General Insurance Conditions (GIC)

ÖKK UNO product line

Edition 2019

ÖKK

Common Provisions

ÖKK Versicherungen AG, Edition 1.1.2019

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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 insurance provider for the ÖKK PROTECT health-legal protection insurance is Coop Rechtsschutz AG, Aarau.

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

The ÖKK Risk capital insurance in the event of death or disability caused by illness is provided by Helvetia Swiss Life Insurance Company Ltd, Basle.

1.3 Scope of insurance

The insurance covers the financial consequences of illness, accident and maternity 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.

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 Collective insurance conditions

The ÖKK UNO GIC also apply for collective insurance policies in the area of treatment costs. Alternative conditions may be agreed in the individual collective contracts; in particular, these relate to acceptance into the policy, the scope of benefits, determining the premium, the duration of the insurance, termination and the allocation of rights and obligations between the policyholder and the insured person.

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

1.6 Insurance Contract Act

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

2. Insurance departments

2.1 Insurance possibilities

The insurance 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 Collective insurance

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

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 insurance policies must be submitted in writing or in another form that can be evidenced in the form of text. 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.

In the event of cancellation of the contract, the obligation of the insurer to provide benefits for claims which have already been made lapses if their occurrence or scope has been influenced by the significant risk circumstance which was not notified or was incorrectly notified. 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 take out the insurance may be withdrawn within 14 days of the date of signing. If a declaration of cancellation is made, all the obligations on the part of the insurer lapse.

If the contents of the insurance policy or the appendices to the policy do not match the agreements reached, policyholders shall demand that the certificate be rectified within four weeks of receiving it; otherwise they are deemed to have accepted the contents of the contract.

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 Right of transfer in the event of termination of the collective contract

Insured persons whose cover lapses by reason of termination of the collective contract are entitled to change to individual insurance without a new health declaration.

This right of transfer must be exercised within 30 days of the end of the collective agreement.

No right of transfer exists if the policyholder has concluded a new collective contract for this group of persons with another insurer.

5.1.4 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. This applies correspondingly for exercising the right to transfer to the individual insurance.

5.2 Waiver of termination by the insurer

The insurer expressly waives his statutory right to terminate on expiry of the contract or to withdraw from the contract if a claim is made.
Exceptions to this are as follows:

– the right of termination of collective contracts; and
– the right to withdraw from the contract in the event of a breach of disclosure obligations or in the event of attempted or successful insurance fraud.

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).

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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 medical-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

An entitlement to benefits exists for the duration of the insurance. No entitlement to benefits exists for costs incurred after the termination of the insurance.

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

6.3 Insured benefits

6.3.1 Scope of benefits

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

6.3.2 Economical treatment

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

In 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.

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.

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 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. If the discount conditions change, the right of termination applies.

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

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

The insured person 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) of 2 April 1908 and the Federal data protection law of 19 June 1992.

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. 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 TOURIST

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 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

The insurance provides benefits towards the uncovered costs of emergency treatment in the event of illness, accident or premature birth during vacations, business travel or stays abroad. It also provides benefits towards transport, search, rescue and recovery operations as well as other services. The following conditions apply with regard to the insurance cover.

1.4 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.

1.5 Geographical scope

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

1.6 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.

1.7 Conclusion of the insurance

This insurance may be concluded by all persons, without any age restrictions.

1.8 Insured persons

Persons who have concluded an ÖKK TOURIST policy with the insurer are insured.

1.8.1 Individuals

The persons listed in the insurance policy are insured.

1.8.2 Families

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

1.9 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

In the case of families, a condition for taking out and holding the ÖKK TOURIST insurance is that at least one parent must be insured with the insurer with a ÖKK GENERAL SUPPLEMENT, ÖKK PRIVATE SUPPLEMENT, ÖKK OPTIMA, ÖKK PREMIUM, ÖKK FAMILY, ÖKK FAMILY FLEX, ÖKK SALTO or ÖKK COMBI insurance policy.

Insured persons at partner companies of the insurer may conclude and hold an ÖKK TOURIST policy provided they have concluded a comparable product with their insurance company. The insurer shall make a definitive decision about whether to accept such persons.

2. Insurance benefits

2.1 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 rates or the contractually agreed rates. A birth is regarded as premature if it is unforeseen and takes place more than six weeks before the medically attested expected birth date.

The statutory cost share applicable to Switzerland is not insured.

2.2 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.

2.3 Trips for visiting purposes and additional travel costs

2.3.1 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 insurer organises and pays for a trip for visiting purposes to the hospital for one person close to the insured person (first-class rail ticket, economy-class airfare).

2.3.2 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.

2.4 Amount of coverage

The following insurance options can be concluded:

2.4.1 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. The following insurance options can be concluded (duration of stay abroad):

– up to 17 days
– up to 40 days.

2.4.2 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. The following insurance options can be concluded (duration of stay abroad):

– up to 17 days
– up to 40 days.

2.5 Services

2.5.1 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.

2.5.2 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.

2.5.3 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.

2.5.4 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.

2.6 Benefit restrictions

2.6.1 Principle

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

2.6.2 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;
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.

2.6.3 Benefit restriction

Where the invoice is clearly for an amount that is too high, the insurer can reduce its benefits or make the payment thereof contingent on the claim for reduction being ceded.

2.7 Statute of limitations

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

3. Cost sharing

No cost sharing applies to benefits provided under ÖKK TOURIST.

4. Obligations in the event of a claim

4.1 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.

4.2 Release from duty of professional 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.

4.3 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.

4.4 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.

5. Third-party benefits

5.1 General provisions

If a third party is liable for a reported illness or accident (or a third party is liable by law or through their fault), the insurer is either not obliged to provide benefits, or is only liable for the uncovered amount of benefits.

5.2 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 GIC no longer applies. The capitalisation of an entitlement to benefits is also considered to be a waiver of benefits.

5.3 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.

5.4 Existing insurance policies with the insurer

Other existing supplementary insurance with the insurer or its partner companies shall take precedence over the benefits under ÖKK TOURIST.

5.5 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.