groups are 0 to 3 years and 4 to 15 years. The age groups then span 5 years, i.e. 16 to 20, 21 to 25 etc. The last age group is 61 to 65.

7. Special provisions

7.1 Military service

Active service – without warlike activities – in order to safeguard Swiss neutrality or to maintain public order within Switzerland are deemed military service during times of peace and are covered by this insurance policy. In the event that Switzerland engages in war or warlike activities, the relevant provisions issued by the Federal Council apply.

7.2 Place of performance

The place of performance is the beneficiary's place of residence in Switzerland. If there is no such place of residence, the legal domicile of ÖKK is deemed to be the place of performance.

7.3 Place of jurisdiction and applicable law

In the event of a dispute arising from this contract, the beneficiaries may choose either their place of residence in Switzerland or the legal domicile of ÖKK as the place of jurisdiction. The contract is exclusively subject to Swiss law.

ÖKK COMPENSA

ÖKK Versicherungen AG, Edition 1.1.2022

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance policy shall apply. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

1.3 Purpose

ÖKK COMPENSA (insurance against loss of earnings for individuals under VVG) is provided in accordance with the provisions of the Swiss Federal Law on Insurance Contracts.

It is used to cover the loss of earnings caused by an inability to work as a result of illness, accident or birth.

ÖKK COMPENSA is also offered to persons who are not in gainful employment.

2. Geographical scope

2.1 General

The insurance cover applies worldwide.

2.2 Inability to work while abroad

In the event of private holiday travel abroad, the insured daily allowances are paid only during hospital stays These rules likewise apply to cross-border workers outside Switzerland and away from their place of residence. This does not apply to stays abroad for professional reasons.

2.3 Stays abroad while unable to work

If an insured person who is unable to work and entitled to benefits travels abroad without the consent of the insurer, there is no entitlement to benefits during the stay abroad. This restriction does not apply to cross-border workers when they are present in Switzerland.

3. Conclusion of the insurance

3.1 Conditions of acceptance

Self-employed, employed and non-active persons (housewives and househusbands, people in education and family members working in a family company who do not receive a salary in cash) can be accepted into ÖKK COMPENSA provided that:

- they are at least 15 and not more than 60 years old;
- they are fully capable of working when the application is made; and
- they reside in Switzerland.

3.2 Doctor's certificate

The insurer may demand a doctor's certificate or an examination by its independent medical examiner. It may designate the doctor and bears the costs.

3.3 Transfer from collective insurance policy

The GIC of the ÖKK LOSS OF EARNINGS INSURANCE for businesses (VVG) apply to transfers from collective insurance policies to individual insurance policies.

Cross-border workers can transfer from the collective daily allowance insurance to this individual insurance if they continue to work in Switzerland immediately after ceasing to belong to the group daily allowance insurance and cannot transfer to another group daily allowance insurance policy or are deemed to be unemployed within the meaning of the Federal Law on Compulsory Unemployment Insurance (AVIG) and are entitled to daily allowances from unemployment insurance.

3.4 AHV retirement age

Insured persons who remain in gainful employment after reaching the AHV retirement age may apply for their insurance to continue. However, this arrangement cannot continue beyond their 70th birthday.

4. Termination

4.1 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 insurer by giving one month's notice to the end of a month.

4.2 Other grounds for termination

In addition to the grounds for termination mentioned in the CP applicable as per the policy, the insurance lapses in the following cases:

a) if the self-employed insured person stops working;
b) if the company's headquarters are transferred abroad, with the exception of regions of foreign countries close to Switzerland's border;
c) on retiring – however, the insured person may apply for the insurance to continue until the age of 70; and
d) on moving abroad, unless the new place of residence is in a region of a foreign country close to Switzerland's border.

The insurer may withdraw from the contract within four weeks

e) if the insured person repeatedly and seriously infringes rulings of the insurer or instructions given by a doctor; or
f) in the event of a breach of disclosure obligations or in the event of attempted or successful insurance fraud.

5. Insurance options

The following insurance options may be selected:

- Daily allowance in case of illness
- Daily allowance in case of accident
- Daily allowance in case of illness and accident

These insurance options can be taken out with different benefit durations.

6. Scope of insurance

6.1 Amount of the insured daily allowance

The amount of the insured daily allowance is agreed between the insured person and the insurer.

6.2 Basis of assessment for the daily allowances

The daily allowance is calculated as one 365th of the insured loss of income in any one year. The calculated daily allowances are paid for every calendar day.

6.3 Maximum cover

6.3.1 Insurable daily allowance

The amount of the insurable daily allowance is limited to CHF 200,000 per year. For persons who transfer from a collective insurance contract of the insurer, the daily allowance is limited to CHF 250,000 per year.

6.3.2 Self-employed persons

Insured persons whose income is derived from self-employment may, over and above their income subject to 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 their work and continue to be incurred during their inability to work, in particular fixed costs for business rents, motor vehicles, insurance, machine depreciation etc.

6.3.3 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.

6.3.4 Non-active persons

Housewives and househusbands, people in education and family members working in a family company who do not receive a salary in cash may take out insurance up to the amount of the simple AHV maximum pension

6.3.5 Unemployed persons

The maximum cover for unemployed persons corresponds to the loss of unemployment insurance.

6.4 Accident cover

Accident cover can be included in the insurance or insured separately.

6.5 Childbirth

The daily sickness allowance includes cover for loss of earnings as a result of childbirth.

6.6 Start of benefits and waiting periods

The insurer offers daily allowance insurance policies with different benefit starting dates.

The entitlement to benefits begins after the expiry of the waiting period. The waiting period begins on the first day of the insured person's inability to work as per the medical certificate, but no earlier than three days before the first medical treatment. Waiting periods of up to and including 21 days are recalculated for each case of illness or accident. Longer waiting periods apply once each calendar year only.

Waiting days are days on which an inability to work of at least 25% exists.

The insurer pays the daily allowance according to the chosen start of benefits after the entitlement to draw benefits begins for the days on which a medically certified inability to 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.

6.7 Adjustment of the insurance

6.7.1 Adjustment for inflation

The insured person may ask for their insurance to be adjusted in line with the annual rate of inflation according to the national consumer price index. The insurer approves this adjustment without any risk assessment provided that no inability to work has existed in the past two years and no daily allowance has been drawn. Adjustments are possible for the last two completed calendar years.

The insured person may also request at any time for their insurance to be adjusted in line with real wage trends at the conditions applicable to higher insurance amounts.

6.7.2 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 insurance at the beginning of unemployment.

7. Insurance benefits

7.1 Conditions for receiving benefits

7.1.1 Inability to work

An inability to work exists if the insured person is wholly or partially unable by reason of illness, accident or childbirth to perform their previous or other reasonable employment activity.

A partial inability to work exists if there is at least a 25% inability to work.

7.1.2 Medical certificate

For daily allowances to be paid, a medical certification of the insured person's inability to work is required. The certificate must be issued by a physician or a chiropractor who is approved by the insurer (in accordance with section 6.1.9 ÖKK LIVE CP or section 6.1.11 ÖKK UNO CP).

Medical certificates and illness or accident reports may not be backdated by more than 3 days.

7.2 Scope of benefits

7.2.1 General

The benefits are determined according to the agreed scope of insurance and the existing insurance conditions.

7.2.2 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

7.2.3 Employees

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.

7.2.4 Partial inability to work

In the event of partial inability to work of at least 25%, the daily allowance is reduced accordingly.

For unemployed persons with an inability to work of more than 25% and a maximum of 50%, one half of the daily allowance is paid; the full daily allowance is paid in the case of an inability to work of more than 50%.

7.2.5 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.

7.2.6 Childbirth

Daily allowances for childbirth are paid on the condition that prior to the birth, equivalent cover was in place for an uninterrupted period of at least 270 days with the insurer or a different insurer (qualifying period for maternity).

Insured persons who gave up their gainful employment more than 8 weeks prior to the birth or who do not receive maternity benefits pursuant to the Loss of Earnings Compensation Act (LECA) are not considered to be gainfully employed.

In the event of birth, ÖKK COMPENSA will pay benefits in addition to the maternity benefits according to the LECA up to the agreed daily allowance sum.

7.3 Duration of benefits

7.3.1 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 consequences of accidents are treated as a new insurance claim if the insured person has been able to work for an uninterrupted period of 12 months since the end of the last benefit payments.

The agreed waiting period counts towards the maximum duration of benefits. Days of partial inability to work count as full days for the purpose of calculating the duration of benefits.

7.3.2 Childbirth

The 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 birth, the maximum duration of benefits is 16 weeks, i.e. in addition to maternity compensation under the LECA, two additional weeks at the rate of the insured daily allowance for 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 counts towards the duration of benefits for childbirth regardless of illness or accident. If the waiting period counted towards the duration of benefits because of complications during pregnancy, no further waiting period is counted with respect to the childbirth allowance.

Childbirth allowances count towards the maximum duration of an insurance claim.

7.3.3 AHV retirement age

In the event the insurance being continued at AHV retirement age, there is an entitlement to the insured daily allowance for 90 days; for persons transferring from a collective insurance of the insurer, for 180 days, but no later than the insured person's 70th birthday.

7.3.4 Unemployed persons

Unemployed persons receive the insured daily allowance at the latest until the end of the maximum period of payment in accordance with the provisions of the Swiss Federal Act on Compulsory Unemployment Insurance and Insolvency Compensation.

7.3.5 Transfer from collective insurance policy

For insured persons who have left the group of insured persons under a collective insurance policy 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.

7.4 Benefit restrictions

7.4.1 Exclusion of benefits

In addition to the excluded benefits mentioned in the CP applicable as per the policy, there is no entitlement to insurance benefits:

a) for consequences of accidents and occupational illnesses which are to be covered by a different insurer;
b) if a certificate of inability to work was issued by a doctor or chiropractor not recognised by the insurer;
c) if the insured person deliberately receives or seeks to receive benefits in an unlawful manner;
d) if the insured person's degree of inability to work is less than 25%;
e) for employees for the duration of unpaid leave; or
f) following termination of the insurance contract with the exception of periodic benefit obligations within the meaning of Art. 35c VVG.

7.4.2 Benefit restrictions

In addition to the benefit restrictions mentioned in the CP applicable as per the policy, benefits may be reduced:

a) if the illness or consequences of an accident are only partially the cause of the inability to work;
b) if the insured person repeatedly and seriously infringes rulings of the insurer or instructions given by a doctor;
c) if the insured person declines a medical check-up by the independent medical examiner required by the insurer; or
d) if the insured person refuses to perform another reasonable employment activity.

The provisions under Art. 45 VVG shall apply.

7.4.3 Reimbursement obligation

The insured person must refund to the insurer any benefits obtained in error or wrongfully.

8. Duty of cooperation in the event of illness and accident

8.1 Notification obligation

The insured person must inform the insurer within five days of every inability to work which may give rise to an 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 inability to work must be given no later than one week before any claim to benefits is made.

The certificate issued by the doctor or chiropractor must be presented to the insurer at the latest ten days after the beginning of the inability to work, or in the case of waiting periods exceeding 21 days, with the notification of the inability to work.

Subject to Art. 45 VVG, if the insured person fails to comply with these requirements without providing sufficient reason, the insurer only grants benefits from the date on which the report is received. Medical certificates and illness or accident reports may not be backdated by more than three days.

Employees must provide evidence of a loss of earnings which is not otherwise covered.

If the degree of inability to work is reduced, the insurer must be notified of this fact without delay.

8.2 Obligation to provide information

In the event of an accident, the insured person must make available to the insurer all the necessary information on the reasons for the accident and any third parties involved in the accident.

In the event of frequent short absences within a short period of time, the insurer is entitled to require the insured person to visit a doctor on the first day of the inability to work.

The insurer may verify the inability to work and the uncovered loss of earnings in every case and make appropriate checks if necessary.

The obligations to provide information apply in accordance with the CP applicable as per the policy.

9. Premiums and payments

9.1 Level of premiums

The level of the premiums is determined in line with the risk entailed, for example based on the insured person's age, place of residence, benefits drawn or industry in which they work. Persons who are transferred from the loss of earnings insurance for businesses to an individual insurance policy form a separate risk group.

In addition, the CP applicable as per the policy apply with regard to determining premiums, paying the premiums, payment default and adjusting the premiums.

9.2 No-claims discount (NCD)

9.2.1 Principle

A premium discount is granted if no claims are made.

9.2.2 Observation period

The observation period runs from 1 September (or the start of the insurance policy) to 31 August of the following year. The processing date of the daily allowance statement is the determining factor for the calculation of benefits in the observation period.

9.2.3 Discount levels

The following discount levels/premiums apply:

Discount level	Premium
0	100%
1	64%

The discount levels can be adjusted in line with changes in costs.

9.2.4 Adjustment of level if benefits are drawn

If the insured person has claimed benefits during an observation period, the discount level will be adjusted to level 0 on 1 January of the following year unless the insured person is already at this level.

9.2.5 Adjustment of level if no benefits are drawn

If the insured person has not claimed any benefits for three consecutive observation periods at discount level 0, they will be adjusted to discount level 1 on 1 January of the fourth year.

9.2.6 Change of insurance cover

The discount level is maintained in the event of any change of insurance cover within ÖKK COMPENSA.

9.3 Payment of benefits

9.3.1 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 inability to work lasts for more than one month, the daily allowance is generally paid out monthly.

9.3.2 Daily allowances for childbirth

Childbirth allowances for employed and self-employed women are only payable after the statement of maternity compensation pursuant to LECA has been submitted to the insurer.

10. Third-party benefits

10.1 Employed persons and unemployed persons

Days with partial benefits following a reduction because the benefits are payable by a third party count as whole days for the calculation of the period of benefits in the waiting period.

Furthermore, the regulations governing third-party benefits apply in accordance with the CP applicable as per the policy.

The insured person assigns to the insurer any claims on the social security scheme for additional payments, in the event that the insurer has made advance payments.

10.2 Self-employed persons

For self-employed persons, the scope of benefits corresponds to the agreed daily allowance amounts.

Furthermore, the regulations governing third-party benefits apply in accordance with the CP applicable as per the policy, with the exception of the regulations governing overinsurance.

The insured person assigns to the insurer any claims on the social security scheme for additional payments, in the event that the insurer has made advance payments.

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