General terms and conditions of insurance (GTC) under the Federal Insurance Contract Act (ICA)

2018 edition

capita accident • capita illness • dental • general supplement • hospita • mondial • plus • premium • private supplement • protect • salto • tourist

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General terms and conditions of insurance

1 Insurance fundamentals

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

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

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

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

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

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

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

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

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

2 Insurance departments

2.1 Insurance possibilities
The insurance departments pursuant to these GTC are as follows:

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

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

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

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

3 Insured persons

3.1 Individual insurance
Insured persons are listed in the insurance policy.

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

4 Start and duration of the insurance

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

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

In submitting the application, the applicant authorizes the health fund to obtain from medical practitioners and other

insurers the information needed to conclude the insurance and clarify its subsequent obligation to pay benefits.

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

4.1.3 Refusal or exclusion of benefits

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

4.1.4 Documentation

When the policy is concluded the policyholder receives

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

4.1.5 Right of cancellation

Any person who applies to the insurer for insurance is held to that application for 14 days if they have not specified a shorter period for the application's acceptance. If the insurer requires a medical examination, the applicant is held to the application for four weeks.

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

4.2 Start of insurance

Insurance begins on the date specified in the policy document.

4.3 Duration of insurance

4.3.1 Insurance term

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

4.3.2 Longer insurance period

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

4.3.3 Time of conclusion of the insurance

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

4.3.4 Extension of insurance

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

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

4.4 Change of insurance

4.4.1 Changes by the policyholder

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

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

4.4.2 Changes by the insurer

If, after conclusion of the insurance, far-reaching changes occur in the background conditions affecting the provision of insurance against the financial consequences of illness, maternity and accident, such as an increase in the number of medical personnel or new categories of medical personnel, extension of the range of medical services, introduction of new cost-intensive forms of therapy or medication and similar developments or amendments to the legislation on social insurance, the insurer is authorized to adjust the insurance provisions accordingly.

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

4.5 Suspension of insurance

4.5.1 Condition

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

4.5.2 Duration and scope of suspension

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

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

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

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

5 Termination of insurance

5.1 Termination by the policyholder

5.1.1 Ordinary termination

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

5.1.2 Termination in the event of a claim

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

5.1.3 Right of transfer on termination of the group contract

Insured persons whose cover lapses when a group contract is terminated are entitled to switch to an individual insurance contract with the same level of insurance. Any switch to a higher level of insurance cover shall necessitate making a new health declaration. This right of transfer must be exercised within 30 days of the end of the collective agreement.

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

5.2 Waiver of termination by the insurer

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

5.3 Other grounds for termination

The insurance expires in the following cases:

a) on the death of the insured person,
b) on removal abroad (except for cross-border commuters, employees posted abroad or if a **mondial** policy is taken out),
c) on reaching the age limit stipulated for insurance cover,
d) on the exhaustion of the rights to draw all the benefits in an insurance department,
e) if the contract is not extended after reaching the maximum policy term (max. 36 months, extension by an additional 36 months possible) for **mondial** or in the event of a suspension,
f) if the insured person is subject to the statutory insurance requirement in Switzerland or in the country of residence in the course of the insurance relationship or exemption from this requirement expires, **mondial** shall expire as at the date that the statutory insurance requirement once again applies, however no earlier than the end of the month in which Sympany receives a corresponding notification.

6 Benefits

6.1 Definitions

6.1.1 Sickness

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

6.1.2 Accident

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

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

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

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

6.1.3 Maternity

Benefits in connection with pregnancy and childbirth are the same as those for illness if at the time of the birth the mother has been covered by the insurer for at least 270 days, or in the event of equivalent previous insurance by another insurer if the health fund confirms that the insurance application was submitted at least 270 days before the birth.

6.2 Scope of benefits

6.2.1 Geographical scope

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

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

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

6.2.2 Temporal scope

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

6.3 Insured benefits

6.3.1 Benefit coverage

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

6.3.2 Economical treatment

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

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

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

6.3.3 Treatment by recognized medical personnel

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

6.4 Limitation of benefits

6.4.1 Pre-existing illnesses and accidents

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

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

6.4.2 Exclusion of benefits

No entitlement to insurance benefits exists:

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

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

6.4.3 Limitation of benefits

Benefits can be reduced:

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

7 Obligations in the event of sickness or accident

7.1 Notification obligation

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

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

7.2 Damage limitation

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

7.3 Obligation to provide information

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

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

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

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

8 Premiums and payments

8.1 Fixing the premiums

8.1.1 General

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

8.1.2 Amount of premiums

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

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

A reduced premium is charged for suspended insurance.

8.1.3 Family discount

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

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

- where the insurance term is at least three years: one parent must have at least the same insurance cover with Sympany as the child and they must live together in the same household (family policy).
- for premium exemptions for the third child and subsequent children: the two oldest siblings, aged up to 25 and living together in the same household (family policy), must have at least the same insurance cover with Sympany.

8.2 Adjustment of premium scales and cost sharing

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

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

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

8.3 Premium payment

8.3.1 Due date

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

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

8.3.2 Payment arrears

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

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

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

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

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

8.4 Profit share

8.4.1 Principle

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

8.4.2 Condition

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

8.4.3 Disbursement

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

8.5 No-claims discount (NCD)

8.5.1 Principle

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

8.6 Other payment provisions

8.6.1 Offsetting

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

8.6.2 Pledging and assignment

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

8.6.3 Disbursement of benefits

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

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

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

8.6.4 Time barring

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

9 Third-party benefits

9.1 Subsidiarity

9.1.1 General

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

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

9.1.2 Public benefits

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

9.1.3 Multiple insurance

If multiple private insurance policies apply, the benefits defined in these General Conditions of Insurance shall be payable only as excess over the benefits of the other insurer. If the other insurer's insurance conditions also contain a subsidiary clause, the rules regarding double insurance shall be applied, pursuant to the Insurance Contracts Act.

9.1.4 Waiver of benefits

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

9.2 Social insurance

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

9.3 Advance payment of benefits and redress

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

9.4 Overinsurance

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

10 Customer card

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

Otherwise the general conditions of insurance relating to compulsory health insurance and the associated special terms and conditions apply.

11 Data protection

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

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

The health fund only obtains and processes data (e.g. personal particulars, information about the state of health, verification of the details given in the application, cash collection, claim processing) required for the insurance contract to be processed pursuant to the ICA. The health fund treats the information obtained as completely confidential.

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

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

12 Notices

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

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

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

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

13 Jurisdiction

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

14 Entry into force

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

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