

Supplementary Care Insurances

Customer information regarding the General Insurance Terms and Conditions of Supplementary Care Insurances

This document defines the insurance provider and provides an overview of the essential content of the insurance contract in accordance with Art. 3 of the Swiss federal law on insurance contracts (VVG/LCA). The rights and duties of the contracting parties are specified in the application, the policy, the General and Additional Insurance Terms and Conditions and the applicable laws, in particular the VVG/LCA.

Who is the insurance provider?

The insurance provider is CONCORDIA Insurances Ltd (CONCORDIA), whose registered office is located at Bundesplatz 15, 6002 Lucerne. CONCORDIA is a public limited company (Aktiengesellschaft/société anonyme/società anonima) under Swiss law.

What risks are insured and what is the scope of the insurance cover?

The insurance covers the financial consequences of the following risks:

- Illness and/or
- Accident and/or
- Maternity

The specific insured risks and the scope of the insurance cover are set out in the application, the policy as well as the General and Additional Insurance Terms and Conditions. A description of the benefits offered by the individual insurance products can be found in the brochure "Insurance and Benefits of CONCORDIA".

The Additional Insurance Terms and Conditions set out whether a particular insurance plan is a fixed sum insurance or indemnity insurance (i.e. provides cover for loss and damage).

The insurance does not cover the following:

- Treatment of illnesses and accidents in connection with the consumption of drugs, narcotics and addictive substances and the abuse of alcohol and medicines (including complications and long-term effects)
- Treatment of illnesses and accidents in connection with attempted or accomplished suicide or self-inflicted injury (including complications and long-term effects)
- Treatment of obesity (including complications and long-term effects)
- Artificial insemination and sterility treatments (including complications and long-term effects)
- Cosmetic treatments and gender affirmation surgery (including complications and long-term effects)
- Cost sharing (deductibles and retention fees) in mandatory health insurance and other insurances

The above list is not exhaustive.

The aforementioned grounds for exclusion also apply if they are only partly responsible for an illness or accident. Further exclusions are set out in the General and Additional Insurance Terms and Conditions.

How much is the premium?

The level of the premium depends on the insured person's age and place of residence according to Swiss civil law, the insured risks as well as the desired cover and cost sharing (deductible and retention fee). All details of the premium and cost sharing are set out in the application, the policy and the Additional Insurance Terms and Conditions. Collective insurance contracts may contain provisions that differ from these.

When does the premium have to be paid?

The annual premium is payable in advance and is due on 1 January of each year or, if paying by instalments, on the first day of each month. In the event that CONCORDIA makes direct payments to healthcare providers (doctors, hospitals, pharmacies, etc.), the policyholder is obligated to refund the stipulated cost-sharing amount within 30 days of issue of the invoice by CONCORDIA.

What other duties does the insured person have?

- **Time-limited duty to notify:** If there are changes in the insured person's state of health between completing the health questionnaire and the insurance being taken out, the applicant or insured person is obliged to notify CONCORDIA promptly in writing and correct the answers in the health questionnaire. The duty to notify ceases to apply once the insurance has been taken out.
- **Duty to mitigate loss:** In the event of illness or accident, the insured person must ensure that they obtain appropriate medical treatment as soon as possible. They must comply with medical instructions and refrain from all actions that could lead to a deterioration in their physical condition.
- **Duty to notify:** In the event of outpatient treatment, the detailed invoices and receipts must be sent in at least once a year and in any case at the end of the treatment. In the event of inpatient treatment, the insured person must notify the insurance provider of admission into a hospital without delay, no later than five days after the admission. In the case of cures, the doctor's prescription for a cure

must be submitted in a timely manner before the cure begins, indicating the name of the spa or sanatorium and the date the cure begins.

- **Duty to cooperate:** The insured person must provide CONCORDIA with complete and truthful information on all matters relating to the insured event (illness, accident, pregnancy) as well as past illnesses and accidents, and releases the health professionals treating them (doctors, etc.) from the professional duty of confidentiality with regard to CONCORDIA.

Further duties are set out in the General, Additional and, where applicable, Special Insurance Terms and Conditions and the VVG/LCA.

When does the insurance cover begin?

Insurance cover begins on the date indicated in the application or the policy.

The policyholder may cancel their application for or acceptance of the contract in writing. The cooling-off period is 14 days from the date on which the policyholder applies for or accepts the contract.

How long does the contract last?

The contract is taken out for life provided that the policy or the Additional Insurance Terms and Conditions do not specify a fixed contract term. The minimum duration of a contract that is taken out for life is one year, unless the application or policy provides for another minimum contract duration. In the case of hospital insurance with an optional deductible, it is only possible to change to a lower deductible after the insurance has been held for three years.

When does the contract end?

The policyholder may cancel the contract in the following circumstances:

- In the case of an insurance that has been taken out for life: after the expiration of the minimum contract duration, at the end of each calendar year, subject to a three-month notice period. The notice of cancellation is considered to have been given on time if it reaches CONCORDIA no later than the last day before the start of the three-month period of notice.
- In the case of a contract with a fixed term: at the end of the contract term, subject to a three-month notice period. If the contract is concluded for more than three years, it may be terminated at the end of the third or every subsequent year subject to a three-month notice period. The notice of cancellation is considered to have been given on time if it reaches CONCORDIA no later than the last day before the start of the three-month period of notice. If the contract is not cancelled, it is automatically renewed for one year at a time.
- After each insured event that is eligible for benefits, but no later than 14 days after being informed of the payout by CONCORDIA.

- If CONCORDIA modifies the premiums. In this case, the notice of cancellation must reach CONCORDIA by the last day of the calendar year.

CONCORDIA may cancel the contract if important facts concerning risks have been concealed or communicated inaccurately (breach of notification duties).

CONCORDIA is not entitled to terminate the contract due to the occurrence of an insured event.

CONCORDIA may withdraw from the contract in the following circumstances:

- If the insured person is in arrears with the payment of the premium, has been sent a reminder and CONCORDIA opts not to take legal action to recover the premium;
- in the case of insurance fraud;
- If the insured person's state of health changes during the period between completing the health questionnaire and taking out the insurance and the applicant or insured person did not report these changes to CONCORDIA in writing immediately.

The contract expires automatically if the insured person moves their civil law place of residence abroad, or moves their habitual place of residence abroad for more than 12 months, once their mandatory health insurance at CONCORDIA Swiss health and accident insurance Ltd ends.

Further grounds for terminating the contract are set out in the General and Additional Insurance Terms and Conditions and the VVG/LCA.

When does the entitlement to benefits end?

The entitlement to benefits (including benefits for earlier or ongoing treatments for illness, accident or maternity, or for dental treatments) expires with the end of insurance or the exclusion of the applicable insurance cover.

What types of documentation are equivalent to the written form?

Other means of documentation in the form of text are deemed to be equivalent to the conventional written form. Exceptions to this principle are listed in the General and Additional Insurance Terms and Conditions.

The following are normally deemed to be equivalent to the written form:

- Text received through CONCORDIA's customer portal;
- Text received through the electronic contact form on CONCORDIA's website (www.concordia.ch) after prior verification of identity. CONCORDIA is not obliged to provide such a contact form;
- Text in signed and scanned pdf documents received by CONCORDIA via e-mail at info@concordia.ch or at the e-mail address listed in the policy;

- Text in e-mails with a qualified electronic signature received by CONCORDIA at info@concordia.ch or at the e-mail address listed in the policy.

For what purpose does CONCORDIA process data?

- **Conclusion and processing of the insurance contract (incl. issuing a quote):** The data are processed for the purpose of creating a quote as well as concluding and processing the insurance contract. In particular, this includes the following purposes: Processing requests; benefit processing; compliance with legal, regulatory and internal provisions; commission settlement; data maintenance; statistical analysis; review of applications and underwriting as well as clarification of a breach of duty to notify (VVG/LCA); customer information; customer correspondence; debt collection and disbursement; customer advisory; insurance card; clarification of insurance requirement; discount review; combating insurance fraud. The data can be stored physically or electronically.
- **Security:** The data are processed to guarantee information security. In particular, this can include the following purposes: Monitoring and documenting the systems and networks of CONCORDIA, ensuring operations, fault management, testing, back-up management.
- **Marketing:** The data are used for the marketing purposes of CONCORDIA. In particular, the affected persons can be contacted once a year by letter and by phone from employees of CONCORDIA Insurances Ltd or through a partner centre. Other marketing activities may include: Determining customer satisfaction and customer needs, market research and provision of tailored services. Consent for the future can be withdrawn at any time. The legality of data processing that is conducted between the time of consent and the withdrawal of consent is not affected by this.

Does CONCORDIA exchange data with third parties?

Under certain circumstances, data can be obtained through third parties (e.g. hospitals, medical experts, other insurers, authorities). The data in these cases relate to insured persons (e.g. name, address, contact data, insurance products) or their health (e.g. invoices, medical reports, statements of benefits). Within the scope of legal and contractual obligations, data can be disclosed to recipients. Depending on the individual case, this relates to the following categories of recipients: Service providers that support CONCORDIA in fulfilling processing purposes (e.g. IT service providers, printing companies, partner centres), authorities, other insurers, reinsurers, external experts, third parties involved in legal disputes as well as other companies of the CONCORDIA Group.

The data may be transferred to the representative office of CONCORDIA in Liechtenstein. The Federal Council has established that the law in Liechtenstein provides adequate protection in accordance with Art. 16 para. 2 of the Federal act on data protection (DSG/LPD/FADP).

Who is responsible for data processing?

CONCORDIA Insurances Ltd, Bundesplatz 15, 6002 Lucerne, is responsible for data processing. Insured persons have the right to request the information stipulated by law from CONCORDIA on the data processed about them. The company data protection officer can be contacted at the following: CONCORDIA, Data Protection, Bundesplatz 15, 6002 Lucerne, info@concordia.ch or +41 41 228 01 11.

You can find comprehensive information on this in the privacy policy at www.concordia.ch/dataprotection.

Supplementary Care Insurances

General Insurance Terms and Conditions

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I. General Information

1 Basis of the Contract

- 1.1 The following constitute the legal basis of the contract:
 - 1.1.1 The General Insurance Terms and Conditions, the Additional Insurance Terms and Conditions, any Special Insurance Terms and Conditions and the provisions in the policy and any addenda.
 - 1.1.2 The written statements made by the policyholder (applicant) and the insured persons (persons to be insured) in the application, the report of the examining doctor and further documents.
- 1.2 Differing provisions in the Additional or Special Insurance Terms and Conditions take precedence over these General Insurance Terms and Conditions. For insured persons who have a special form of mandatory health insurance (such as the HMO or family doctor models) in accordance with Art. 62 of the Swiss federal law on health insurance (KVG/LAMal), the corresponding Special Insurance Terms and Conditions also apply.
- 1.3 If a set of circumstances is not expressly regulated in these documents, the Swiss federal law on insurance contracts (VVG/LCA) of 2 April 1908 applies.

2 Insurance Provider, Insured Persons

- 2.1 The insurance provider in the sense of the following provisions is CONCORDIA Insurances Ltd, Lucerne, hereinafter referred to as CONCORDIA.
- 2.2 Persons insured are the persons listed in the policy.

3 Application

- 3.1 In order to be admitted into the insurance or to adjust the insurance cover, applicants must complete the designated application form truthfully and in full and submit it to the insurance provider. The same applies to any additional information that may be requested. The decision may be made subject to the outcome of a medical examination.
- 3.2 A newborn child may be insured from the day of birth if the application has reached the insurance provider prior to the birth.
- 3.3 If, in answering questions in the application form, the applicant or insured person conceals or inaccurately communicates a significant fact of which they were aware or should have been aware, in particular concerning illnesses or consequences of accidents that existed at the time of the application or existed in the past, the insurance provider is entitled to cancel the contract in writing within four weeks of learning about the breach of the duty to notify. The cancellation takes effect when it is received by the policyholder.
- 3.4 If, after answering the questions and before the conclusion of the insurance, there are any changes in the insured person's state of health, the applicant or the insured person must notify

the insurance provider promptly in writing and correct their responses to the questions. If this duty of notification is breached, the insurance provider is entitled to cancel the contract in writing within four weeks of becoming aware of the breach. The cancellation takes effect when it is received by the policyholder.

II. Scope of Insurance

4 Object of Insurance

- 4.1 The insurance provider grants insurance cover for the financial consequences of illness, maternity and accident in addition to mandatory health insurance according to the KVG/LAMal and accident insurance according to the Swiss federal law on accident insurance (UVG/LAA/LAINF). Benefits are paid subsequent to the benefits of these mandatory insurances.
- 4.2 Details of the different insurance plans are regulated in the Additional Insurance Terms and Conditions.

5 Admission into the Insurances

- 5.1 The insurance provider is entitled to apply a pre-existing condition exclusion to particular illnesses or consequences of accidents or to decline to provide insurance completely.
- 5.2 No pre-existing condition exclusion is applied to the admission of children if the application is submitted before the child's birth. Differing provisions in the Additional Insurance Terms and Conditions remain reserved.

6 Geographical Area of Validity

- 6.1 The insurances are valid worldwide.
- 6.2 Benefits are paid outside Switzerland if this is provided for in the Additional Insurance Terms and Conditions.
- 6.3 If the insurances are continued abroad in accordance with Art. 16.4 or 16.5, it is not possible to conclude a new supplementary care insurance or to increase the insurance cover.

III. Definitions

7 Written Form, Types of Documentation Equivalent to the Written Form

In principle, other means of documentation in the form of text are deemed to be equivalent to the conventional written form. The insurance provider may stipulate requirements on its website (www.concordia.ch) and in the customer information in accordance with Art. 3 VVG/LCA for the other forms to be accepted as equivalent to the written form. Mandatory statutory provisions and related court rulings remain

reserved. The use of other forms of text may be associated with increased data protection risks. The insurance provider is not liable for actions that are the policyholder's own responsibility.

8 Illness, Maternity

8.1 An illness is defined as any medically ascertainable involuntary physical or mental health disorder necessitating medical treatment, which cannot be attributed to an accident or accident-like bodily injuries as per the definition in mandatory accident insurance.

8.2 Pregnancy and childbirth are deemed equivalent to illness provided that the mother has been insured for at least one year before childbirth.

9 Accident

An accident is defined as the sudden, involuntary damaging effect of an unusual external factor on the human body as well as accident-like bodily injuries as per the definition in mandatory accident insurance.

10 Healthcare Providers

Healthcare providers, in the sense of the contract, are considered to be persons, institutions and facilities that are licensed to practise within mandatory health insurance according to Art. 35 ff. KVG/LAMal or mandatory accident insurance according to Art. 53 UVG/LAA/LAINF, and that meet the conditions laid down in such legislation.

11 Insurance Period

The insurance period is the calendar year.

IV. Start and End of Insurance

12 Start of Insurance Cover

The insurances may be taken out from the first day of each month. Insurance cover begins as soon as the insurance provider has accepted the application in writing, however no earlier than the start date of insurance indicated in the application or policy.

13 Cooling-off Period

The policyholder may withdraw their application for or acceptance of the contract in writing. The cooling-off period is 14 days from the date on which the policyholder applies for or accepts the contract.

14 Contract Term

14.1 The contract is concluded for the fixed contract term stated in the policy. It is tacitly renewed for one year at a time unless the policyholder has cancelled the contract at the end of its term.

14.2 If no fixed contract term is stipulated in the policy, the insurances are taken out for the lifetime of the insured person.

15 Replacement Policy

If a policy is replaced, previously drawn benefits that are subject to contractual restrictions with regard to amount or duration are taken into account when calculating future benefits.

16 End of Insurance

The insurances expire:

16.1 upon death of the insured person;

16.2 upon cancellation;

16.3 upon withdrawal of the policyholder or the insurance provider (Art. 22.2);

16.4 upon transfer abroad of the place of residence according to civil law, once mandatory health insurance at CONCORDIA Swiss health and accident insurance Ltd ends;

16.5 upon transfer abroad of the place of habitual residence for more than twelve months, once mandatory health insurance at CONCORDIA Swiss health and accident insurance Ltd ends.

The suspension of the insurances remains reserved.

17 Cancellation

17.1 The policyholder may cancel the insurances:

– in the case of contracts with a fixed term: at the end of the contract term, subject to a three-month notice period;

– in the case of insurances taken out for life: after a minimum contract term of one year at the end of each insurance period, subject to a three-month notice period. The Additional Insurance Terms and Conditions or the policy may provide for a longer minimum term of a maximum of three years for particular insurances;

– if premium tariffs or cost-sharing regulations are adjusted (Art. 24);

– if the insurance terms and conditions are adjusted (Art. 42);

– after each insurance case for which the insurance provider has furnished benefits, but no later than 14 days after the policyholder is informed of the payout;

– at any time for cause within the meaning of Art. 35b VVG/LCA.

17.2 Notice of cancellation must be given in writing. The notice of cancellation is considered to have been given on time if it reaches CONCORDIA no later than the last day prior to the start of the notice period.

17.3 The insurance provider does not have a right of cancellation, including in the event of a claim. The insurance provider's right of cancellation remains reserved in the event of breaches of notification duties or attempted or accomplished insurance fraud.

18 Expiry of Entitlement to Benefits
Entitlement to benefits (including benefits for previous or ongoing treatment of illnesses and accidents or dental treatment) expires at the end of the insurance or when corresponding insurance coverage is excluded from the contract, subject to any periodic benefit obligations within the meaning of Art. 35c VVG/LCA.

19 Suspension

- 19.1 A suspension of the insurances with a premium reduction may be granted for a maximum of 2 years during a stay or period of residence abroad, provided the insured person is not subject to mandatory health insurance in Switzerland.
- 19.2 The request for suspension must be submitted to CONCORDIA in writing before leaving Switzerland, enclosing all required documents (e.g. official confirmation of departure). It is entirely at CONCORDIA's discretion whether or not to grant a suspension.
- 19.3 There is no entitlement to insurance benefits during a suspension. Increases in the insurance cover are not possible for the duration of a suspension.
- 19.4 There is no insurance cover – either during or after a suspension – for the financial consequences of a risk (illness, accident or maternity) that occurs while a suspension is in effect.
- 19.5 The suspension ends when the reason for the suspension ceases to apply (e.g. returning to Switzerland and the Swiss mandatory health insurance coming back into force) or the two-year period has expired. The policyholder or insured person is obliged to notify CONCORDIA.

V. Premiums and Cost Sharing

20 Premium Tariff

- 20.1 Premiums are calculated per insurance period (Art. 11) and incorporated into the premium tariff.
- 20.2 The premium tariff may provide for a grading of the premiums according to the age, gender, profession, activity or place of residence according to Swiss civil law of the insured person or the domicile of the policyholder. If changes occur in the profession, activity or place of residence according to Swiss civil law of the insured person or the domicile of the policyholder, the insurance provider must be notified of these immediately in writing. Premiums may be adjusted with effect from the date of the change.
- 20.3 The relevant age classes are as follows:
– 0-15 years of age
– Thereafter age classes in 5-year increments
– Up to the final age class of 61 years of age and above. The premium increases upon reaching a higher age class. Differing age classes in the Additional Insurance Terms and Conditions remain reserved.

21 Due Date, Payment of Premiums

- 21.1 The annual premium is payable in advance. It is due on 1 January of each year or, in the event that insurance starts during the course of the year, upon delivery of the invoice for the remainder of a year.
- 21.2 The annual premium may also be paid in instalments against a surcharge. The instalments must also be paid in advance.
- 21.3 If the policyholder has taken out several insurances (including mandatory health insurance), they must choose one standard mode of payment.
- 21.4 If payment by instalments is chosen, the instalments that fall due in the course of the year are considered as only deferred.
- 21.5 If the policyholder is in arrears with the payment of an instalment, the remainder of the premium for the current insurance period immediately becomes due.

22 Reminder, Payment Default

- 22.1 If the premium is not paid by the due date, the policyholder is requested in writing, with reference made to the consequences of defaulting on payments, to pay the outstanding premiums within 14 days of the reminder being sent. If this reminder remains unsuccessful, the duty to provide benefits is suspended as from the end of the reminder period.
- 22.2 If legal action is not taken to recover the outstanding premium within two months of the end of the reminder period in accordance with Art. 22.1, it is assumed that the insurance provider, by waiving payment of the outstanding premium, is withdrawing from the contract.
- 22.3 If the premium is recovered by legal action, or the insurance provider accepts a payment of arrears, the duty to provide benefits resumes from the date on which the outstanding premium, along with interest and costs, is paid. The insurance provider is not liable to provide benefits for insurance cases that occur during the duration of the default and after the reminder period is over.

23 Reimbursement of Premiums

- 23.1 If the insurance is revoked for legal or contractual reasons before the expiration of the stipulated insurance period, the insurance provider reimburses the premiums paid for the insurance period that has not yet taken effect or waives the payment of instalments due later.
- 23.2 These regulations do not apply if the policyholder cancels the contract following an insurance case that occurs before the expiration of the first insurance year.

24 Adjustment of the Premium Tariff

If the premium tariffs or cost-sharing regulations are modified, the insurance provider may require the insurance to be adjusted from the first day of

the forthcoming insurance period. The insurance provider is required to notify the policyholder in writing of the new contract terms and conditions no later than 25 days before they enter into force. The policyholder then has the right to cancel the insurance with effect from the end of the current insurance period. If they exercise this right, the insurance expires at the end of the current insurance period. The notice of cancellation must reach the insurance provider no later than the last day of the current insurance period. If the policyholder does not cancel the insurance, they are deemed to have consented to the adjustment of the insurance.

25 Modification of the Premium Grading

25.1 If a change in age, profession, activity, place of residence according to Swiss civil law of the insured person or domicile of the policyholder leads to a reclassification within the premium grading, the insurance provider may adjust the premiums accordingly with effect from the time of the change.

25.2 No grounds for cancellation in the sense of Art. 24 exist other than when premiums are modified due to an age-related modification to the premium grading.

26 Repayment of Cost Sharing

26.1 In the event that direct payments are made to healthcare providers, the policyholder is obliged to refund the stipulated deductibles and retention fees to the insurance provider within 30 days of issue of the bill.

26.2 If the policyholder does not comply with their duty to pay, Art. 22 applies by analogy.

VI. Duties and Proof of Entitlement

27 Duty to Seek Medical Treatment, Duty to Give Information

27.1 If an illness or accident is likely to lead to the insured person receiving benefits, they must arrange for professional medical treatment as soon as possible. The insured person is obligated to comply with the instructions of the doctor or other healthcare providers.

27.2 The insurance provider is entitled to obtain additional documentary proof and information, in particular doctor's certificates, from healthcare providers. Furthermore, the policyholder or insured person must provide complete and truthful information on all matters relating to the claim as well as to past illnesses and accidents, and releases the healthcare providers that are providing or have provided treatment from the professional duty of confidentiality with regard to the insurance provider.

27.3 Moreover, the insured person is obligated to undergo an examination performed by doctors appointed by the insurance provider on request.

28 Duty to Notify in Case of Outpatient Treatment

In the event of outpatient treatment, the detailed invoices and receipts must be sent in at least once a year and in any case at the end of the treatment. The insurance provider may request the original documents.

29 Duty to Notify in Case of Inpatient Treatment

29.1 Notification of admission into a hospital must be given without delay, no later than five days after admission.

29.2 A guarantee of payment is issued upon admission into a hospital at the request of the healthcare provider or the insured person.

30 Duty to Notify in Case of Cures

The doctor's prescription for a cure at a spa/sanatorium must be submitted in a timely manner before the cure begins, indicating the name of the health spa/sanatorium and the date the cure begins.

31 Proof of Entitlement

31.1 When the entitlement to benefits is asserted by the insured person, all doctor's certificates, reports, documentary proof and bills issued by healthcare providers must be submitted. The insurance provider may request the original documents.

31.2 If other social or private insurance providers (e.g. disability insurance, military insurance, other health and accident insurances), in addition to the insurance provider, are liable to provide benefits for an illness or for the consequences of an accident, the statements of account of these insurance providers must also be submitted, in addition to the documents mentioned.

31.3 The policyholder or the insured person must inform the insurance provider about the nature and amount of all benefits due to illness or accident that will be paid out to them or that they can claim against a third party by virtue of tort, contract or the law.

31.4 The insurance provider's benefits under the insurance contract lapse five years after the occurrence of the event that gives rise to the benefit obligation.

VII. Limitations on Insurance Cover

32 Exclusion from Benefits

32.1 Illnesses and accidents, as well as the complications and long-term effects of these, arising in connection with the following events, are excluded from insurance cover:

– The consequences of war-like incidents in Switzerland or abroad. However, if the insured person is caught unaware by the outbreak of

such events in the country in which they are staying, the insurance cover does not lapse until 14 days after their initial occurrence;

- Military service abroad;
- Participation in acts of war or terrorism;
- Participation in unrest, demonstrations or similar events;
- Crimes and offences committed deliberately or through gross negligence;
- Participation in brawls and fights, unless the insured person has been injured as a bystander or while coming to the aid of a defenceless person;
- Dangers to which the insured person exposes themselves by severe provocation of others;
- The effects of ionising radiation and damage caused by nuclear energy;
- The consumption of drugs, narcotics and other addictive substances as well as the abuse of alcohol and pharmaceuticals;
- Attempted or accomplished suicide or self-inflicted injury.

The above grounds for exclusion also apply if they are only partly responsible for an illness or accident.

32.2 Furthermore, no benefits are provided for the following:

- Treatment of obesity (including complications and long-term effects);
- Treatments (including complications and long-term effects) whose effectiveness, appropriateness and cost effectiveness has not been demonstrated by scientific methods;
- Artificial insemination and sterility treatments (including complications and long-term effects);
- Cosmetic treatments (including complications and long-term effects);
- Gender affirmation surgery (including complications and long-term effects);
- Cost sharing (deductibles and retention fees) in mandatory health insurance and other insurances.

33 Reduction of Benefits

The insured benefits are reduced or, in particularly serious cases, denied:

- if the policyholder or insured person does not fulfil their obligations and responsibilities, unless they can prove that the breach of duty occurred through no fault of their own, or the breach had no impact on the occurrence of the insured event and the scope of benefits payable by the insurance provider;
- in the event that the insured event is caused by the gross negligence of the policyholder or insured person;
- in the event of accidents resulting from reckless ventures. Reckless ventures are acts where the

insured person exposes themselves to a particularly great danger without taking or being able to take precautions that limit the risk to a reasonable degree. However, attempts to rescue other persons are insured, even if they may be regarded as reckless ventures in themselves.

34 Third-Party Benefits, Secondary Liability

34.1 Benefits from supplementary care insurance are provided subsequent to those under the Swiss federal legislation on health, accident, military and disability insurance and to those of corresponding foreign insurance schemes. If the insured person is entitled to benefits from the social insurances mentioned above, benefits from supplementary care insurance are only paid out if these insurance providers were notified of the case in a timely manner.

34.2 If private insurance contracts are held with a number of insurance providers that are liable to provide benefits, the benefits are provided only once in total. In this case, it is determined how much each insurance provider would have to pay out of its particular insurance if it were solely liable to provide benefits, and the total sum of these benefits is then calculated. Each insurance provider must only bear the proportion that corresponds to its share of the total sum.

34.3 If third parties or their liability insurance providers are liable to provide benefits for the consequences of illness and accident, CONCORDIA only grants benefits when these have provided their benefits and only to the extent that, in consideration of these benefits, no profit accrues for the insured person. Advance benefits in accordance with Art. 35 remain reserved.

34.4 If another insurance provider reduces or denies its benefits on grounds which, in accordance with Art. 33, entitle the insurance provider to reduce its benefits, the loss resulting from the reduction in benefits of the other insurance provider is not replaced.

35 Advance Benefits and Recourse

35.1 The insurance provider may provide benefits in advance on condition that the insured person assigns their claims against third parties liable to provide benefits to the insurance provider, up to the amount of the benefits it has paid, and on condition that the insured person undertakes not to do anything that would prevent the insurance provider from asserting a possible right of recourse.

35.2 The duty to provide benefits ceases if the insured person, without the consent of the insurance provider, makes any agreement with a third party liable to provide benefits under which the insured person waives insurance benefits or compensation for damage in part or in full or receives a lump-sum settlement.

VIII. Miscellaneous Provisions

36 Duty to Pay

In principle, the insured person is the debtor of fees with regard to the healthcare providers. However, the policyholder or insured person accepts contracts made to the contrary between the insurance provider and the healthcare providers, which provide for direct payments to be made to the healthcare providers.

37 Fee Agreements and Tariffs

Fee agreements made between the insured person and the healthcare provider are not binding on the insurance provider. Entitlement to benefits exists only within the framework of the tariffs recognised by the insurance provider.

38 Place of Performance and Place of Jurisdiction

38.1 The obligations arising from the contract shall be fulfilled in Switzerland and in Swiss currency.

38.2 In the event of disputes arising from the contract, the policyholder or insured person may choose either Lucerne or their Swiss place of residence as the place of jurisdiction at their discretion.

39 Notifications

39.1 All notifications may be directed in legally valid form to the head office of CONCORDIA or the agency designated in the policy.

39.2 If the supplementary insurances of CONCORDIA are provided by another insurance provider, the notifications and announcements directed to that insurance provider have the same validity as if they were directed to CONCORDIA.

39.3 Notifications from the insurance provider are legally valid when sent to the policyholder's last given address in Switzerland.

39.4 Notifications may also be sent electronically. The insurance provider may stipulate requirements on its website (www.concordia.ch) and in the customer information in accordance with Art. 3 VVG/LCA for electronic forms of notification to be deemed to have been delivered in a legally valid manner. Mandatory statutory provisions and related court rulings remain reserved.

40 Special Agreements

The insurance provider is only bound by agreements extraneous to these provisions if they have been confirmed in writing by its head office.

41 Offsetting, Assignment, Pledging and Reimbursement

41.1 The policyholder or insured person is not entitled to offset outstanding premiums owed to the insurance provider against benefit entitlements.

41.2 The entitlement to insured benefits may neither be assigned nor pledged without the express consent of the insurance provider.

41.3 Benefits that are wrongly drawn by the insured person shall be reimbursed to the insurance provider.

42 Adjustment of the Insurance Terms and Conditions

42.1 The insurance provider is entitled to adjust the insurance terms and conditions, in particular in case of:

42.1.1 An increase in the number of healthcare providers or the establishment of new types of providers;

42.1.2 Developments in modern medicine;

42.1.3 The establishment of new or cost-intensive forms of therapy (medicines, types of operations, diagnostic techniques, etc.);

42.1.4 Changes to the benefit provisions of the KVG/LAMal or its implementing enactments.

42.2 If the insurance terms and conditions are adjusted for such reasons, the new terms and conditions apply to the policyholder, the insured person and the insurance provider. The insurance provider will notify the policyholder of the modifications in writing no later than 25 days before they enter into force. The policyholder then has the right to cancel the insurance with effect from the end of the current insurance period. If they exercise this right, the insurance expires at the end of the current insurance period. The notice of cancellation must reach the insurance provider no later than the last day of the current insurance period. If the policyholder does not cancel the insurance, they are deemed to have consented to the adjustment of the insurance.

43 Grandfathering Provisions for the Amendments from 1 January 2022

43.1 If the amendments to the General or Additional Insurance Terms and Conditions (GITC/AITC) from 1 January 2022 are disadvantageous for the insured person, the provisions of the GITC or AITC applicable up to 31 December 2021 will apply to supplementary care insurances concluded before 2022. Otherwise the new General or Additional Insurance Terms and Conditions apply.

43.2 The grandfathering provisions apply to the following areas in particular:

– Cross-border commuters (Art. 6.3 GITC, 2007 edition; Art. 25.2 DIVERSA AITC, 2017 ed.)

– Private tariffs (Art. 36.2 GITC, 2007 ed.)

– Medical aids (Art. 16 DIVERSA AITC, 2017 ed.)

– Spa treatments (Art. 5 DIVERSA AITC, 2017 ed.; Art. 10 Hospital Insurance AITC, 2010 ed.; Art. 13 LIBERO Hospital Insurance AITC, 2007 ed.)

– Right to choose during a hospital stay (Art. 7.2 LIBERO Hospital Insurance AITC, 2007 ed.)

– Treatment by relatives and persons living in the same household (newly inserted sentence 3 in Art. 6 NATURA AITC, 2022 ed., does not apply)

44 Application of the Revised Federal Law on Insurance Contracts effective 1 January 2022

For supplementary care insurances concluded before 2022, the transitional provisions of Art. 103a of the revised Swiss federal law on insurance contracts (VVG/LCA) of 2 April 1908 entered into force on 1 January 2022 apply.

If there are differences in content between the English and the German, French or Italian Insurance Terms and Conditions, the Insurance Terms and Conditions in the language in which the policy is written apply.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these General Insurance Terms and Conditions:

VVG/LCA

VVG: Bundesgesetz über den Versicherungsvertrag
LCA: Loi fédérale sur le contrat d'assurance
LCA: Legge federale sul contratto d'assicurazione
Swiss federal law on insurance contracts

KVG/LAMal

KVG: Bundesgesetz über die Krankenversicherung
LAMal: Loi fédérale sur l'assurance-maladie
LAMal: Legge federale sull'assicurazione malattie
Swiss federal law on health insurance

UVG/LAA/LAINF

UVG: Bundesgesetz über die Unfallversicherung
LAA: Loi fédérale sur l'assurance-accidents
LAINF: Legge federale sull'assicurazione contro gli infortuni
Swiss federal law on accident insurance



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